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VIRGINIA PIONEERS MENTAL HEALTH TRANSPORTATION ALTERNATIVE FOR CHILDREN UNDER TEMPORARY DETENTION ORDER

*Snapper Tams and Tori Zicker**

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ABSTRACT

Children in Virginia who are experiencing a mental health crisis have traditionally been shackled while they are transported to a mental health facility for treatment. Such shackling is traumatizing for children and detrimental to their cognitive and emotional development. Shackling has been required by law enforcement personnel, the default providers of mental health transportation. However, alternative transportation options to law enforcement exist and are actively being explored in Virginia in order to de-stigmatize mental health crises and minimize trauma caused by the transportation process. The Virginia Department of Behavioral Health and Developmental Services funded a pilot program in southwestern Virginia that allowed many adults experiencing mental health crisis to be diverted from law enforcement to a third party for transportation. The program was so successful that the Virginia Department of Criminal Justice Services established an alternative transportation workgroup to analyze the efficacy of adopting a statewide program. The workgroup adopted recommendations based on the pilot program, explored potential alternative service providers, and expanded their program to be child-inclusive. The General Assembly has adopted a three-year phased implementation of this proposal to allow for continual evaluation and assessment. This alternative transportation program is critical to ensuring better long-term care for children in crisis, as it represents a critical step away from the criminalization of juveniles and mental health issues to the rehabilitation of children and a treatment-focused approach to mental health.

INTRODUCTION

Mental health crises are not unique to adults. The Center for Disease Control and Prevention estimates that 13-20% of children nationwide experience a mental health disorder in any given year.¹ In Virginia, an estimated “117,592 to 143,724 children and adolescents have a serious emotional disturbance,” more than half of whom exhibit extreme impairment.² When a

¹Ruth Perou et al., *Mental Health Surveillance Among Children – United States, 2005–2011*, CTRES. FOR DISEASE CONTROL & PREVENTION (May 17, 2013), <https://www.cdc.gov/mmwr/preview/mmwrhtml/su6202a1.htm> (“Mental health disorders among children are described as ‘serious deviations from expected cognitive, social, and emotional development.’”).

²VA. DEP’T OF BEHAVIORAL HEALTH & DEV. SERVS., COMPREHENSIVE STATE PLAN 2014-2020, at ii, app. B 3–4 (Dec. 2013), <http://www.dbhds.virginia.gov/library/quality%20risk%20management/opd->

child is suffering from a mental health crisis in Virginia, a magistrate may issue a Temporary Detention Order (TDO), requiring that the child be held involuntarily at a mental health facility for treatment.³ Typically, evaluation for a TDO and treatment under a TDO occur at different locations.⁴ When treatment is deemed necessary, the child is transported to the treating facility by law enforcement personnel in a marked law enforcement vehicle while restrained in two or four-point shackles.⁵ Because it is standard law enforcement practice to restrain any detainee transported to ensure the safety of the officers, shackles are applied to all children requiring TDO transport, regardless of whether there is any indication that they pose a risk of flight or harm to themselves or others.⁶

While children experiencing a mental health crisis may at times pose a risk to themselves or others, violent or physically harmful incidents are uncommon, and these children rarely pose a flight risk.⁷ Other, less invasive methods of transportation can better protect the child from hurting themselves or others, minimizing the infliction of further trauma. Additionally, this reliance on law enforcement personnel to facilitate TDO transportation burdens local police and sheriff departments, unnecessarily consuming limited resources. More importantly, indiscriminate shackling is detrimental to a trauma-informed treatment model for children and only criminalizes and further stigmatizes the mental health crisis.

In 2018, the Virginia General Assembly responded to an ongoing call for improved mental health resources throughout the Commonwealth by allocating \$7 million to fund a three-year phased implementation of a mental health transportation system.⁸ The model—an alternative to the existing practice, which relies on law enforcement personnel as the primary providers of TDO transportation—utilizes family members, Community Services Board (CSB) representatives, and private providers with specialized training in mental health support to transport individuals in need of immediate

stateplan2014thru2020.pdf (“Serious Emotional Disturbance means a serious mental health problem that affects a child...and can be diagnosed under *DSM-IV-TR* or meets specific functional criteria.”).

³ See VA. CODE § 37.2-809(D) (2018).

⁴ *Id.* § 37.2-808(B).

⁵ VA. DEP’T OF BEHAVIORAL HEALTH AND DEV. SERVS., ALTERNATIVE TRANSPORTATION WORKGROUP FINAL REPORT: HB 1436 (Garrett)/SB 1221 (Barker) 8 (Oct. 1, 2017), <https://rga.lis.virginia.gov/Published/2017/RD337/PDF> [hereinafter VDBHDS].

⁶ *Id.*

⁷ *Id.* at 8–9 (noting that, from January 1, 2106 to March 13, 2017 there were 1159 TDO transports. Of these, only 303 were reported as instances of a high safety risk to harm self and others, or risk of elopement.).

⁸ Creigh Deeds, *State Budget Addresses Mental Health Reform - But the Work Goes On*, RICH. TIMES-DISPATCH (June 30, 2018), https://www.richmond.com/opinion/their-opinion/guest-columnists/creigh-deeds-column-state-budget-addresses-mental-health-reform-/article_04e171b3-7f8e-5e5b-9751-6a2ec66e7d17.html.

mental health care.⁹ While a separate Virginia alternative transportation pilot program for adults was successful in 2015, this is the first private, non-law enforcement mental health transportation system for children in the country.¹⁰

I. BACKGROUND

Shackling children who are experiencing a mental health crisis is more harmful than it is beneficial. The current default use of law enforcement personnel and physical restraints in the TDO process is traumatic, expensive, and unnecessary. Reliance on law enforcement—rather than a dedicated mental health transportation alternative—consumes scarce resources, which is particularly burdensome on police and sheriff departments in rural regions. Most importantly, the TDO process is intended to aid those in crisis. However, with no alternative transportation options, the TDO process often criminalizes mental health issues, inhibiting rehabilitation efforts and exacerbating the traumatic episode it was intended to remedy.

A. The TDO Process

A Temporary Detention Order legally requires an individual to be involuntarily admitted to a treatment facility for evaluation and stabilization.¹¹ TDOs are issued to individuals—adults and children alike—who are experiencing a mental health crisis.¹² For TDO purposes, a mental health crisis “include[s], but is not limited to: suicidal or homicidal thinking and/or behavior, acute psychotic symptoms, increased drug or alcohol use, and sudden changes in mental status.”¹³

The TDO process in Virginia begins with an Emergency Custody Order (ECO).¹⁴ A magistrate will issue an ECO if there is probable cause to be-

⁹ VDBHDS, *supra* note 5, at 4.

¹⁰ *Id.* at 8; Ashley Everette, *Support a Statewide Alternative Transportation System for Children and Adults in Mental Health Crisis*, VOICES FOR VA.’S CHILD. BLOG (Feb. 9, 2018), <https://vakids.org/our-news/blog/support-a-statewide-alternative-transportation-system-for-children-and-adults-in-mental-health-crisis> (noting that Virginia may be at the forefront of implementing an alternative transportation system for children).

¹¹ NAT’L ALL. ON MENTAL ILLNESS, GUIDE TO PSYCHIATRIC CRISIS AND CIVIL COMMITMENT PROCESS IN VIRGINIA 2 (2016), <https://namivirginia.org/wp-content/uploads/sites/127/2016/03/GuidetoPsychiatricCrisisandCivilCommitmentProcessforWebsite-justlawscriteria2016.pdf>.

¹² *See id.* at 6.

¹³ *Id.* at 1.

¹⁴ VA. CODE. § 37.2-809(D) (2018) (noting an exception when an individual was examined by a Community Services Board evaluator within the previous seventy-two hours, and there is significant physical, psychological, or medical risk to the person if another evaluation were to take place. In this instance,

lieve that the person (1) has a mental illness and there is a substantial likelihood that the person will cause serious physical harm to himself or others, or will suffer serious harm, (2) is in need of hospitalization or treatments, and (3) is unwilling to accept or incapable of volunteering to go to treatment.¹⁵ If a magistrate issues an ECO, a law enforcement officer will take the individual into custody for further psychiatric evaluation, which typically occurs at a hospital.¹⁶ Only law enforcement officers participate in the ECO transport to the evaluation site unless the magistrate expressly authorizes and requests that another party complete the transport.¹⁷

A clinician who is trained in diagnosing and treating mental illness and is designated by the local CSB will complete an evaluation within eight hours of the issuance of the ECO and may recommend involuntary psychiatric admission based on criteria set forth in the Code of Virginia.¹⁸ Based on this evaluator's assessment, a magistrate will issue a TDO if it appears that the individual:

- i. has a mental illness and there is a substantial likelihood that, as a result of mental illness, the person will, in the near future,
 - a. cause serious physical harm to himself or others as evidenced by recent behavior causing, attempting, or threatening harm and other relevant information, if any, or
 - b. suffer serious harm due to his lack of capacity to protect himself from harm or to provide for his basic human needs;
- ii. is in need of hospitalization or treatment; and
- iii. is unwilling to volunteer or incapable of volunteering for hospitalization or treatment.¹⁹

A magistrate is not limited to the clinician's recommendation based on these criteria and may also consider the individual's past behavior, previous mental health treatment, medical records, or even hearsay evidence when determining whether to issue a TDO.²⁰ The ECO will expire if a TDO is not executed within twenty-four hours of the issuance of the ECO.²¹

When the magistrate does issue a TDO, the local CSB will identify a treatment facility with availability.²² Sometimes the nearest facility will not have any beds available for a new intake or may choose to deny the invol-

the magistrate may issue a TDO without first issuing an ECO).

¹⁵ *Id.* § 37.2-808(A).

¹⁶ *See* NAT'L ALL. ON MENTAL ILLNESS, *supra* note 11, at 5.

¹⁷ VA. CODE § 37.2-808(C) (2018).

¹⁸ *Id.* § 37.2-808(B); NAT'L ALL. ON MENTAL ILLNESS, *supra* note 11, at 5.

¹⁹ VA. CODE § 37.2-809(B) (2018).

²⁰ *Id.* § 37.2-809(C).

²¹ *Id.* § 37.2-809(I).

²² *Id.* § 37.2-809(E).

untary admission.²³ Moreover, some facilities may have more beds than their on-duty staff members can cover, forcing these facilities to deny requests they might otherwise be able to approve.²⁴ The only public treatment facility with a child psychiatric unit is located in Staunton, Virginia. It has forty-eight beds and, unlike private facilities, can only deny involuntary admissions if it lacks available bed space.²⁵ Similarly, while private facilities are permitted to deny requests for involuntary admission regardless of their availability, they are prohibited from doing so if no other facility is able to accept the involuntary admission.²⁶ However, given these constraints, finding a facility that will admit a child under a TDO can be difficult, and it may require that the child travel a significant distance from the evaluation center to the treatment center.

Once a treatment facility has granted involuntary admission under TDO, the magistrate arranges transportation by either specifying which law enforcement agency will execute the order, or, if requested, considering an alternate provider.²⁷ If the magistrate designates a law enforcement department for transportation, the officer(s) will apply shackles to physically restrain the child per law enforcement protocol for transporting detainees.²⁸

B. Shackles Generally

Shackles are tools, typically iron or metal handcuffs and sometimes hard plastic straps (such as zip ties), that are commonly used to physically restrain an individual.²⁹ Law enforcement personnel use shackles when transporting criminal defendants or convicted inmates who either pose a flight risk or may be a danger to themselves, the officers, or others.³⁰ They are intended to restrict the individual's ability to move freely. Shackles can be applied either at two-points (both hands or both feet restrained together) or four-points (two sets of two-point shackles connected together with a metal

²³ Telephone interview with John Oliver, Univ. of Va. Inst. for Law, Psychiatry, and Pub. Policy (Dec. 4, 2017) [hereinafter Oliver Interview].

²⁴ *Id.*

²⁵ *Id.*

²⁶ VA. CODE § 37.2-809.1(B) (2018).

²⁷ *Id.* § 37.2-810(B) (stating that an alternative transportation provider “may be a person, facility, or agency, including a family member or friend of the person who is the subject of the temporary detention order, a representative of the [CSB], or other transportation provider with personnel trained to provide transportation in a safe manner”).

²⁸ *See Id.* § 37.2-810; Sandy Hausman, *Law Enforcement on the Front Lines of a Mental Health Crisis*, RADIO IQ WTVF (Dec. 6, 2016), <http://www.wvtf.org/post/law-enforcement-front-lines-mental-health-crisis>.

²⁹ *See* Kim M. McLaurin, *Children in Chains: Indiscriminate Shackling of Juveniles*, 38 WASH. U. J.L. & POL'Y 213, 215–16 (2012).

³⁰ *See* VDBHDS, *supra* note 5, at 4.

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chain, further restricting the individual's ability to move).³¹ While "shackling" an inmate or a criminal defendant may be appropriate to protect the transporting officers or to ensure the individual does not flee custody, it is an unnecessarily oppressive technique unless evidence otherwise suggests an increased risk of harm or flight. Shackling an individual who is experiencing a mental health crisis may actually exacerbate the situation, only increasing the likelihood that he or she may pose a threat to self or others.

C. Shackling Children is Especially Problematic

In the 1990s, America witnessed a deep pendulum swing toward the adultification of children—the viewing and treatment of children more as adults than as still developing individuals.³² Judges increasingly sentenced children to more severe punishments that would otherwise be reserved for adults.³³ Political rhetoric was fraught with descriptions of child “super-predators;” kids were perceived as remorseless and violent criminals.³⁴ Beginning in the 2000s, however, the United States Supreme Court took it upon itself to usher in a new trend in criminal justice that influenced the widespread public perception of juveniles.³⁵

Through a string of opinions, the Supreme Court “embraced a developmental model of juvenile crime regulation” that signaled a defiant rejection of the prevailing approach.³⁶ This shift provided fertile ground for a new wave of scientific exploration into childhood development. Research has indicated that adolescence is a period of “significant brain plasticity,” a developmental stage where the child’s brain is profoundly influenced by his or her environment.³⁷ Given that cognitive development is particularly shaped by experience, stressful experiences and negative influences or events can be permanently damaging to teenage children who are only beginning to develop cognitive flexibility and complex reasoning skills.³⁸ As childhood experiences consolidate, the growing teenager establishes a sense of personal identity.³⁹ Leading research in education, mental health, disability

³¹ See McLaurin, *supra* note 29, at 215–16.

³² Elizabeth S. Scott, “*Children Are Different*”: *Constitutional Values and Justice Policy*, 11 OHIO ST. J. CRIM. L. 71, 91 (2013).

³³ See *id.* at 93–94.

³⁴ *Id.* at 91.

³⁵ See *id.* at 97–98.

³⁶ *Id.* at 92.

³⁷ Donald Rosenblitt Aff. ¶ 13, Jan. 6, 2015, <http://njdc.info/wp-content/uploads/2014/09/Rosenblitt-Affidavit-Notarized-CV-Final-1-6-15.pdf> [hereinafter Rosenblitt Aff.].

³⁸ *Id.*; see also Gwen Wurm Aff. ¶ 9, Jan. 7, 2015, <http://njdc.info/wp-content/uploads/2015/01/Gwen-Wurm-full-shackling-affidavit-Jan-2015.pdf> [hereinafter Wurm Aff.].

³⁹ Wurm Aff., *supra* note 38, at ¶ 9.

law, and academic literature stresses the importance of placing children in the “least restrictive” setting possible.⁴⁰ Doing so respects the significant role of identity formation in healthy development.⁴¹ The indiscriminate use of shackles counteracts this understanding.⁴² The current approach is excessively punitive and, given that it can trigger or intensify an ongoing traumatic reaction, can actually make the child and the transporters less safe.⁴³

1. Shackling is Shameful, Humiliating, and Traumatizing

The type of children most likely to have mental health crises have experienced prior trauma including physical and sexual abuse, exposure to domestic violence, bullying (often due to learning disabilities and school failure), and the death of loved ones.⁴⁴ Their untreated trauma is precisely what has prompted their fearfulness and difficulty trusting others and spurred their depression, aggression, and any potential substance abuse that may be used to cope.⁴⁵ Children who have experienced trauma are more susceptible to activations of that trauma through flashbacks.⁴⁶ While shackling itself is not necessarily traumatic in all instances, physical restraints can trigger memories of past traumas and intensify Post Traumatic Stress Disorder (PTSD) symptoms including anxiety, anger, noncompliance, depression, and dissociation.⁴⁷ The use of shackles during TDO transport is likely to evoke painful memories that effectively re-victimize any child who has been physically or sexually abused.⁴⁸ This re-victimization at such a highly sensitive period of a child’s development can cause permanent and significant harm.⁴⁹

Shackling intensifies symptoms of untreated trauma including anger and distrust.⁵⁰ While behaviors of violence or flight are easily identifiable, freezing behavior (dissociation) is more passive but potentially more detrimental given that it prevents the child from talking, listening, or communicating.⁵¹

⁴⁰ *Id.* at ¶ 15.

⁴¹ *Id.*

⁴² *Id.*

⁴³ See Eugene Griffin Aff. ¶ 11, Dec. 12, 2014, <http://njdc.info/wp-content/uploads/2014/09/Griffin-Affidavit-II.pdf> [hereinafter Griffin Aff.].

⁴⁴ Marty Beyer Aff. ¶ 18, Jan. 15, 2015, <http://njdc.info/wp-content/uploads/2014/09/Beyer-Affidavit-w-CV-Jan-2015-Final.pdf> [hereinafter Beyer Aff.].

⁴⁵ *Id.*

⁴⁶ Rosenblitt Aff., *supra* note 37, at ¶ 12.

⁴⁷ Julian Ford Aff. ¶ 13, Dec. 11, 2014, <http://njdc.info/wp-content/uploads/2014/09/Ford-Affidavit-Final-Dec-2014.pdf> [hereinafter Ford Aff.].

⁴⁸ Beyer Aff., *supra* note 44, at ¶ 18.

⁴⁹ See Rosenblitt Aff., *supra* note 37, at ¶ 13.

⁵⁰ Beyer Aff., *supra* note 44, at ¶ 19.

⁵¹ Griffin Aff., *supra* note 43, at ¶ 19.

Any of these classic traumatic responses can inhibit treatment efforts aimed at the very stabilization and rehabilitation that the TDO was issued to promote.⁵² The shackles used to prevent a child from fleeing or hurting themselves or others are exactly what makes it more likely that the child will attempt to flee or hurt themselves or others. Because shackling is such a stigmatizing experience for children, it can cause severe stress reactions that reduce behavioral self-control and impair decision-making.⁵³ Rather than ensuring a safe transport, the use of shackles makes the TDO process more dangerous for all involved.⁵⁴ A child upset and re-traumatized due to external physical restraints is less likely to think rationally and more likely to act out.⁵⁵

Shackling is inherently shame producing and it stimulates underlying psychological disorders, making it more likely a child will engage in problematic and damaging behavior.⁵⁶ It is a practice that works contrary to any rational effort that might help psychologically empower a child, and instead only perpetuates “feelings of guilt, humiliation, embarrassment, hopelessness, powerlessness, fear, and panic.”⁵⁷ An adolescent naturally feels ashamed when shackled in front of family.⁵⁸ The humiliation created by shackles is especially concerning when children are involved, as they are more vulnerable than adults to the lasting harm of a humiliating event.⁵⁹ The feeling of powerlessness induced by shackles reinforces the child’s existing belief that he or she cannot control the hurtful things that happen to him or her.⁶⁰ This powerlessness may undermine any progress the child has made in recovering from previous trauma and will hinder attempts to help the child regain control of the current crisis.⁶¹

⁵² *See id.* at ¶ 19–21.

⁵³ Ford Aff., *supra* note 47, at ¶ 6.

⁵⁴ *See* Griffin Aff., *supra* note 43, at ¶¶ 11, 17 (explaining how the punitive effects of shackling trigger reactive behavior that puts others at risk).

⁵⁵ *Id.* at ¶ 17.

⁵⁶ Rosenblitt Aff., *supra* note 37, at ¶ 11.

⁵⁷ *Id.* at ¶¶ 8, 11 (quoting DISABILITY RIGHTS CAL., RESTRAINT & SECLUSION IN CALIFORNIA SCHOOLS: A FAILING GRADE 25 (June 2007), <https://www.disabilityrightsca.org/system/files/file-attachments/702301.pdf>).

⁵⁸ Beyer Aff., *supra* note 44, at ¶ 9.

⁵⁹ *Id.* at ¶ 10; Rosenblitt Aff., *supra* note 37, at ¶ 11.

⁶⁰ Beyer Aff., *supra* note 44, at ¶ 18.

⁶¹ *See id.*

2. Shackling Impairs the Development of a Healthy and Positive Identity

Shackling a child experiencing a mental health crisis can have a profound negative effect on his or her identity development.⁶² A critical component of healthy adolescent psychological growth is the development of a strong personal identity.⁶³ Teens, still forming their own sense of self, are acutely aware of how they are perceived.⁶⁴ The approval of others is a powerful influence on an adolescent's self-esteem.⁶⁵ Because adolescents are already intently focused on how they are perceived by others, this humiliation can be permanently damaging to a child's sense of self and self-worth.⁶⁶ The developing personal identity is defined by a dynamic interplay between the child's vision of self and how society responds to the child's vision of self.⁶⁷ Children struggling with mental health issues such as depression, anxiety disorders, severe Attention Deficit Disorder (ADD), Attention Deficit Hyperactivity Disorder (ADHD), and/or conduct disorders (such as acting out) often have existing issues with low self-esteem.⁶⁸ Shackling a child with low self-esteem conveys the message that a depressed teen is powerless, which causes him to perpetuate his own self-blame.⁶⁹

3. Shackling Interferes with a Child's Physical and Psychological Autonomy

Shackling deprives an individual of the ability to control his or her own body, impeding the child's development of physical and psychological autonomy.⁷⁰ When physically restrained, a person "loses control over his behavior at the most basic level."⁷¹ This suggests the child is untrustworthy and inherently violent, which can alter (or reinforce) a perceived negative self-image and can increase their propensity to not only ignore their own safety, but to also disregard any responsibility for others as members of a

⁶² See *Rosenblitt Aff.*, *supra* note 37, at ¶¶ 8, 10–13 (explaining the re-victimization that many shackled juveniles—who have experienced humiliation and lack of control from prior traumas such as child abuse—go through and the likelihood that these children will be more inclined to continue criminal conduct).

⁶³ See *Wurm Aff.*, *supra* note 38, at ¶ 9.

⁶⁴ *Ford Aff.*, *supra* note 47, at ¶ 8.

⁶⁵ *Beyer Aff.*, *supra* note 44, at ¶ 9.

⁶⁶ *Rosenblitt Aff.*, *supra* note 37, at ¶ 13; *Wurm Aff.*, *supra* note 38, at ¶ 11.

⁶⁷ *Wurm Aff.*, *supra* note 38, at ¶ 9.

⁶⁸ *Id.* at ¶ 14.

⁶⁹ See *id.*

⁷⁰ *Ford Aff.*, *supra* note 47, at ¶ 9.

⁷¹ *Rosenblitt Aff.*, *supra* note 37, at ¶ 9.

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community.⁷² Rather than focusing on controlling his own behavior, an individual who is shackled experiences “an intense need to break free from those restraints.”⁷³

The use of shackles unnecessarily stifles the appropriate development of self-regulation skills, which are necessary to help the child focus attention, control emotions, and manage thoughts, behavior, and feelings.⁷⁴ In controlling the body, shackles also excessively control behavior.⁷⁵ The shackles around a child’s arms and legs teach him or her that external controls are more dominant than their internal self-regulation, which only hinders their motivation and their ability to develop necessary self-regulation skills at a crucial point in their growth.⁷⁶ Shackles can lead a child to view themselves as powerless, which can yield increased difficulty with initiating and completing self-directed activities.⁷⁷

4. Shackling for TDO Transport Criminalizes and Stigmatizes Mental Health

Being shackled is also a criminalizing, stigmatizing experience, especially for children.⁷⁸ This is only magnified for an individual experiencing a mental health crisis. The image of a person shackled conveys a sense of danger, something resembling a contained monster that should only be feared.⁷⁹ A child who feels as though they are merely being contained because they pose a risk to others will develop a sense of inferiority leading to a weakening of social ties.⁸⁰ Shackling sends and reinforces negative messages to impressionable children affirming their dangerousness and, most powerfully, signaling they are less than human.⁸¹ A child with a traumatic history that includes depression and anxiety already believes these perceptions, and reinforcing these views only increases the likelihood of problematic behavior.⁸² An adolescent with a malleable self-image cannot merely

⁷² Ford Aff., *supra* note 47, at ¶ 8.

⁷³ *Id.* at ¶ 11 (stating that a child, “[i]nstead of thinking, ‘How should I be behaving right now?’ ... will think, ‘How do I get out of these? How can I escape?’”).

⁷⁴ See Rosenblitt Aff., *supra* note 37, at ¶ 9; see also DESIREE W. MURRAY ET AL., SELF-REGULATION AND TOXIC STRESS: FOUNDATIONS FOR UNDERSTANDING FROM AN APPLIED DEVELOPMENTAL PERSPECTIVE 5–6 (2015) (explaining self-regulation development).

⁷⁵ Ford Aff., *supra* note 47, at ¶ 10.

⁷⁶ *Id.*

⁷⁷ *Id.* at ¶ 9.

⁷⁸ See Rosenblitt Aff., *supra* note 37, at ¶ 14 (explaining that shackling can increase the likelihood of problematic behaviors, including criminal behaviors).

⁷⁹ See Wurm Aff., *supra* note 38, at ¶ 10.

⁸⁰ Beyer Aff., *supra* note 44, at ¶ 10.

⁸¹ Rosenblitt Aff., *supra* note 37, at ¶ 14.

⁸² See *id.*

ignore this negative perception. Instead, it becomes ingrained in his or her own identity formation.⁸³

Shackling a child is inherently punitive;⁸⁴ the practice effectively punishes a child for having a mental health crisis. The indiscriminate use of shackles on all children transported to the treating hospital under a TDO perpetuates a system where shackles are applied to even those children who have demonstrated no signs of violence or intent to escape.⁸⁵ The indiscriminate shackling of children for transport violates basic tenets of developmental pediatric practice, which mandates that should shackles be necessary, they be used situationally.⁸⁶

5. Shackling Prompts a Child's Distrust of Adults

A child shackled while enduring a mental health crisis will distrust those treating him, only complicating any attempt at rehabilitation.⁸⁷ Abuses of power by adults can provoke feelings of self-blame and betrayal, both of which can lead to self-destructiveness or amplified aggression in a child with a history of trauma.⁸⁸ If a child has experienced severe trauma, it is likely that an adult was the aggressor.⁸⁹ Adults further attempting to incapacitate the youth can trigger classic traumatic responses of fighting, fleeing, or freezing.⁹⁰

6. Shackling is Difficult for Parents to Witness

Shackling is not only a traumatic experience for the child, it can be very upsetting for parents as well. Parents who witness shackling report a profound reaction to seeing their child restrained.⁹¹ Witnessing one's own child suffering is extremely painful.⁹² Children sometimes younger than ten years old can be ordered for involuntary psychiatric admission under a TDO.⁹³ In

⁸³ Wurm Aff., *supra* note 38, at ¶ 10.

⁸⁴ Griffin Aff., *supra* note 43, at ¶ 10.

⁸⁵ *See id.* at ¶ 16 (explaining that shackling a child who has shown no use of violence or intent to escape can be perceived as excessive and unfair by the child).

⁸⁶ Wurm Aff., *supra* note 38, at ¶¶ 8, 15.

⁸⁷ *Id.* at ¶ 14.

⁸⁸ Beyer Aff., *supra* note 44, at ¶ 18; *see also* Rosenblitt Aff., *supra* note 37, at ¶ 12 (explaining that children with a history of trauma are susceptible to flashbacks and such re-traumatization increases the likelihood of problematic or criminal behavior).

⁸⁹ *See* Griffin Aff., *supra* note 43, at ¶ 18.

⁹⁰ *Id.* at ¶ 19.

⁹¹ Beyer Aff., *supra* note 44, at ¶ 24; Wurm Aff., *supra* note 38, at ¶ 12.

⁹² Wurm Aff., *supra* note 38, at ¶ 12.

⁹³ Oliver Interview, *supra* note 23.

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these scenarios, a parent may have to take action on the child's behalf, and the sight of their child shackled and detained by law enforcement personnel may interfere with their ability to do so.⁹⁴ More importantly, "the way parents deal with their emotions during traumatic experiences is crucial in setting an example for their children and conveying reassuring messages of safety that encourage resilience in their children."⁹⁵ A child may react negatively to seeing their parent become upset, only intensifying their ongoing mental health crisis.

7. Courts Are Moving Away from Using Shackles in Criminal Justice Proceedings

Courts in states throughout the nation have enacted rules that prohibit shackling juveniles during criminal proceedings due to the growing body of literature that has revealed the harmful effects caused by physically restraining children.⁹⁶ Similarly, the negative effects associated with the use of shackles on developing teenagers have discouraged juvenile correctional facilities from shackling those it incarcerates unless unusual circumstances require such invasive physical restraints.⁹⁷ This trend only underscores the importance of abandoning the use of shackles for a child experiencing a mental health crisis. During mental health transport, the use of shackles is best limited to at least the same standard adopted by courts in other jurisdictions: prohibiting the practice in all cases unless there is an identifiable risk to safety and protecting against it cannot be achieved through a less restrictive method.⁹⁸

D. Impact on Law Enforcement

The current reliance on law enforcement officers for transportation depletes limited resources and strains law enforcement departments.⁹⁹ Bed shortages may force the nearest facilities to reject admission or the child may have unique needs that require treatment at a specific facility.¹⁰⁰ As a result, travel can regularly exceed four or five hours, and trips as long as

⁹⁴ Rosenblitt Aff., *supra* note 37, at ¶ 16.

⁹⁵ Beyer Aff., *supra* note 44, at ¶ 24.

⁹⁶ See, e.g., ALASKA CT. R. 21.5 (2018); FLA. R. JUV. P. 8.100 (2018); IND. CODE § 31-30.5.-2-1 (2018); NEB. REV. STAT. § 43-251.03 (2018); N.H. REV. STAT. §126-U:13 (2018); N.M. STAT. §10-223A (2018); 9 N.Y. COMP. CODES R. & REGS. § 168.3 (2018); N.C. GEN. STAT. § 7B-2402.1 (2018); PA. CONS. STAT. § 6336.2 (2018); S.C. CODE § 63-19-1435 (2018).

⁹⁷ Beyer Aff., *supra* note 44, at ¶ 13.

⁹⁸ See Rosenblitt Aff., *supra* note 37, at ¶ 19.

⁹⁹ VDBHDS, *supra* note 5, at 6.

¹⁰⁰ Oliver Interview, *supra* note 23.

eight hours each way are not uncommon.¹⁰¹ Such long trips necessitate that two on-duty officers be removed from regular patrol duties or that off-duty officers be called in and paid overtime to work an extra shift.¹⁰² Smaller police or sheriff departments often have no surplus of officers to call and are forced to reassign officers from the field during their shift if a magistrate issues a TDO in their jurisdiction.¹⁰³

Magistrates tend to prefer and rely on law enforcement as the default TDO transportation provider due to two perceived benefits: (1) law enforcement officers are necessary to ensure safety and (2) law enforcement can provide the fastest and most efficient transportation.¹⁰⁴ Despite this belief that law enforcement is best equipped to complete TDO transports, law enforcement officers often receive minimal training on interacting with mentally ill individuals. Only two hours of the twenty-two week police training academy are dedicated to mental health.¹⁰⁵ Most of those two hours are instruction on the legal documents specific to mental health concerns rather than training on how to appropriately assist an individual experiencing an ongoing mental health crisis.¹⁰⁶ Crisis Intervention Training (CIT)¹⁰⁷ programs have become increasingly available.¹⁰⁸ Despite this, CIT programs remain optional for law enforcement officers, yielding an inconsistent degree of mental health education for frontline responders.¹⁰⁹

II. EXISTING MENTAL HEALTH TRANSPORT

A mental health transportation alternative to law enforcement involvement is not a novel concept. Other states, including some of Virginia's neighbors, utilize private providers and family members or friends of the individual in crisis to ensure safe and efficient transportation to treatment

¹⁰¹ VDBHDS, *supra* note 5, at 6.

¹⁰² *See id.* at 6–7.

¹⁰³ *Id.* at 6.

¹⁰⁴ *Id.*

¹⁰⁵ Hausman, *supra* note 28.

¹⁰⁶ *Id.*

¹⁰⁷ Crisis Intervention Training is an emerging best practice approach to educate law enforcement officers and other first responders on how to most effectively assist individuals with mental illness who are experiencing emotional crisis. Programming focuses on helping participants recognize signs and symptoms of behavioral health issues, as well as teaching communication skills to help de-escalate individuals in crisis. VA. DEP'T OF BEHAVIORAL HEALTH & DEV. SERVS., VIRGINIA'S CRISIS INTERVENTION TEAM PROGRAMS: 2015 CIT INVENTORY SERVICES 2 (Jan. 2016), <http://www.dbhds.virginia.gov/library/forensics/fofo%20-%20cit%20inventory%202015%20final%20report.pdf> [hereinafter VDBHDS].

¹⁰⁸ *See* Hausman, *supra* note 28.

¹⁰⁹ *See* VDBHDS, *supra* note 107, at 7.

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facilities.¹¹⁰ In 2015, Virginia operated a pilot program to research the viability of a mental health transportation alternative in the Commonwealth.¹¹¹ While costs were higher than anticipated, the program successfully prevented intensifying ongoing crises while also preserving law enforcement resources. As a result, state legislators and mental health advocates began developing a comprehensive trauma-informed approach for transporting those experiencing an ongoing mental health crisis.

A. Mental Health Transport Outside Virginia

Other states authorize alternative options for individuals requiring TDO transport. In West Virginia, for example, both sheriffs and magistrates are permitted to determine whether an individual is eligible for alternative transportation.¹¹² Sheriffs and local community mental health centers worked together to develop an agreement for alternative transportation options.¹¹³ Similarly, sheriffs in Tennessee can determine whether an individual qualifies to go with a “secondary transportation agent,” who would transport the individual to the treatment facility without using restraints.¹¹⁴ In Michigan, when a minor needs to be hospitalized in a psychiatric unit, the default transporter is the person who requested hospitalization.¹¹⁵ If this is infeasible or unsafe, reasonable efforts must be made to find another non-law enforcement solution, and only in the absence of any acceptable option can the court order a peace officer to transport the child for evaluation and/or treatment.¹¹⁶ Moreover, Georgia law explicitly encourages courts to utilize family members to transport a child in crisis whenever possible.¹¹⁷

In addition to permitting alternative transportation options, many of these states have established guidelines to ensure the transportation itself remains treatment-focused to minimize the stigmatization of the mental health crisis. For example, Georgia law prohibits, “whenever possible,” the use of vehicles regularly utilized in prisoner transport for use in the involuntary commitment process.¹¹⁸ In South Carolina, transporting officers must dress in

¹¹⁰ ALT. TRANSP. SUB-GRP. OF THE MENTAL HEALTH CRISIS RESPONSE & EMERGENCY SERVS. ADVISORY PANEL, INTERIM REPORT 3 (Oct. 2016), <http://dls.virginia.gov/groups/mhs/final%20interim%20report.pdf> [hereinafter ATSG].

¹¹¹ *Id.* at 1–2.

¹¹² W. VA. CODE § 27-5-10(a), (c) (2018).

¹¹³ *See id.* § 27-5-10(b).

¹¹⁴ TENN. CODE § 33-6-901(a)(2) (2018).

¹¹⁵ *See* MICH. COMP. LAWS § 330.1498t (2018).

¹¹⁶ *Id.*

¹¹⁷ GA. CODE § 37-3-101(a) (2018).

¹¹⁸ *Id.*

plain clothes rather than uniforms.¹¹⁹ Similarly, North Carolina requires transporting officers to dress in plain clothes and drive unmarked vehicles.¹²⁰

North Carolina has also worked with G4S, a private security company, to offer an alternative option for individuals requiring mental health transport.¹²¹ G4S cars are generally inconspicuous and are identified only by small G4S logos on the car or van.¹²² The inside of the vehicle includes partitions between the front seat and the rear of the vehicle to prevent physical interaction between the driver and the passenger.¹²³ Cars are stationed at hospitals around the clock and are dispatched as necessary by a single twenty-four hour dispatch center.¹²⁴ Each G4S vehicle features cameras that the supervisor can access and a GPS tracking device that updates every five minutes.¹²⁵

While some states have taken proactive steps to reduce the criminalization of mental health crises, only Vermont specifically prohibits the application of mechanical restraints on individuals being transported to a psychiatric treatment facility.¹²⁶ Vermont law requires that transportation be completed in a way that “prevents physical and psychological trauma” and that “represents the least restrictive means necessary for the safety of the patient.”¹²⁷ Even then, Vermont law permits restraints when “circumstances dictate that such methods are necessary.”¹²⁸ While the success of programs in each of these jurisdictions demonstrates not only the viability but also the benefits of adopting a trauma-informed approach, none have developed mental health-focused alternatives to law enforcement transport specifically for children.

B. Virginia’s Adult Alternative Transportation Pilot Program

In 2015, the Virginia Department of Behavioral Health and Developmental Services (VDBHDS) funded an alternative transportation pilot program with the Mount Rogers CSB, located in southwestern Virginia.¹²⁹ VDBHDS

¹¹⁹ S.C. CODE § 44-17-440(A) (2018).

¹²⁰ N.C. GEN. STAT. § 122C-251(c) (2018).

¹²¹ VDBHDS, *supra* note 5, at 10.

¹²² *Id.* at 11.

¹²³ *Id.*

¹²⁴ *Id.*

¹²⁵ *Id.*

¹²⁶ VT. STAT. tit. 18, § 7511(d) (2012).

¹²⁷ *Id.* § 7511(a).

¹²⁸ *Id.* § 7511(d).

¹²⁹ ATSG, *supra* note 110, at 5; VDBHDS, *supra* note 5, at 8.

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contracted with Steadfast Security, LLC, a private security company, to provide transportation for individuals 18 years and older.¹³⁰ All drivers and dispatch service personnel were required to complete Mental Health First Aid and CIT courses, were dressed in plain clothes, were unarmed, and drove an unmarked vehicle.¹³¹ The use of restraints was not permitted during the pilot program under any circumstances.¹³²

The process began with pre-screening to determine whether the individual was eligible for transportation.¹³³ Because restraints were prohibited, any individual who posed a legitimate risk of harm or presented a flight risk was ineligible for alternate transportation with Steadfast, and law enforcement would be responsible for transportation.¹³⁴ If the individual was approved, a twenty-four hour dispatch center would relay the information to on-duty drivers who would meet the individual at the evaluation center and transport him or her to the treatment facility.¹³⁵

During the fourteen months that the pilot program operated, 1,159 individuals required TDO transport in the Mount Rogers CSB region, all of whom were transported by either Steadfast Security or law enforcement personnel.¹³⁶ Steadfast Security transported 472 (41%) individuals.¹³⁷ All 472 arrived at the treating facility without incident.¹³⁸ Of the 687 (59%) transported by law enforcement, 311 (45.3% of those taken by law enforcement) needed to travel only a short distance to the treatment facility and law enforcement personnel were already present at the evaluation center, while 303 (44% of those taken by law enforcement) were denied eligibility for alternative transport based on a finding that they posed some risk of harm or flight.¹³⁹ The other seventy-three (10.5%) were denied by the magistrate for other, unspecified reasons.¹⁴⁰ The rate at which magistrates approved alternative transportation increased from 30% at the beginning to 50% by the program's conclusion.¹⁴¹ While some individuals only required transportation for a short distance, the average trip for those approved to

¹³⁰ VDBHDS, *supra* note 5, at 8.

¹³¹ *Id.*

¹³² *Id.*

¹³³ *See id.* at 6.

¹³⁴ *See id.* at 8.

¹³⁵ *See id.* at 11.

¹³⁶ *Id.* at 8.

¹³⁷ *Id.* at 11.

¹³⁸ *Id.*

¹³⁹ *Id.* at 9 (explaining that seventy-three individuals posed a risk of harm to self, seventy-eight individuals posed a risk of harm to other, and 152 individuals posed a risk of flight).

¹⁴⁰ *Id.*

¹⁴¹ *Id.* at app. A, slide 16.

ride with Steadfast Security was 138 miles.¹⁴² Since the conclusion of the Mount Rogers pilot program, law enforcement agencies have commented on an increased burden stemming from the need to conduct more TDO transports.¹⁴³

VDBHDS intended for the grant to maintain the program until late spring 2017, nearly eighteen months after it commenced.¹⁴⁴ However, the funds were depleted by early March 2017, and operation of the alternative transportation pilot program was forced to conclude prematurely.¹⁴⁵ The greatest regular expense was attributed to vehicle availability, including driver wages.¹⁴⁶ Not factored into the regular expense budget, however, was the cost required to establish a central dispatch infrastructure, which was more expensive than anticipated and presented the greatest overall expense.¹⁴⁷ The dispatch center received an average of thirty-six to fifty calls each day.¹⁴⁸ Implemented statewide, the strain of establishing the infrastructure should be minimized on a cost per trip basis.

C. The Alternative Transportation Workgroup of the Senate Joint Resolution No. 47 Advisory Panel on Mental Health Crisis Response and Emergency Services

As a result of the Mount Rogers pilot program's success, VDBHDS and the Virginia Department of Criminal Justice Services established a workgroup tasked with developing an alternative transportation model for the ECO and TDO processes based on the results of the Mount Rogers pilot.¹⁴⁹ In its final report, the workgroup recommended implementing a single statewide alternative transportation system for both children as well as adults to provide a reliable, non-law enforcement option for individuals requiring TDO transport.¹⁵⁰ While this recommendation largely resembles the

¹⁴² ATSG, *supra* note 110, at 6.

¹⁴³ See Oliver Interview, *supra* note 23.

¹⁴⁴ VDBHDS, *supra* note 5, at app. A, slide 5.

¹⁴⁵ See *Id.* at 8.

¹⁴⁶ *Id.* at app. A, slide 13 (explaining that keeping five drivers on duty each day accounted for 76.2% of the daily costs, compared to 19.7% to maintain dispatch services and only 4.2% for mileage costs. Steadfast Security drivers were paid \$31.25 per day).

¹⁴⁷ *Id.* at 18.

¹⁴⁸ *Id.*

¹⁴⁹ This was required pursuant to House Bill 1426 and Senate Bill 1221. After some consideration, the workgroup decided to focus solely on developing a model for TDOs, because individuals requiring TDO transport, which would occur subsequent to an ECO transport, "have already been deemed safe from weapons, narcotics, and medically cleared, making it functionally different and more immediately feasible than providing alternative transportation for individuals under an ECO," who present more unknown variables and thus greater likelihood of risk. See *id.* at 9–10.

¹⁵⁰ *Id.* at 15.

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Mount Rogers model, the workgroup went further and actively solicited information from potential providers regarding anticipated costs and logistical solutions to efficiently establish a 24/7 dispatch center.¹⁵¹ Based on the responses the workgroup received, it estimated that full statewide implementation of an adult and adolescent mental health transportation system would cost \$10.2 million.¹⁵²

In addition to making a final recommendation, the workgroup set forth four primary goals for the statewide alternative transportation program: that the system (1) be safe for passengers, transporters, and anybody else who may be involved,¹⁵³ (2) be focused on behavioral health recovery, (3) relieve the strain on law enforcement, and (4) reduce the stigma of mental illness and substance use disorders.¹⁵⁴ Because the workgroup prioritized a focus on behavioral health and treatment, it identified VDBHDS as the most appropriate agency to oversee implementation and evaluation of the program.¹⁵⁵ Finally, the workgroup highlighted potential barriers to programmatic success, including hesitation by CSB staff and magistrates to consider alternative transportation as a viable option and a discomfort in recommending it when available, the statutory identification of law enforcement as the default providers of transportation, and a lack of funding for quality alternative transportation services.¹⁵⁶ Most notably, the workgroup initially pushed for a separate pilot program to specifically examine the viability of an alternative transportation option for children and adolescents.¹⁵⁷

Developing a model for children presents unique issues, many of which may not have been previously encountered. In Virginia, the age of consent for hospitalization is fourteen years old, meaning that a child between the ages of fourteen and eighteen can decide to receive hospitalization services on their own.¹⁵⁸ Any child who is younger than fourteen years old can only receive hospitalization at the discretion of his or her parents or legal guardian.¹⁵⁹ Often, a child is involuntarily admitted for psychiatric care when there are concerns regarding both the child as well as parents.¹⁶⁰ Given this, the

¹⁵¹ *Id.* at 5.

¹⁵² *Id.* at app. A, slide 23.

¹⁵³ This likely includes CSB employees, clinicians, magistrates, family members, and even other civilians who might be at risk in the event of escape.

¹⁵⁴ VDBHDS, *supra* note 5, at 15.

¹⁵⁵ *Id.* at 14.

¹⁵⁶ *Id.*

¹⁵⁷ *Id.* at 17.

¹⁵⁸ NAT'L ALL. ON MENTAL ILLNESS, *supra* note 11, at 1.

¹⁵⁹ *Id.*

¹⁶⁰ Telephone interview with Mark Larsen, Dir. of Adult Behav. Health Servs., Mount Rogers Cmty. Servs. Bd. (Dec. 4, 2017) [hereinafter Larsen Interview] (explaining that a TDO may be issued for a child suffering a mental health crisis who is believed to be the victim of abuse; and involuntary admis-

magistrate may have to balance whether it would be more beneficial for a parent to be allowed to ride with the child (which might help comfort the child) or if the child would be better served separate from the guardian despite traveling multiple hours. Vehicles must also be adapted to safely and comfortably transport children of varying ages. Finally, drivers must complete additional training requirements that demonstrate their understanding of child psychological development and child-specific CIT techniques.

Despite the workgroup's recommendation of a separate pilot for children, Virginia is best served incorporating children into the existing expansion of the Mount Rogers pilot program. A child-inclusive model, as opposed to an independent child-only model, offers three advantages. First, the costs required to construct a separate dispatch service solely for a child-exclusive pilot program would make per trip costs prohibitively expensive. Second, more than half of the adults requiring TDO transport were ineligible for alternate transportation because they posed a risk of flight or harm to themselves or others. At least one of the companies offering alternative transportation services would be able to transport individuals who would otherwise be disqualified due to their risk of flight or harm. Children must have access to the same resources available to adults in order to avoid unnecessary disqualification from alternative transportation. Finally, the oversight, implementation, and execution aspects of the alternative transportation program have already been assigned to VDBHDS, and it would be more appropriate to implement a child-focused program concurrently and examine the program's results using the same set of established criteria.¹⁶¹

D. Advantages to a Child-Inclusive Model

1. Funding

Incorporating a child-focused pilot as a component of the workgroup's recommendation is a critical step toward successfully implementing an alternative treatment option that protects those most in need of trauma-informed care. However, establishing a system equivalent to the Mount Rogers pilot program exclusively for children would be infeasible given the projected cost per transport.¹⁶² In the Mount Rogers CSB region, as many as

sion is necessary to examine the child without parental interference).

¹⁶¹ Evaluation has thus far revolved around whether the alternative program has proven to be (1) safe (given that removing physical restraints and applying a treatment-based approach is exactly the proactive step that would make the transport safer for the passenger, the answer to this question is more unclear from the driver's perspective) and (2) financially possible to sustain. See VDBHDS, *supra* note 5, at 15, 17.

¹⁶² See *id.* at app. A, slide 13.

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fifty children could require TDO transport in one year.¹⁶³ Even if each child could be diverted to an alternate provider, the cost of operation would be prohibitively expensive due to the requirement of re-establishing a separate central dispatch infrastructure and maintaining a supply of drivers on standby around the clock. Accordingly, while gathering information on the unique needs of children is critical to developing a best practices model, this program can only exist if incorporated within a framework that already absorbs the costs associated with establishing a central dispatch center and communications network.

Moreover, given the geographical diversity of Virginia, adequate conclusions could not be reliably extrapolated from a child exclusive model operated in only one region. Instead, VDBHDS is better served executing a phased implementation of the child-focused model across regions that better represent an accurate cross-section of Virginia's diverse geographical regions. A phased implementation approach allows VDBHDS to better understand the unique needs of children during TDO transport, allowing them to evaluate and streamline subsequent implementations throughout the other CSB regions.

2. Complete Diversion to Non-Law Enforcement Providers

While magistrates became increasingly comfortable diverting individuals to alternative transportation providers by the conclusion of the program, nearly one-third of individuals experiencing a mental health crisis were still ineligible for transportation because they posed some risk and Steadfast Security was prohibited from using restraints.¹⁶⁴ G4S, a private company identified by the workgroup as a potential provider of alternative transportation services in the Commonwealth, trains its drivers on when and how to appropriately apply soft restraints, which effectively mitigate risk without the same harmful effects presented by traditional shackles.¹⁶⁵ While using no restraints (the approach in the Mount Rogers pilot program) is the ideal and default protocol, the permitted use of soft restraints by alternative transportation providers when necessary is still preferable to the current practice requiring use of shackles and involvement of law enforcement personnel for those individuals having the most severe reactions. Allowing alternative providers to apply soft restraints situationally increases the program's inclusivity by ensuring that those who require TDO transport are afforded an op-

¹⁶³ Larsen Interview, *supra* note 160.

¹⁶⁴ See VDBHDS, *supra* note 5, at 8.

¹⁶⁵ Oliver Interview, *supra* note 23.

portunity to arrive at their treatment facility safely and without unnecessarily enduring further trauma.

3. Existing Oversight Structure

The workgroup tasked VDBHDS with oversight of the statewide alternative transportation system.¹⁶⁶ Outcomes will be monitored and measured by VDBHDS staff to track the frequency of TDO transport, the rate diverted to transportation through alternative providers, and the effectiveness of these programs.¹⁶⁷ The process of phased implementation allows VDBHDS and other program stakeholders to assess the program's effectiveness and to ensure efficient implementation over the course of three years. The Institute of Law, Psychiatry, and Public Policy at the University of Virginia proposed a three-pronged evaluation focused on assessing processes, outcomes, and efficiency.¹⁶⁸ The process assessment aims merely to determine whether the program was implemented as originally proposed and outlined.¹⁶⁹ The outcomes assessment investigates whether the program achieved its goals and projected outcomes, focusing on the burden experienced by law enforcement, the reduction of trauma and stigma felt by the target population, and the improved clinical outcomes for program participants.¹⁷⁰ The efficiency assessment compares the costs of the program with its effectiveness and perceived benefits, both fiscal and non-monetary, to determine the overall value and success of the program.¹⁷¹

Incorporating this child-focused model within the currently recommended framework ensures uniformity in implementation and evaluation. While there are unique issues specific to children, both the current statewide recommendation and the child-focused option are alternatives available to individuals who require TDO transport. The differences between children and adults are not so great as to warrant oversight by an agency other than VDBHDS. Accordingly, a child-inclusive model that is incorporated within the current recommendation is crucial to ensure that children are afforded at least the same standard of care that adults receive.

¹⁶⁶ VDBHDS, *supra* note 5, at 15.

¹⁶⁷ See JOINT COMM'N ON HEALTH CARE, ALTERNATIVE TRANSPORTATION PILOT slide 8, <http://jchc.virginia.gov/documents/2016/aug/2%20Alternative%20Transportation%20CLR.pdf> (last visited Oct. 13, 2018).

¹⁶⁸ K. M. FARIS & A. A. ALLEN, TO ACCOMPANY THE ALTERNATIVE (NON-LAW ENFORCEMENT) TRANSPORTATION OF CHILDREN AND ADULT IN MENTAL HEALTH CRISIS: RECOMMENDATION FOR THE GENERAL ASSEMBLY SESSION 2 (2017), <http://dls.virginia.gov/groups/mhs/EvaluationProposal.pdf>.

¹⁶⁹ *Id.* at 2–3.

¹⁷⁰ *Id.* at 4–5.

¹⁷¹ *Id.* at 2, 5–6.

E. Child-Specific Issues

Due to the uniquely impressionable nature of adolescents and the ongoing presence of parents in their lives, the children's pilot program must have the capacity to facilitate transportation of the child's parent or guardian along with the child to the treatment facility even though not all transports will include parents. While some parents may provide relief in a high-stress situation and minimize the trauma, others might exacerbate the child's traumatic response. The magistrate must exercise discretion in deciding whether it is in the child's best interest to be accompanied by their parent or guardian.

When individuals who are experiencing a mental health crisis present a low risk, even the private provider may not be necessary. Instead, ideal transportation in situations where the child's mental state is stabilized and the child presents no risk of flight or harm might be for a parent, guardian, or other related adult to transport the child to the treatment facility independently. While this might only be applicable in a minority of cases, affording magistrates the discretion to choose this option might help reduce the expenditure of limited resources offered by the private providers and, in some cases, yield the most beneficial result.

Drivers and dispatch operators in the Mount Rogers pilot program completed both CIT and Mental Health First Aid training.¹⁷² CIT is crucial to ensure drivers are equipped to handle the issues most likely to arise with the child on the way to the treatment facility. Moreover, some localities in Virginia have specific child-focused CIT programs. Any child-focused pilot or child-inclusive program must implement CIT that is specifically geared toward mental health issues and traumatic responses unique to children. Drivers must also be trained in childhood development to understand the psychological impact of the entire situation on the child they are transporting.

Finally, those who will have children in their care must be required to pass additional safety checks. For example, child care centers in Virginia require employees to pass a background check.¹⁷³ Given that drivers will undertake a role similar to temporary guardianship, the Commonwealth and private providers must screen all drivers with a background check similar to what is required for employees of licensed day care centers. Such screening would include a "(1) sworn statement or affirmation; (2) criminal history record check; (3) national criminal background check; and (4) central regis-

¹⁷² VDBHDS, *supra* note 5, at app. A, slide 8.

¹⁷³ 22 VA. ADMIN. CODE § 40-191-40(A) (2018).

try search.”¹⁷⁴ Finally, gender matching of driver and passenger may be an issue. In its North Carolina alternative transportation program, G4S was able to implement a system to efficiently match gender between drivers and passengers.¹⁷⁵ VDBHDS staff must consider and evaluate the necessity and benefits of this feature throughout each phase of implementation.

III. 2018 LEGISLATIVE RESPONSE

A. Acts of the General Assembly

Given the estimated \$10.2 million cost of full statewide implementation, the workgroup provided a secondary recommendation for a phased implementation toward a statewide system over the course of three years.¹⁷⁶ Phase one would require an annual budget of \$1.7 million, ensuring sufficient funding for (1) “an anticipated increase in non-law enforcement transports” from 50% of total TDO transports in the Mount Rogers pilot to 66% in the new program, and (2) the inclusion of alternative transportation availability for children.¹⁷⁷

Based on the workgroup’s report and recommendations, legislators introduced four separate proposals to fund alternative transportation. Senator Emmett Hanger (R-Mount Solon) co-sponsored a budget proposal that would have provided the full \$10.2 million necessary for immediate statewide implementation with Senator Creigh Deeds (D-Bath), who chairs SJ 47, a Joint Subcommittee to Study Mental Health Services in the Commonwealth in the Twenty-First Century (also known as the “Deeds Commission”).¹⁷⁸ Senator Siobhan Dunnivant (R-Henrico) and Delegate Vivian Watts (D-Annandale) independently sponsored similar proposals that also

¹⁷⁴ *Id.* § 40-191-20(A).

¹⁷⁵ VDBHDS, *supra* note 5, at 11.

¹⁷⁶ TRANSP. WORKGROUP OF THE SJ 47 ADVISORY PANEL ON MENTAL HEALTH CRISIS RESPONSE & EMERGENCY SERVS., ALTERNATIVE (NON-LAW ENFORCEMENT) TRANSPORTATION OF CHILDREN AND ADULTS IN MENTAL HEALTH CRISIS: RECOMMENDATIONS FOR THE 2018 GENERAL ASSEMBLY SESSION 1, <http://dls.virginia.gov/groups/mhs/alt%20transportation.pdf> (last visited Sept. 23, 2018) [hereinafter TRANSP. WORKGROUP].

¹⁷⁷ *Id.* at 2.

¹⁷⁸ S.B. 30 (Item 311 #1s), 2018 Gen. Assemb., Reg. Sess. (Va. 2018); Ashley Everette, *Building A Stronger Mental Health System For Virginia’s Kids: 2018 Budget Amendments*, VOICES FOR VA.’S CHILD. BLOG (Jan. 23, 2018), <https://vakids.org/our-news/blog/building-a-stronger-mental-health-system-for-system-for-virginias-kids-2018-budget-amendments>; Jennifer McClellan, *Sen. Jennifer McClellan: The Cost of Mental Health Failures in Virginia is Way Too High*, RICH. TIMES-DISPATCH (Feb. 18, 2017), https://www.richmond.com/opinion/their-opinion/guest-columnists/sen-jennifer-mcclellan-the-cost-of-mental-health-failures-in/article_001dabbb-f59a-5902-b8de-e9ec541201d3.html (referring to the Commission chaired by Creigh Deeds as the “Deeds Commission”).

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would have provided the full \$10.2 million in 2019 and 2020.¹⁷⁹ Additionally, Delegate T. Scott Garrett's (R-Lynchburg) proposed budget included \$1.7 million in each of the next two years to commence the phased implementation of alternative transportation.¹⁸⁰ All four proposals specified the inclusion of children as well as adults, and each noted that "alternative transportation could be provided by a family member or friend of the individual, a representative of the CSB, or an alternative provider trained to safely provide transportation."¹⁸¹

B. House Bill 5002

The General Assembly declined to adopt the workgroup's initial recommendation of full immediate statewide implementation.¹⁸² Instead, state legislators elected for a phased implementation process through House Bill 5002, allocating general funds from the biennial budget of \$2.5 million in 2019 and \$4.5 million in 2020.¹⁸³ Most importantly, the bill mandated that VDBHDS "structure the contract to phase in the program over a three-year period such that in year three the contract will result in the provision of services statewide."¹⁸⁴ The pilot is slated to begin operating in seven CSBs, including six of the ten CSBs in VDBHDS Region Three (southwestern Virginia) as well as in Region Ten CSB, comprising of Charlottesville and the counties of Albemarle, Fluvanna, Greene, Louisa, and Nelson.¹⁸⁵ The workgroup recommended southwestern Virginia CSBs, including the Mount Rogers CSB, because its rural setting particularly strains resources in small local law enforcement departments and because "there is both experience and expertise regarding alternative transportation," which should facilitate smooth implementation.¹⁸⁶ The workgroup selected central Virginia's Region Ten CSB because of its diverse landscape, comprising urban, suburban, and rural localities, which is expected to "provide vital experience on the challenges involved in implementing alternative transport" across Virginia.¹⁸⁷ Moreover, Region Ten CSB also borders Staunton,

¹⁷⁹ S.B. 30 (Item 303 #40s), 2018 Gen. Assemb., Reg. Sess. (Va. 2018); H.B. 30 (Item 311 #2h), 2018 Gen. Assemb., Reg. Sess. (Va. 2018); Everette, *supra* note 178.

¹⁸⁰ H.B. 30 (Item 311 #3h), 2018 Gen. Assemb., Reg. Sess. (Va. 2018); Everette, *supra* note 178.

¹⁸¹ S.B. 30 (Item 303 #40s), 2018, Gen. Assemb., Reg. Sess. (Va. 2018); S.B. 30 (Item 311 #1s), 2018, Gen. Assemb., Reg. Sess. (Va. 2018); H.B. 30 (Item 311 #2h), 2018 Gen. Assemb., Reg. Sess. (Va. 2018); H.B. 30 (Item 311 #3h), 2018, Gen. Assemb., Reg. Sess. (Va. 2018).

¹⁸² See H.B. 5002 (Item 311), 2018 Gen. Assemb., Spec. Sess. I (Va. 2018).

¹⁸³ *Id.*

¹⁸⁴ *Id.*

¹⁸⁵ TRANSP. WORKGROUP, *supra* note 176, at 1.

¹⁸⁶ *Id.*

¹⁸⁷ *Id.*

where the only public psychiatric facility for children and adolescents in the Commonwealth is located and where much of the interagency communication and collaboration for alternative transportation will be based.¹⁸⁸ If the first phase is successful in achieving its anticipated benefits in the target areas, phase two in 2020 would expand alternative transportation service into all CSBs located in VDBHDS Region One (central Virginia) and VDBHDS Region Three (southwestern Virginia).¹⁸⁹

CONCLUSION

Shackling children who are experiencing a mental health crisis is more harmful than beneficial. Reliance on law enforcement personnel, who regularly use physical restraints in the TDO process, is traumatic, expensive, and unnecessary. Alternatives are available that not only better ensure the child's safety and minimize the traumatic effects of transport, but also reduce the current burden on law enforcement departments. Such mental health transportation is already utilized in neighboring states, and the Mount Rogers pilot program demonstrated the viability of implementing an effective statewide alternative in Virginia. The General Assembly's grant of funding to begin researching and establishing a mental health transportation network is an encouraging step toward ensuring improved access to mental health care in Virginia. Moreover, the inclusion of children in the program protects perhaps the most vulnerable population from unnecessarily enduring additional trauma.

To ensure the greatest access to a treatment-focused approach, the governing statute must be amended to make specialized, mental health transportation providers the default option for individuals requiring TDO transport.¹⁹⁰ Use of law enforcement officers for transport should be viewed as the alternative to a well-established system of mental health transportation options, allowing officers and deputies to be included only as a last resort where necessary due to identifiable and considerable safety concerns that cannot otherwise be mitigated. VDBHDS must also facilitate an ongoing education process to ensure magistrates are informed about the traumatic effects inherent in the shackling of children, as well as the mental health transportation alternatives that are available. Magistrates became increas-

¹⁸⁸ See Michael Martz & Sarah Kleiner, *Director of Virginia's Behavioral Health Hospital for Children Has Been Reassigned*, RICH. TIMES-DISPATCH (Dec. 21, 2016), https://www.richmond.com/news/virginia/director-of-virginia-s-behavioral-health-hospital-for-children-has/article_c1c187d7-e0fa-512e-9e9f-cd8acbbca291.html.

¹⁸⁹ TRANSP. WORKGROUP, *supra* note 176, at 2.

¹⁹⁰ See VA. CODE § 37.2-810(B) (2018) (indicating that law-enforcement officers are the current default).

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ingly comfortable with designating alternate providers for transportation throughout the course of the Mount Rogers pilot. Their continued training on these issues—and their understanding of the options when confronting a child in need of a TDO transport—will yield the greatest care for children in the Commonwealth through the successful implementation of trauma-informed mental health transportation.

Despite the costs associated with the alternative transportation pilot program, a statewide mental health transportation system that includes children with adults is necessary to ensure the safety of children throughout the Commonwealth. Children face unique issues that must be considered in any transportation program, and their need for high-quality, efficient transportation alternatives that divert them from contact with law enforcement is critical to maintaining a treatment-focused approach. The evaluation process over the next three years will help to ensure better long-term care for children in crisis and most in need of safe and effective intervention.

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