REPORT OF THE
JOINT SUBCOMMITTEE

STUDYING THE FUTURE DELIVERY OF PUBLICLY FUNDED MENTAL HEALTH, MENTAL RETARDATION AND SUBSTANCE ABUSE SERVICES (HJR 240)

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

HOUSE DOCUMENT NO. 77

COMMONWEALTH OF VIRGINIA
RICHMOND
1998

MEMBERS OF THE JOINT SUBCOMMITTEE

Delegate Franklin P. Hall, Co-Chairman
Senator Joseph V. Gartlan, Jr., Co-Chairman
Delegate Robert S. Bloxom, Vice Chairman
Delegate David G. Brickley
Delegate Mary T. Christian
Delegate Julia A. Connally
Delegate Jay W. DeBoer
Delegate A. Victor Thomas
Senator Mark L. Earley
Senator Stephen H. Martin
Senator William C. Wampler, Jr.
Robert C. Metcalf, Secretary of Health and Human Resources, ex officio
Richard E. Kellogg, Acting Commissioner, DMHMRSAS, ex officio
Timothy A. Kelly, Commissioner, DMHMRSAS (ex officio May 1996-Sept. 1997)

STAFF

Division of Legislative Services:
Gayle N. Vergara, ***Research Associate***
Nancy L. Roberts, ***Section Manager***
Amy Marschean, ***Staff Attorney***

House of Delegates:
Anne R. Howard, ***Assistant Clerk***
William L. Owen, ***Senior Committee Clerk***

Christopher J. Spanos, ***Consultant***
Susan E. Massart, ***Legislative Fiscal Analyst,***
House Appropriations Committee
Martha J. Mead, ***Director of Legislation***
and Public Relations, DMHMRSAS

TABLE OF CONTENTS

Appendices

I. EXECUTIVE SUMMARY

The Joint Subcommittee Studying the Future Delivery of Publicly Funded Mental Health, Mental Retardation and Substance Abuse Services (House Joint Resolution 240) was directed by the 1996 Session of the General Assembly to conduct a comprehensive evaluation of the Commonwealth's system of delivering mental health, mental retardation and substance abuse services. During the course of its two-year study, the joint subcommittee found both significant strengths and opportunities for improvement in Virginia's services delivery system. The joint subcommittee's recommendations are intended to provide future policy direction for the Commonwealth, strengthen the state-local partnership, renew the commitment to a community-based system, ensure that the system is responsive and accountable, streamline procedures, improve efficiencies, incorporate new technologies, and, most importantly ensure that the system meets the needs and respects the human rights of individual consumers and their families. Taken together, the changes recommended by the joint subcommittee initiate the first important steps toward developing and sustaining an integrated system of inpatient facilities that provide specialized care and comprehensive community services that are tailored to the needs of individuals.

Consumer Involvement, Participation, and Choice. Increasing opportunities for consumer involvement, choice, and participation are among the most important recommendations of the joint subcommittee. The joint subcommittee found that more opportunities are needed for consumers and their representatives to be involved in policy making; services planning, delivery, and evaluation; and decisions about their treatment, whether in public or private settings. Where possible, the joint subcommittee believes that consumers should have a choice of treatment providers, and services should be delivered in those settings that promote the highest quality of life for the individual. Toward that end, the joint subcommittee recommends that: (i) the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS), community services boards (CSBs), and state facilities increase the involvement and participation of consumers and family members; (ii) the pool of service providers be expanded by creating incentives for private providers and opportunities for consumers and families to provide services; (iii) consumer satisfaction measures be included in state facility and community services board performance contracts; and (iv) dispute resolution mechanisms be implemented to allow consumers and family members to have prompt and fair resolution of their concerns about services.

Future Responsibilities of State and Local Government, Private Providers, and the Academic Community. In fiscal year 1996, more than 200,000 Virginians received state facility and community services from the state and local network of publicly funded programs. However, the dual system of state-operated facilities and

locally administered outpatient and residential services has often resulted in an unequal distribution of state-controlled financial resources and inconsistent service availability and accessibility.

To strengthen the state-local partnership and ensure service consistency, the joint subcommittee recommends that a local elected official be added to the membership of the State Mental Health, Mental Retardation and Substance Abuse Services Board and that the Board oversee the development of a Comprehensive State Plan and develop policies that define service priorities. The Department should: continue to be responsible to the General Assembly for all publicly funded mental health, mental retardation, and substance abuse services; provide system leadership and direction; conduct state-level strategic planning; operate state facilities; contract for community services; establish statewide standards related to consumer access and quality; and maintain a statewide services information system. In addition, the joint subcommittee recommends that the Department create separate Offices of Substance Abuse Services and Prevention, develop utilization targets for adult state psychiatric bed days, disseminate performance report cards on facilities and community services boards, and develop and update a biennial comprehensive state plan.

The joint subcommittee also believes that state government should continue to fund and operate 15 mental health and mental retardation facilities. While there will continue to be an important role for state facilities in the future, roles may focus more on specialty services, such as forensic, extended rehabilitation, and geriatric, and on services to populations with multiple disabilities or significant medical needs. The Department should develop uniform clinical protocols for admission to and discharge from its facilities and should revise state facility catchment areas as necessary to achieve better coordination and access.

To ensure an orderly and measured approach to facility downsizing, the joint subcommittee recommends that the Department develop a Community and Facility Master Plan by December 1, 1998. In developing its plan, the Department should determine the number of individuals who can be served in the community and who will continue to need facility care, the optimal size and location of facilities, and options for staff and localities that are affected by facility downsizing.

Local governments should continue to be responsible for organizing and managing community-based mental health, mental retardation, and substance abuse services and are

encouraged to partner with other local governments to stay competitive and responsive to consumer needs. Localities should continue to fund local priorities that are not funded by the state.

The joint subcommittee proposes legislation to distinguish between two types of CSBs: those that function as local government departments and those that operate more autonomously. Different levels and types of accountability are recommended for each. Also recommended are: (i) the addition of case management as a mandated service; (ii) requiring one-third of CSB appointments to be consumers or family members; (iii) permitting the appointment of local government officials to the CSB; (iv) designating the CSB as the single point of entry for publicly funded services; and (v) clarifying that CSBs should be local care coordinators and not the primary or only providers of services.

The joint subcommittee encourages the Department to: (i) examine the needs and opportunities for regional cooperation; (ii) continue to expand the involvement of private providers in policy development, planning, service delivery, and oversight and evaluation; and (iii) establish a forum for expanding linkages between the academic community and state facilities and CSBs.

Accountability. Virginia's public mental health, mental retardation, and substance abuse services system is accountable to consumers, family members, government officials, and taxpayers, but the absence of outcome data, uniform cost accounting standards and systems, compatible management information systems, and consistent data bases make meaningful evaluations difficult. The joint subcommittee supports advancing to the next phase of implementing the Performance and Outcome Measurement System (POMS) and developing a strengthened version of the performance contracts with CSBs and facilities. These enhanced performance contracts would include approaches to reward superior performance and deal with poor performance of CSBs and state facilities.

Human Rights. Following reports of serious incidents and deaths in state mental health and mental retardation facilities, the joint subcommittee asked the State Mental Health, Mental Retardation and Substance Abuse Services Board to study and provide recommendations on issues related to human rights protections afforded consumers in state facilities and community programs. Based on that report, the joint subcommittee recommends strengthening the human rights programs in state facilities and communities, revising and consolidating the regulations, and assuring adequate standards and oversight. Moreover, the joint subcommittee agrees that the most effective structure and location of an external human rights protection system should receive further study. Key to the

effectiveness of any system are free and open access to advocacy services, equal availability of services, adequate resources, mechanisms for the standardization and coordination of rights protection systems, and reliable, accessible, and timely data.

Restructuring the flow of funding and maximizing Medicaid. Since 1991, community Medicaid funds for mental health and mental retardation have grown from $15 million to $134.9 million for fiscal year 1998. While the increase has resulted in an expansion of total spending for the community services system, it has exacted a price from existing financial resources. Through fiscal year 1997, over $42 million of CSB state general funds have been transferred to the Department of Medical Assistance Services (DMAS) for Medicaid match. The transfer has reduced state funding for consumers who are not Medicaid-eligible and has limited the ability of the Commonwealth to address the significant unmet need for community services. In addition, if community capacity were expanded through the Medicaid Waiver, mental retardation facility beds could be reduced by approximately one-half; but the state general fund match for private providers comes from the CSB base budget, a practice that is inconsistent with the allocation of the general fund match for other Medicaid services.

The joint subcommittee recommends that state general funds currently used by CSBs to match Medicaid dollars be restored to the CSBs to provide individualized packages of services in the communities for individuals who are on waiting lists or can be discharged from state facilities. In addition, match funding should be appropriated to the Department of Medical Assistance Services for mental health, mental retardation services, and substance abuse services as it is for all other health care services. Finally, Medicaid coverage of mental health, mental retardation, and substance abuse services should continue to be expanded to ensure the maximum use of federal funds for Medicaid-eligible persons.

To restructure the flow of funds and to achieve a full integration of Medicaid, the joint subcommittee makes these recommendations: (i) the DMHMRSAS should develop and implement a funding mechanism that reallocates a reasonable proportion of resources saved through state facility bed reductions to CSBs, provided that facilities continue to meet appropriate standards of care; and (ii) the Secretary of Health and Human Resources, the DMHMRSAS, and the DMAS should present a plan to subcontract (carve-out) the administration of Medicaid-covered mental health, mental retardation, and substance abuse services to the DMHMRSAS prior to the 2001 Session of the General Assembly.

Mental health, mental retardation, and substance abuse services. The joint subcommittee found that issues related to residential alternatives, primary health care, and geriatric services affected consumers of mental health, mental retardation, and substance abuse services. For example, over 11,000 individuals are currently waiting for residential services; publicly funded primary health care is being delivered increasingly through health maintenance organizations, raising questions about adequacy and the desirability of integrating primary health care and behavioral health care; and elderly Virginians with mental disabilities or substance abuse disorders require special services that will integrate treatment for their disorders with services to address the effects of aging.

The joint subcommittee recommends that (i) pilot projects be developed to determine the appropriate treatment and supports for persons with mental illness, mental retardation, or substance abuse problems who reside in adult care residences and (ii) a study be conducted on the feasibility of creating a capital fund to address the housing needs of persons with mental disabilities or substance abuse problems. The joint subcommittee also recommends that an assessment be made of the primary health care needs of persons with mental illness, mental retardation, and substance abuse problems, and that the feasibility of providing a supplement to private nursing homes and other alternatives to expand community-based services for elderly individuals with mental disabilities and drug abuse problems be examined.

The availability of the new atypical antipsychotic medications, intensive treatment programs, and psycho-social rehabilitation in community settings is critical to keeping consumers in the community and to downsizing state facilities successfully. Individuals with brain injuries who receive treatment in the mental health system, individuals who are deaf or deaf and blind and have mental disorders, and children with or at risk of serious emotional disorders require additional services and plans for tailoring services to their individual needs. The joint subcommittee recommends that (i) the availability of antipsychotic medications be increased; (ii) intensive community treatment teams be established in communities with the highest usage of state mental health facility beds; (ii) psycho-social rehabilitation services continue to be available for consumers; and (iv) plans be made for enhancing services for persons with brain injuries who receive treatment in the mental health system, persons who are deaf or deaf and blind and have mental disorders, and children with or at risk of severe emotional disturbance.

The joint subcommittee believes that persons with mental retardation should be provided with a full array of supports and services, including both state facility and community-based services, so that access to services can adjust to meet the changing needs of the individual. Toward that end, the joint subcommittee recommends that

Medicaid funding for mental retardation services be maximized; state general funds be allocated for consumers in the greatest need on the basis of individualized service plans; plans be made to implement aggressive prevention programs; and pilot projects be implemented for housing development, mobile community crisis stabilization, community facilities for medically fragile children, a Center for Developmental Medicine, and regional emergency management funds.

The joint subcommittee learned that drug addiction affects everyone, either directly or indirectly, because substance abuse is often at the root of crime, family violence, poverty, diminished physical and mental well-being, and lost productivity and income. The Department of Mental Health, Mental Retardation and Substance Abuse Services estimates that more 500,000 Virginians need treatment for alcohol and other drug abuse. To combat the problem of substance abuse, the joint subcommittee recommends that (i) leadership and coordination of substance abuse services and resources be strengthened among state and local agencies; (ii) consumers have access to a continuum of care, including prevention, in every community; and (iii) offenders have access within available resources to substance abuse treatment. The joint subcommittee also recommends further study of welfare reform and substance abuse policy and exploring the feasibility of expanding Medicaid reimbursement for substance abuse services.

Resource requirements. In the Comprehensive State Plan for 1998-2004, the CSBs identified $75.11 million in unmet community need for fiscal year 1999, $150.23 million for fiscal year 2000, and over $360 million annualized for the six-year period from 1998 to 2004. The Plan also proposed that $31.7 million in fiscal year 1999 and $36.9 million in fiscal year 2000 be allocated to expand community services and avoid the use of state facilities. The mental health, mental retardation, and substance abuse work groups confirmed that funding such items as atypical medications, intensive community treatment programs, adult care residences pilot projects, drug courts, treatment for offenders, wrap-around services, Medicaid mental retardation waiver expansion, crisis stabilization teams, housing projects, and alternative community facilities for medically fragile children would support needed policy and treatment advances in Virginia. Although some items have a delayed implementation, the joint subcommittee recommends a total of $400 million in new spending over the next biennium to implement their recommendations.

Conclusion. Following two years of review and analysis, the Joint Subcommittee Studying the Future Delivery of Publicly Funded Mental Health, Mental Retardation and Substance Abuse Services has made recommendations to effect sweeping changes in the

governance and structure of the system, allocation of resources, access and availability of publicly funded services, the use of managed care techniques, accountability, consumer participation, and protection of human rights. The joint subcommittee believes that many additional issues still need to be resolved and oversight is required for the implementation of recommendations contained in this report. The joint subcommittee's final recommendation is that the review of publicly funded mental health, mental retardation, and substance abuse services be continued to oversee the following areas: (i) implementation of the numerous statutory and policy changes and budget initiatives recommended by the joint subcommittee, (ii) the results of the Performance and Outcome Measurement (POMS) project, (iii) development of the Community and Facility Master Plan, (iv) implementation of the Medicaid carve-out, (v) results from the priority population pilot projects and the primary health care needs assessment, and (vi) the findings from recommended studies on human rights and other significant issues identified by the joint subcommittee.

II. INTRODUCTION

The Joint Subcommittee Studying the Future Delivery of Publicly Funded Mental Health, Mental Retardation and Substance Abuse Services was established by House Joint Resolution 240, introduced in the 1996 Session of the General Assembly. The Resolution directed the joint subcommittee to examine:

- the current services system;
- principles and goals of a comprehensive publicly funded program;
- the range of services and eligibility for those services;
- methods of funding publicly supported community and facility services, including operations and capital needs, and projecting the costs of meeting identified needs;
- relationships between the Department and components of the system, such as the CSBs and the state facilities;
- information and related technology needs to provide appropriate and enhanced accountability;
- changes needed to the *Code of Virginia* relating to mental health, mental retardation, and substance abuse services;
- ways to effectively involve consumers and families in planning and evaluating the publicly funded system; and
- recommendations of previous studies and the work of the Secretary's System Reform Task Force.

The first year of the joint subcommittee's work was devoted to learning about the services system in Virginia and examining systems in other states. In 1996, the joint subcommittee conducted five two-day meetings, each consisting of focused work sessions, public hearings, and tours of community programs and state facilities. Meetings were held in Richmond/Chesterfield/Petersburg, Tidewater, Roanoke, Southwest Virginia, Lynchburg/Danville, and Northern Virginia. The members listened to hours of public testimony in each site, hearing from citizens about the needs in each locality and about the services needed for family members and loved ones. The joint subcommittee heard concerns about:

- the future role and function of the State Mental Health, Mental Retardation and Substance Abuse Services Board, the Department, state facilities, community services boards, and private providers;
- prioritizing who should be served with limited public resources;
- managed behavioral healthcare;

- consumer assurance of legitimate choices in service providers and participation in decisions about treatment and supports;
- accountability to assure high quality outcomes for consumers;
- local government's future role in managing the services system at the local level;
- access to and availability of services;
- system-wide funding, including state general funds, federal funds, Medicaid, and local matching funds;
- how to provide services to consumers and families who are not eligible for Medicaid, but who cannot afford private care; and
- issues of efficiency and quality of services.

In 1997, the joint subcommittee established three work groups. The Mental Health Work Group was chaired by Senator Gartlan, the Mental Retardation Work Group was chaired by Delegate Bloxom, and the Substance Abuse Work Group was chaired by Delegate Hall. The work groups made recommendations to the joint subcommittee regarding populations and services to be supported by public resources in community and state facility settings, consumer participation, and prevention services.

The joint subcommittee wishes to express its gratitude to the numerous dedicated consumers, families, professionals, local government officials, and others who contributed to the products of the work groups. The cooperation and innovative thinking that was evident in their deliberations was truly remarkable and contributed enormously to the overall quality of the work of the joint subcommittee.

The joint subcommittee met regularly in extensive sessions hearing presentations and developing recommendations. Prior to each meeting, and frequently between meetings of the full joint subcommittee, the work groups met to develop their specific proposals. Throughout the year, the joint subcommittee issued a series of staff "Issue Briefs." These issue briefs were circulated widely and public comment was solicited and received. The joint subcommittee established an Internet web site **(http://legis.state.va.us/dls/hjr 240)** where anyone could access the documents and download the full text for analysis and comment.

The joint subcommittee reviewed public comment received at each meeting and revised the issue briefs to reflect the public comment decisions made at the meetings. In November, the joint subcommittee released its preliminary recommendations for public comment. In December, the joint subcommittee conducted four public hearings to hear

from citizens about their reactions to the recommendations. In general, the testimony at the public hearings was supportive of the joint subcommittee's preliminary recommendations. Those testifying urged the joint subcommittee to continue its oversight of the services system to assure implementation of its recommendations.

III. OVERVIEW OF VIRGINIA'S PUBLIC MENTAL HEALTH, MENTAL RETARDATION, AND SUBSTANCE ABUSE SERVICES SYSTEM

A. Current Services System Structure And Responsibilities

Title 37.1, Chapters 1 through 15, of the *Code of Virginia* designates the Department of Mental Health, Mental Retardation and Substance Abuse Services as the state authority for alcoholism, drug abuse, mental health, and mental retardation services. As the state authority, the Department assures that efficient, accountable, and effective services are available for citizens with the most serious mental disabilities and alcohol or other drug abuse problems.

By statute, the State Mental Health, Mental Retardation and Substance Abuse Services Board offers policy direction for Virginia's services system. The Department's central office provides system leadership, direction, and accountability through a variety of functions, including policy interpretation and implementation, strategic planning, licensure, human rights, technical guidance, operational oversight and monitoring, funding, performance contracting, risk management and quality assurance, research and evaluation, and staff development and training.

Virginia's publicly supported services system includes 15 state facilities and 40 community services boards and behavioral health authorities. These are listed in Appendix 2. Community services boards and behavioral health authorities are the local government agencies responsible for delivering community-based mental health, mental retardation, and substance abuse services, either directly or through contracts with private providers. Throughout this report, references to CSBs include behavioral health authorities, unless otherwise stated. The enabling legislation for CSBs, Chapters 10 and 15 of Title 37.1 of the *Code*, prescribes requirements and responsibilities for the Boards.

The CSBs serve as the single point of responsibility and authority for assessing consumer needs, accessing a comprehensive array of services and supports; and managing state-controlled funds for community-based services. Today, the 40 CSBs provide services in all 135 cities and counties in Virginia. Only emergency services are mandated. In fiscal year 1996, the unduplicated counts of people receiving CSB services by program area were: 116,344 received mental health services; 19,169 received mental retardation services; and 64,354 received substance abuse services.

In addition to their service provision responsibilities, CSBs are advocates for consumers; community educators, planners and organizers; and advisors to local government. Boards also serve as gatekeepers for accessing needed services and supports through case management and state facility preadmission screening and predischarge planning activities.

The CSBs exhibit tremendous variety in almost all aspects of their composition, organizational structure, services, and relationships. At present, 11 CSBs serve one city or county; 29 serve from two to 10 localities. Other indications of CSB diversity are budget size and rural/urban population characteristics. Currently, nine CSBs are classified as small boards, with total budgets of less than $5 million each; 21 CSBs are medium boards, with total budgets of between $5 and $11 million; and 10 CSBs are large boards, with total budgets over $11 million. CSBs with a population density of fewer than 130 people per square mile are classified as rural boards and those with 130 or more people per square mile are classified as urban boards.

The Department operates 15 state mental health or mental retardation facilities which provide highly-structured intensive care, inpatient treatment, and training services. The state mental health facilities provide a range of psychiatric, psychological, nursing, support, and ancillary services. Specialized programs are provided for geriatric, child and adolescent, and forensic patients. The mental retardation training centers provide residential care and training in areas such as language, self-care, independent living, socialization, academic skills, and motor development. The Hiram Davis Medical Center provides medical care to state facility patients and residents. All state mental health facilities are accredited by the Joint Commission for Accreditation of Healthcare Organizations (JACHO) and all training centers are certified by the U.S. Health Care Financing Administration (HCFA) as meeting Medicaid standards of quality.

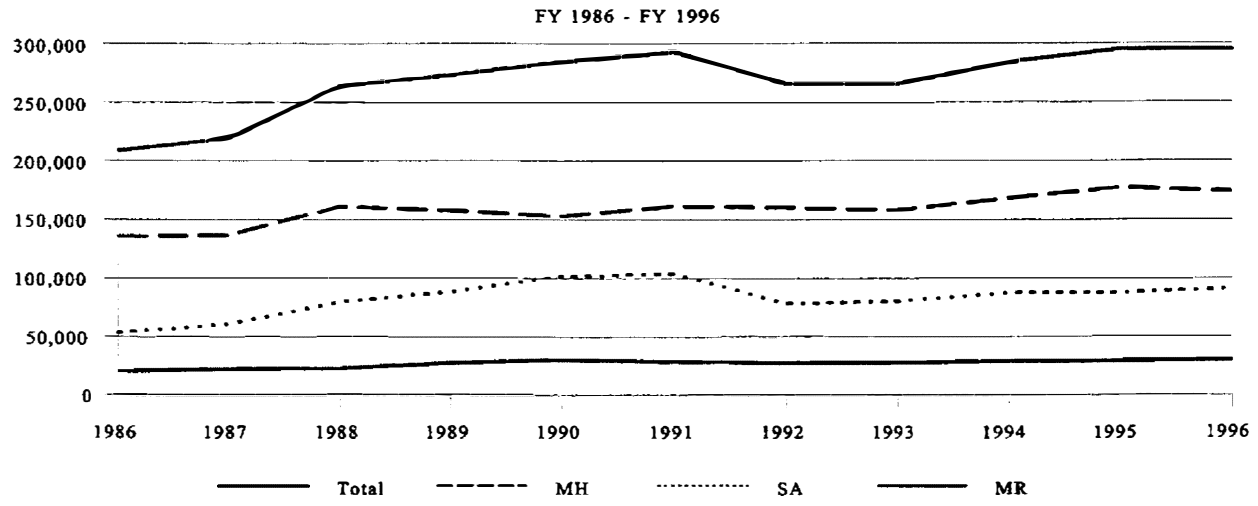
B. Recent Trends

Historically, the Commonwealth of Virginia has assumed major responsibility for the provision of services for its citizens with mental disabilities and substance abuse problems. As recently as 30 years ago, the state mental health and mental retardation facilities were the major providers of care and treatment for these individuals.

The enactment of legislation in 1968 enabling the creation of local community mental health and mental retardation services boards (CSBs) provided the vehicle for the local operation of comprehensive community-based mental health and mental retardation services. According to the Department's *Comprehensive State Plan for 1998-2004*,

between fiscal year 1986 (the first year that annual performance contract data were submitted by CSBs) and fiscal year 1996, the number of people receiving various CSB services grew from 208,453 to 294,882, an increase of 41.5 percent. From fiscal year 1986 to fiscal year 1996, total CSB resources increased from $147.5 million to $392 million, a 165.7 percent increase. Trends in the number of individuals receiving mental health, mental retardation, and substance abuse services from CSBs are included in the following graph.

Trends in Numbers of Individuals Served by CSBs

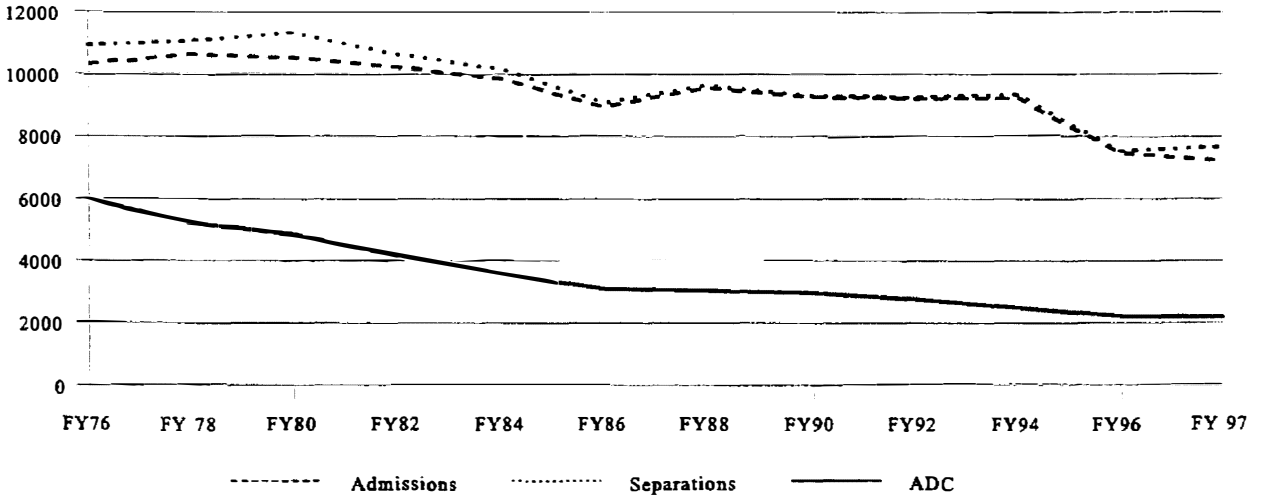


These numbers are taken from fourth quarter CSB performance reports of people receiving services by core service categories. Often, a person receives more than one service. Therefore, the numbers do not represent unduplicated numbers of people served.

Between fiscal year 1986 and fiscal year 1997, total state mental health and mental retardation facility resources increased from $ 263.6 million to $ 372.1 million, a 41.2 percent increase. Admission, separation, and average daily census trends (FY 1976 - FY 1997) for state facilities, excluding the Hiram Davis Medical Center, are included in the following graphs.

MH Facility Admissions, Separations, & Average Daily Census (ADC) Trends

FY 1976 - FY 1997

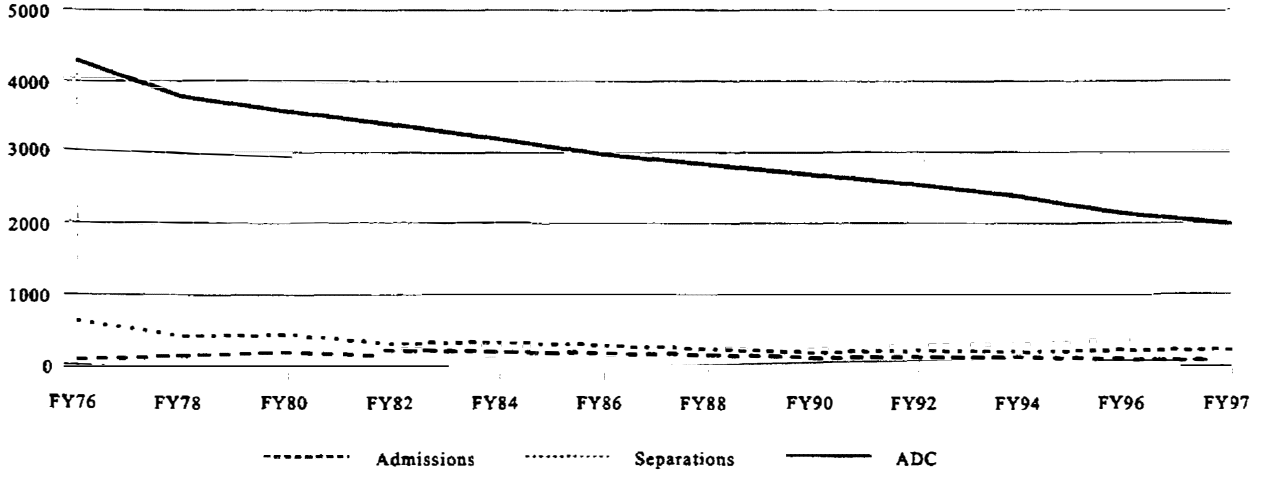


Note: The average daily census (ADC) and numbers of admissions and separations include the Virginia Treatment Center for Children (VTCC) through fiscal year 1991, when VTCC was transferred to MCV.

The average daily census has been declining at state mental health facilities since the 1970s. The rate of decline was 19 percent between fiscal years 1976-1980, two percent between fiscal years 1981-1985, 10 percent between fiscal years 1985-1990, and two percent between fiscal years 1991-1997.

MR Training Center Admissions, Separations, & Average Daily Census (ADC) Trends

FY 1976 - FY 1997



The average daily census has been declining steadily at state mental retardation training centers. The rate of decline was 17 percent between fiscal years 1976-1980, 12 percent between fiscal years 1981- 1985, 13 percent between fiscal years 1985-1990, and 19 percent between fiscal years 1991-1997.

C. Summary Of Services System Funding

The final adjusted appropriation of state funding for mental health, mental retardation, and substance abuse services in fiscal year 1997 (in millions) follows. It is important to note that while state facility funding information includes **all** revenue sources, the community services information reflects **only state appropriations**.

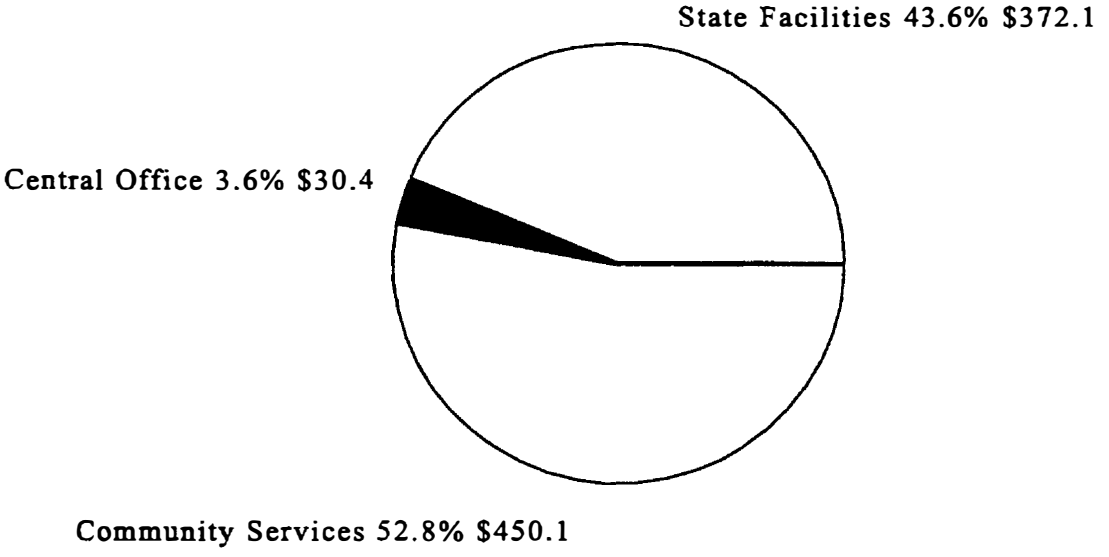
State Budget for State Facilities, Community Services, and Central Office
FY 1997 (Millions)

	FY 1997	Percent
State Mental Health and Mental Retardation Facilities	$372.1	53%
Community Services DMHMRSAS ($157.3) Department of Medical Assistance Services ($148.5)	$305.8	43%
DMHMRSAS Central Office	$30.4	4%
Total	$708.3	100%

The following charts from the *Comprehensive State Plan for 1998-2004* provide the total services system's final adjusted appropriation for **fiscal year 1997** from **all sources** (rounded and in millions), including local match and all fees as well as Medicaid Mental Retardation Home and Community-Based Waiver payments to private vendors. (Percentages may not add to 100 percent due to rounding.)

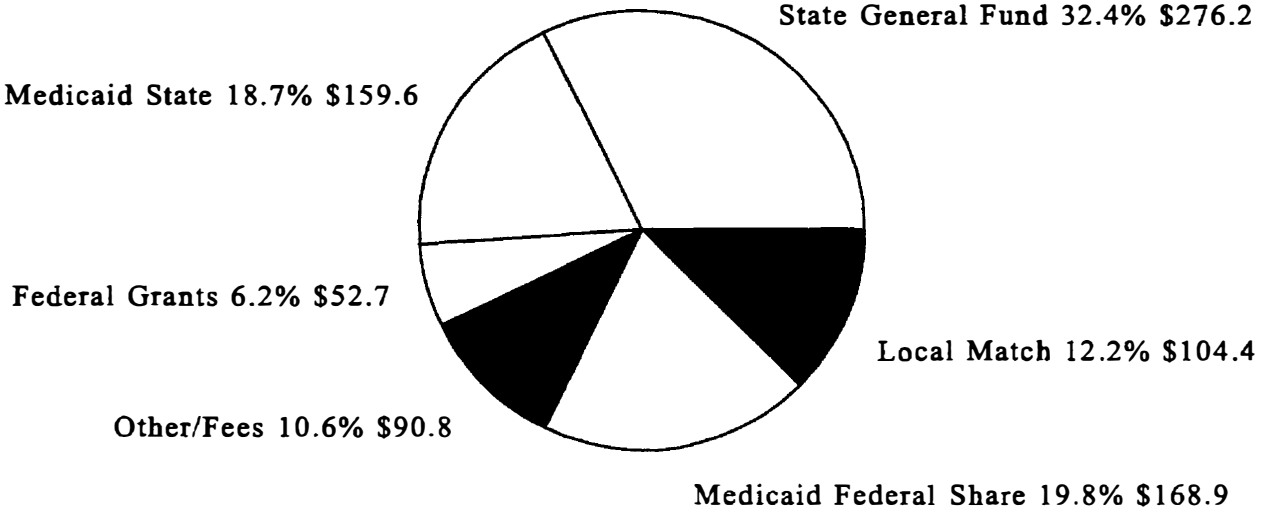
Total Services System Funding -- FY 1997

$ 852.6 Million



Total Services System Funding -- FY 1997

$ 852.6 Million



IV. FINDINGS AND RECOMMENDATIONS

The recommendations of the joint subcommittee provide future policy direction for the Commonwealth in the delivery of services to persons with mental illness, mental retardation, and substance abuse problems. These recommendations build on the strengths of the current state-local partnership that has fostered the development of a system of community-based services with state-level policy direction, oversight, and funding. Over the past three decades, the Commonwealth has demonstrated a commitment to the development and evolution of a community-based system.

The legislative and administrative changes offered by the joint subcommittee begin the process of restructuring the services system. These changes initiate the first important steps toward a system of inpatient facilities that provide specialized care and community services that are comprehensive and tailored to the needs of individuals. This new policy direction and guidance will increase opportunities for consumers and their families to be more involved in their treatment, as well as in policy making and services planning, delivery, and evaluation at both the state and local levels. In addition, service plans will be developed that focus on meeting individual needs.

As these recommendations are adopted and implemented, providers of services will be held accountable for their performance, as well as for the outcomes of the services provided to consumers. In addition, the recommendations begin to incorporate selected managed care practices such as pre-authorization, utilization management and review, and consumer satisfaction surveys and reports into the everyday operations of state facilities and community services boards. These practices and the required technology to assure financial and programmatic accountability to consumers, family members, and the public will move the services system to be more consumer-oriented and more efficiently operated and managed.

A. Consumer Involvement, Participation, And Choice

The joint subcommittee found that improvements in the services system are needed to increase opportunities for consumers and their representatives to be more involved in policy making; services planning, delivery, and evaluation; and decisions about their treatment, whether in public or private settings. "Best practice strategies" to expand consumer participation are being tested through the Department's Consumer and Family Involvement Pilot project. In addition, choices of treatment providers and support services for consumers and families should be broadened. The choice of services should, to every extent possible and practicable, be made by the consumer.

One of the services system values expressed by virtually every group and constituency that addressed the joint subcommittee is consumer choice; they believe that consumers should receive services in those settings that promote the highest quality of life. While this value must be balanced responsibly with the availability of services and the money to pay for them, the members of the joint subcommittee agree that consumers should be able to express and realize, to the greatest extent practical, their preferences regarding the services that they receive.

There are at least two important aspects of consumer choice: which services are provided and who provides the service. The services that are provided and available are enhanced by the full participation of the consumer in the needs assessment and services planning process at the state and local levels. The choice of providers is improved by developing a diverse network of providers from which the consumer can choose. If a consumer is not able to choose among available services and providers, family members or significant others in that person's life should be consulted and involved in making those choices. However, providers should make every possible effort to discern and respond to a consumer's preferences. Some individuals with severe disabilities are still able to express their preferences, sometimes even non-verbally.

Each individual should be encouraged to choose among service options designed to promote independence and functioning at the highest level possible within his or her physical or mental capability. The most appropriate but least intrusive supports or least restrictive options for services should be offered in each case to avoid excessive or unnecessary services or services that make the consumer dependent. Least intrusive or least restrictive, however, does not mean that community services will always be preferred over facility services, or that services in the home are more appropriate than services in a group or inpatient setting.

Public services should complement, not replace, natural family and community resources and supports that are adequate and continuing. The provision of the least intrusive levels of support will increase opportunities for people to build upon natural abilities and supports and to take more control over their lives by making their own decisions about the services and supports they want and need. If there is a disagreement between providers and consumers or their representatives, the parties should engage in good-faith efforts to reach consensus on a case-by-case basis. In no case should a provider's disagreement with a consumer's or a family member's choice limit the ability of a consumer to take advantage of an available service which is appropriate for him.

The joint subcommittee found that addiction, in particular, is a stigmatized disease, and as a result, barriers to consumer representation and advocacy have been significant. The substance abuse recovery community has been unable to play a positive role in policy development similar to that of other disease and disability groups. The Director of the National Institute on Drug Abuse calls the gap between the public's perception of drug abuse and the scientific data a "great disconnect." The public often views drug abuse and addiction as strictly a social problem and believes that addicts are simply unwilling to change their behaviors. In fact, scientific research demonstrating the effectiveness of treatment has raced far ahead of the public's perception on this issue.

Recommendation 1: *The Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS), Community Services Boards (CSBs), and state facilities should increase the involvement and participation of consumers and family members in policy and decision-making; service development, operation, and evaluation; and decisions about their treatment, habilitation, and recovery. The "best practice" strategies being developed through the Consumer and Family Involvement Pilot Projects of the Department should be used to form future policies, directives, and actions of the State Board, DMHMRSAS, CSBs, other providers, and local governments.*

Recommendation 2: *The DMHMRSAS should work with the CSBs to expand the pool of service providers through incentives to private providers and by creating opportunities for consumers and family members to provide services.*

Recommendation 3: *The DMHMRSAS should ensure that performance measures included in the performance contracts for both state facilities and CSBs include consumer satisfaction indicators. These indicators should reflect the range and variety of services offered by providers and the consumer's perception of his or her ability to choose among appropriate and desirable local service providers.*

Recommendation 4: *The DMHMRSAS, CSBs, and state facilities should develop and implement easy-to-use instruments to assess consumer and family member satisfaction and disseminate reports presenting the results of such surveys.*

Recommendation 5: *The DMHMRSAS and the CSBs should develop and implement consumer dispute resolution mechanisms that enable consumers and family members to raise and resolve with DMHMRSAS (including facilities) and CSBs concerns, issues, or disagreements about services without adversely*

affecting their access to or receipt of appropriate levels and amounts of current or future services from DMHMRSAS or CSBs.

Recommendation 6: *An education and advocacy network for the prevention and treatment of substance abuse should be created. This organization would educate the public and provide expertise for state and local policy development.*

B. Future Responsibilities Of State And Local Government, Private Providers, And the Academic Community

Since 1773, the Commonwealth has provided inpatient psychiatric care through state-operated mental health facilities. Since 1911, Virginia has provided inpatient habilitation services through mental retardation training centers.

Beginning in the 1940s and until establishment of the CSBs in the 1970s, state government was also responsible for providing community mental health services through a network of state-operated mental health clinics. Virginia provided community-based alcohol services through local health department clinics and local drug abuse services through grants to a variety of public and private providers.

In 1968, local governments began assuming the responsibility for providing local mental health, mental retardation, and substance abuse services. Initially, this occurred on a permissive basis until the *Code* was amended in 1980 to require every locality to join or establish a CSB. The *Code* only requires community services boards to provide emergency services.

In fiscal year 1996, more than 200,000 Virginians received state facility and community services from this network of publicly funded programs. However, this dual system of state-operated inpatient facilities and locally administered outpatient and residential services has led to an unbalanced distribution of state-controlled financial resources, inconsistent distribution of services, and a widely disparate availability of even a minimum array and level of services across the state.

There is no statutory language that clearly defines which part of the services system is ultimately responsible for the care of individuals who need treatment or support. This absence of clear responsibility leads to uncoordinated discharges from facilities to inappropriate placements in communities, lack of continuity of care between state facilities and community settings, sometimes inadequate care in the community, and difficulties in accessing appropriate services.

Because localities or CSBs provide no funding towards state facility care, many perceive that local governments and CSBs have few incentives, at least fiscally, for decreasing their use of state facilities, since this could increase the cost of locally provided services. Since the establishment of CSBs, local governments have provided significant but highly variable amounts of local funds for CSBs. In fiscal year 1997, 135 localities provided almost $103 million of local money for CSBs, ranging from a low of $63,370 for the smallest CSB to a high of $43 million for the largest CSB.

While the *Code* defines all 40 community services boards as agencies of the cities and counties that established them, local government relationships with and control over CSBs vary widely across Virginia.

The Department classifies 11 CSBs as city or county government departments. These CSBs, some of which serve more than one locality, are parts of their local governments' personnel and accounting systems. In some instances, the CSB's executive director functions as a city or county department head. The remaining 29 CSBs are classified as autonomous boards. Several of these CSBs serve a single city or county, but they are not part of their jurisdictions' personnel and accounting systems.

The array or range of services and the ways in which they are delivered are decided by each CSB. Thus, the way in which a person may access services, the types of services provided, the admission criteria, the fees charged, and consumers' liability for the costs of services vary considerably across Virginia. How CSB boards of directors guide, direct, and monitor the operations of their agencies also differs widely across the state.

The ability of consumers and family members to serve on CSB boards of directors varies among the CSBs. They also have different opportunities to provide services and make decisions about planning, implementing, and evaluating services. Consumers' abilities to raise and resolve grievances and concerns easily and effectively without the fear or perception of possible negative consequences also varies.

The unique relationships between particular CSBs and their local governments, the range of organizational structures among CSBs, and the marked differences in service availability across the state have raised concerns. Primarily, the joint subcommittee is concerned about the highly variable levels of accountability and service quality and the lack of consistency in service availability across the system.

The joint subcommittee recommends a number of legislative actions to clarify the roles and responsibilities of state and local governments for the provision of services. These recommendations are described in the following sections and the proposed legislation is included in Appendix 3 of this report.

1. Relationships and Responsibilities of the State Mental Health, Mental Retardation and Substance Abuse Services Board

The joint subcommittee does not recommend any changes in the State Board's responsibilities. The Board's statutory responsibilities include promulgating programmatic and fiscal policies governing the operation of state facilities and CSBs and ensuring the development of long-range programs and plans for the services system.

The State Board recommended to the joint subcommittee that the Secretary of Health and Human Resources designate a staff person in the Secretary's Office to serve as liaison with the Board. The joint subcommittee agrees that such liaison would improve the Board's ability to carry out its statutory duty to advise the Governor on matters related to the services system.

The services system will need to be responsive to the needs and concerns of local governments in managing state facilities and community services. As the body which provides policy direction for the services system, the State Board should promote, nurture, and oversee these relationships.

It is clear to the joint subcommittee that the emphasis of the future services system should be on tailoring packages of individualized services and supports to the particular needs of consumers who have the highest priority need for publicly funded services. However, the Commonwealth must ensure that future policies defining priority populations will not prevent individuals who need services from getting them.

Many citizens and professionals testified that the Department's *Comprehensive State Plan* is a valuable tool for documenting the needs of the services system and for long-range planning. The State Board is responsible under § 37.1-10 of the *Code* "to ensure the development of long-range programs and plans for mental health, mental retardation and substance abuse services provided by the Commonwealth and by community services boards."

Recommendation 7: *To ensure that issues of concern to local governments are resolved at the highest policy level, one member of the State Board should be an elected local government official.*

Recommendation 8: *Legislation on priority populations should not be enacted this year. However, the State Board should use the results of the pilot projects on Priority Populations to begin the development of policies that define priority populations. The State Board should involve the Department, CSBs, Virginia Hospital and Healthcare Association, Virginia Network of Private Providers, and consumer and advocacy groups in the development of these policies.*

Recommendation 9: *The State Board should provide oversight for the development and implementation of the Comprehensive State Plan.*

2. Relationships and Responsibilities of the Department of Mental Health, Mental Retardation and Substance Abuse Services

The Department of Mental Health, Mental Retardation and Substance Abuse Services should continue to be responsible to the General Assembly for all publicly funded mental health, mental retardation, and substance abuse services. To carry out its responsibilities, the Department must:

- provide system leadership and direction;
- conduct state-level strategic planning;
- develop and enforce state-wide quality and utilization standards;
- implement policy;
- maintain a statewide services information system;
- establish and monitor consumer appeals mechanisms;
- disseminate report cards on community and state facility services;
- operate state facilities;
- contract for community services; and
- ensure the effective utilization of state-controlled funds by CSBs and state facilities.

Consumer Choice. A critical responsibility of the Department in managing the future services system is to ensure true consumer choice. The Department must address concerns about the inherent role conflict when the provider of services also coordinates and manages a consumer's access to and use of services while directly delivering some or all of those services. A number of groups advocate the complete organizational

separation of these two functions. Others note that, while this concept might be desirable, it is not practical in many places in Virginia.

While legitimate concerns exist about the possible adverse effects of service monopolies on consumer choice and service efficiency, effectiveness, and responsiveness, it may not always be possible or desirable to organizationally separate case management and direct service provision. Similarly, concerns have been expressed about the potentially negative consequences a rigid separation of these functions would have on service coordination.

Priority Populations. The Department has begun the process, through pilot projects, to develop mechanisms to ensure that individuals with the most serious mental illnesses, mental retardation, or alcohol or other drug abuse problems receive the highest priority for publicly funded services. This includes adults with serious mental illnesses, children and adolescents with serious emotional disturbances, and individuals with mental retardation or alcohol or other drug abuse or dependence who have lower levels of functioning, more intense service and support needs, and life situations that increase their risk of abuse or exploitation.

The joint subcommittee circulated for public comment proposed legislation that would direct the Department to allocate a significant proportion of its funds to priority populations and provide funds for other populations. This legislation would have directed the State Board to develop the policies that define priority populations. The Department would be required to develop funding mechanisms to support the provision of individualized services and supports to the priority groups, as well as to others. However, the joint subcommittee decided not to introduce the proposed legislation in 1998. This decision was based on the fact that information required to develop the policies on priority populations is being formulated through the pilot projects that the Department is currently conducting. The results of the pilots will not be known until mid-1998.

Comprehensive State Plan. Through language in the 1997 Appropriation Act, the General Assembly directed the Department to produce a *Comprehensive State Plan for 1998-2004*. The plan is developed through a broad-based regional process that involves CSBs, state facilities, consumers, families, advocates, and others. In addition to providing service needs and identifying demand, the Plan documents unmet need across the Commonwealth. Local governments recommended that local officials sign off on the data submitted by CSBs to the Department for the Comprehensive State Plan. However, the joint subcommittee believes that this is a requirement that could be imposed administratively by the local governments, if they choose to do so.

Office of Substance Abuse Services. Currently, responsibilities for substance abuse and mental health services are merged in one office in the Department. The lack of a separate office and dedicated staffing have resulted in diminished focus, inability to compete successfully for needed resources, and insufficient leadership and statewide advocacy for substance abuse services.

Through the independence and visibility of a separate substance abuse office, the director could provide strong professional leadership, expertise, and accountability to attack the mounting problems associated with substance abuse across the Commonwealth. Under a separate Office of Substance Abuse Services, the director would be the single state manager for matters concerning substance abuse treatment in the Commonwealth. Since Department resources can be reallocated, no additional funds or positions are necessary to establish a separate office.

Office of Prevention Services. The leadership structure at the state level for prevention programs needs to be strengthened to ensure better planning, coordination, and accountability. Establishing a separate Office of Prevention in the Department will ensure that staff and resources are allocated exclusively to planning, implementing, and evaluating prevention programs. Leadership that is divided between treatment and prevention results in diminished attention to the prevention of substance abuse and related problem behaviors.

Quality of Care and Department of Justice Requirements. The U.S. Department of Justice (DOJ), under the authority of the Civil Rights of Institutionalized Patients Act (CRIPA), has been involved in state mental health and mental retardation systems nationwide since the early 1980s. DOJ's first investigation of state facilities in Virginia began in 1990 with the Northern Virginia Training Center in Falls Church. DOJ investigated Eastern State Hospital in Williamsburg in 1993, the Northern Virginia Mental Health Institute in Fairfax in 1994, and Central State Hospital in Petersburg in 1996. The Commonwealth has reached settlement agreements with DOJ with regard to the Northern Virginia Training Center, Eastern State Hospital, and the Northern Virginia Mental Health Institute. Negotiations are ongoing for both the civil and forensic programs at Central State Hospital.

Although the specific plans of correction for the various facilities are privileged, the focus of the changes required by DOJ are:

- additional staffing
- individualized treatment planning

- active treatment models
- aggressive discharge planning
- lower facility census

To meet these requirements, the Commonwealth has already invested and will continue to invest significant resources in state-operated facilities. In November 1997, the Acting Commissioner estimated that if other large facilities (Central Virginia Training Center in Lynchburg, Southside Virginia Training Center in Petersburg, and Western State Hospital in Staunton), which have not to date been investigated by DOJ, were to meet the federal requirements for active treatment, the Commonwealth would need approximately 930 staff and an estimated $24 million annually in state general funds just for those facilities.

Capital Improvements. An additional resource requirement for the Commonwealth is the need to maintain and improve the current buildings and campuses of the state mental health and mental retardation facilities. The Department's six-year capital plan projects that $394 million in improvements will be required if the present facilities and beds are maintained and modernized.

Clearly, the Commonwealth needs a plan to downsize selected state facilities while expanding the capacity of communities to care for persons who will be discharged from those facilities.

Recommendation 10: *The DMHMRSAS should establish statewide standards in areas of consumer access to services, outreach to consumers and families, service quality, consumer grievances and appeals, and consumer satisfaction. The Department should establish mechanisms for dealing with providers, including CSBs and state facilities, who do not comply with these standards.*

Recommendation 11: *The DMHMRSAS should be authorized to contract with other public agencies and with private non-profit or for-profit organizations for local services when a CSB, after remediation efforts have proven to be unsuccessful, remains in substantial non-compliance with its performance contract, or when the CSB fails to serve certain populations.*

Recommendation 12: *The DMHMRSAS should establish a dispute resolution mechanism for private providers that contract with CSBs or state facilities to use if these providers cannot achieve a satisfactory resolution of issues, concerns, or problems with a CSB or state facility.*

Recommendation 13: *The DMHMRSAS should develop more sophisticated management oversight systems (e.g., management information systems, utilization review staff and processes, quality assurance, and consumer involvement mechanisms) and require adherence to these management practices through an enhanced Performance Contract with each CSB.*

Recommendation 14: *The DMHMRSAS, with input from CSBs, consumer and family groups, private providers, and local government representatives, should develop and implement an adult state psychiatric bed day allocation system through the CSB performance contract. This system should identify specific bed utilization targets for each CSB and include financial incentives or disincentives which should be applied through the CSB performance contracting mechanism.*

Recommendation 15: *The DMHMRSAS should obtain the assistance of knowledgeable and experienced professional consultants, well versed in public mental health and mental retardation facility census management, as it develops this bed utilization target mechanism.*

Recommendation 16: *The DMHMRSAS should implement strategies and procedures that are intended to increase services access, effectiveness, and choice through competition and other practices that foster competition. Such practices include contract negotiation, publication and dissemination of report cards, outcome and performance measures, and consumer satisfaction surveys. These practices will help to mediate potential role conflicts. Actual or perceived conflicts of interests should be addressed by identifying and correcting deficiencies in consumer choice and satisfaction through contracting mechanisms. Provider performance measures and consumer satisfaction indicators should be used to evaluate the degree to which a CSB has addressed these dual function concerns.*

Recommendation 17: *The DMHMRSAS should complete the pilot projects on Priority Populations and recommend to the Governor and General Assembly, by December 1, 1999, legislation to implement priority populations. The draft legislation of the joint subcommittee should serve as the basis for the Department's review and recommendations.*

Recommendation 18: *The DMHMRSAS should be required to develop and update a Comprehensive State Plan on a biennial basis. Before the next biennial update of the Comprehensive State Plan in 1999, the DMHMRSAS, with input from CSBs, state facilities, consumers and family members, advocacy groups, and local*

governments, should develop an easily applied, consistent, and quantifiable methodology to document the unmet needs for services. This methodology should clearly define what is included in the calculation of unmet needs and to which populations that methodology will be applied. The results of this methodology should be verifiable, at least on a sample basis.

Recommendation 19: *The DMHMRSAS should re-establish a separate Office of Substance Abuse Services to strengthen leadership and system planning.*

Recommendation 20: *The DMHMRSAS should re-establish the Office of Prevention Services within the Department to provide leadership in planning, implementing, and evaluating prevention programs.*

Recommendation 21: *The DMHMRSAS should develop a Community and Facility Master Plan by December 1, 1998. The Community and Facility Master Plan should utilize nationally recognized private sector consultants to determine the future number of individuals that can be served in the communities, resources needed to provide appropriate community capacity, the numbers of individuals that will continue to require facility care, the optimum size, and location of facilities. The DMHMRSAS should ensure that representatives of consumers, families, and advocacy groups participate in the development of this Plan.*

Options for staff transition, economic impact on localities, and potential alternative uses for state facilities should be included in the final report. In addition, the master plan should determine the feasibility of utilizing other operating models for state facilities, such as operation of a facility or a specialized program area by a private contractor.

As specific plans for downsizing or changing the use of facilities are formulated, the Department should work with the Virginia Municipal League and the Virginia Association of Counties to ensure that those local governments that will be most affected will be consulted and included in the formulation and implementation of any plans regarding state facilities.

3. Relationships and Responsibilities of State Mental Health and Mental Retardation Facilities

The joint subcommittee believes that state government should continue to fund and operate the current 15 mental health and mental retardation facilities. While there will be

an important role for state facilities in the future services system, roles may focus more on specialty services, such as forensic, extended rehabilitation, geriatric services, and services to populations with multiple disabilities or significant medical needs.

Trained and experienced staff at state mental health facilities and mental retardation training centers should be considered an asset to the services system and provided opportunities for transitioning to expanding community services that are receiving discharged patients and residents from those facilities.

Recommendation 22: *The DMHMRSAS, with input from state facilities and CSBs, should examine and, where necessary, revise state facility catchment areas. This study should identify any proposed changes or realignments in facility catchment areas needed to improve CSB and state facility coordination, increase appropriate consumer access to state facility services nearer to home communities, and enhance pre-discharge planning and the best community placements for patients and residents in state facilities.*

Recommendation 23: *Given the current variability in admission and discharge criteria and protocols across state facilities, the DMHMRSAS, with input from facility directors and staff, CSBs, consumers and family members, and advocacy groups, should develop consistent and, where applicable, uniform clinical protocols for admission to and discharge from its facilities. The DMHMRSAS should seek consultation in the development of these protocols from managed care organizations or administrative services-only organizations that are experienced in the management of public mental health services.*

Recommendation 24: *Whenever possible, acute short-term psychiatric inpatient services should be provided in the community by private hospitals, which can receive Medicaid funding for this service. Local inpatient care for individuals who are not enrolled in Medicaid should be supported to the extent possible by state general funds allocated to the CSBs.*

Recommendation 25: *The DMHMRSAS, in consultation with state facility directors, should develop and implement a consistent, uniform methodology for determining the actual numbers of beds funded at and operated by each state facility. These figures should become the official capacity figures for the state facility system for planning, costing, and census management purposes.*

Recommendation 26: *The DMHMRSAS should develop and include options for state facility staff in any future planning regarding state mental health and mental retardation facilities. Among the options that should be considered are:*

- *reasonable access to and priority for community services positions for which they are qualified by their training and experience;*
- *access to a reasonable relocation package;*
- *access to training; and*
- *access to a reasonable severance packages, based on years of employment by the state.*

4. Relationships and Responsibilities of Local Governments and Community Services Boards

The partnership with local government that has fostered and increased the resource base of the publicly funded mental health, mental retardation, and substance abuse services system should be continued and strengthened. The joint subcommittee believes that the Department of Mental Health, Mental Retardation and Substance Abuse Services should continue to be the statewide manager of care and resources. However, decisions about services should continue to be made at the community level, by CSBs, within a policy and funding framework for state-controlled resources established by the State Board and Department.

Local governments should continue to be responsible for organizing and managing community-based mental health, mental retardation, and substance abuse services. Localities are encouraged to partner with other local governments to stay competitive and be responsive to consumer needs. Local governments should provide more flexible staffing policies and budgeting mechanisms to allow CSBs to be cost-competitive. Localities should continue to provide funds for local priorities that are not funded by the state. Local maintenance of effort should be continued; however, unfunded mandates should not be permitted.

To the extent possible, relationships between local governing bodies and CSBs should be clarified to provide for more consistent responsibilities and clearer accountability across the state. The joint subcommittee recommends extensive revisions to Chapter 10 of Title 37.1 of the *Code* to distinguish between CSBs that function as local government departments and those that operate more autonomously. The statutory changes describe two types of community services boards:

(1) policy-making CSBs that set policy and monitor the operations of those local government departments, and
(2) operating CSBs, which resemble many of the more autonomous CSBs that typically serve more rural areas and more than one city or county.

The changes require different levels and types of accountability to the Department and to local government for these two types of CSBs. Other proposed changes include:

- mandating the provision of an additional service, case management, which all CSBs now provide;
- requiring consumer and family membership on community services boards, but with no other membership mandates;
- permitting but not requiring expansion of local government and private provider membership;
- clarifying the CSB's unambiguous role as the single point of entry into the services system;
- placing an enhanced version of the CSB performance contract in the statute;
- giving the Department the option, after exhausting all other remedies, of contracting with another organization if the CSB remains in substantial non-compliance with its performance contract; and
- clarifying local government match requirements.

Similar revisions to Chapter 15, Behavioral Health Authorities, are recommended to conform that chapter as much as possible to the applicable provisions in Chapter 10 related to operating CSBs. Rather than reexamining the creation of behavioral health authorities by local governments, the joint subcommittee recommends changes to reflect the revisions proposed to Chapter 10 and to increase the accountability of behavioral health authorities to both the Department and the local governments that establish them.

Recommendation 27: *CSBs that are actual departments of a city or county government should be distinguished from CSBs that function as autonomous operating boards.*

Recommendation 28: *Local governments should have flexibility to establish either a local government department with a policy-making board or an operating board. An operating board should function relatively independently of the local governments that created it.*

Recommendation 29: *CSBs should be local care coordinators and not the primary or only providers of services. Where this is not possible, the CSB, with the Department's authorization, may be the primary provider of services.*

Recommendation 30: *One-third of the appointments to CSBs must be consumers or family members of consumers and at all times at least one member must be a consumer. Consumers and family members must be identified.*

Recommendation 31: *Local governments should be permitted but not required to appoint to the CSBs no more than two elected or appointed local government officials from any city or county belonging to the CSB, one of whom may be a sheriff, when practical. Private providers may also be appointed to the board.*

Recommendation 32: *For CSBs that are not actual city or county government departments (operating CSBs), the DMHMRSAS should participate in the recruitment and approve the selection of the executive director before a final offer of employment has been made.*

Recommendation 33: *For operating CSBs, executive directors should be employed under contracts with clearly defined performance expectations. The DMHMRSAS should review and approve these employment contracts.*

Recommendation 34: *For operating CSBs, the compensation packages for executive directors and senior management staff (e.g., mental health, mental retardation, and substance abuse directors) should be reviewed and approved by the DMHMRSAS.*

Recommendation 35: *The CSBs' responsibilities for arranging discharge from state facilities should be clarified. CSB staff who prescreen individuals for temporary detention and commitment should be certified by the DMHMRSAS.*

Recommendation 36: *CSBs should contract with private providers for any service which can be provided effectively and at a reasonable cost.*

Recommendation 37: *CSBs should be contractually responsible for the effective and efficient use of all state-controlled funds. This should occur through the management of funding allocations from the DMHMRSAS for individualized packages of services and supports and for general access services, such as emergency services, that will be available to any resident of the community, and*

through the management of state facility resources (bed days) allocated to CSBs through mechanisms such as bed utilization targets.

Recommendation 38: *Managed care practices such as pre-authorization, utilization review, consumer satisfaction surveys, and report cards should be integrated into CSB management practices and monitored by the DMHMRSAS through an enhanced performance contract.*

5. Regional Cooperation

Several aspects of the services system demand coordination and cooperation at a higher level than the individual CSB or state facility. Responsible downsizing of state facilities requires coordinated planning and implementation at a regional level. Providing programs for persons with low-incidence clinical conditions or disabilities (e.g., Prader-Willi Syndrome) requires regional planning and service development. Peer review of local services and operations would be greatly facilitated by a regional coordinating mechanism.

The concept of regional partnerships proposed in the State Board's System Reform Model and presented to the joint subcommittee is one approach for stimulating and supporting regional responses. The Board's model suggests a number of functions for these partnerships: regional problem-solving, planning services, reviewing service utilization, implementing and monitoring special projects (such as using telemedicine and recruiting professionals), and making recommendations to the Department about future utilization of system resources.

The Southwestern Virginia Mental Health Board and other models have demonstrated that there are effective approaches to coordinating services and finding alternatives to facility admissions on a regional basis. Such models may be utilized to provide incentive funds to CSBs to finance community placements for individuals in state facilities and to avoid hospital admissions for others.

The recent Comprehensive State Plan development effort revealed both the difficulties and the value of regional planning. It also identified several regional catchment area issues that should be addressed.

Recommendation 39: *The DMHMRSAS, with input from state facilities and CSBs, should examine the needs and opportunities for regional cooperation, existing models, and proposals for enhancing regional cooperation. The DMHMRSAS*

study should identify models that could be used when regional responses to an issue or situation are needed.

6. Private Providers

Private providers deliver essential, high quality mental health, mental retardation, and substance abuse services annually to tens of thousands of Virginians in local communities. Private providers should continue to play this key role in the network of publicly funded mental health, mental retardation, and substance abuse services in Virginia.

CSBs should be encouraged to continue and expand the provision of services by private providers. Private providers offer a readily available means of increasing choice for consumers.

Recommendation 40: *The DMHMRSAS, with input from CSBs and representatives of private providers, such as the Virginia Hospital and Healthcare Association, Virginia Association of Health Maintenance Organizations, and Virginia Network of Private Providers, should develop specific proposals and strategies for increasing the provision of community services, especially local acute psychiatric inpatient services, by private providers across the state.*

Recommendation 41: *The State Board and the DMHMRSAS should continue and expand efforts to involve and increase the participation of private providers in policy development, planning, service delivery, and oversight and evaluation activities.*

Recommendation 42: *The DMHMRSAS should continue to explore and, where feasible and desirable, institute or expand the provision of services by private providers at its state facilities. Such initiatives should be carefully developed, with close attention devoted to economic efficiency, effectiveness, service quality, and continuity of care criteria in making the decision of whether to contract services.*

7. Linkages with the Academic Community

The Department and the CSBs recognize the importance of existing relationships and programs involving institutions of higher education. These relationships enhance the quality of services provided in state facilities and in community programs. Virginia colleges and universities also are instrumental in upgrading the skills of existing

community and facility staff through continuing education and in-service training activities and in preparing students for careers in state facilities and community settings through practicum experiences. These institutions include public medical schools, universities and colleges, and the community college system. Programs of particular interest include psychiatry; psychology; clinical social work; physical, speech, and occupational therapy; counseling; and rehabilitation at the college and university level and psychiatric or behavioral aide or technician training at the community college level.

Recommendation 43: *The DMHMRSAS should establish an informal forum of representatives from the institutions of higher education, CSBs, state facilities, and consumer and family advocacy groups to examine current and possible future roles for the academic community in the publicly funded mental health, mental retardation, and substance abuse services system. This forum should produce a report to the Commissioner that defines the appropriate roles for the colleges and universities in the publicly funded services system. The report should also present proposals for expanding linkages between the academic community and the state facilities and CSBs, particularly for the disciplines and specialties mentioned.*

C. Accountability

Virginia's public mental health, mental retardation, and substance abuse services system is accountable or answerable to consumers, family members, government officials, and taxpayers. Currently, accountability in the services system is described and measured through audits, cost containment practices, collection of fees and other revenues, types and amounts of services provided, and the existence of particular policies and procedures. Community services boards that are not city or county government departments submit annual CPA audits to the Department. CSBs that are city or county government departments might not be audited every year. Typically, these CSBs are included in their local government's audit on a periodic sample basis. State facilities and the Department are audited by the Auditor of Public Accounts.

State facility financial and service operations are documented in the financial management system (FMS) and the patient and resident automated information system (PRAIS). FMS includes cost, revenue, and staffing information about the cost centers in each state facility. PRAIS includes demographic, diagnostic, and clinical information about each patient and resident in state facilities. Neither system includes consumer outcome or provider performance measures.

The services to be provided and how they are funded are documented in the annual performance contracts that the Department negotiates with each CSB and in the reports associated with those contracts. The CSB performance contracts and reports are structured around core services (i.e., emergency, outpatient, case management, day support, residential, and prevention and early intervention). Costs, revenues, numbers of beds and slots, numbers of full time equivalent staff positions, and numbers of consumers served in each of six core service categories and 27 subcategories are projected in the contracts. Actual costs, revenues, units of service, and consumers served are displayed in second and third quarter reports for each service. These data, plus limited demographic and clinical information about consumers, are contained in the fourth quarter (annual) reports. Again, these documents contain no consumer outcome or provider performance measures. All of this information has been automated by the Department.

The CSB performance contracts and reports establish and measure mutually negotiated, very basic indicators, such as types and amounts of services and the costs of services. The CSB performance contract also contains an extensive listing of compliance expectations (e.g., statutes, policies, procedures). It includes a mechanism to negotiate specific performance expectations for a particular CSB. These expectations are usually related to addressing process and procedure deficiencies or problems such as financial, reporting, or reimbursement issues. During the past fiscal year, administrative standards with fiscal sanctions for poor or non-performance were added to the contract and enforced by the Department in several instances.

The absence of uniform cost accounting standards and systems, compatible management information systems, and consistent data bases across the state make analytical comparisons of these data very difficult, if not impossible, among CSBs and between CSBs and state facilities.

The Department negotiates state facility director performance agreements, which contain standard and tailored process and compliance expectations, with each state facility director. However, state facilities do not have performance contracts that are comparable to the CSB performance contract.

While the types of process and output accountabilities contained in the CSB performance contract and state facility performance agreements are useful and necessary, they do not measure the impact or effect of services or agency efforts on the individuals who are served by those agencies or organizations. There is now considerable interest in

more meaningful measures of an organization's effectiveness and the efficacy of its services. The General Assembly has directed the Department and CSBs to develop improved fiscal and performance information. Consumer and family advocacy groups also have expressed a desire for more meaningful measures of accountability.

The CSBs, Department, and consumer and family advocacy groups have developed the Performance and Outcome Measurement System (POMS) in response to this interest. Performance measures assess the effectiveness of provider organizations (e.g., state facilities and CSBs). Outcome measures assess the effects of services on their recipients. The POMS is now being piloted at selected CSBs and state facilities. The results of the pilots will be available in December 1998.

The joint subcommittee supports the development of approaches to reward superior performance and to deal appropriately with poor performance of CSBs and state facilities, as measured through POMS and relevant process and output indicators. Examples could include: retention of unspent funds, reduction of CSB administration funds for late reports, or payment for state facility bed days used in excess of utilization targets. For example, if a CSB met its contractual obligations for services delivered and consumers served with excellent performance and outcome measures, it could retain all of its unspent funds. If a CSB delivered 90 percent of its contractual projections with excellent performance and outcome measures, it could retain a slightly smaller portion of its unspent state funds.

Recent experience with the development of the *Comprehensive State Plan for 1998-2004* and the Medicaid rate survey point to the need for greater consistency, uniformity, and comparability in the data and information that is available on all facilities and community services boards, including local inpatient services. In addition, it is recognized that over the next biennium and beyond, substantial resources for information systems will be needed by the Department and CSBs.

> ***Recommendation 44:*** *The current CSB performance contract and report mechanism should be expanded and refined by adding a focus on provider performance and consumer outcomes by July 1, 1999. These include service accessibility, quality, and appropriateness standards; inter-system performance measures; and requirements for consumer and family member participation in policy development and service planning, delivery, and evaluation. Additionally, a mechanism to measure and report on consumer satisfaction should be added to the contract mechanism.*

Recommendation 45: *The CSB performance contracts should be voted on by each local governing body involved in the CSB.*

Recommendation 46: *The DMHMRSAS should negotiate annual performance contracts with each state facility, similar to the performance contracts between CSBs and the Department.*

Recommendation 47: *Once POMS has been successfully piloted, revised, and implemented statewide, appropriate and relevant measures from it should be included in the CSB and state facility performance contracts and reports. Changes in POMS should be based on the results of the POMS pilots.*

Recommendation 48: *The DMHMRSAS should explore the development and implementation of approaches to reward superior performance and deal with poor performance for inclusion in CSB and state facility performance contracts.*

Recommendation 49: *The DMHMRSAS, the Department of Medical Assistance Services, and the CSBs should identify mechanisms to increase the consistency, uniformity, and validity of community services information, including standardized cost accounting systems and client information data bases.*

Recommendation 50: *The DMHMRSAS and the CSBs should jointly develop an implementation plan that describe statewide costs on a phased, multi-year basis for the full implementation of POMS and the information systems required to support it. The DMHMRSAS should report to the Governor and General Assembly prior to the 2000 Session of the General Assembly on the status of and resources required for fully implementing POMS.*

D. Human Rights

Serious incidents and deaths in state mental health and mental retardation facilities were brought to the attention of the joint subcommittee by advocates, families, consumers, and others. The joint subcommittee requested that the State Mental Health, Mental Retardation and Substance Abuse Services Board study issues related to the human rights protections provided to consumers in state facilities and in community programs. The State Board appointed a study group representing consumers and advocates, state facilities, professionals, the private sector, the Office of the Attorney General, and other relevant state agencies. The group was charged with examining the human rights system in Virginia for people with mental disabilities; reviewing current

policies, including how those policies affect procedures involving human rights issues; and making recommendations to the State Board.

After receiving the report of the study group, the State Board conducted its own analysis of the study group's *Report on the Human Rights System in Virginia for People With Mental Disabilities*. The Board also reviewed data on human rights complaints from the Department's Office of Human Rights for the past ten years, examined the structure and functioning of the Department's human rights system, reviewed the activities of the Department for Rights of Virginians with Disabilities (DRVD), examined the current interrelationship between the Department and the DRVD, and reviewed the structure of advocacy programs in other states. The Board presented its report and recommendations to the joint subcommittee in January 1998.

The joint subcommittee expresses its sincere appreciation to the members of the State Board who addressed the human rights issues and actively participated in the public hearings and meetings throughout the two-year study. The expertise and advice of the State Board were an invaluable asset for the joint subcommittee.

Currently, there are two distinct statewide rights protection programs for persons with mental disabilities in the Commonwealth. One program is operated by the DMHMRSAS. Because the DMHMRSAS also provides services to the some of the same persons protected by its own rights protection program, the DMHMRSAS program is commonly referred to as an "internal" human rights system. This internal system is authorized by § 37.1-84.1 of the *Code*. Regulations are promulgated by the State Board under the authority of this statute. The other statewide program is operated by the DRVD under the federal Protection and Advocacy for Individuals with Mental Illness Act (PAIMI) and the Developmental Disabilities Assistance and Bill of Rights Act (DD).

The joint subcommittee believes that the internal DMHMRSAS human rights program must be maintained, expanded, and strengthened. In addition, there must also be an effective external rights protection program. To be truly effective in protecting the rights of persons with mental disabilities, the DRVD must be strengthened considerably. Critical to the effectiveness of any system, whether external or internal are:

- free and open access to advocacy services;
- equal availability of the service to all consumers;
- adequate resources to support the system;
- mechanisms for standardization and coordination of rights protection services; and

- reliable, accessible, and timely data assured by the use of modern information systems.

The Department's human rights program currently places its emphasis and the majority of its resources in the state facilities, not in community programs. Regional advocates have unequal CSB and private program caseloads. The DMHMRSAS Commissioner has no direct authority to enforce human rights regulations in non-DMHMRSAS programs. Although CSB and private programs are required to notify consumers of their rights and the availability of a complaint process, the general public is usually unaware of both the rights protection systems available and their ability to participate in the process as a member of a Local Human Rights Committee (LHRC). The current membership of LHRCs is required to be broadly representative of consumer and professional interests in the community; however, proportions of consumer and professional representation are not specified. The community human rights system, both public and private, should be considerably strengthened and expanded through restructuring and reorganizing to assure adequate availability, accessibility, rights protections, and resources.

The integrity of the current internal system depends to a great extent on the quality, independence, and involvement of LHRC and State Human Rights Committee (SHRC) members. These individuals volunteer their time and attention and put much effort into the important work that they do. This volunteer system can be very effective and should be supported. However, because each facility and community program is permitted to form its own LHRC, recruitment of a sufficient numbers of volunteers willing to serve on the many current CSB and private provider LHRCs has historically been difficult.

In all cases, one of the most important services a human rights system can provide for consumers who may be vulnerable is adequate protection from harm, abuse, and neglect at the hands of caregivers. The current human rights regulations emphasize the importance of this protection by prescribing a definitive role for advocates to represent the abused consumer, permitting independent investigations by the advocates, offering a complaint resolution process, and requiring employees to cooperate with abuse investigations. The regulations do not, however, cover personnel issues related to abuse and neglect. Rather, the Department prescribes, through Departmental Instruction No. 33, actions that facility employees and facility directors must take in reporting, investigating, and taking appropriate personnel actions against employees involved in abuse or neglect of consumers. Community services boards and private programs provide their own policies.

As plans are being developed to move the services system toward more of a managed care environment, insufficient attention is being paid to the role of how an internal human rights system could function in relationship to facilities, CSBs, and private providers. Currently, there are no uniform standards of care to guide treatment of individuals with mental disabilities across facilities, CSBs, and private programs.

The effectiveness of the internal human rights system depends upon the support that it is given at the highest levels of the organization. The State Board, the DMHMRSAS Commissioner, State Human Rights Committee, and the State Human Rights Director are therefore key components of the system.

Currently, there is a widespread perception that there is no effective external human rights system in the Commonwealth. Virginia is only one of a few states that has chosen to place the PAIMI and Developmental Disabilities functions in an executive agency of state government. To be effective, the joint subcommittee believes that an external system should:

- have complete independence from the internal human rights system;
- complement, but not duplicate, the internal system;
- be supported by adequate levels of state resources, including resources for staffing;
- afford increased consumer access to rights protection in a timely fashion;
- have increased oversight responsibility for human rights protections in all programs for persons with mental disabilities; and
- be able to present an objective viewpoint.

Recommendation 51: *The State Board should ensure the consolidation of all existing human rights regulations governing facilities, CSBs, and private programs into one comprehensive regulatory framework as soon as possible. Once implemented, the DMHMRSAS should review these regulations regularly to assess their adequacy in affording human rights protections.*

Recommendation 52: *The human rights program in state facilities should be strengthened and expanded to assure adequate availability, accessibility, rights protections, and resources. The DMHMRSAS should redistribute facility advocates in proportion to facility censuses so that each consumer has equal access to an advocate.*

Recommendation 53: *The DMHMRSAS should study the adequacy of advocate positions in the state facilities and request additional resources in the next budget cycle, if needed, to assure that each consumer has sufficient access to an advocate.*

Recommendation 54: *The DMHMRSAS should remove immediately all potential for influence on human rights advocates by the state mental health and mental retardation facilities. All advocate and advocate support positions should be supported by the DMHMRSAS Central Office maximum employment level (MEL) positions and budget.*

Recommendation 55: *The DMHMRSAS should require facility directors to provide adequate office space, equipment, and supplies to support all day-to-day operations of the advocates within their facilities. The DMHMRSAS should ensure that state facility directors and staff play no role in the recruitment, hiring, supervision, or training of the advocates.*

Recommendation 56: *The State Board should revise the human rights regulations to prohibit the practice of facility directors serving as authorized representatives for medical and treatment decisions for patients and residents in state facilities.*

Recommendation 57: *The DMHMRSAS should arrange for training in the areas of mental disabilities and human rights for judges who hear cases involving consent to medical and psychiatric treatment decisions.*

Recommendation 58: *Decisions other than medical and treatment decisions (e.g., consent to release of records or participation in an outside activity) can continue to be made by facility directors, but only with adequate, consistent, and formal oversight by local human rights committees, and only when there is no alternative.*

Recommendation 59: *The human rights regulations should be revised to prohibit the use of seclusion and restraint for behavior modification purposes; place clear limitations on the use of seclusion and restraint for any other purpose; provide for adequate monitoring of each use of seclusion and restraint; and require that the DMHMRSAS develop, implement, and enforce a system-wide policy governing the use of seclusion and restraint.*

Recommendation 60: *The DMHMRSAS should study the adequacy of advocate positions in CSBs and request additional resources in the next budget cycle, if needed, to assure that consumers in CSB and other community programs have*

sufficient and equal access to advocates regardless of the location of the program in which they are receiving services.

Recommendation 61: *The DMHMRSAS should be authorized to sanction programs for non-compliance with the human rights regulations. Mechanisms should include funds withdrawal, fines, and/or penalties. The DMHMRSAS should regularly monitor and enforce the human rights regulations in all public and private mental health, mental retardation, and substance abuse programs.*

Recommendation 62: *The practice of allowing CSBs and private providers to nominate persons for appointment to the Local Human Rights Committees that oversee the CSBs should be prohibited. Nominations to local human rights committees should be made through the advocates directly to the State Office of Human Rights.*

Recommendation 63:. *The State Board should revise the human rights regulations to require CSBs and private programs to publicize, at least annually, information about the existence and purpose of the human rights program. CSBs should actively encourage interested citizens to contact the regional advocate for potential appointment to Local Human Rights Committees whenever there is a vacancy.*

Recommendation 64: *The DMHMRSAS and the State Human Rights Committee should implement a procedure to ensure inclusion of adequate consumer and family representation on all Local Human Rights Committees.*

Recommendation 65: *The human rights regulations should be revised to require consolidation of CSB, private provider, and facility Local Human Rights Committees into regional committees wherever appropriate and feasible, in order to strengthen membership, assist in recruitment, and promote consistency in decision-making. The DMHMRSAS should provide training to Local Human Rights Committees at least annually and should reimburse expenses incurred in carrying out their duties in accordance with state travel regulations.*

Recommendation 66: *The DMHMRSAS should provide statewide educational seminars on an annual basis for Local Human Rights Committee members and any other interested persons, on a cost basis for participants if funding is not otherwise available.*

Recommendation 67: *The DMHMRSAS should conduct a thorough review and revision of the current Departmental Instruction on reporting and investigating allegations of abuse, redouble efforts to require all facilities to abide strictly by the terms of the statewide policy, prohibit the development of alternative facility policies, and monitor and affirmatively enforce the statewide policy. Minimally, the statewide policy should provide that investigations into all allegations of abuse and neglect be conducted by highly trained and skilled neutral investigators who have no interest in the outcome of the investigation. The policy should be regularly reviewed and revised to assure its maximum effectiveness.*

Recommendation 68: *CSBs and private programs should be required to develop policies governing prevention, detection, reporting, and suspension of employees, and investigation and follow-up on all allegations of abuse or neglect, with such policies subject to the review and approval of the DMHMRSAS Commissioner. CSBs and private programs should be required to report to the DMHMRSAS Office of Human Rights all allegations of abuse or neglect.*

Recommendation 69: *All programs providing services to persons with mental disabilities should be authorized statutorily to access information about potential employees' criminal convictions of violent crimes or past abusive acts in other programs and to provide such information concerning their own employees. A central registry should be established. Immunity should be provided for program personnel who share information about current or past employees. The DMHMRSAS should examine the availability and utility of other mechanisms to assist in screening out potential employees who are likely to abuse consumers.*

Recommendation 70: *The DMHMRSAS should study the issues involved in the employee grievance procedure to develop solutions for prohibiting the reinstatement to work of facility employees who are terminated for acts of abuse or neglect.*

Recommendation 71: *The DMHMRSAS should assure that adequate human rights oversight mechanisms are built into any managed care system, including clearly articulated and enforced human rights standards, immediate advocate access, and an effective appeals mechanism for handling complaints from denials of care or treatment.*

Recommendation 72: *The DMHMRSAS should develop and implement statewide standards of care for the state facilities and for CSB programs.*

Recommendation 73: *The DMHMRSAS should design and implement a modern, reliable, current, and effective data collection system for human rights information.*

Recommendation 74: *The DMHMRSAS should provide the resources necessary to provide appropriate oversight of the internal human rights program.*

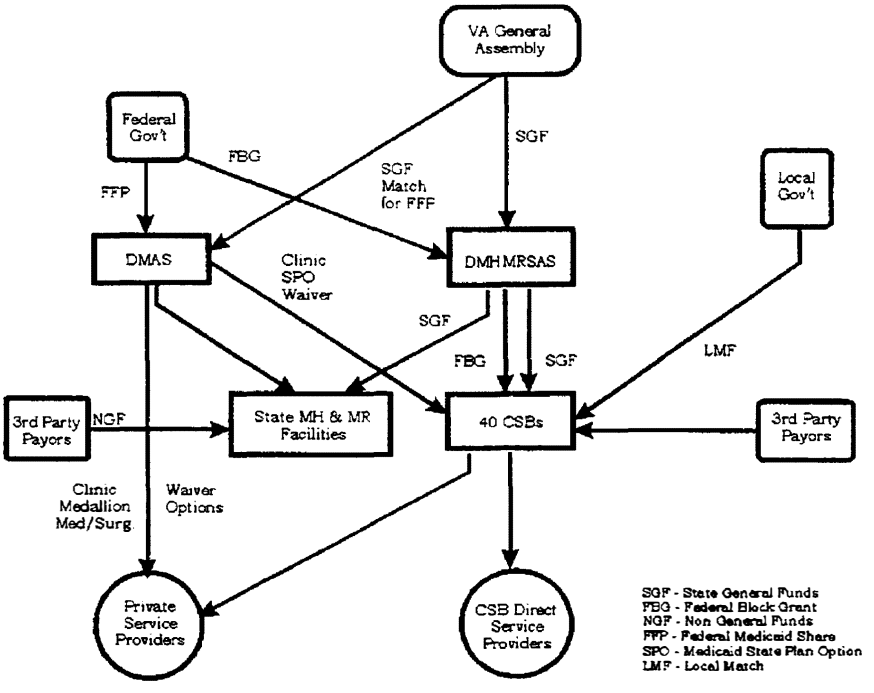
Recommendation 75: *The State Board, State Human Rights Committee, the Commissioner, and the State Human Rights Director should make a continuous effort to review and assess the effectiveness of the internal human rights system and make improvements where needed. Interaction and communication among these entities should increase.*

Recommendation 76: *The most effective structure and location for an external human rights protection system in Virginia should be studied. The study should explore whether an external system located within the executive branch of state government can adequately protect consumers and whether placement in the judicial branch of government would better serve consumers. The DMHMRSAS, the State Board, DRVD, the PAIMI Council, the Board for People with Disabilities, the Supreme Court, and representatives from consumer and advocacy groups, CSBs, and private providers should be included in the study.*

E. RESTRUCTURING THE FLOW OF FUNDS AND MAXIMIZING MEDICAID

The diagram below, presented to the joint subcommittee by the Department of Mental Health, Mental Retardation and Substance Abuse Services, represents the sources of funds flowing through Virginia's publicly funded mental health, mental retardation, and substance abuse services system.

Sources of Funds Flowing Through Virginia's Mental Health, Mental Retardation and Substance Abuse Services System



This diagram illustrates the flow of funds from the Virginia General Assembly, federal and local governments, and third party payers. The General Assembly directly provides state general funds (SFG) to the Department. The General Assembly also appropriates federal block grants (FBG) for mental health services and substance abuse prevention and treatment services, federal financial participation (FFP) or the federal share of Medicaid, and non general funds (NGF) or fees collected in state mental health and mental retardation facilities. These fees include Medicare, private insurance payments, and fees paid by private individuals.

Under the Virginia Medicaid Program, state mental retardation training centers are reimbursed for their allowable Medicaid costs. The training centers must meet

Intermediate Care Facility/Mentally Retarded (ICF/MR) criteria as defined in the *Virginia State Plan for Medical Assistance*. Medicaid funds also support state facility mental health services for persons ages 65 and older at Catawba Hospital, Piedmont Geriatric Hospital, and Hancock Geriatric Treatment Center at Eastern State Hospital. Medicaid funds also support community-based services through the Mental Retardation Home and Community-Based Services Waiver (MR Waiver) and through State Plan Option Services.

1. Medicaid MR Waiver and State Plan Option Services and Match

In 1991, the State initiated the Mental Retardation Home and Community-Based Waiver. The MR Waiver allows for the provision of community-based residential and day support, personal care, respite, environmental modifications, supported employment, therapeutic consultation, private duty nursing, and assistive technology services to individuals who would otherwise require placement in an ICF/MR facility. Providers may be CSBs or private providers not affiliated with CSBs.

In addition to the mandatory services required for all state Medicaid programs, states have the option to elect to provide services in certain major categories. Under the State Plan Option, Virginia elected in 1991 to provide an array of community-based mental health and mental retardation services. The 1996-98 Appropriation Act (Item 322 D.5) required the amendment of the State Medicaid Plan to increase coverage for community mental health, mental retardation, and substance abuse services. Regulations implementing these expanded services became effective in January 1998.

Since 1991, community Medicaid funds for mental health and mental retardation services have grown from $15 million to $134.9 million for fiscal year 1998. State Plan Option services will amount to $67.4 million, and Mental Retardation Home and Community-Based Waiver services will amount to $67.5 million. While this increase has resulted in expansion of total funding for the community services system, associated negative effects on existing financial resources have occurred. Through fiscal year 1997, over $42 million of CSB state general funds have been transferred to the Department of Medical Assistance Services (DMAS) for Medicaid state match. This has reduced state funding for serving consumers who are not eligible for Medicaid and is not consistent with state budgeting practices for the provision of general fund match for other Medicaid providers such as hospitals, nursing homes, physicians, and pharmacists. Considerable unmet need for community services could have been addressed if the Medicaid state general fund match had not been removed from the CSB system.

In addition, if community capacity were expanded through the Medicaid Waiver, mental retardation facility beds could be reduced potentially by one-half. Presently, state general fund match for private providers who contract for services financed by the Mental Retardation Home and Community-Based Waiver is provided from the CSB base budget. Increased use of the private sector to deliver community mental health and mental retardation services should not be contingent upon diverting local CSB state general funds to Medicaid. The Medicaid general fund match should be budgeted and increased on the same basis as other services funded through the Virginia Medical Assistance Plan.

The joint subcommittee learned in its analysis of the funding of mental health, mental retardation, and substance abuse services that some CSBs have been more aggressive than others in their utilization of Medicaid funding for services. Of particular concern to the joint subcommittee are those boards that have not pursued actively the conversion to Medicaid financing of mental retardation services through the Waiver.

***Recommendation** 77: The current practice of providing Medicaid SPO and Waiver match through transfers from CSB appropriations should be ended. Match funds should be appropriated in the DMAS budget, as is the case for all other health care providers in the Commonwealth.*

***Recommendation** 78: State general funds currently being used by CSBs to match Medicaid dollars should be restored to the CSBs to provide individualized packages of services and supports to people who have been identified as ready for discharge from state facilities or who are on waiting lists in communities.*

***Recommendation** 79: The DMHMRSAS should identify those CSBs that have not converted and expanded Medicaid Services. The performance contract and future level of state funding to CSBs should be adjusted to reflect, to the extent possible, a comparable degree of effort to convert existing services to Medicaid and to expand Medicaid-funded services.*

***Recommendation** 80: The DMHMRSAS and DMAS should continue to review and expand Medicaid covered services for mental health, mental retardation, and substance abuse services as a budget and service policy to ensure the maximum use of federal funds available for individuals eligible for Medicaid.*

2. *Integrated Funding Streams*

Integrating or merging some funding streams, for example Medicaid and state general funds at the state level or all funding sources for community services at the local level, is desirable from accountability and management effectiveness perspectives. However, integrating other funding streams, such as state general and special funds for state facilities with community services funding, is neither desirable nor necessary.

The joint subcommittee does not support the single stream funding proposal of the Virginia Association of Community Services Boards to merge state-controlled funds for state facilities with funds for CSBs. The Virginia Municipal League, the Virginia Association of Counties, and individual local governments have expressed serious reservations about this approach. They are particularly concerned that, if all resources for state facility operations were transferred to CSBs, local governments would become liable for additional operating expenses and legal actions resulting from service provision.

Advocacy groups, state facilities, and communities also have raised concerns about merging state facility and community funds. They are particularly concerned about the potential effects of such a change on the stability and continuity of state facility operations and budgets.

Rather than the single stream funding approach, the joint subcommittee recommends a different method. As beds at a state facility are reduced, a reasonable proportion of its resources should be reallocated to the communities to which the patients or residents will return, once facilities meet Department of Justice standards of quality. This would enable the transfer of sufficient resources to finance individualized packages of services and supports for identified consumers or groups of consumers while preserving the financial stability and viability of essential state facility operations. These packages would be preauthorized and periodically reviewed using managed care utilization review and management practices. This transfer of facility resources to the community should follow the basic approach outlined below.

- Before a state facility bed is closed, the CSB would be required to assess the person's needs and develop a discharge plan that would be reviewed by the Department, using an Administrative Services Only organization. The discharge plan should include the services to be provided, the costs of those services, and where and by whom services will be provided.

- The treatment or habilitation plan and the person's progress would be routinely and periodically reviewed by using the Administrative Services Only organization's utilization management and review processes.

- CSBs would have the flexibility to shift resources among service categories within a service plan or among services plans.

- The transfer of funds should be linked to outcome-based individualized packages of services and supports for specific persons. The implementation of these services packages should be reviewed and monitored by DMHMRSAS.

- Local government should not be required to provide matching funds for these transferred state facility funds. Because these funds would be tied to treatment or habilitation plans of individualized packages of services and supports, these dollars should be separately identified and excluded from matching requirements.

Recommendation 81: *The DMHMRSAS should develop and implement a funding mechanism that reallocates a reasonable proportion of resources saved through state facility bed reductions to CSBs where patients or residents will return and incorporates managed care utilization review and management practices, provided that state facilities meet appropriate standards of quality.*

3. Medicaid Carve-Out

As the Department of Medical Assistance Services (DMAS) moves the Medical Assistance Program into a managed care environment through Medallion II, the effects of this decision on mental health, mental retardation, and substance abuse services and on the individuals receiving those services have attracted considerable interest.

The first phase of this move, in Tidewater, included mental health (MH) clinic services (e.g., outpatient therapy and medication management) and psychiatric inpatient hospitalization services in capitated contracts negotiated with health maintenance organizations (HMOs). This process continues and, in some instances (e.g., MH clinic services), it has increased fragmentation of service delivery, making it more difficult for consumers and their families to obtain needed services that are coordinated and integrated. State facility services, mental retardation (MR) home and community-based waiver services, community MR intermediate care facilities, and State Plan Option services were excluded from those contracts. These services continue to be reimbursed on a fee-for-service or prospective payment and cost settlement basis. The current

proposal for implementing Medallion II in Northern Virginia includes psychiatric inpatient hospitalization in the capitated contracts, but it excludes MH clinic services along with the services excluded in the Tidewater contracts.

Different states have selected a variety of solutions to the question of how best to fund, administer, and deliver mental health, mental retardation, and substance abuse services financed by Medicaid. One approach involves ***carving out*** all of these services from any managed care contracts negotiated with HMOs or other networks of physical health care service providers. The joint subcommittee endorses the concept of a carve-out approach, in which the Department of Medical Assistance Services would subcontract the administration of Medicaid-covered mental health, mental retardation, and substance abuse services to the Department of Mental Health, Mental Retardation and Substance Abuse Services.

In order to have sufficient time to develop the data and evaluative foundation to manage the proposed carve-out, the joint subcommittee recommends that implementation of all subcontracting or carve-out proposals, with the exception of replacing the match currently transferred from grants to localities, be deferred until the 2001 Session of the General Assembly. The joint subcommittee's Issue Brief: *Restructuring Medicaid Financing of Publicly-Supported Mental Health, Mental Retardation and Substance Abuse Services* (Appendix 4) should provide guidance for the development of recommendations related to the implementation of such a carve-out in Virginia.

> ***Recommendation 82:*** *The Secretary of Health and Human Resources, DMHMRSAS, and DMAS should present recommendations prior to the 2001 Session of the General Assembly on implementation of the carve-out which would be effective July 1, 2001.*

4. Bridge or Transition Funding for State Facility Bed Reductions

Bridge funding should be viewed as a mechanism for transferring funds rather than as a separate appropriation or source of funds. After an initial appropriation to reduce state facility beds, such as the Department's proposed 692-bed reduction that was presented to the joint subcommittee on November 18, 1997, some funds may become available in a facility's budget, once the discharges have been implemented and any costs associated with the closed beds have been paid. Currently, significant savings in facility budgets may not be available until DOJ requirements for active treatment and staffing levels are met and maintained, even as patients and residents are discharged to the community.

F. Mental Health, Mental Retardation, And Substance Abuse Services

The joint subcommittee offers a number of findings and recommendations for improving the availability and accessibility of services across the Commonwealth. The efforts of the work groups and the constituents who participated in their deliberations contributed significantly to addressing these essential service needs. Section G: *Resource Requirements* identifies proposed budget initiatives to implement recommendations requiring additional funds.

1. Services to All Populations

Residential Alternatives. The *Comprehensive State Plan for 1998-2004* indicates that over 11,700 individuals are on CSB waiting lists for residential services or are known by name as people who need housing. Adult care residences (ACRs) have served as an important housing resource for adults with mental disabilities. Currently, 4,800 public-pay residents of adult care residences have a diagnosis of mental illness, mental retardation, or other neurologically-related disorder. The 1997 *JLARC Study of the Mental Health Needs of Residents of Adult Care Residences (ACRs)* recommended a number of steps that should be taken to improve services, standards, enforcement, and payment mechanisms for ACRs operating in Virginia.

In addition, Virginia has relied in large part on federal Housing and Community Development (HUD) resources to develop special-needs housing. Renewals of existing Section 8 (rental assistance) projects will consume most of HUD's budget over the next five years, and the HUD 811 (housing for people with disabilities) program is dwindling. Virginia needs to address these immediate housing shortage problems as well as plan for thousands of people who currently need housing, are now living with aging caregivers, or will be discharged as state facilities are downsized.

Primary Health Care Needs. Publicly funded primary (physical) health care is beginning to be delivered increasingly through health maintenance organizations and other managed care entities. This raises serious questions about the adequacy of the primary health care services provided to persons with mental disabilities and substance abuse problems. The joint subcommittee believes that it is essential that the primary health care needs of these populations be assessed, and that issues regarding the feasibility of integrating primary health care services and services to persons with mental disabilities and substance abuse problems be carefully studied.

Geriatric Services. The needs of persons who are over 65 and who have mental disabilities or substance abuse problems require special attention by the Commonwealth. According to the *Comprehensive State Plan for 1998-2004,* by the year 2000 the aged population in Virginia will increase by 62,465. Among this age group, 15-20 percent (approximately 200,000 Virginians) will have a psychiatric disorder. National prevalence rates indicate that approximately 50 percent of nursing home residents in the United States have Alzheimer's disease or a related disorder. Elderly Virginians with mental disabilities or substance abuse disorders require special services that integrate treatment for their disorders with services to address the effects of aging. As state facilities are downsized, community-based special services for this population must be addressed.

Recommendation 83: *The Department of Social Services (DSS) and the DMHMRSAS should develop pilot projects in areas that have high concentrations of ACRs. The pilot projects should determine and provide the appropriate treatment and supports for persons with mental illness, mental retardation, or substance abuse problems who reside in ACRs. The DSS and DMHMRSAS should submit a report to the House Appropriations and Senate Finance Committees on the pilot projects prior to the 1999 Session of the General Assembly.*

Recommendation 84: *The Secretaries of Administration, Commerce and Trade, and Health and Human Resources should study the feasibility of creating a residential alternatives capital fund to address the housing needs of persons with mental disabilities and substance abuse problems. The Secretaries should complete their study and report to the House Appropriations and Senate Finance Committees prior to the 1999 Session of the General Assembly.*

Recommendation 85: *The Department of Health, in cooperation with DMHMRSAS, should conduct a comprehensive assessment of the primary health care needs of persons with mental illness, mental retardation, or substance abuse problems. The assessment should include a review of patients and residents in state facilities and persons served by community services boards. The needs assessment should be presented to the Governor and General Assembly prior to the 1999 Session of the General Assembly.*

Recommendation 86: *As part of a comprehensive long-range plan for addressing the increasing aging population, the DMHMRSAS and DMAS should explore the feasibility of providing a supplement to private nursing homes and other*

alternatives to expand community-based services for elderly individuals with mental disabilities. This plan should be presented to the Governor and General Assembly prior to the 1999 Session of the General Assembly.

2. *Mental Health Services*

The availability of the new atypical anti-psychotic medications in community settings is critical to keeping consumers in the community and to downsizing state facilities successfully. These medications are able to reduce the negative symptoms of mental illness with a lower incidence of unpleasant side effects. Thus, consumers are more likely to comply with their treatment and to improve. Individuals whom professionals and families thought would never be discharged from hospitals have benefited from the new medications and have been able to function successfully in their communities. These medications are essential to preventing hospitalization and to shortening lengths of stay in hospitals.

Intensive community treatment programs provide 24 hours-per-day, seven days-per-week services to consumers in their homes and communities through teams of doctors, nurses, case managers, and counselors. Programs of Assertive Community Treatment (PACT) and other intensive community treatment models have been successful in Virginia and in other states for consumers with severe psychiatric and substance abuse disorders, people with mental illness who are at high risk for arrest and incarceration, and homeless people with mental illness. This program reduces hospital use, improves family and social relationships, and helps people return to homes and to jobs.

Psycho-social rehabilitation, including the clubhouse model, is an essential component of comprehensive community treatment for persons with mental illness. These programs provide opportunities for consumers to gain social and job skills to help them enjoy productive lives and participate in their communities. To support these programs and provide additional options in the community, the employment needs of persons with serious mental illness should be addressed.

Other populations require additional services, evaluation of their service needs, and plans for tailoring services to provide treatment and support. These include persons with acquired brain injuries who receive treatment in the publicly funded mental health system, persons who are deaf or deaf and blind and have mental disorders, and children with or at risk of serious emotional disorders.

Recommendation 87: *Atypical antipsychotic medications should be the first line of treatment for persons with serious mental illness in state facilities and community programs.*

Recommendation 88: *The DMAS should be directed to mandate the availability of atypical antipsychotic medications on all formularies used by Medicaid managed care companies (e.g., HMOs) in Virginia.*

Recommendation 89: *The DMHMRSAS and the CSBs should establish intensive and assertive community treatment teams in communities with the highest usage of state mental health facility beds per 100,000 population. The DMHMRSAS should establish targets to reduce state facility bed utilization as these teams become operational.*

Recommendation 90: *In a managed care environment, the DMHMRSAS, DMAS, and CSBs should ensure that psycho-social rehabilitation services continue to be available for consumers.*

Recommendation 91: *The Department of Rehabilitative Services and the DMHMRSAS should work together to address the employment needs of persons with serious mental illness and report their recommendations to the 1999 Session of the General Assembly.*

Recommendation 92: *The DMHMRSAS and the Department of Rehabilitative Services should develop a plan for the appropriate treatment of persons with acquired brain injuries who receive treatment in the publicly funded mental health system and present it to the 1999 Session of the General Assembly.*

Recommendation 93: *The DMHMRSAS should enhance and better coordinate facility and community services for persons who are deaf or deaf and blind and have mental disorders. The special unit for the deaf and deaf-blind at Western State Hospital should not be included in plans for downsizing.*

Recommendation 94: *The State Board and DMHMRSAS should ensure that the service needs of children with or at risk of severe emotional disturbance are a primary consideration in the development and implementation of priority populations.*

3. Mental Retardation Services

The joint subcommittee worked with professionals, advocates, consumers, and families to develop a long-range vision and plan for the provision of mental retardation services in the Commonwealth. Described in the following paragraphs are the components of the long-range vision and plans that are unique to future policy and service decisions for persons with mental retardation.

Vision. The publicly funded mental retardation service system will, by the year 2004, serve all Virginia residents with mental retardation adequately, (no waiting lists) with supports and assistance.

General Eligibility For Services. Any Virginia resident who is an infant, child, or adult who meets the current AAMR definition of mental retardation, or who is under 6 years of age with or at risk of a developmental disability, and who requests services should be eligible for services.

Service Array. The services provided by the public system will be broad and will be based on consumer choice, need, and the level of natural supports. In addition, the services will meet the following guiding principles:

- services and supports will be those that are least intrusive and least restrictive;
- persons will receive services at an intensity level that is neither too low nor too high, but that is appropriate to the strengths and needs of that individual;
- personal resources and natural supports will be maximized; and
- person-centered or family-centered, highly tailored goals and service plans will be developed for each individual based upon a multi-dimensional assessment conducted with the individual and the family.

Process for Prioritizing Service Needs. The Department, in concert with representatives of CSBs, advocacy groups, local government, and others, is currently piloting a process for accessing publicly supported mental retardation services with measurable criteria for prioritizing needs for services and identifying the level of need. The process is divided into three steps:

(1) assuring the individual meets the diagnostic criteria for mental retardation or developmental delay for children between the ages of 3 and 6 (children under three are referred to the early intervention services);

(2) determining the relative priority of need for service; and

(3) completing a multi-dimensional assessment utilizing nationally recommended instruments.

To improve accountability, funds should be allocated to individual service plans. These services plans should be based on the specific needs of the individuals identified through multi-dimensional assessments and person-centered service planning.

State Facility and Community Roles. For persons with mental retardation, the service system should provide a full array of supports and services, including both state facility and community-based services so, that the services accessed by an individual can change over time as the individual's needs change.

The types of services should complement each other. Certain core services will be provided by all state facilities and CSBs. However, each facility and CSB may provide some services uniquely needed in the region served. State facilities should focus on more specialized and intensive services that are often more difficult and more costly to provide on a smaller scale or in a more widely disbursed setting. Community services should be those that can be effectively provided at sites closer to consumers and their families. Specialized services at state facilities, such as medical and dental care, should be made available on a fee-for-service basis to the community at large for those who choose this option. State facilities also should offer training for direct care staff in the community.

State facilities for persons with mental retardation should have a capacity of no more than 200 people each. Facilities of this size can be operated efficiently, yet are capable of providing individualized services and supports to residents. These facilities should have sufficient permanent professional staff, such as physicians, therapists, and behavioral specialists. As there is not consensus on how many residents will need care in an intermediate care facility for persons with mental retardation in the future, the population figure for each state facility is a target. The important points are that smaller facilities are more effective, and there should be an adequate number of facilities by 2004.

Prevention and Early Intervention. Primary prevention focuses on the implementation of educational and medical strategies to address well-defined and clearly understood causes of mental retardation. Prevention measures include educational programs on environmental hazards, genetic counseling, carrier detection, pregnancy screening, prenatal diagnosis, immunizations, blockage of Rh isoimmunization, newborn screening and treatment, injury prevention, shaken baby syndrome, avoidance of toxic

exposures, early diagnosis of infections, and improved neonatal care. For example, by focusing on special medical and educational activities that should be a part of comprehensive and continuous prenatal care, the incidence of prematurity, low birth weight, and toxemia, all of which are risk factors for mental retardation, can be reduced.

Secondary Prevention. The provision of early intervention services to infants and toddlers with disabilities and their families eliminates or significantly minimizes the effects of their disabling conditions. As a result, expenditures for special education and other support services are substantially reduced over the life of the individual. Early intervention for infants and toddlers with disabilities and their families is funded, in part, through the Individuals with Disabilities Education Act and includes such services as special instruction, physical therapy, occupational therapy, and speech therapy for children from birth through three years old and their families.

In 1996, 4,430 children were enrolled in early intervention services. While there have been steady, expected increases in enrollments over the last decade due to the influx of federal funds and the stabilization of the statewide program, national utilization data show that only about half of the children who could benefit from early intervention in the Commonwealth are actually being served. Based upon well-established disabilities prevalence rates among infants and toddlers, approximately 9,200 Virginia children from birth to age three are estimated to need and could benefit from early intervention services each year. This disparity in actual enrollees versus well-documented prevalence and utilization information strongly suggests that many children are eligible for services, but have not yet been identified.

Medicaid. If the Medicaid Mental Retardation Home and Community Based Mental Retardation Waiver were streamlined through less paperwork and a less cumbersome process, and if Medicaid resources were maximized, Virginia could significantly increase its resource base to serve many of the individuals now on waiting lists. Given the high percentages of consumers who are eligible for Medicaid and the MR Waiver, many states have successfully leveraged the majority of their state general funds as state match to maximize federal financial participation.

In 1997, forty-eight percent of state mental retardation general funds were used as Medicaid match in Virginia, establishing a baseline for increased utilization. A previous study has shown that approximately 75 percent of Virginians with mental retardation are currently Medicaid-eligible. While maximizing Virginia's use of Medicaid is essential,

not every individual with mental retardation who requires public assistance will be eligible for Medicaid. Funds must be available to serve these non-Medicaid-eligible individuals.

Building Additional Community Services Capacity. The *Comprehensive State Plan for 1998-2004* indicates that 1,974 individuals are waiting for day support services, including 534 persons who graduated from special education in June 1997. Some 500 people will graduate from Special Education each year, subsequently adding to this number. In addition, 5,069 adults and children are waiting for residential supports, including 445 individuals who will have an emergency need for residential support each year.

Some individuals on waiting lists and others who enter the system because of a family or personal crisis require appropriate residential supports immediately. Usually, these individuals need a safe place to live because they do not have family or friends with whom they can reside. Accordingly, these individuals would be included among those with the highest priority for accessing services.

New funding is needed to develop community infrastructure to prevent and avoid future inappropriate admissions and readmissions to state facilities. Without such infrastructure building projects, unnecessary admissions to state facilities will still happen, even if downsizing occurs. The joint subcommittee's budget proposals include one-time funding requests for housing development pilots, mobile community crisis stabilization team pilots, and on-going resources for regional emergency management funds.

Recommendation 95: *The Health Department should continue to be responsible for primary prevention strategies that target mental retardation. These activities should occur in collaboration with CSB efforts that address primary prevention activities related to alcohol and substance abuse. In addition, the Health Department should be responsible for developing and monitoring specific goals, strategies, and outcomes addressing the prevention of mental retardation in collaboration with the local coordinating councils for prevention.*

Recommendation 96: *A new plan for early intervention services should be developed by the Virginia Interagency Coordinating Council and the Local Interagency Coordinating Councils. It should emphasize more aggressive*

outreach efforts to identify more unserved infants and toddlers, and it should include expanded state support and increased use of Medicaid as a funding source.

Recommendation 97: *The DMHMRSAS, DMAS, and CSBs should maximize Medicaid funding for mental retardation services. A target should be an amount equivalent to at least 75 percent of the current state general funds which support community mental retardation services being used as Medicaid match.*

Recommendation 98: *The DMAS, DMHMRSAS, and the mental retardation field should work together to develop a more inclusive Waiver that reimburses flexible and informal supports.*

Recommendation 99: *Once the priority populations pilot projects are completed and the necessary legislation and policies have been passed, state general funds should be allocated for any consumer found to meet the highest priority emergency need category through the priority population assessment process.*

Recommendation 100: *The majority of State general funds should be allocated to CSBs on the basis of individualized service plans.*

Recommendation 101: *The DMHMRSAS and the CSBs should implement five pilot projects:*

- *Housing Development Pilots*
- *Mobile Community Crisis Stabilization Team Pilots*
- *Alternative Community Facilities for Medically Fragile Children*
- *Center for Developmental Medicine/Ancillary Services*
- *Regional Emergency Management Funds*

4. Substance Abuse Services

Drug addiction affects everyone, either directly or indirectly. Substance abuse is often at the root of crime, family violence, poverty, diminished physical and mental well-being, and lost productivity and income. Yet, research shows that drug addiction is a highly treatable disease, although often one of the most stigmatized. A growing number of national studies confirm that appropriate treatment significantly reduces alcohol and other drug use, improves medical and social functioning, increases earnings through employment, and reduces drug-related crime and the risk of AIDS.

Appropriate treatment is cost-effective. A study of treatment outcomes for welfare recipients in California showed that the benefit to taxpayers exceeded the cost of treatment by more than $2 to $1. Similarly, the benefits of Oregon's treatment program exceeded costs by more than $5 to $1, and Ohio found cost offsets ranging from three to seven times the cost of treatment.

Perhaps most importantly, drug abuse is preventable. Sixty-six percent of high school seniors say they know a peer with a drinking problem. Almost 25 percent of Virginia middle school students responding to a survey reported drinking alcohol in the 30 days prior to the survey. Local prevention efforts are showing very positive results, particularly with children and adolescents. Some facts about the problem in Virginia are:

- The Department of Mental Health, Mental Retardation and Substance Abuse Services estimates that more than 500,000 Virginians need treatment for alcohol or other drug problems.
- Of the more than $100 million that Virginia spends on substance abuse services each year, only one-third are state general fund dollars, and community services boards receive no state general funds for prevention.
- Allocated among six agencies of state government, funding is fragmented and lacks overall planning and coordination. Equal access to treatment services is not available across the Commonwealth.
- Alcohol is the leading drug of abuse. Alcohol-related death rates have remained relatively constant since 1990, but drug-related deaths have shown a steady increase. Arrests related to alcohol and other drug use increased by 126 percent during the last decade.
- The 1996 KIDS COUNT in Virginia reports that the rate of students possessing alcohol or other drugs increased 43.9 percent from fiscal year 1991 to fiscal year 1995.
- More than half of the inmates in local jails report being under the influence of drugs and alcohol at the time of their offense.
- One-third of state prisoners and two-fifths of youths in long-term, state-operated facilities admit they were under the influence of an illegal drug at the time of their offense.
- Approximately 46 percent of all persons admitted to substance abuse treatment programs operated by community services boards in fiscal year 1996 were referred by the criminal justice system.
- Three drug groups dominate as drugs of abuse: alcohol (62.7 percent), cocaine/crack (21.7 percent), and marijuana and hashish (10 percent).

- According to the U.S. Department of Health and Human Services, between 10 and 20 percent of welfare recipients have a substance abuse problem, with about five percent of recipients affected enough to cause a substantial limitation in their day-to-day functioning. Substance abuse has emerged as one of the primary barriers to employment among welfare recipients.

Substance Abuse Goals and Policy. A strong substance abuse policy for the Commonwealth is essential to addressing the problems currently faced by so many adults and young people. The joint subcommittee endorsed the following goals for the future delivery of publicly funded substance abuse services:

- Leadership and coordination of substance abuse services and resources are strengthened among state and local agencies.
- Virginia consumers have access to a continuum of care in every community that is accountable, is consistent with minimum standards, and will help individuals lead a normal life as productive members of society.
- Offenders in the criminal justice system have access within available resources to substance abuse treatment, both in corrections facilities and the community.
- Prevention becomes an established component of the continuum of care in every community.

Governor's Council on Alcohol and Drug Abuse Problems. Substance abuse prevention and treatment require urgent and high priority attention. The existing Governor's Council on Alcohol and Drug Abuse Problems has not functioned over the past several years, and, as a result, there has been no leadership, coordinated policy development, or comprehensive goal setting for substance abuse services in the Commonwealth. Planning and accountability for substance abuse resources is currently fragmented among the six departments that receive substance abuse funding.

The Council should provide the necessary leadership, planning, deliberation, and coordination to target resources and prevent duplication. Specifically, the Council should:

- oversee planning, funding, and evaluation of publicly funded programs serving persons who have substance abuse problems;
- recommend policies and goals for substance abuse prevention and treatment to the Governor, the General Assembly, and the State Board;
- review and endorse budget requests regarding substance abuse services from state agencies; and

- make recommendations to the Governor and the General Assembly for improvements in prevention and treatment programs.

Minimum Range of Services. Although services must be tailored to the needs of individual consumers, best practices require that, at a minimum, CSBs should provide and be accountable for comprehensive assessment, case management, outpatient counseling, detoxification, and residential treatment. CSBs are currently serving about 58,000 substance abuse consumers. Additional resources are needed to meet the current demand for the minimum range of services in communities. These services include comprehensive assessment (10,000 persons), case management (3,606 persons), outpatient counseling (8,842 persons), detoxification (2,391 persons), and residential treatment (1,170 persons).

Wrap-around Services. In addition to standardized treatment, some consumers are in need of an array of diverse wrap-around services, such as housing, transportation, child care, education, vocational training, and employment placement assistance to aid in their long-term recovery. Providing these services on an ongoing basis throughout treatment prepares the consumer to re-enter the community and helps prevent relapse to alcohol and other drug abuse. These services help prevent criminal behavior and, coupled with appropriate treatment, are cost-effective and make communities safer.

The joint subcommittee is aware that between 60 and 85 percent of criminal offenders are substance abusers. It makes sense to pay for treatment. The combined average per person cost of treatment ($3,136) and wrap-around services ($2,142) is less than half of the cost of one-year of incarceration in a corrections facility ($16,500).

Crime Commission Recommendations for Services to Offenders. Over the past year, the Crime Commission has conducted a study of substance abuse services for offenders in the criminal justice system. The preliminary recommendations of the Crime Commission included the following items:

- Substance abuse screening and assessment would be required for all felony convictions (except capital convictions), Class 1 misdemeanor drug and alcohol convictions, and juvenile delinquent adjudications during the pre-sentencing phase.
- Initial screening and assessment would be funded through a fee charged to felony and misdemeanor drug offenders.
- Treatment would be provided through existing networks and systems by licensed programs or providers.

- A management information system would be established for offender tracking and performance evaluation.

Drug Courts. Pilot drug courts currently operate in three jurisdictions: Roanoke, Charlottesville, and Richmond. The judge is the central figure in managing the offender through frequent interaction and drug testing. The pilot drug courts have operated for fewer than two years, but preliminary results and anecdotal information indicate that the results of such intervention are excellent. The cost is approximately $3,000 per offender versus the cost of incarceration which averages about $16,500, not including the substantial public and private cost of crimes necessary to support the addiction.

Grants for Innovative Local Programs. Innovative community programs that emphasize local collaboration and planning should be awarded grants on a competitive basis. Capacity building for services to offenders should include drug courts, community residential treatment for juveniles and adults, jail treatment programs, and aftercare and transition services for offenders and their families. Resources should be provided for 10 drug courts, five residential programs, eight aftercare and transition programs, and 10 jail treatment programs.

The Virginia Council on Coordinating Prevention. Strengthening the leadership structure for prevention programs will ensure better planning, coordination, and accountability. The Council is currently hindered in fulfilling its duties because it lacks staff and adequate funding, and it has overlapping responsibilities with the State Executive Council for the Comprehensive Services Act for At-Risk Youth and Families. Fully implementing the Virginia Council on Coordinating Prevention will provide the leadership needed to develop and implement a broad prevention agenda for the Commonwealth.

Local Prevention Planning. Pilot projects, working with existing local programs, could address the risk behaviors associated with substance abuse, teen pregnancy, youth crime and violence, and school failure. Local planning and advisory groups could oversee these pilot demonstration projects. Some prevention strategies might include volunteer and youth internships to develop work skills, peer support and youth leadership opportunities, and anti-drug campaigns. Research protocols should be established by participating universities and should measure outcomes and cost savings.

Department of Education Youth Risk-Behavior Survey. According to the National Public Health Service, people between the ages of 15 and 24 are at special risk of developing behaviors that may later become permanent health hazards. In 1993, the

Department of Education administered a survey to 1,923 students in 35 of Virginia's public high schools. The purpose of this survey was to monitor and determine the prevalence of high priority heath-risk behaviors. In 1994, the Department of Education decided not to participate in the survey which was to have been administered every two years. Because of the need for data to plan and evaluate prevention programs, in February 1997 the Virginia Congress of Parents and Teachers endorsed the assessment of youth risk behaviors "...provided that it protects the privacy of students, allows parents/guardians the right to opt-out their students, and participation is voluntary."

Medicaid. Residential and day treatment for pregnant women is the only Medicaid-reimbursable substance abuse service (with the exception of medical detoxification). According to an informal survey of community services boards in October 1997, nearly 3,000 Medicaid-eligible persons were being treated for substance abuse. The number of Medicaid-eligible persons who need (but are not currently receiving) substance abuse treatment is unknown. If the State Plan for Medical Assistance Services were amended to maximize reimbursement for substance abuse services, more than half of the cost of treating these individuals could be paid by the federal government.

Welfare Reform and Substance Abuse Policy. New time limits and strict work participation requirements in the federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996 and the Virginia Initiative for Employment not Welfare (VIEW) make it necessary for most adult caretakers who receive cash benefits to find jobs that will support their families on a sustained basis. Yet, national studies confirm that many welfare recipients experience a wide range of employment barriers, including problems with the abuse of alcohol and other drugs. A study is needed to determine how welfare recipients in Virginia are affected and what treatment programs will be needed to improve their functioning and employability.

Recommendation 102: *The General Assembly should affirm a strong substance abuse policy for the Commonwealth and provide resources to increase capacity and reduce waiting lists for persons who need substance abuse treatment services.*

Recommendation 103: *The Governor's Council on Alcohol and Drug Abuse Problems should be reconstituted as the Substance Abuse Services Council and its powers and duties should be redefined. The twenty-three members of the new Council should include the heads of agencies that receive substance abuse funding*

and representatives of local government, community services boards, the Virginia Sheriff's Association, the General Assembly, consumer and advocacy organizations, and statewide provider associations.

Recommendation 104: *The recommendations of the Crime Commission's study (HJR 443, 1997) concerning alcohol and other drug screening and assessment for offenders should be adopted and implemented.*

Recommendation 105: *The General Assembly should establish drug courts in those judicial circuits that express interest and that have high drug offense case dockets and sufficient correctional and treatment services to support the drug court.*

Recommendation 106: *An incentive fund should be established to develop innovative local programs to treat offenders.*

Recommendation 107: *The Virginia Council on Coordinating Prevention should be fully implemented and strengthened.*

Recommendation 108: *All local agencies that receive prevention funding should be required to participate in local planning and advisory groups. Ten prevention projects should be established to demonstrate the effectiveness of research-based prevention strategies.*

Recommendation 109: *The Department of Education should be requested to administer a youth risk-behavior survey.*

Recommendation 110: *The Department of Medical Assistance Services should be requested to study the costs and benefits of expanding Medicaid reimbursement for substance abuse services.*

Recommendation 111: *Further study should be made of the integration of welfare reform and substance abuse policy to determine what treatment programs will improve the functioning and employability of Virginia Initiative for Employment Not Welfare (VIEW) participants.*

G. Resource Requirements

Given the economic downturn in 1990-91, as well as budget and other public priorities in recent years, there has not been any significant increase in resources to the services system. Limited increases in targeted funding have occurred over the past six years in such areas as new atypical medications, Mental Retardation Medicaid Waiver services, Mental Health State Plan Option Services, and residential services.

Only in recent years, with the growth of Medicaid funding, has spending in community services begun to exceed facility expenditures. Even so, Virginia remains heavily invested on a per capita basis in facility spending. As discussed earlier in this report, Virginia now faces a critical period of having to invest in facility staffing to meet U.S. Department of Justice requirements for active treatment. Over the next decade, the Commonwealth will be required to invest significant capital resources in facilities. If the present number of large, older facilities is maintained and brought up to current building standards, a significant investment in community services capacity will be required to reduce the Commonwealth's reliance on these facilities.

In the *Comprehensive State Plan for 1998-2004*, the CSBs identified $75.11 million in unmet community need for fiscal year 1999, $150.23 million for fiscal year 2000, and over $360 million annualized for the full 1998-2004 six year period. The *Plan* proposed that $31.7 million in fiscal year 1999 and $36.9 million in fiscal year 2000 be allocated to expand community services targeted toward avoiding the use of state facilities.

The joint subcommittee heard requests for specific service needs during the many hours of testimony by citizens of the Commonwealth during the public hearings in 1996. Presentations from state and national leaders and the joint subcommittee's Mental Health, Mental Retardation, and Substance Abuse Work Groups confirmed that funding such items as atypical medications, intensive community treatment programs, adult care residences pilot projects, expansion of drug courts, innovative local substance abuse programs to treat offenders, wrap-around substance abuse services, Medicaid Mental Retardation Waiver expansion, mental retardation mobile crisis stabilization teams, mental retardation housing development projects, and alternative community facilities for medically fragile children would support needed policy and treatment advances in Virginia. The joint subcommittee also heard testimony on the need to enhance services to specific populations, including persons who are deaf, deaf/blind or hearing impaired, and persons with brain injuries who receive services in the mental health system.

The Department and CSBs presented information which supports the need for a number of service system enhancements, including the implementation of POMS, development of a human rights information system, implementation of consumer support pilot projects, and development of managed care technologies. The tables below list the budget initiatives recommended by the joint subcommittee.

Table 1

HJR 240 Joint Subcommittee Proposed Budget Amendments: Summary
(In Millions)

	FY 1999	**FY 2000**	**Biennium**
General Management Initiatives	$ 15.99	$ 16.78	$ 32.77
Mental Health Services	57.53	91.19	148.72
Mental Retardation Services	44.38	89.33	133.71
Substance Abuse Services	36.74	49.03	85.77
TOTAL	$ 154.64	$ 246.33	$ 400.97

Table 2
HJR 240 Joint Subcommittee Proposed General Management Budget Amendments

Item	Proposed Budget Amendment	FY 1999	FY 2000
1	General Fund match replacement for existing Medicaid State Plan Option and MR Waiver services to be targeted for individualized packages of services and supports for non-Medicaid-eligible consumers who have been identified as ready for discharge from state facilities or who are on waiting lists in communities. This request represents the first two years of a proposed four-year phase in of Medicaid match replacement. Also, added budget language to deal with the issue of additional General Fund match for Medicaid in the future (after fiscal year 1999) due to utilization growth and cost increases.	$10.50 M	$10.50 M
2	Implement managed care technology for item 1 (preauthorization and utilization review)	1.20 M	1.20 M
3	Implement the Performance and Outcome Measurement System statewide	621,500	1,864,230
4	Expand the Consumer Support and Involvement Pilot Project	588,374	585,770
5	Enhance the Human Rights Information System	180,000	7,000
6	Conduct capacity and comparability analysis of services system	200,000	-0-
7	Human rights system improvements (State Board report recommendations)	123,600	123,600
8	Health Care Needs Survey	75,000	-0-
9	Adult Care Residences Pilot Projects (for people with mental illnesses, mental retardation, or substance abuse problems)	2.50 M	2.50 M
	TOTAL	$15.99 M	$16.78 M

These proposed general budget amendments do not apply to just one program area (mental health, mental retardation, or substance abuse), but are management or funding initiatives that have broader applicability.

Table 3

HJR 240 Joint Subcommittee Proposed Mental Health Budget Amendments

(General Funds In Millions)

Item	Proposed Budget Amendment	FY 1999	FY 2000
1	Atypical antipsychotic medications	$ 3.75	$ 3.75
2	Assertive community treatment programs	3.75	3.75
3	Residential services for adults with serious mental illness	10.00	10.00
4	Children's services	3.00	3.00
5	Services for deaf/blind persons	1.00	1.00
6	Catawba Hospital 20-bed expansion of the adult psychiatric unit and community bed purchase for Roanoke and Southwest Virginia	1.50	1.50
7	Transitional residential program at Catawba Hospital	.78	.78
8	DMHMRSAS-approved certification program for CSB prescreeners per House Bill No. 681	.10	.10
9	Unmet community service needs (1998-2000, Comprehensive State Plan)	33.65	67.31
	TOTAL	$ 57.53	$ 91.19

Table 4
HJR 240 Joint Subcommittee Proposed Mental Retardation Budget Amendments

(General Funds)

Item	Proposed Budget Amendment	FY 1999	FY 2000
1	MR Residential Rate Adjustment	$ 2.20 M	$ 2.20 M
2	Mental Retardation Waiver match for census reduction with 200 persons each year identified as ready to return to the community in fiscal years 1999 and 2000	5.34 M	13.88 M
3	Departmental resources (e.g., managed care technology such as preauthorization and utilization management and review) to implement item 2	1.30 M	3.40 M
4	Regional emergency management funds to prevent or manage severe family crises and divert facility admissions to community services (300 persons in fiscal year 1999, 555 persons in fiscal year 2000)	5.62 M	10.41 M
5	Mobile Community Crisis Stabilization Pilots (five projects)	200,000	300,000
6	Alternative community facilities for medically fragile children	150,000	300,000
7	Health care for individuals in community-based services, provided at Northern Virginia Training Center	152,000	255,000
8	Housing development projects ($50,000 per project for 10 projects over two years in association with HUD 811 funds or other sources - one time funds)	250,000	250,000
9	Address unmet needs for residential and/or day support services to begin to address current waiting list	26.00 M	26.00 M
10	Other unmet community services needs (1998-2000, Comprehensive State Plan) [1]	3.17 M	32.34 M
	TOTAL	$44.38 M	$89.33 M

[1] The Comprehensive State Plan identified $29.17 million in fiscal year 1999 and $58.34 million in fiscal year 2000 for unmet community services needs. The $26 million in item 9 for each year of the biennium for unmet needs, identified in the MR Work Group paper, is subtracted from these Comprehensive State Plan figures to produce the numbers in item 10.

Table 5
HJR 240 Joint Subcommittee Proposed Substance Abuse Budget Amendments
(General Funds)

Item	Proposed Budget Amendment	FY 1999	FY 2000
1	Services to divert primary substance abusers from state facilities	$ 4.00 M	$ 4.00 M
2	Wrap-around services for substance abuse clients	5.90 M	5.90 M
3	Increase substance abuse treatment capacity in communities for offenders, including establishing drug courts	12.25 M	12.25 M
4	Fund a seed grant for education and advocacy network	50,000	50,000
5	Increase capacity and reduce waiting lists for substance abuse services [1]	12.29 M	24.58 M
6	Establish and fund prevention demonstration projects	2.00 M	2.00 M
7	Establish a separate Office of Prevention Services in the Department (five FTEs)	250,000	250,000
	TOTAL	$36.74 M	$49.03 M

[1] The Comprehensive State Plan identified $12.29 million and $24.58 million for unmet community services needs in fiscal year 1999 and fiscal year 2000, respectively. The Substance Abuse Work Group identified $20 million per year, but item 5 is adjusted to match the Comprehensive Plan data.

V. CONCLUSION

Following two years of review and analysis, the Joint Subcommittee Studying the Future Delivery of Publicly Funded Mental Health, Mental Retardation and Substance Abuse Services has made recommendations to effect sweeping changes in the governance and structure of the system, allocation of resources, access and availability of publicly funded services, the use of managed care techniques, accountability, consumer participation, and protection of human rights. The joint subcommittee believes that many additional issues still need to be resolved and oversight is required for the implementation of recommendations contained in this report. In particular, continued review and oversight are needed in the following areas: (i) implementation of the numerous statutory and policy changes and budget initiatives recommended by the joint subcommittee; (ii) the results of the Performance and Outcome Measurement System (POMS) project; (iii) development of the Community and Facility Master Plan; (iv) implementation of the Medicaid carve-out; (v) results from the priority population pilot projects and the primary health care needs assessment; and (vi) the findings from recommended studies on human rights and other significant issues.

Recommendation 112: *The General Assembly should establish a Behavioral Healthcare Commission or continue the joint subcommittee to conduct further analysis of the issues and provide oversight for implementation of the recommendations.*

Respectfully submitted,

Del. Franklin P. Hall, Co-Chairman
Sen. Joseph V. Gartlan, Jr., Co-Chairman
Del. Robert S. Bloxom, Vice-Chairman
Del. Mary T. Christian
Del. Jay W. DeBoer *
Del. A. Victor Thomas
Sen. Stephen H. Martin
Sen. William C. Wampler, Jr.
Attorney General Mark L. Earley
David G. Brickley
Julia A. Connally
Richard E. Kellogg

* Dissenting

Appendix 1

House Joint Resolution No. 240

GENERAL ASSEMBLY OF VIRGINIA -- 1996 SESSION

HOUSE JOINT RESOLUTION NO. 240

Establishing a joint subcommittee to evaluate the future delivery of publicly funded mental health, mental retardation, and substance abuse services.

Agreed to by the House of Delegates, March 6, 1996
Agreed to by the Senate, March 1, 1996

WHEREAS, it has now been twenty-eight years since Virginia adopted legislation that established community based treatment and support for persons with mental disabilities, and significant progress has been made in the commonwealth's publicly funded mental health, mental retardation, and substance abuse services delivery system; and

WHEREAS, several legislative commissions, especially the Hirst Commission and the Bagley Commission, have endorsed and confirmed the importance of care in the least restrictive environment as close to the clients' home supports as possible; and

WHEREAS, since 1970, enabled by the development of new forms of mental health treatment as well as new types of effective drug therapies and the establishment of a comprehensive array of community based services, the population census of mentally ill clients treated in state mental health facilities has dropped from about 9,343 to approximately 2,417 in 1995, and the census in state mental retardation facilities has likewise dropped from 5,327 to 2,249 in that same period; and

WHEREAS, recent figures show that while facilities serve only 4.8 percent of the mentally disabled population, funding for facilities accounted for 68.1 percent of state support for the mental health budget and 49.7 percent of the system's total federal, state, local, and fee support; and

WHEREAS, on the other hand, approximately 95.2 percent of the mentally disabled population was served through the Community Services Boards, using 26.6 percent of the state budget and 46.7 percent of the system's total federal, state, local, and fee support; and

WHEREAS, increased pressure is being placed on the delivery of publicly funded mental health, mental retardation, and substance abuse services due to continued downsizing of state facilities without reinvestment of all funds saved into the system, anticipated changes in federal programs of Medicaid and mental health and substance abuse block grant funding, and greater use of managed care; and

WHEREAS, the Commonwealth of Virginia must make every effort to assure cost-effective service delivery; access to services for citizens in need of mental health, mental retardation, and substance abuse services; and accountability to the Commonwealth; and

WHEREAS, the need for community based mental health, mental retardation, and substance abuse services exceeds current capacity as determined by the recent Department of Mental Health, Mental Retardation and Substance Abuse Services Continuum of Care Study; and

WHEREAS, while over 185,000 citizens receive services through the publicly funded mental health system, at least 10,000 more remain on waiting lists for services; and

WHEREAS, consumer and family advocacy groups, Community Services Boards, the State Mental Health, Mental Retardation and Substance Abuse Services Board and the Department of Mental Health, Mental Retardation and Substance Abuse Services have expressed considerable interest in and support for system reform and new methods of financing and providing services and have devoted significant effort to developing proposals for improving Virginia's publicly funded system of services; and

WHEREAS, during the period 1994-1996, the Joint Subcommittee Studying the Effects of Deinstitutionalization has established a significant base of information that demonstrates the need for continued, consistent oversight of publicly funded mental health, mental retardation, and substance abuse services; and

WHEREAS, the Health and Human Resources Secretary's System Reform Task Force will meet for approximately three months in order to develop by July 31, 1996, recommendations for one or more regional pilot projects; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That a joint subcommittee be established to evaluate the future delivery of publicly funded mental health, mental retardation, and substance abuse services. The joint subcommittee shall be composed of thirteen members to be

appointed as follows: seven members of the House of Delegates to be appointed by the Speaker of the House; four members of the Senate to be appointed by the Senate Committee on Privileges and Elections; the Secretary of Health and Human Resources and the Commissioner of Mental Health, Mental Retardation and Substance Abuse Services, who shall serve ex officio without voting privileges.

The joint subcommittee shall be assisted in its work by volunteer technical advisory groups with membership from public and private service providers, local government officials representing a variety of local interests, and consumers and their families.

In its deliberations, the joint subcommittee shall examine and make recommendations on, but not be limited to, the following issues:

1. The current system of delivering mental health, mental retardation, and substance abuse services in the Commonwealth;

2. The principles and goals for a comprehensive publicly funded mental health, mental retardation, and substance abuse services program in the Commonwealth;

3. The range of services, and eligibility for those services, necessary to serve Virginians' needs for publicly funded mental health, mental retardation, and substance abuse services;

4. The proper method of funding publicly supported community and facility mental health, mental retardation, and substance abuse services, including operations and capital needs, and projecting costs of meeting identified needs and revenue required;

5. The proper relationship between the Department of Mental Health, Mental Retardation and Substance Abuse Services and the components of the publicly funded system that deliver services, the Community Services Boards, and the state facilities;

6. The information, such as outcome and consumer satisfaction measures and comparable cost and utilization review data, and the technology needed to provide appropriate and enhanced accountability;

7. The applicable chapters and sections of Title 37.1 of the Code of Virginia;

8. The ways to more effectively involve consumers and families in planning and evaluating the Commonwealth's publicly funded mental health, mental retardation, and substance abuse services system; and

9. The possible changes in the system based on the recommendations made by the Joint Subcommittee Studying the Effects of Deinstitutionalization, pursuant to House Joint Resolution No. 139 (1994) and House Joint Resolution No. 549 (1995), and on the possible recommendations by the Health and Human Resources Secretary's System Reform Task Force regarding the development of regional pilot projects.

The direct costs of this study shall not exceed $26,400.

An estimated $100,000 is allocated for consulting services. Such expenses shall be funded by a separate appropriation from the General Assembly.

The Division of Legislative Services shall provide staff support for the study. Technical assistance shall be provided by the staffs of the House Committee on Appropriations and the Senate Committee on Finance. All agencies of the Commonwealth shall provide assistance to the joint subcommittee, upon request.

The joint subcommittee shall complete its work in time to submit its findings and recommendations to the Governor and the 1998 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

Implementation of this resolution is subject to subsequent approval and certification by the Joint Rules Committee. The Committee may withhold expenditures or delay the period for the conduct of the study.

Appendix 2

State Facilities and Community Services Boards

State Facilities and Community Services Boards

State Mental Health Facilities:

Catawba Hospital (Catawba)
Central State Hospital (Dinwiddie)
DeJarnette Center (Staunton)
Eastern State Hospital (Williamsburg)
Northern Virginia Mental Health Institute (Falls Church)
Piedmont Geriatric Hospital (Burkeville)
Southern Virginia Mental Health Institute (Danville)
Southwestern Virginia Mental Health Institute (Marion)
Western State Hospital (Staunton)

State Mental Retardation Training Centers:

Central Virginia Training Center (Lynchburg)
Northern Virginia Training Center (Fairfax)
Southeastern Virginia Training Center (Chesapeake)
Southside Virginia Training Center (Dinwiddie)
Southwestern Virginia Training Center (Hillsville)

Medical Center:

Hiram W. Davis Medical Center (Dinwiddie)

Community Services Boards:

CSB	Localities Served by CSB
Alexandria CSB	City of Alexandria
Alleghany-Highlands CSB	County of Alleghany and the Cities of Clifton Forge and Covington
Arlington CSB	County of Arlington
Blue Ridge Community Services	Counties of Botetourt, Craig, and Roanoke and the Cities of Roanoke and Salem
Central Virginia Community Services	Counties of Amherst, Appomattox, Bedford, and Campbell and the Cities of Bedford and Lynchburg
Chesapeake CSB	City of Chesapeake
Chesterfield CSB	County of Chesterfield
Colonial MH & MR Services	Counties of James City and York and the Cities of Poquoson and Williamsburg
Crossroads Services Board	Counties of Amelia, Buckingham, Charlotte, Cumberland, Luenburg, Nottoway, and Prince Edward
Cumberland Mountain Community Services	Counties of Buchanan, Russell, and Tazewell
Danville-Pittsylvania Community Services	County of Pittsylvania and the City of Danville
Dickenson County Community Services	County of Dickenson
District 19 CSB	Counties of Dinwiddie, Greensville, Prince George, Surry, and Sussex and the Cities of Colonial Heights, Emporia, Hopewell, and Petersburg
Eastern Shore CSB	Counties of Accomack and Northampton

Fairfax-Falls Church CSB	County of Fairfax and the Cities of Fairfax and Falls Church
Goochland-Powhatan CSB	Counties of Goochland and Powhatan
Hampton-Newport News CSB	Cities of Hampton and Newport News
Hanover County CSB	County of Hanover
Harrisonburg-Rockingham CSB	County of Rockingham and the City of Harrisonburg
Henrico Area MH&R Services Board	Counties of Charles City, Henrico, and New Kent
Highlands Community Services	County of Washington and City of Bristol (VA)
Loudoun County CSB	County of Loudoun
Middle Peninsula-Northern Neck CSB	Counties of Essex, Gloucester, King & Queen, King William, Lancaster, Mathews, Middlesex, Northumberland, Richmond, and Westmoreland
Mount Rogers Community MH&MR Services Board	Counties of Bland, Carroll, Grayson, Smyth, and Wythe, and the City of Galax
New River Valley Community Services	Counties of Floyd, Giles, Montgomery, and Pulaski, and the City of Radford
Norfolk CSB	City of Norfolk
Northwestern Community Services	Counties of Clarke, Frederick, Page, Shenandoah, and Warren, and the City of Winchester
Piedmont Community Services	Counties of Franklin, Henry, and Patrick, and the City of Martinsville
Planning District 1 CSB	Counties of Lee, Scott, and Wise, and the City of Norton
Portsmouth CSB	City of Portsmouth

Prince William County CSB	County of Prince William and Cities of Manassas and Manassas Park
Rappahannock Area CSB	Counties of Caroline, King George, Spotsylvania, and Stafford, and the City of Fredericksburg
Rappahannock-Rapidan CSB	Counties of Culpeper, Fauquier, Madison, Orange, and Rappahannock
Region Ten CSB	Counties of Albemarle, Fluvanna, Greene, Louisa, and Nelson, and the City of Charlottesville
Richmond Behavioral Health Authority	City of Richmond
Rockbridge Area CSB	Counties of Bath and Rockbridge and the Cities of Buena Vista and Lexington
Southside CSB	Counties of Brunswick, Halifax, and Mecklenburg
Valley CSB	Counties of Augusta and Highland and the Cities of Staunton and Waynesboro
Virginia Beach CSB	City of Virginia Beach
Western Tidewater CSB	Counties of Isle of Wight and Southampton and the Cities of Franklin and Suffolk

Appendix 3

Proposed Legislation

1998 Session of the General Assembly

984211661

HOUSE BILL NO. 428

Offered January 15, 1998

A BILL to amend and reenact §§ 37.1-194 through 37.1-202.1 and 37.1-242 through 37.1-253 of the Code of Virginia, and that the Code of Virginia is amended adding in Article 2 of Chapter 1 of Title 37.1 a section numbered 37.1-48.1, and by adding sections numbered 37.1-194.1 and 37.1-248.1, relating to community mental health, mental retardation and substance abuse services; behavioral health authorities; Comprehensive State Plan.

Patrons—Hall, Bloxom, Christian, Melvin, Thomas and Van Landingham; Senators: Gartlan, Lambert, Martin and Wampler

Referred to Committee on Health, Welfare and Institutions

Be it enacted by the General Assembly of Virginia:

1. That §§ 37.1-194 through 37.1-202.1 and 37.1-242 through 37.1-253 of the Code of Virginia are amended and reenacted, and that the Code of Virginia is amended by adding in Article 2 of Chapter 1 of Title 37.1 a section numbered 37.1-48.1, and by adding sections numbered 37.1-48.1, 37.1-194.1 and 37.1-248.1, as follows:

§ 37.1-48.1. Comprehensive State Plan for mental health, mental retardation and substance abuse services.

The Department, in consultation with community services boards, behavioral health authorities and state mental health and mental retardation facilities and with consumers, families, advocacy organizations, and other interested parties, shall develop and update bienially a six-year Comprehensive State Plan for mental health, mental retardation and substance abuse services. The Comprehensive State Plan shall identify the needs of and the resource requirements for providing services and supports to persons with mental illness, mental retardation or alcohol or other drug abuse or dependence across the Commonwealth and shall propose strategies to address these needs. The Comprehensive State Plan shall be the basis for the Department's biennial budget submission to the Governor and the General Assembly.

§ 37.1-194. Purpose; services to be provided.

The Department, for the purposes of establishing, maintaining, and promoting the development of mental health, mental retardation and substance abuse services in the Commonwealth, may ~~make matching grants~~ *provide funds* to assist any *city or* county ~~having a population of approximately 50,000 or more or any city having a population of approximately 75,000 or more~~, or any combination of political subdivisions ~~having a combined population of approximately 50,000 or more, or any city or county or combination thereof which has less than the above prescribed populations which the Department determines is in need of such services~~, in the ~~establishment and operation of local mental health, mental retardation and substance abuse programs~~*provision of such services*. Every county and city shall establish, either singly or in combination with ~~another~~ *other* political ~~subdivisions~~*subdivisions*, ~~a~~ *an operating* community services board *or a policy-making community services board and a local government department* on or before July 1, ~~1983~~*1999*.

The core of ~~program~~ services to be provided by *operating* community services boards *or local government departments* within the political subdivisions *that* they serve shall include emergency *and case management* services and may include inpatient ~~services~~, outpatient, ~~and~~ day-support ~~services~~, residential ~~services~~, prevention, ~~and~~ early intervention ~~services~~, and other appropriate mental health, mental retardation and substance abuse ~~programs~~ *services* necessary to provide ~~a comprehensive system of services~~ *packages of individualized services and supports to persons with mental illnesses, mental retardation, or alcohol or other drug abuse or dependence.*

§ 37.1-194.1. Definitions.

As used in this chapter, unless a different meaning clearly appears from the context:

"Operating community services board" means the public body organized in accordance with the provisions of this chapter that is appointed by and accountable to the local governing body of the political subdivision that established it for the direct provision of mental health, mental retardation and substance abuse services.

"Policy-making community services board" means the public body organized in accordance with the provisions of this chapter that is appointed by and accountable to the local governing body of the political subdivision that established it to set policy for the local government department that provides mental health, mental retardation and substance abuse services.

"Performance contract" means the annual agreement negotiated by an operating community services board or policy-making community services board and a local government department with the Department through which it provides state and federal funds appropriated for mental health, mental retardation and substance abuse services to that operating community services board or local government department.

§ 37.1-195. Community services board; appointment; membership; duties of fiscal agent.

Every city, county or combination of counties or cities or counties and cities ~~establishing a community mental health, mental retardation and substance abuse services program,~~ before it shall come within the provisions of this ~~act~~*chapter*, shall establish a single community services board, with neither less than ~~five~~ *six* nor more than eighteen members. When any city or county singly establishes a ~~program~~*community services board*, the board shall be appointed by the governing body of the local political subdivision establishing ~~such a program~~*the board*. When any combination of counties or cities or counties and cities establishes a community services ~~program~~*board*, the board of supervisors of each county ~~in the case of counties~~ or the council ~~in the case~~ of ~~cities~~ *each city* shall ~~establish~~*mutually agree on* the size of the board~~,~~ ~~shall elect~~ and appoint the members of the *community services* board ~~and shall designate an official of one member city or county to act as fiscal agent for the board~~.

Appointments to the community services board shall be broadly representative of the community ~~and shall include representation by~~ . *One third of the appointments to the board shall be identified* consumers or family members of consumers *and at least one member at all times shall be a consumer. One or more members may be non-governmental service providers.* Sheriffs or their designees shall also be included, when practical.

~~The county or city which comprises a single board and the county or city whose designated official serves as fiscal agent for the board in the case of joint boards shall annually audit the total revenues of the board and its programs and shall, in conjunction with the other participating political subdivisions in the case of joint boards, arrange for the provision of legal services to the board.~~

No such board shall be composed of a majority of *local government* officials, elected *or appointed*, as members, nor shall any county or city be represented on such board by more than ~~one~~ *two* elected ~~official~~ *or appointed officials*.

The board appointed pursuant to this section shall be responsible to the governing body or bodies of the county or city or combination thereof ~~which~~ *that* established such board.

A city council or county board of supervisors may establish its community services board either as a policy-making community services board, which sets policy for a city or county government department that fulfills the responsibilities and duties in §§ 37.1-197 A and 37.1-197.1, or as an operating community services board, which directly fulfills these responsibilities and duties. A combination of cities or counties or cities and counties may establish a joint community services board either as a policy-making community services board, which sets policy for a local government department that fulfills the responsibilities and duties in §§ 37.1-197 A and 37.1-197.1, or as an operating community services board, which directly fulfills those responsibilities and duties.

The county or city that establishes a policy-making community services board shall provide an annual audit of the total revenues and expenditures of the city or county government department to the board and the Department, employ sufficient staff in the city or county government department to carry out the responsibilities and duties enumerated in §§ 37.1-197 A and 37.1-197.1, and provide legal services to the board. When a combination of cities or counties or cities and counties establishes a policy-making community services board, the participating subdivisions shall designate which local government shall operate the city or county government department. This local government shall provide an annual audit of the total revenues and expenditures of that department to the board and the Department, employ sufficient staff to carry out the responsibilities and duties enumerated in §§ 37.1-197 A and 37.1-197.1, and, in conjunction with the other participating political subdivisions in the case of joint boards, arrange for the provision of legal services to the board.

The county or city that establishes an operating community services board shall receive an annual audit of the total revenues and expenditures of that board, provide a copy of the audit to the Department, and arrange for the provision of legal services to the board. The combination of cities or counties or cities and counties that establishes an operating board shall designate an official of one member city or county to act as fiscal agent for the board. The county or city whose designated official serves as fiscal agent for the board in the case of joint boards shall annually audit the total revenues of the board and its services and shall, in conjunction with the other participating political subdivisions in the case of joint boards, arrange for the provision of legal services to the board.

§ 37.1-196. Same; term; vacancies; removal.

The term of office of each member of the *operating* community services boards *or of the policy-making boards* shall be for three years from the first day of January of the year of appointment, or, at the option of the governing body of a county or city, from the first day of July of the year of appointment, except that of the members first appointed, several shall be appointed for terms of one year each, several for terms of two years each, and the remaining members of the board for terms of three years each. The selection of members for one, two, and three-year terms shall be as nearly equal as possible with regard to the total number of members on the board. If a governing body has appointed members for terms commencing January one or July one but desires to change the date the terms of office commence, the governing body may, as the terms of the members then in office expire, appoint successors for terms of two and one-half or three and one-half years so as to expire on June thirty or December thirty-one. Vacancies shall be filled for unexpired terms in the same manner as original appointments. No person shall be eligible to serve more than two ~~successive~~ *full three-year* terms; provided that persons heretofore or hereafter appointed to fill vacancies may serve two additional ~~successive~~ *full three-year* terms. Any member of a board may be removed by the appointing authority for cause, after being given a written statement of the causes and an opportunity to be heard thereon.

§ 37.1-196.1. Compensation of board members.

The governing body of any county or city, or the governing bodies of any combination thereof, which establishes ~~a~~ *an operating* community services board *or a policy-making board* may, out of the general fund or funds of the participating political subdivisions, pay to each member of the board not in excess of $600 per year as compensation for his attendance at meetings of the board. No political subdivision shall be reimbursed out of either state or federal funds for any part of the compensation paid.

§ 37.1-197. Community services board; local government department; powers and duties.

A. Every *operating* community services board *or local government department* shall *have the following powers and duties*:

1. Review and evaluate all existing and proposed public community mental health, mental retardation and substance abuse services and facilities available to serve the community and such private services and facilities as receive funds through ~~the board~~ *it* and advise the ~~appropriate~~ local ~~governments~~*governing body or bodies of the political subdivision or subdivisions that established it* as to its findings.

2. ~~Submit~~*Pursuant to § 37.1-198, submit* to the governing body ~~or bodies~~ of each political subdivision~~, of which~~ *that established* it ~~is an agency, a program of~~ *an annual performance contract for* community mental health, mental retardation and substance abuse services ~~and facilities~~ for its approval *prior to submission of the contract to the Department.*

3. Within amounts appropriated therefor~~, execute such programs and maintain~~ *provide* such services as may be authorized under such ~~appropriations~~*performance contract.*

4. In accordance with its approved ~~program~~*performance contract*, enter into contracts *with other providers* for *the* rendition or operation of services or facilities.

5. *In the case of operating boards,* ~~Make~~ *make* rules, *policies,* or regulations concerning the rendition or operation of services and facilities under its direction or supervision, subject to applicable standards, *policies,* or regulations promulgated by the State Board.

6. Appoint ~~a coordinator or~~ *an executive* director of community mental health, mental retardation and substance abuse services, according to minimum qualifications ~~as may be~~ established by the Department, and prescribe his duties. The compensation of ~~such coordinator or~~*the executive* director

shall be fixed by the board within the amounts made available by appropriation therefor. *In the case of operating community services boards, the executive director shall serve at the pleasure of the board and be employed under an annually renewable contract that contains performance objectives and evaluation criteria. For operating community services boards, the Department shall (i) participate in and approve the selection of the executive director, (ii) review and approve the executive director's contract, and (iii) review and approve the compensation packages of the executive director and senior management staff.*

7. Prescribe a reasonable schedule of fees for services provided by personnel or ~~facilities~~ *contract agencies* under ~~the~~ *its* jurisdiction or supervision ~~of the board~~ and *establish procedures for the* collection of the same. All fees collected shall be included in the ~~program~~ *performance contract* submitted to the local governing body or bodies pursuant to subdivision 2 hereof and ~~in the budget submitted to the local governing body or bodies pursuant to~~ § 37.1-198 and shall be used only for community mental health, mental retardation and substance abuse purposes. Every *operating* board *and local government department* shall institute a reimbursement system to maximize the collection of fees from persons receiving services under ~~the~~ *their* jurisdiction or supervision ~~of the board~~ consistent with the provisions of § 37.1-202.1 and from responsible third-party payors. ~~Boards~~ *Operating boards and local government departments* shall not attempt to bill or collect fees for time spent participating in involuntary commitment hearings pursuant to § 37.1-67.3.

8. Accept or refuse gifts, donations, bequests or grants of money or property from any source and utilize the same as authorized by the governing body or bodies of the political subdivision or subdivisions ~~of which~~ *that established* it ~~is an agency~~.

9. Seek and accept funds through federal grants. In accepting such grants the *operating* board *or local government department* shall not bind the governing body or bodies of the political subdivision or subdivisions ~~of which~~ *that established* it ~~is an agency~~ to any expenditures or conditions of acceptance without the prior approval of such governing body or bodies.

10. Have authority, notwithstanding any provision of law to the contrary, to disburse funds appropriated to it in accordance with such regulations as may be established by the governing body *or bodies* of the political subdivision ~~of which the board is an agency or, in the case of a joint board, as may be establish by agreement~~ *or subdivisions that established it.*

11. Apply for and accept loans as authorized by the governing body or bodies of the political subdivision or subdivisions ~~of which~~ *that established* it ~~is an agency~~. This provision is not intended to affect the validity of loans so authorized and accepted prior to July 1, 1984.

12. Develop joint annual written agreements, consistent with policies and procedures established by the State Board, with local school divisions; health departments; boards of social services; housing agencies, where they exist; courts; sheriffs; area agencies on aging and regional Department of Rehabilitative Services offices. The agreements shall specify what services will be provided to ~~clients~~*consumers*. All participating agencies shall develop and implement the agreements and shall review the agreements annually.

13. Develop and submit to the Department the necessary information for the preparation of the Comprehensive State Plan for Mental Health, Mental Retardation and Substance Abuse pursuant to § 37.1-48.1.

14. Take all necessary and appropriate actions to maximize the involvement and participation of consumers and family members of consumers in policy formulation and services planning, delivery, and evaluation.

15. Institute, singly or in combination with other operating boards or local government departments, a dispute resolution mechanism that is approved by the Department and enables consumers and family members of consumers to resolve concerns, issues, or disagreements about services without adversely affecting their access to or receipt of appropriate types and amounts of current or future services from the operating board or local government department.

16. Notwithstanding the provisions of § 37.1-84.1 or any regulations promulgated thereunder, release data and information about individual consumers to the Department so long as the Department implements procedures to protect the confidentiality of such information.

B. Every policy-making community services board shall:

1. Review and evaluate the operations of the local government department and advise the local

governing body of each political subdivision that established it as to its findings.

2. Review the community mental health, mental retardation and substance abuse services developed by the local government department and advise the local governing body of each political subdivision that established it as to its findings.

3. Make rules, policies, or regulations concerning the rendition or operation of services and facilities by the local government department, subject to applicable standards, policies, or regulations promulgated by the State Board.

4. Review and comment on the annual performance contract, quarterly and annual performance reports, and comprehensive state plan proposals developed by the local government department. The board's comments shall be attached to the performance contract, performance reports, and comprehensive state plan proposals prior to their submission to the local governing body of each political subdivision that established it and to the Department.

5. Take all necessary and appropriate actions to maximize the involvement and participation of consumers and family members of consumers in policy formulation and services evaluation.

6. Participate in the selection and the annual performance evaluation of the local government department director employed by the city or county establishing that department pursuant to § 37.1-195.

§ 37.1-197.1. Prescription team; prescreening; predischarge planning.

A. In order to provide comprehensive mental health, mental retardation and substance abuse services within a continuum of care, the *operating* community services board *or local government department* shall *function as the single point of entry into the publicly funded mental health, mental retardation and substance abuse services system and shall fulfill the following responsibilities*:

1. Establish and coordinate the operation of a prescription team ~~which~~ *that* shall be composed of representatives from the *operating* community services board *or local government department*, social services or public welfare department, health department, Department of Rehabilitative Services *office* serving in the community services board's area and, as appropriate, the social services staff of the state institution*(s)* serving the community services board's catchment area and the local school division. Such other human resources agency personnel may serve on the team as the team deems necessary. The team, under the direction of the *operating* community services board *or the local government department*, shall be responsible for integrating the community services necessary to accomplish effective prescreening and predischarge planning for ~~clients~~ *consumers* referred to the *operating* community services board *or local government department*. When prescreening reports are required by the court on an emergency basis pursuant to § 37.1-67.3, the team may designate one team member to develop the report for the court and report thereafter to the team.

2. Provide prescreening services prior to the admission for treatment pursuant to § 37.1-65 or § 37.1-67.3 of any person who requires emergency mental health services while in a political subdivision served by the *operating community services* board *or local government department.*

3. ~~Cooperate and participate in~~ *Provide, in consultation with the appropriate state mental health facility or training center,* predischarge planning for any person, who prior to ~~hospitalization~~ *admission* resided in a political subdivision served by the *operating community services* board *or local government department* or who chooses to reside after hospitalization in a political subdivision served by the board, who is to be released from a state ~~hospital~~ *mental health facility or training center* pursuant to § 37.1-98. *The predischarge plan must be completed prior to the person's discharge. The plan must be prepared with the involvement and participation of the consumer or his representative and must reflect the consumer's preferences to the greatest extent possible. The plan must include all of the mental health, mental retardation, substance abuse, social, educational, medical, employment, housing, legal, advocacy, transportation, and other services that the consumer will need and identify the public or private agencies that have agreed to provide them.*

4. No person shall be discharged from a state mental health facility or training center without completion by the operating community services board or local government department of the discharge plan described in subdivision A 3 of this section. If state facility staff identify a patient or resident as ready for discharge and the operating community services board or local government department that is responsible for the person's care refuses to develop a discharge plan to accept the person back into his community, the state facility and the operating board or local government

department shall accept the Department's mediation of this situation and implement the Department's final decision. The operating community services board or local government department must document in the treatment plan the reason(s) for not discharging a person identified by the state mental health facility or training center as being ready for discharge to a community setting. This documentation must be placed in the person's treatment plan at the mental health facility or training center within thirty days of this identification.

B. The *operating* community services board *or local government department* may perform the functions set out in ~~subsection A~~ *subdivision A 1* hereof, *regarding the prescription team*, in the case of children by referring ~~clients~~ *consumers* who are minors to the locality's family assessment and planning team and *by* cooperating with the community policy and management team in the coordination of services for troubled youths and their families. *The operating community services board or local government department may involve the family assessment and planning team and the community policy and management team, but it remains responsible for performing the functions set out in subdivisions A 2 and 3 hereof in the case of children.*

§ 37.1-197.2. Background checks required.

A. Every *operating* community services board, *local government department* and behavioral health authority shall, on and after July 1, 1997, require any applicant who accepts employment in any direct ~~client~~ *consumer* care position with the *operating* community services board, *local government department* or behavioral health authority to submit to fingerprinting and provide personal descriptive information to be forwarded through the Central Criminal Records Exchange to the Federal Bureau of Investigation (FBI) for the purpose of obtaining national criminal history record information regarding such applicant.

The Central Criminal Records Exchange, upon receipt of an individual's record or notification that no record exists, shall submit a report to the requesting executive director of the *operating* community services board, *local government department* or the behavioral health authority. If any applicant is denied employment because of information appearing on the criminal history record and the applicant disputes the information upon which the denial was based, the Central Criminal Records Exchange shall, upon request, furnish the applicant the procedures for obtaining a copy of the criminal history record from the Federal Bureau of Investigation. The information provided to the executive director of any *operating* community services board, *local government department* or behavioral health authority shall not be disseminated except as provided in this section.

B. ~~The~~ *Operating* community services boards, *local government departments* and behavioral health authorities shall also require, as a condition of employment for all such applicants, written consent and personal information necessary to obtain a search of the registry of founded complaints of child abuse and neglect maintained by the Department of Social Services pursuant to § 63.1-248.8.

C. The cost of obtaining the criminal history record and search of the child abuse and neglect registry record shall be borne by the applicant, unless the *operating* community services board, *local government department* or behavioral health authority, at its option, decides to pay such cost.

D. As used in this section, the term "direct ~~client~~*consumer* care position" means any position with a job description that includes responsibility for (i) treatment, case management, health, safety, development or well-being of a ~~client~~*consumer*, or (ii) immediately supervising a person in a position with such responsibility.

§ 37.1-198. Performance contract for mental health, mental retardation and substance abuse services.

A. The Department shall develop and initiate negotiation of the performance contracts through which it provides funds to operating community services boards or local government departments to accomplish the purposes set forth in this chapter. Six months prior to the beginning of each fiscal year, the Department shall make available to the public the standard performance contract form that it intends to use as the performance contract for that fiscal year, and solicit public comments for a period of sixty days.

B. Any ~~city, county or combination of counties or cities or counties and cities which establishes a~~ *operating* community services board *or local government department* ~~administering a mental health, mental retardation and substance abuse services program~~ may apply for the assistance ~~as~~ provided in this ~~act~~ *chapter* by submitting annually to the Department its ~~plan and budget~~ *proposed performance*

contract for the next fiscal year together with the recommendations of the *operating* community services ~~board thereon~~*board's board of directors or, in the case of local government departments, the policy-making community services board, and the approval by formal vote of the governing body of each political subdivision that established it.* ~~The plan and budget shall include a comprehensive needs assessment of the service area, an inventory of available services provided by the board and other local agencies and expected utilization of such services.~~ *The operating community services board or local government department shall make its proposed performance contract available for public review and solicit public comments for a period of thirty days prior to submitting it for approval to the operating community services board's board of directors or, for local government departments, the policy-making community services board and the governing body of each political subdivision.*

C. The performance contract shall (i) delineate the responsibilities of the Department and the operating community services board or the local government department and its policy board; (ii) specify conditions that must be met for the receipt of state-controlled funds; (iii) identify the groups of consumers to be served with state-controlled funds; (iv) beginning on July 1, 1999, contain specific consumer outcome and provider performance measures, consumer satisfaction and consumer and family member participation and involvement indicators, and state facility bed utilization targets that have been negotiated with the operating community services board or local government department; (v) establish an enforcement mechanism, including notice and an appeal process, should an operating community services board or local government department fail to comply with any provisions of the contract, including provisions for the withholding of funds, methods of repayment of funds, and for the Department to exercise the provision of subdivision E hereof; and (vi) include reporting requirements and revenue, cost, service, and consumer information displayed in a consistent, comparable format determined by the Department.

D. No ~~program~~ *operating community services board or local government department* shall be eligible ~~for a grant hereunder~~ *to receive state-controlled funds for mental health, mental retardation, or substance abuse services* unless *(i)* its ~~plan and budget have~~ *performance contract has* been approved by the governing body ~~or bodies~~ of each political subdivision ~~of which~~ *that established* it ~~is an agency~~ and by the Department*.; (ii) it provides service, cost, revenue, and aggregate and individual consumer data and information, notwithstanding the provisions of § 37.1-84.1 or any regulations promulgated thereunder, to the Department in the format prescribed by the Department; and (iii) beginning on July 1, 1999, it uses standardized cost accounting and financial management systems approved by the Department.*

E. If, after unsuccessful use of the remediation process described in the performance contract, an operating community services board or local government department remains in substantial noncompliance with its performance contract with the Department, the Department may, after affording the board or department an adequate opportunity to use the appeal process described in the performance contract, terminate the contract. Using the state-controlled resources associated with that contract, the Department, after consulting with the governing body of each political subdivision that established the operating board or local government department, may negotiate a performance contract with another operating community services board or local government department or a private nonprofit or for-profit organization to obtain the services that were the subject of the terminated performance contract.

§ 37.1-199. Mental health, mental retardation and substance abuse services; allocation of funds by Department; withdrawal of funds.

~~(a)~~ *A.* At the beginning of each fiscal year the Department ~~may~~ *shall* allocate available *state-controlled* funds to ~~the~~ *operating* community services boards *and local government departments* for disbursement in accordance with ~~such~~ *Department*-approved ~~plans and budgets~~*performance contracts.*

B. From time to time during the fiscal year, the Department shall review the ~~budgets and expenditures~~ *performance reports* of the ~~various programs~~*operating boards and local government departments and the utilization management and review reports on their operations.* ~~If funds are not needed for a program to which they were allocated, the Department may withdraw such funds as are unencumbered, after reasonable notice and opportunity for hearing, and reallocate them to other~~

~~programs.~~ ~~It~~ *The Department, after affording the operating board or local government department adequate opportunity to use the appeal process described in the performance contract,* may withdraw funds from any *operating* community services board *or local government department* ~~program~~ ~~which~~ *that* is not being administered in accordance with ~~the~~ *its* approved ~~plan~~ ~~and~~ ~~budget~~ ~~of~~ ~~the~~ ~~community services board~~*performance contract; that does not need the funds, based on its performance reports or utilization management and review reports;* or ~~which~~ *that* is not in compliance with the *operational, provider performance, consumer outcome, consumer satisfaction, or consumer and family member involvement* standards for ~~such~~ ~~a~~ ~~program~~ ~~as~~*community services that are* promulgated by the State Board.

~~(b)~~ *C. The Department shall notify the governing body of each political subdivision that established the operating community services board or local government department before implementing any reduction of state-controlled funds. Before any political subdivision withdraws local government matching funds, it shall notify its operating board or local government department and the Department, since this could affect the amount of state-controlled funds provided by the Department.*

D. Allocations to be made to each ~~local~~*operating* board *or local government department* shall be determined by the Department after careful consideration of all of the following factors:

(1) The total amount of funds appropriated for this purpose~~,~~*;*

(2) The total amount of *matching* funds ~~requested~~ *appropriated* by the ~~local~~ ~~board~~*cities and counties participating in the community services board*~~,~~*;*

(3) The financial abilities of all of the cities and counties participating in the local *community services* board to provide funds required to generate the requested state match~~.~~*;*

(4) The type and extent of ~~programs~~ ~~and~~ services ~~conducted~~ *provided* or planned by the ~~local~~*operating community services* board *or local government department*~~,~~*;*

(5) The availability of services provided by the ~~local~~ *operating* board *or local government department* in the area served by it~~,~~ ~~and~~*;*

(6) The ability of the ~~programs~~ ~~and~~ services provided by the ~~local~~*operating community services* board *or local government department* to decrease financial costs to the Department and increase the effectiveness of ~~patient~~ treatment *or training* by reducing the number of ~~patients~~ *consumers* being admitted to or retained in state ~~hospitals~~*mental health facilities and training centers* from the cities or counties participating in the ~~local~~*community services* board~~.~~*; and*

(7) The performance of the operating board or local government department, as measured by provider performance, consumer outcome, consumer satisfaction, and consumer and family member involvement standards and criteria promulgated by the State Board.

~~(c)~~ *E.* Allocations to any one *operating community services* board *or local government department* shall not exceed the following proportions:

(1) For the construction of facilities: ninety percent of the total ~~costs~~ ~~of~~ *amount of state and local matching funds provided for* such construction.

(2) For salaries and other operational costs: ninety percent of the total ~~costs~~*amount of state and local matching funds provided for these expenses.*

~~(3) [Repealed.]~~

~~(d)~~ *F.* All fees collected ~~may~~ *shall* be kept by the *operating community services* board *or local government department* and used for operational costs.

§ 37.1-200. Same; withdrawal of county or city from a community services board.

No county or city participating in a joint community services board shall withdraw therefrom without two years' notice to the other participating counties or cities unless the other counties or cities consent to an earlier withdrawal.

§ 37.1-202.1. Liability for expenses of services.

The income and estate of a ~~client~~ *consumer* shall be liable for the expenses of services ~~or facilities~~ under the jurisdiction or supervision of any *operating* community services board ~~which~~ *or local government department that* are utilized by the ~~client~~ *consumer*. Any person or persons responsible for holding, managing or controlling the income and estate of the ~~patient~~ *consumer* shall apply such income and estate toward the expenses of the services ~~or facilities~~ utilized by the ~~client~~*consumer*.

Any person or persons responsible for the support of a ~~client~~ *consumer* pursuant to § 20-61 or a

common law duty to support shall be liable for the expenses of services ~~or facilities~~ under the jurisdiction or supervision of any *operating* community services board ~~which~~ *or local government department that* are utilized by the ~~client~~ *consumer* unless the ~~client~~*consumer*, regardless of age, qualifies for and is receiving aid under a federal or state program of assistance to the blind or disabled. Any such person or persons responsible for support of a ~~client~~ *consumer* pursuant to § 20-61 or a common-law duty to support shall no longer be financially liable, however, when a cumulative total of 1,826 days of (i) care and treatment or training for the ~~client~~ *consumer* in a state ~~hospital~~*mental health facility or training center*, or (ii) the utilization by the ~~client~~ *consumer* of services ~~or facilities~~ under the jurisdiction or supervision of any *operating* community services board *or local government department*; or (iii) a combination of (i) and (ii) has passed, and payment for or a written agreement to pay the assessment for 1,826 days of care and services has been made. Not less than ~~3~~*three* hours of service per day shall be required to include ~~1~~*one* day in the cumulative total of 1,826 days of utilization of services under the jurisdiction or supervision of ~~a~~ *any operating* community services board *or local government department*. In order to claim this exemption, the person or persons legally liable for the ~~client~~ *consumer* shall produce evidence sufficient to prove eligibility therefor.

§ 37.1-242. Behavioral health authorities; purpose.

Conditions resulting from evolving health care reform and behavioral health care delivery system reforms necessitate public instrumentalities to respond, organize, and effect ~~mental/~~behavioral health care coverage and services for citizens of the Commonwealth. ~~Behavioral~~ *In behavioral* health authorities ~~are required so that~~ the administration of public funds resides at the same organizational level, the behavioral health authority, as the responsibility and accountability for consumers and services. Such a public instrumentality is in the public interest and hereby authorized consistent with the following legislative provisions.

§ 37.1-243. Definitions.

As used in this chapter, unless a different meaning clearly appears from the context:

"Authority" means a behavioral health authority, a public body and a body corporate and politic organized in accordance with the provisions of this chapter for the purposes and with the powers and duties hereinafter set forth.

"Behavioral health" means the full range of mental health ~~care~~, mental retardation, ~~developmental disabilities~~ and substance abuse services~~,~~ and ~~the full range of~~ treatment modalities ~~including, but not limited to~~, *which must include* emergency~~,~~ *and case management services and may include* ~~prevention, early intervention, outpatient,~~ inpatient, *outpatient*, day support, residential, *prevention, early intervention* and other appropriate *mental health, mental retardation and substance abuse* services ~~to effect an accessible and integrated continuum of care~~ *necessary to provide packages of individualized services and supports to persons with mental illnesses, mental retardation, or alcohol or other drug abuse or dependence.*

"Behavioral health authority board of directors" means the public body organized in accordance with provisions of this chapter *that is appointed by* and accountable to the local governing ~~bodies~~ *body of the political subdivision that established it.*

"Behavioral health project" means all facilities suitable for providing adequate facilities and care for concentrated centers of population, and ~~shall also include~~ *includes* structures, buildings, improvements, additions, extensions, replacements, appurtenances, lands, rights in land, franchises, machinery, equipment, furnishings, landscaping, approaches, roadways and other facilities necessary or desirable in connection therewith or incidental thereto.

"Member" means ~~the respective~~ *a person appointed by the* local governing ~~body's appointee~~*body* to the behavioral health authority board of directors.

"Performance contract" means the annual agreement negotiated by a behavioral health authority with the Department through which it provides state and federal funds appropriated for mental health, mental retardation and substance abuse services to that authority.

"Service area" means the ~~locality participating in and formulating~~ *political subdivision that established* the behavioral health authority.

"State Board" means the Virginia Mental Health, Mental Retardation and Substance Abuse Services Board.

"Unit" means any department, institution or commission of the Commonwealth and any public corporate instrumentality thereof, and any district, and shall include counties and municipalities.

§ 37.1-244. Governing body to pass resolution.

The governing body of any city with a population of ~~350,000~~*400,000* or greater, any city with a population between ~~200,000~~*192,000* and ~~250,000~~*210,000* and any county with a population between 200,000 and 210,000 wishing to establish a behavioral health authority shall declare its intention by resolution.

§ 37.1-245. Board of directors; appointment; membership.

Every ~~locality~~ *city or county* establishing a behavioral health authority, before it comes within the provisions of this chapter, shall establish a board of directors with neither less than ~~five~~ *six* nor more than eighteen members. When any such ~~locality~~ *city or county* establishes a behavioral health authority, the board of directors shall be appointed by the governing body of the ~~locality~~*political subdivision establishing the authority*. Appointments to the board of directors shall be broadly representative of the community~~, to include~~. *One third of the appointments to the board shall be identified* consumers and family members of consumers *and at least one member at all times shall be a consumer. One or more members may be non-governmental services providers. Sheriffs or their designees shall also be included,* when practical.

No board of directors shall ~~be composed of a majority of~~ *include more than two local government* officials, elected *or appointed,* as members.

The board of directors appointed pursuant to this section shall be responsible to the governing body of the ~~locality which~~ *city or county that* established such authority.

The county or city that establishes a behavioral health authority shall receive an annual audit of the total revenues and expenditures from the authority, provide a copy of the audit to the Department, and arrange for the provision of legal services to the authority.

§ 37.1-246. Board of directors; terms; vacancies; removal.

The term of office of each member of the behavioral health authority board of directors shall be for three years from January 1 of the year of appointment, or, at the option of the governing body of the ~~locality~~ *city or county*, from July 1 of the year of appointment, except that of the members first appointed, several shall be appointed for terms of one year each, several for terms of two years each, and the remaining members for terms of three years each. The selection of members for one-year, two-year, and three-year terms shall be as nearly equal as possible with regard to the total number of members. If the governing body has appointed members for terms commencing January 1 or July 1 but desires to change the date the terms of office commence, the governing body may, as the terms of the members then in office expire, appoint successors for terms of two and one-half or three and one-half years so that the terms expire on June 30 or December 31. Vacancies shall be filled for unexpired terms in the same manner as original appointments. No person shall be eligible to serve more than two ~~successive~~ *full three-year* terms, although persons appointed to fill vacancies may serve two additional ~~successive~~ *full three-year* terms. Any member of the board of directors may be removed by the appointing governing body for cause, after being given a written statement of the causes and an opportunity to be heard thereon.

§ 37.1-247. Behavioral health authority board of directors officers; meetings.

The members of the behavioral health authority board of directors shall annually elect one of their members as chairman and another as vice-chairman and shall also elect a secretary and a treasurer for terms to be determined by the members, who may or may not be one of the members. The same person may serve as both secretary and treasurer. The members shall make such rules, regulations, and bylaws for their own government and procedure as they shall determine; they shall meet at least once each month and may hold such special meetings as they deem necessary. *Such rules, regulations, and bylaws shall be submitted to the governing body of the political subdivision that established the authority for review and comment.*

§ 37.1-248. Behavioral health authorities; powers and duties.

Every authority shall be deemed to be a public instrumentality, exercising public and essential governmental functions to provide for the public mental health, welfare, convenience and prosperity of the residents and such other persons who might be served by the authority and to provide behavioral health ~~care and related~~ services to such residents and persons. An authority ~~is authorized to~~

~~exercise the~~ *shall have the* following powers *and duties*:

1. Review and evaluate all existing and proposed public community mental health, mental retardation, and substance abuse services and facilities available to serve the community and such private services and facilities as receive funds through the authority and advise the ~~locality~~ *governing body of the political subdivision that established it* as to its findings.

2. *Pursuant to § 37.1-248.1 and in order to obtain state, local, federal, Medicaid, and other revenues appropriated or reimbursed for the provision of mental health, mental retardation and substance abuse services, submit to the governing body of the political subdivision that established it an annual performance contract for community mental health, mental retardation, and substance abuse services for its approval prior to submission of the contract to the Department.*

3. Within amounts ~~allocated by local, state, federal, Medicaid, and other payers, execute programs and services~~ *appropriated therefor, provide such services as may be authorized under such performance contract* for consumers in need.

~~3~~*4. In accordance with its approved performance contract, enter into contracts with other providers for the rendition or operation of services or facilities.*

4a. Make and enter into all *other* contracts or agreements, as the authority may determine, which are necessary or incidental to the performance of its duties and to the execution of powers granted by this chapter, including contracts with any federal agency, the Commonwealth, or with any unit thereof, behavioral health providers, insurers, and managed care/health care networks on such terms and conditions as the authority may approve.

*4*5. Make rules, *policies,* or regulations concerning the rendition or operation of services and facilities under its direction or supervision, subject to applicable standards, *policies,* or regulations promulgated by the State Mental Health, Mental Retardation and Substance Abuse Services Board.

~~5~~*6.* Appoint a chief executive officer of the behavioral health authority, *according to minimum qualifications established by the Department,* and prescribe his duties. The compensation of such chief executive officer shall be fixed by the authority ~~and he~~ *within the amounts made available by appropriation therefor. The Department shall review and approve the compensation of the chief executive officer and senior management staff. The chief executive officer* shall serve at the pleasure of the ~~authority~~*authority's board of directors and be employed under an annually renewable contract that contains performance objectives and evaluation criteria. The Department shall participate in and approve the selection of the chief executive officer, and the Department shall review and approve his contract.*

~~6.~~ Empower the chief executive officer to maintain a complement of professional staff to operate the behavioral health authority's service delivery system.

7. Prescribe a reasonable schedule of fees for services provided by personnel or ~~facilities~~ *contract agencies* under the jurisdiction or supervision of the authority and *establish procedures for the* collection of the same. *All fees collected shall be included in the performance contract submitted to the local governing body pursuant to subdivision 2 hereof and § 37.1-248.1 and shall be used only for community mental health, mental retardation and substance abuse purposes.* Every authority shall institute a reimbursement system to maximize the collection of fees from persons receiving services under the jurisdiction or supervision of the authority consistent with the provisions of § 37.1-202.1 and from responsible third-party payers. *Authorities shall not attempt to bill or collect fees for time spent participating in involuntary commitment hearings pursuant to § 37.1-67.3.*

8. *As authorized by the governing body of the political subdivision that established it,* ~~Accept loans~~*accept or refuse gifts, donations, bequests, or* grants *of money or property* or *other* assistance from ~~the federal government, the Commonwealth, any municipality thereof, or from~~ any ~~other sources~~*source*, public or private~~,~~*; utilize the same* to carry out any of its purposes; and enter into any agreement or contract regarding or relating to the acceptance or use or repayment of any such ~~loan,~~ grant or assistance.

9. Seek and accept funds through federal grants. In accepting such grants, the authority shall not bind the governing body of the political subdivision that established it to any expenditures or conditions of acceptance without the prior approval of such governing body.

~~9~~*10.* Notwithstanding any provision of law to the contrary, disburse funds ~~allocated to it in accordance with applicable regulations~~*appropriated to it in accordance with such regulations as may*

be established by the governing body of the political subdivision that established it.

11. Apply for and accept loans as authorized by the governing body of the political subdivision that established the authority.

~~10~~*12.* Develop joint annual written agreements, consistent with policies and procedures established by the State Board, with local school divisions; health departments; boards of social services; housing agencies, where they exist; courts; sheriffs; area agencies on aging; and regional Department of Rehabilitative Services offices. The agreements shall specify what services will be provided to consumers. All participating agencies shall develop and implement the agreements and shall review the agreements annually.

13. Develop and submit to the Department the necessary information for the preparation of the Comprehensive State Plan for Mental Health, Mental Retardation, and Substance Abuse Services pursuant to § 37.1-48.1.

14. Take all necessary and appropriate actions to maximize the involvement and participation of consumers and family members of consumers in policy formulation and service planning, delivery, and evaluation.

15. Institute, singly or in combination with operating community services boards or local governments, a dispute resolution mechanism that is approved by the Department and enables consumers and family members of consumers to resolve concerns, issues, or disagreements about services without adversely affecting their access to or receipt of appropriate types and amounts of current or future services from the authority.

16. Notwithstanding the provisions of § 37.1-84.1 and regulations promulgated thereunder, release data and information about individual consumers to the Department, so long as the Department implements procedures to protect the confidentiality of such information.

~~11~~*17.* Fulfill all other duties *and be subject to applicable provisions* specified in the Code of Virginia pertaining to community services boards including, *but not limited to*: § 37.1-65.1 (judicial certification of eligibility for admission of mentally retarded persons); §§ 37.1-67.1 through 37.1-67.6 (involuntary detention); *§ 37.1-84.1 (human rights); § 37.1-98.2 (exchange of information; § 37.1-183.1 (licensure);* § 37.1-197.1 (prescription team); ~~§ 37.1-198 (plans and budgets);~~*§ 37.1-197.2 (background checks)* § 37.1-199 (allocation of funds by the Department of Mental Health, Mental Retardation, and Substance Abuse Services); and § 37.1-202.1 (consumer liability for expenses of services).

~~12. Fulfill all applicable rules, regulations and standards pertaining to the rendition of mental health, mental retardation, and substance abuse services including, but not limited to, confidentiality, human research assurances, service and facility licensing, and client rights' protection.~~

~~13. As a public instrumentality, ensure compliance with all applicable organizational and administrative rules, regulations and standards pertaining to human resources; equal employment; fair labor practices; public procurement; risk management; and governmental finance and accounting requirements.~~

~~14~~*18.* Make loans and provide other assistance to corporations, partnerships, associations, joint ventures or other entities ~~in carrying~~, *in accordance with such regulations as authorized by the governing body of the political subdivision that established it, to carry* out any activities authorized by this chapter.

~~15~~*19.* Transact its business, locate its offices and control, directly or through stock or nonstock corporations or other entities, facilities that will assist the authority in carrying out the purposes and intent of this chapter, including without limitations the power to own or operate, directly or indirectly, behavioral health facilities in its service area.

~~16. Plan, design, construct, renovate, enlarge, equip, maintain and operate programs for the purpose of providing behavioral health care and related services and other appropriate purposes.~~

~~17~~*20.* ~~Acquire~~ *In accordance with such regulations as authorized by the governing body of the political subdivision that established it, acquire* property, real or personal, by purchase, gift, devise on such terms and conditions, and in such manner as it may deem proper, and such rights, easements or estates therein as may be necessary for its purposes, and sell, lease and dispose of the same, or any portion thereof or interest therein, whenever it shall become expedient to do so.

~~18~~*21.* ~~Participate~~ *In accordance with such regulations as authorized by the governing body of the*

political subdivision that established it, participate in joint ventures with individuals, corporations, partnerships, associations or other entities for providing behavioral health care or related services or other activities that the authority may undertake to the extent that such undertakings assist the authority in carrying out the purposes and intent of this chapter.

~~19~~22. ~~Conduct~~ *In accordance with such regulations as authorized by the governing body of the political subdivision that established it, conduct* or engage in any lawful business, activity, effort or project, necessary or convenient for the purposes of the authority or for the exercise of any of its powers.

~~20~~23. As a public instrumentality, operationalize its administrative management infrastructure in whole or in part independent of the local governing body; however, nothing in the chapter precludes behavioral health authorities from acquiring support services through existing government entities.

~~21~~24. ~~Operationalize~~ *As authorized by the governing body of the political subdivision that established it, operationalize* capital improvements and bonding through existing economic or industrial development authorities.

~~22~~25. Establish retirement, group life insurance, and group accident and sickness insurance plans or systems for its employees in the same manner as cities, counties and towns are permitted under § 51.1-801.

~~23~~26. Make an annual report to the ~~State~~ *Virginia Department of* Mental Health, Mental Retardation and Substance Abuse Services ~~Board~~ of the authority's activities.

~~24~~27. Ensure a continuation of all ~~client~~ *consumer* services during any transition period.

§ 37.1-248.1. Performance contract for mental health, mental retardation and substance abuse services.

A. The Department shall develop and initiate negotiation of the performance contracts through which it provides funds behavioral health authorities to accomplish the purposes set forth in this chapter. Six months prior to the beginning of each fiscal year, the Department shall make available to the public the standard performance contract form that it intends to use as the performance contract for that fiscal year, and solicit public comments for a period of sixty days.

B. Any behavioral health authority may apply for the assistance provided in this chapter by submitting annually to the Department its proposed performance contract for the next fiscal year together with the recommendations of the behavioral health authority's board of directors and the approval by formal vote of the governing body of the political subdivision that established it. The behavioral health authority shall make its proposed performance contract available for public review and solicit public comments for a period of thirty days prior to submitting it for approval to the behavioral health authority's board of directors.

C. The performance contract shall (i) delineate the responsibilities of the Department and the behavioral health authority; (ii) specify conditions that must be met for the receipt of state-controlled funds; (iii) identify the groups of consumers to be served with state-controlled funds; (iv) beginning on July 1, 1999, contain specific consumer outcome and provider performance measures, consumer satisfaction and consumer and family member participation and involvement indicators, and state facility bed utilization targets that have been negotiated with the behavioral health authority; (v) establish an enforcement mechanism, including notice and an appeal process, should the behavioral health authority fail to comply with any provisions of the contract, including provisions for the withholding of funds, methods of repayment of funds, and for the Department to exercise the provisions of subdivision E hereof; and (vi) include reporting requirements and revenue, cost, service, and consumer information displayed in a consistent, comparable format determined by the Department.

D. No behavioral health authority shall be eligible to receive state-controlled funds for mental health, mental retardation, or substance abuse services unless (i) its performance contract has been approved by the governing body of the political subdivision that established it and by the Department; (ii) it provides service, cost, revenue, and aggregate and individual consumer data and information, notwithstanding § 37.1-84.1 or any regulations promulgated thereunder, to the Department in the format prescribed by the Department; and (iii) beginning on July 1, 1999, it uses standardized cost accounting and financial management systems approved by the Department.

E. If, after unsuccessful use of the remediation process described in the performance contract, a

behavioral health authority remains in substantial noncompliance with its performance contract with the Department, the Department may, after affording the authority an adequate opportunity to use the appeal process described in the performance contract, terminate the contract. Using the state-controlled resources associated with that contract, the Department, after consulting with the governing body of the political subdivision that established the behavioral health authority, may negotiate a performance contract with an operating community services board or local government department or a private nonprofit or for-profit organization to obtain the services that were the subject of the terminated performance contract.

§ 37.1-249. Exemption from taxation.

The exercise of the powers granted by this chapter shall be in all respects for the benefit of the inhabitants of the Commonwealth and for the promotion of their safety, health, welfare, convenience and prosperity. As the operation and maintenance of any behavioral health project which the authority is authorized to undertake will constitute the performance of an essential governmental function, the authority shall not be required to pay any taxes or assessments upon any behavioral health project acquired or constructed by it, nor on the revenues generated by its operation.

§ 37.1-250. Transfer of facilities and assets.

The governing body of the ~~locality~~ *political subdivision that established the authority* is authorized to transfer to the authority the operation and maintenance of such suitable facilities as are now or may be hereafter owned by the ~~locality~~*,city or county* on such terms and conditions ~~which~~ *that* it may prescribe; but this section shall not be construed as authorizing the authority to maintain and operate such facilities until the operation thereof has been transferred by the governing body of the ~~locality~~*the political subdivision that established it.*

§ 37.1-251. Local appropriations.

The ~~locality~~ *city or county that established the authority* is authorized to make appropriations and to provide funds for the operation of the authority and to further its purposes. *Such appropriations for the authority shall be subject to the same requirements for operating community services boards and local government departments as set forth in § 37.1-199.*

§ 37.1-252. Proceedings for dissolution.

Whenever it appears to the board of directors of a behavioral health authority that the need for such authority in the ~~locality~~ *city or county* in which it was created no longer exists, then, upon petition by the board of directors of the authority to the circuit court of such ~~locality~~ *city or county* after giving to the ~~locality~~ *city or county* ~~thirty~~ *ninety* days' notice~~,~~ and upon the production of the satisfactory evidence in support of such petition, the court may, in its discretion, enter an order declaring that the need for such authority in the locality no longer exists and approving a plan for the winding up of the business of the authority, the payment or assumption of its obligations, and the transfer of its assets. *In order to be approved by the court, this plan must describe specifically how the city or county that established the authority will fulfill the same duties and responsibilities required for community services boards under §§ 37.1-194 through 37.1-202.1, and how the city or county will assure continuity of care for consumers who are receiving services from the authority.*

§ 37.1-253. When powers and duties cease to exist.

If the court shall enter an order, as provided in § 37.1-252, that the need for such *behavioral health* authority no longer exists, then, except for the winding up of its affairs in accordance with the plan approved by the court, ~~its~~ *that authority's* authorities, powers and duties to transact business or to function shall cease to exist as of that date set forth in the order of the court.

989000661

HOUSE BILL NO. 681

Offered January 22, 1998

A BILL to amend and reenact §§ 37.1-67.01 and 37.1-67.1 of the Code of Virginia, relating to involuntary detention.

Patrons—Thomas, Bloxom, Christian, Clement, Cranwell, Croshaw, Darner, DeBoer, Deeds, Diamonstein, Dickinson, Hall, Hull, Jackson, Joannou, Johnson, Jones, J.C., Keating, Moran, Murphy, Phillips, Plum, Puller, Robinson, Spruill, Stump, Tate, Van Landingham, Van Yahres, Williams and Woodrum; Senators: Gartlan and Martin

---

Referred to Committee on Health, Welfare and Institutions

Be it enacted by the General Assembly of Virginia:

1. That §§ 37.1-67.01 and 37.1-67.1 of the Code of Virginia are amended and reenacted as follows:

§ 37.1-67.01. Emergency custody; issuance and execution of order.

Based upon probable cause to believe that the person is mentally ill and in need of hospitalization and that the person presents an imminent danger to self or others as a result of mental illness, or is so seriously mentally ill as to be substantially unable to care for self, any magistrate may, upon the sworn petition of any responsible person or upon his own motion, issue an emergency custody order requiring any person within his judicial district who is incapable of volunteering or unwilling to volunteer for treatment to be taken into custody and transported to a convenient location to be evaluated by a person designated by the community services board who is skilled in the diagnosis and treatment of mental illness *and who has completed a certification program approved by the Department* in order to assess the need for hospitalization. A law-enforcement officer who, based upon his observation or the reliable reports of others, has probable cause to believe that a person meets the criteria for emergency custody as stated in this section may take that person into custody and transport that person to an appropriate location to assess the need for hospitalization without prior authorization. Such evaluation shall be conducted immediately. The person shall remain in custody until a temporary detention order is issued or until the person is released, but in no event shall the period of custody exceed four hours. A law-enforcement officer may lawfully go to or be sent beyond the territorial limits of the county, city or town in which he serves to any point in the Commonwealth for the purpose of executing an order for emergency custody pursuant to this section. Nothing herein shall preclude a law-enforcement officer from obtaining emergency medical treatment or further medical evaluation at any time for a person in his custody as provided in this section.

If an order of emergency custody is not executed within four hours of its issuance, the order shall be void and shall be returned unexecuted to the office of the clerk of the issuing court or, if such office is not open, to any judge or magistrate thereof.

§ 37.1-67.1. Involuntary temporary detention; issuance and execution of order.

For the purposes of this section, a designee of a community services board is defined as an examiner able to provide an independent examination of the person who is not related by blood or marriage to the person, who has no financial interest in the admission or treatment of the person, who has no investment interest in the hospital detaining or admitting the person under this article and, except for employees of state hospitals and of the U.S. Department of Veterans Affairs, who is not employed by such hospital. For purposes of this section, investment interest means the ownership or holding of an equity or debt security, including, but not limited to, shares of stock in a corporation, interests or units of a partnership, bonds, debentures, notes, or other equity or debt instruments.

A magistrate may, upon the advice of, and only after an in-person evaluation by, an employee of the local community services board or its designee who is skilled in the assessment and treatment of mental illness *and who has completed a certification program approved by the Department*, issue an order of temporary detention if it appears from all evidence readily available that the person is mentally ill and in need of hospitalization and that the person presents an imminent danger to self or others as a result of mental illness, or is so seriously mentally ill as to be substantially unable to care for self, and the person is incapable of volunteering or unwilling to volunteer for treatment. Such

order may include transportation of the person to such other medical facility as may be necessary to obtain emergency medical evaluation or treatment prior to placement.

A magistrate may issue such order of temporary detention without an emergency custody order proceeding. A magistrate may issue an order of temporary detention without a prior in-person evaluation if (i) the person has been personally examined within the previous seventy-two hours by an employee of the local community services board or its designee who is skilled in the assessment and treatment of mental illness *and who has completed a certification program approved by the Department* or (ii) there is a significant physical, psychological or medical risk, to the person or to others, associated with conducting such evaluation.

An employee of the local community services board or its designee shall determine the facility of temporary detention for all individuals detained pursuant to this section. The facility shall be identified on the prescreening report and indicated on the temporary detention order. The Board of Medical Assistance Services shall, by regulation, establish a reasonable rate per day of inpatient care for temporary detention. The institution or other place of detention shall be approved pursuant to regulations of the Board of Mental Health, Mental Retardation and Substance Abuse Services. The employee of the community services board or its designee who is conducting the evaluation pursuant to this section shall determine, prior to the issuance of the temporary detention order, the insurance status of the person. Except as provided herein for defendants requiring hospitalization in accordance with subdivision A 2 of § 19.2-169.6, such person shall not be detained in a jail or other place of confinement for persons charged with criminal offenses.

A law-enforcement officer may lawfully go to or be sent beyond the territorial limits of the county, city, or town in which he serves to any point in the Commonwealth for the purpose of executing any order for temporary detention pursuant to this section. The duration of temporary detention shall not exceed forty-eight hours prior to a hearing. If the forty-eight-hour period herein specified terminates on a Saturday, Sunday or legal holiday, such person may be detained, as herein provided, until the next day which is not a Saturday, Sunday or legal holiday, but in no event may he be detained for longer than seventy-two hours or ninety-six hours when such legal holiday occurs on a Monday or Friday. For purposes of this section, a Saturday, Sunday, or legal holiday shall be deemed to include the time period up to 8:00 a.m. of the next day which is not a Saturday, Sunday, or legal holiday. Nothing herein shall preclude a law-enforcement officer from obtaining emergency medical treatment or further medical evaluation at any time for a person in his custody as provided in this section.

In any case in which temporary detention is ordered pursuant to this section upon petition of a person having custody of a defendant in accordance with subdivision A 2 of § 19.2-169.6, the magistrate executing the order of temporary detention shall place such person in a hospital designated by § 19.2-169.6 B, or if such facility is not available, the defendant shall be detained in a jail or other place of confinement for persons charged with criminal offenses and shall be transferred to such hospital as soon as possible thereafter. The hearing shall be held, upon notice to the attorney for the defendant, either (i) before the court having jurisdiction over the defendant's case, or (ii) before a judge as defined in § 37.1-1 in accordance with the provisions of § 37.1-67.4, in which case the defendant shall be represented by counsel as specified in § 37.1-67.3. In any case in which temporary detention is ordered pursuant to this section upon petition for involuntary commitment of a minor, the petition shall be filed and the hearing scheduled in accordance with the provisions of § 16.1-341.

On such petition and prior to a hearing as authorized in § 37.1-67.3 or § 16.1-341, the judge may release such person on his personal recognizance or bond set by the judge if it appears from all evidence readily available that such release will not pose an imminent danger to himself or others. In the case of a minor, the judge may release the minor to his parent. The director of the hospital in which the person is detained may release such person prior to a hearing as authorized in § 37.1-67.3 or § 16.1-341 if it appears, based on an evaluation conducted by the psychiatrist or clinical psychologist treating the person, that the person would not present an imminent danger to self or others if released.

If an order of temporary detention is not executed within twenty-four hours of its issuance, or within such shorter period as is specified in the order, the order shall be void and shall be returned unexecuted to the office of the clerk of the issuing court or if such office is not open, to any judge or

magistrate thereof. Subsequent orders may be issued upon the original petition within ninety-six hours after the petition is filed. However, a magistrate must again obtain the advice of an employee of the local community services board or its designee who is skilled in the diagnosis or treatment of mental illness *and who has completed a certification program approved by the Department* prior to issuing a subsequent order upon the original petition. Any petition for which no order of temporary detention or other process in connection therewith is served on the subject of the petition within ninety-six hours after the petition is filed shall be void and shall be returned to the office of the clerk of the issuing court.

The chief judge of each general district court shall establish and require that a magistrate, as provided by this section, be available seven days a week, twenty-four hours a day, for the purpose of performing the duties established by this section. Each community services board shall provide to each general district court and magistrate's office within its jurisdiction a list of its employees and designees who are available to perform the evaluations required herein.

Official Use By Clerks

Passed By The House of Delegates		**Passed By The Senate**	
without amendment	☐	without amendment	☐
with amendment	☐	with amendment	☐
substitute	☐	substitute	☐
substitute w/amdt	☐	substitute w/amdt	☐

Date: _____ Date: _____

_____ _____

Clerk of the House of Delegates Clerk of the Senate

986006260

HOUSE BILL NO. 1292

Offered January 26, 1998

A BILL to amend and reenact §§ 2.1-1.7, 9-6.23, 9-6.25:1, 18.2-254, 37.1-203 through 37.1-207 and 37.1-219 through 37.1-223 of the Code of Virginia and to repeal §§ 37.1-208, 37.1-209 and 37.1-214 through 37.1-218 of the Code of Virginia, relating to substance abuse services.

Patrons—Christian, Behm, Blevins, Crittenden, Deeds, Drake, Grayson, Hull, Jackson, Jones, J.C., Kilgore, McClure, McEachin, Melvin, Moran, Robinson and Shuler; Senators: Hanger, Lucas, Miller, Y.B. and Ticer

---

Referred to Committee on Health, Welfare and Institutions

Be it enacted by the General Assembly of Virginia:

1. That §§ 2.1-1.7, 9-6.23, 9-6.25:1, 18.2-254, 37.1-203 through 37.1-207 and 37.1-219 through 37.1-223 of the Code of Virginia are amended and reenacted as follows:

§ 2.1-1.7. State councils.

A. There shall be, in addition to such others as may be established by law, the following permanent collegial bodies either affiliated with more than one agency or independent of an agency within the executive branch:

Adult Education and Literacy, Virginia Advisory Council for
Agricultural Council, Virginia
~~Alcohol and Drug Abuse Problems, Governor's Council on~~
Apprenticeship Council
Blue Ridge Regional Education and Training Council
Child Day-Care Council
Citizens' Advisory Council on Furnishing and Interpreting the Executive Mansion
Coastal Land Management Advisory Council, Virginia
Commonwealth Competition Council
Commonwealth's Attorneys' Services Council
Developmental Disabilities Planning Council, Virginia
Disability Services Council
Equal Employment Opportunity Council, Virginia
Housing for the Disabled, Interagency Coordinating Council on
Human Rights, Council on
Human Services Information and Referral Advisory Council
Indians, Council on
Interagency Coordinating Council, Virginia
Job Training Coordinating Council, Governor's
Land Evaluation Advisory Council
Maternal and Child Health Council
Military Advisory Council, Virginia
Needs of Handicapped Persons, Overall Advisory Council on the
Prevention, Virginia Council on Coordinating
Public Records Advisory Council, State
Rate-setting for Children's Facilities, Interdepartmental Council on
Revenue Estimates, Advisory Council on
Southside Virginia Marketing Council
Specialized Transportation Council
State Health Benefits Advisory Council
Status of Women, Council on the
Substance Abuse Services Council
Technology Council, Virginia
Virginia Business-Education Partnership Program, Advisory Council on the
Virginia Recycling Markets Development Council.

B. Notwithstanding the definition for "council" as provided in § 2.1-1.2, the following entities shall be referred to as councils:

Council on Information Management
Higher Education, State Council of
Independent Living Council, Statewide
Rehabilitation Advisory Council, Statewide
Rehabilitation Advisory Council for the Blind, Statewide.
Transplant Council, Virginia

§ 9-6.23. Prohibition against service by legislators on boards, commissions, and councils within the executive branch.

Members of the General Assembly shall be ineligible to serve on boards, commissions, and councils within the executive branch which are responsible for administering programs established by the General Assembly. Such prohibition shall not extend to boards, commissions, and councils engaged solely in policy studies or commemorative activities. If any law directs the appointment of any member of the General Assembly to a board, commission, or council in the executive branch which is responsible for administering programs established by the General Assembly, such portion of such law shall be void, and the Governor shall appoint another person from the Commonwealth at large to fill such a position. The provisions of this section shall not apply, however, to members of the Board for Branch Pilots, who shall be appointed as provided for in § 54.1-901; to members of the Board on Veterans' Affairs, who shall be appointed as provided for in § 2.1-741; to members of the Council on Indians, who shall be appointed as provided for in § 9-138.1; to members of the Virginia Technology Council, who shall be appointed as provided for in § 9-145.51; to members of the Board of Trustees of the Southwest Virginia Higher Education Center, who shall be appointed as provided for in § 23-231.3; to members of the Maternal and Child Health Council, who shall be appointed as provided for in § 9-318; to members of the Virginia Interagency Coordinating Council who shall be appointed as provided for in § 2.1-750; to members of the Advisory Council on the Virginia Business-Education Partnership Program, who shall be appointed as provided in § 9-326; to members of the Advisory Commission on Welfare Reform, who shall be appointed as provided for in § 63.1-133.44; to members of the Virginia Correctional Enterprises Advisory Board, who shall be appointed as provided for in § 2.1-451.2; to members appointed to the Virginia Veterans Cemetery Board pursuant to § 2.1-739.2; to members appointed to the Board of Trustees of the Roanoke Higher Education Authority pursuant to § 23-231.15; to members of the Commonwealth Competition Commission, who shall be appointed as provided for in § 9-343; to members of the Virginia Geographic Information Network Advisory Board, who shall be appointed as provided for in § 2.1-563.41; ~~or~~ to members of the Advisory Commission on the Virginia Schools for the Deaf and the Blind, who shall be appointed as provided for in § 22.1-346.1*; or to members of the Substance Abuse Services Council, who shall be appointed as provided for in § 37.1-207.*

§ 9-6.25:1. Advisory boards, commissions and councils.

There shall be, in addition to such others as may be designated in accordance with § 9-6.25, the following advisory boards, commissions and councils within the executive branch:

Advisory Board for the Department for the Deaf and Hard-of-Hearing
Advisory Board for the Department for the Aging
Advisory Board on Child Abuse and Neglect
Advisory Board on Medicare and Medicaid
Advisory Board on Occupational Therapy
Advisory Board on Physical Therapy to the Board of Medicine
Advisory Board on Rehabilitation Providers
Advisory Board on Respiratory Therapy to the Board of Medicine
Advisory Board on Teacher Education and Licensure
Advisory Commission on the Virginia Schools for the Deaf and the Blind
Advisory Council on Revenue Estimates
Advisory Council on the Virginia Business-Education Partnership Program
Appomattox State Scenic River Advisory Board
Aquaculture Advisory Board

Art and Architectural Review Board
Board for the Visually Handicapped
Board of Directors, Virginia Truck and Ornamentals Research Station
Board of Forestry
Board of Military Affairs
Board of Rehabilitative Services
Board of Transportation Safety
Board of Trustees of the Family and Children's Trust Fund
Board of Visitors, Gunston Hall Plantation
Board on Veterans' Affairs
Catoctin Creek State Scenic River Advisory Board
Cave Board
Chickahominy State Scenic River Advisory Board
Clinch Scenic River Advisory Board
Coal Surface Mining Reclamation Fund Advisory Board
Coastal Land Management Advisory Council, Virginia
Commonwealth Competition Council
Council on Indians
Council on the Status of Women
Debt Capacity Advisory Committee
Emergency Medical Services Advisory Board
Falls of the James Committee
Goose Creek Scenic River Advisory Board
~~Governor's Council on Alcohol and Drug Abuse Problems~~
Governor's Mined Land Reclamation Advisory Committee
Hemophilia Advisory Board
Human Services Information and Referral Advisory Council
Interagency Coordinating Council on Housing for the Disabled
Interdepartmental Board of the State Department of Minority Business Enterprise
Litter Control and Recycling Fund Advisory Board
Local Advisory Board to the Blue Ridge Community College
Local Advisory Board to the Central Virginia Community College
Local Advisory Board to the Dabney S. Lancaster Community College
Local Advisory Board to the Danville Community College
Local Advisory Board to the Eastern Shore Community College
Local Advisory Board to the Germanna Community College
Local Advisory Board to the J. Sargeant Reynolds Community College
Local Advisory Board to the John Tyler Community College
Local Advisory Board to the Lord Fairfax Community College
Local Advisory Board to the Mountain Empire Community College
Local Advisory Board to the New River Community College
Local Advisory Board to the Northern Virginia Community College
Local Advisory Board to the Patrick Henry Community College
Local Advisory Board to the Paul D. Camp Community College
Local Advisory Board to the Piedmont Virginia Community College
Local Advisory Board to the Rappahannock Community College
Local Advisory Board to the Southside Virginia Community College
Local Advisory Board to the Southwest Virginia Community College
Local Advisory Board to the Thomas Nelson Community College
Local Advisory Board to the Tidewater Community College
Local Advisory Board to the Virginia Highlands Community College
Local Advisory Board to the Virginia Western Community College
Local Advisory Board to the Wytheville Community College
Maternal and Child Health Council

Medical Advisory Board, Department of Motor Vehicles
Migrant and Seasonal Farmworkers Board
Motor Vehicle Dealer's Advisory Board
North Meherrin State Scenic River Advisory Board
Nottoway State Scenic River Advisory Board
Personnel Advisory Board
Plant Pollination Advisory Board
Private College Advisory Board
Private Enterprise Commission
Private Security Services Advisory Board
Psychiatric Advisory Board
Radiation Advisory Board
Rappahannock Scenic River Advisory Board
Recreational Fishing Advisory Board, Virginia
Reforestation Board
Rockfish State Scenic River Advisory Board
Shenandoah State Scenic River Advisory Board
Small Business Advisory Board
Small Business Environmental Compliance Advisory Board
St. Mary's Scenic River Advisory Committee
State Advisory Board on Air Pollution
State Advisory Board for the Virginia Employment Commission
State Building Code Technical Review Board
State Health Benefits Advisory Council
State Land Evaluation Advisory Council
State Networking Users Advisory Board
State Public Records Advisory Council
Statewide Independent Living Council
Statewide Rehabilitation Advisory Council
Statewide Rehabilitation Advisory Council for the Blind
Staunton Scenic River Advisory Committee
Substance Abuse Services Council
Telecommunications Relay Service Advisory Board
Virginia-Israel Advisory Board
Virginia Advisory Commission on Intergovernmental Relations
Virginia Advisory Council for Adult Education and Literacy
Virginia Coal Mine Safety Board
Virginia Coal Research and Development Advisory Board
Virginia Commission for the Arts
Virginia Commission on the Bicentennial of the United States Constitution
Virginia Correctional Enterprises Advisory Board
Virginia Council on Coordinating Prevention
Virginia Equal Employment Opportunity Council
Virginia Geographic Information Network Advisory Board
Virginia Interagency Coordinating Council
Virginia Military Advisory Council
Virginia Public Buildings Board
Virginia Recycling Markets Development Council
Virginia Technology Council
Virginia Transplant Council
Virginia Veterans Cemetery Board
Virginia Water Resources Research Center, Statewide Advisory Board
Virginia Winegrowers Advisory Board.

§ 18.2-254. Commitment of convicted person for treatment for drug or alcohol abuse.

A. The court trying the case of any person alleged to have committed any offense designated by this article or by the Drug Control Act (§ 54.1-3400 et seq.) or in any other criminal case in which the commission of the offense was motivated by, or closely related to, the use of drugs and determined by the court to be in need of treatment for the use of drugs may commit such person, upon his conviction and with his consent and the consent of the receiving institution, to any facility for the treatment of persons for the intemperate use of narcotic or other controlled substances, licensed or supervised by the State Mental Health, Mental Retardation and Substance Abuse Services Board, if space is available in such facility, for a period of time not in excess of the maximum term of imprisonment specified as the penalty for conviction of such offense or, if sentence was determined by a jury, not in excess of the term of imprisonment as set by such jury. Confinement under such commitment shall be, in all regards, treated as confinement in a penal institution and the person so committed may be convicted of escape if he leaves the place of commitment without authority. The court may revoke such commitment, at any time, and transfer the person to an appropriate state or local correctional facility. Upon presentation of a certified statement from the director of the treatment facility to the effect that the confined person has successfully responded to treatment, the court may release such confined person prior to the termination of the period of time for which such person was confined and may suspend the remainder of the term upon such conditions as the court may prescribe.

B. The court trying a case in which commission of the offense was related to the defendant's habitual abuse of alcohol and in which the court determines that such defendant is an alcoholic as defined in § ~~37.1-217~~ *37.1-1* and in need of treatment, may commit such person, upon his conviction and with his consent and the consent of the receiving institution, to any facility for the treatment of alcoholics licensed or supervised by the State Mental Health, Mental Retardation and Substance Abuse Services Board, if space is available in such facility, for a period of time not in excess of the maximum term of imprisonment specified as the penalty for conviction. Confinement under such commitment shall be, in all regards, treated as confinement in a penal institution and the person so committed may be convicted of escape if he leaves the place of commitment without authority. The court may revoke such commitment, at any time, and transfer the person to an appropriate state or local correctional facility. Upon presentation of a certified statement from the director of the treatment facility to the effect that the confined person has successfully responded to treatment, the court may release such confined person prior to the termination of the period of time for which such person was confined and may suspend the remainder of the term upon such conditions as the court may prescribe.

§ 37.1-203. Definitions.

As used in this chapter:

1. "Substance" means both alcoholic beverages and *other* drugs.

2. "Substance abuse" means the use, without compelling medical reason, of ~~any substance~~ *alcohol and other drugs* which results in psychological or physiological dependency *or danger to self or others* as a function of continued use in such a manner as to induce mental, emotional or physical impairment and cause socially dysfunctional or socially disordering behavior.

~~3, 4. [Repealed.]~~

3. "Substance abuser" means any individual experiencing the effects of substance abuse.

4. "Office" means the Office of Substance Abuse Services.

5. "Director" means the Director of the Office of Substance Abuse Services.

6. "Approved treatment facility" means a publicly funded facility that has been licensed pursuant to Chapter 8 (§ 37.1-179 et seq.) of Title 37.1.

§ 37.1-204. Department responsible for substance abuse services; office established; qualifications of staff.

The Department of Mental Health, Mental Retardation and Substance Abuse Services shall be responsible for the administration, planning and regulation of substance abuse services in the Commonwealth. The Commissioner shall *establish an Office of Substance Abuse Services and* employ *a Director and* staff to carry out this responsibility who shall have knowledge ~~of~~ and experience in ~~both~~ the fields of alcoholism and *other* drug abuse.

§ 37.1-205. Powers and duties generally.

The Department shall have the following powers and duties:

1. To act as the sole state agency for the planning, coordination and evaluation of the ~~state~~

comprehensive *interagency state* plan ~~or plans~~ for substance abuse *services*.

2. To ~~investigate and promote research concerning the extent and scope of all problems relating to substance abuse within the Commonwealth~~ *provide staff assistance to the Substance Abuse Services Council*.

3. To ~~survey periodically existing and potential facilities and services available in state and local, public and private, agencies, institutions, and associations which can be cooperatively applied to the solution of existing and anticipated problems relating to substance abuse~~ *(i) develop, implement, and promote, in cooperation with federal, state, local and other publicly funded agencies, a comprehensive interagency state plan for substance abuse services, consistent with federal guidelines and regulations, for the long-range development of adequate and coordinated programs, services and facilities for research, prevention, and control of substance abuse and for treatment and rehabilitation of substance abusers; (ii) review such plan annually; and (iii) make such revisions as may be necessary or desirable*.

4. To ~~coordinate, mobilize, and utilize the research and public service resources of institutions of higher education, all levels of government, business, industry, and the community at large in the understanding and solution of problems relating to substance abuse~~ *develop in cooperation with the Department of Corrections, Virginia Parole Board, Department of Juvenile Justice, Department of Criminal Justice Services, Commission on the Virginia Alcohol Safety Action Program, Office of the Executive Secretary of the Supreme Court of Virginia, Department of Education, Department of Health, Department of Social Services, and other appropriate agencies, a section of the comprehensive interagency state plan for substance abuse services which addresses the need for treatment programs for substance abusers who are involved with these agencies*.

5. To ~~formulate, in cooperation with federal, state, local and private agencies, a comprehensive state plan or plans for substance abuse, consistent with federal guidelines and regulations, for the long-range development of adequate and coordinated programs, services and facilities for research, prevention and control of substance abuse and for treatment and rehabilitation of substance abusers through the utilization of federal, state, local and private resources; to review such plan or plans annually and to make such revisions as may be necessary or desirable~~ *specify uniform methods for keeping statistical information for inclusion in the comprehensive interagency state plan for substance abuse services*.

6. To ~~promote the effectuation of the comprehensive state plan or plans for substance abuse in cooperation with other federal, state, local and private agencies~~ *provide technical assistance and consultation services to state and local agencies in planning, developing and implementing services for substance abusers*.

7. To review and comment on all applications for state or federal funds or services to be used in substance abuse programs in accordance with § 37.1-206 and on all requests by state agencies for appropriations from the General Assembly for use in substance abuse programs.

8. To recommend to the Governor and the General Assembly legislation necessary to implement programs, services, and facilities for the prevention and control of substance abuse and the treatment and rehabilitation of substance abusers.

~~9, 10. [Repealed.]~~

~~11. To encourage and assist community services boards in the formation of locally based substance abuse prevention, education, crisis intervention, treatment and rehabilitation programs.~~

~~12. [Repealed.]~~

9. To organize and foster training programs for all persons engaged in the treatment of substance abuse.

10. To encourage general hospitals and other appropriate health facilities to admit substance abusers without discrimination and to provide them with adequate and appropriate treatment.

11. To identify, coordinate, mobilize, and use the research and public service resources of institutions of higher education, all levels of government, business, industry, and the community at large in the understanding and solution of problems relating to substance abuse.

§ 37.1-205.1. Department to report to General Assembly.

The Department shall report ~~annually~~ *biennially* to the General Assembly on ~~its~~ *the comprehensive interagency state plan for substance abuse services and the Department's* activities in administering,

planning and regulating substance abuse services and shall specifically state the extent to which the Department's duties as specified in this chapter *and in Chapter 8 (§ 37.1-179 et seq.) and Chapter 10 (§37.1-194 et seq.) of Title 37.1* have been performed.

§ 37.1-206. Review of applications for state or for federal funds or services.

A. No local or state agency which is empowered to issue final approval or disapproval of, or to make a final review and comment upon, any application for state or federal funds or services which are to be used in a substance abuse program shall take final action on or transmit such application until the application is first reviewed and commented upon by the Department *to determine its compatibility with the comprehensive interagency state plan for substance abuse services*, and thereafter such review and comment by the Department shall remain a part of the application documents.

B. Every applicant for any federal or state funds, services, loans, grants-in-aid, matching funds or services which are to be used in connection with any substance abuse program shall submit a copy of the application for such funds, services, loans, grants-in-aid, matching funds or services to the Department for review and comment, as provided in subsection A hereof.

C. The Department shall review and comment upon and return each application within forty-five days after receiving such application.

D. Each state agency requesting an appropriation from the General Assembly for substance abuse programs shall submit such request to the Department for review and comment *to determine its compatibility with the comprehensive interagency state plan for substance abuse services* and shall supply the Department with all relevant information including a full report on funds expended pursuant to prior appropriations. The Department shall provide the Governor and the General Assembly with its assessment of each such request for an appropriation by a state agency.

§ 37.1-207. Substance Abuse Services Council.

A. There is hereby established the ~~Governor's~~ *Substance Abuse Services* Council ~~on Alcohol and Drug Abuse Problems~~, hereafter referred to in this section as "the Council." The Council shall advise and make recommendations to the Governor, *the General Assembly, and the Board* on broad policies, goals and on the coordination of the Commonwealth's public and private efforts to control alcohol and *other* drug abuse.

B. The Council shall consist of ~~nineteen~~ *twenty-two* members ~~appointed by the Governor, one of whom shall represent the Office of the Secretary of Health and Human Resources, one of whom shall represent the Office of the Secretary of Transportation, one of whom shall represent the Office of the Secretary of Public Safety, five of whom shall represent state agencies with responsibility in the area of substance abuse, and two of whom shall represent local governmental agencies concerned with alcohol and drug abuse. All of the above members shall serve on the Council at the pleasure of the Governor~~ *as follows: six members of the General Assembly, including four members of the House of Delegates, to be appointed by the Speaker of the House, and two members of the Senate, to be appointed by the Senate Committee on Privileges and Elections, to serve as ex officio members of the Council with full voting privileges; one member each representing the Virginia Sheriff's Association, the Virginia Association of Community Services Boards, and a statewide consumer and advocacy organization to be appointed by the Speaker of the House of Delegates; one member each representing the Virginia Association of Community Services Boards and a statewide consumer and advocacy organization, to be appointed by the Senate Committee on Privileges and Elections; the Commissioner of the Department of Mental Health, Mental Retardation and Substance Abuse Services; the Commissioner of Health; the Superintendent of Public Instruction; the Directors of the Departments of Juvenile Justice, Corrections, Criminal Justice Services, and Social Services; and the Executive Director of the Commission on the Virginia Alcohol Safety Action Program or his designee; and the chairs or their designees of the Virginia Association of Drug and Alcohol Programs, the Virginia Association of Alcoholism and Drug Abuse Counselors, and the Substance Abuse Council and Prevention Task Force of the Virginia Association of Community Services.*

C. ~~The remaining nine members shall be from the general public. The nine public members shall each have a professional, research, or personal interest in drug or alcohol abuse and at least four of such members shall represent statewide organizations with alcohol or drug abuse concerns. When appointing members to the Council, the Governor shall assure that minority and low income groups~~

~~are provided representation on the Council.~~ *Appointments of agency heads shall be for terms consistent with their terms of office.* All *other* appointments of ~~public~~ *nonlegislative* members shall be for terms of three years, except an appointment to fill a vacancy which shall be for the unexpired term. The ~~Governor~~ *Council* shall ~~appoint~~ *elect* a chairman from ~~the general public who shall call all meetings~~ *among its members*.

No person shall be eligible to serve more than two successive terms, provided that a person appointed to fill a vacancy may serve two full successive terms.

D. The Council shall meet at least four times annually and more often if deemed necessary or advisable by the chairman.

E. The members of the Council shall receive no compensation for their services but shall be reimbursed for their actual and necessary expenses incurred in the performance of their duties.

F. The duties of the Council shall be:

1. To ~~formulate and~~ recommend policies and goals to the Governor, *the General Assembly, and the Board*;

2. To ~~review and comment on agency plans for substance abuse~~ *coordinate agency programs and activities, to prevent duplication of functions, and to combine all agency plans into a comprehensive interagency state plan for substance abuse services*;

3. To review and comment on annual *state agency* budget ~~provisions~~ *requests* regarding substance abuse and on all applications for state or federal funds or services to be used in substance abuse control programs;

4. To ~~develop recommendations and plans for strengthening substance abuse control activities~~ *define responsibilities among state agencies for various programs for persons with substance abuse problems and to encourage cooperation among agencies*; and

5. To make investigations, issue annual reports to the Governor and the General Assembly and make recommendations relevant to substance abuse upon the request of the Governor.

G. Staff assistance shall be provided to the Council ~~as directed by the Secretary of Health and Human Resources, the Secretary of Transportation, and the Secretary of Public Safety~~ *by the Office of Substance Abuse Services of the Department of Mental Health, Mental Retardation and Substance Abuse Services*.

§ 37.1-219. Standards for treatment facilities; inspections; list of facilities; filing of information.

A. The Board shall adopt reasonable regulations prescribing standards for ~~the sanitation, hygiene and safety of~~ *substance abuse* treatment facilities ~~and standards~~ to ~~assure~~ *ensure* proper attention, service and treatment to persons treated in such facilities. The Board may categorize treatment facilities in accordance with the character of treatment, care or service rendered or offered and prescribe such standards for each category. Such standards must be met by a ~~public or private~~ *substance abuse* treatment facility to be approved ~~pursuant to regulations promulgated by the Board~~ *to receive public funds*.

B. The Commissioner shall periodically cause to be inspected ~~approved public and private~~ *substance abuse* treatment facilities at reasonable times and in a reasonable manner.

C. The Department shall maintain a current list of approved ~~public and private~~ *substance abuse* treatment facilities, which shall be made available upon request.

D. Each approved ~~public and private~~ *substance abuse* treatment facility shall file with the Department such data, statistics, schedules and information as may be reasonably required.

E. Upon petition of the Commissioner and after a hearing held upon reasonable notice to the facility, a general district court may issue a warrant to an officer or employee of the Department authorizing him to enter and inspect at reasonable times, and examine the books and accounts of, any approved ~~public or private~~ *substance abuse* treatment facility ~~which~~ *that* refuses to consent to inspection or examination by authorized agents of the Department.

§ 37.1-220. Services for treatment of substance abuse.

~~A. B. [Repealed.]~~

~~C~~*A*. The comprehensive ~~programs~~ *services* for ~~alcoholics and intoxicated persons~~ *substance abusers* established by community services boards may include, *but are not limited to*:

1. ~~Public information~~ *Prevention* and education programs.

2. ~~Approved treatment facilities for facilitating access into care and rehabilitation by detoxifying~~

~~and evaluating alcoholics and intoxicated persons and providing entrance into additional treatment programs. Such facilities shall have available the services of a licensed physician for medical emergencies and routine medical assistance~~*Comprehensive assessment and evaluation.*

3. ~~Approved~~ *Residential* treatment ~~facilities providing inpatient or full-time residential treatment.~~

4. ~~Approved treatment facilities providing intermediate treatment or residential treatment that is less than full time~~*Outpatient treatment and case management.*

5. ~~Facilities providing outpatient and follow-up treatment where the client is not a full-time or part-time resident of the treatment facility. Such services may be offered in clinics, social services centers or in the patient's home~~*Approved facilities for detoxification of persons with substance abuse problems.*

~~D~~*B.* No person who is not already within the correctional system may be referred to treatment programs operating within correctional institutions.

~~E. All appropriate public and private facilities and services shall be coordinated with and utilized in the program if possible.~~

~~F. [Repealed.]~~

§ 37.1-221. Regulations for acceptance for treatment of substance abuse.

The Board shall adopt regulations for acceptance of persons into approved *substance abuse* treatment facilities. In establishing the regulations the Board shall be guided by the following standards:

A. Whenever possible a ~~patient~~ *person abusing substances* shall be treated on a voluntary rather than an involuntary basis.

~~B. A patient shall be initially assigned or transferred to outpatient or intermediate treatment, unless he is found to require inpatient treatment.~~

~~C~~*B.* A person shall not be denied treatment solely because he has withdrawn from treatment against medical advice on a prior occasion or because he has relapsed after earlier treatment.

~~D~~*C.* An individual treatment plan shall be prepared and maintained on a current basis for each ~~patient~~*person.*

~~E~~*D.* Adequate communication and referral systems shall be maintained between *all approved* treatment ~~components~~ *facilities and programs* to ~~insure~~ *ensure* smooth transition from one facility or form of treatment to another.

~~F~~*E.* An attempt shall be made to include ~~all~~ family members at the earliest possible phase of treatment.

§ 37.1-222. Voluntary treatment of substance abusers.

~~A. Any approved treatment facility may admit as a patient any person requesting admission who, having been examined by an appropriate member of the staff of such facility, is deemed to be in need of treatment for alcoholism.~~

~~B.~~ The administrator in charge of an approved treatment facility may determine who shall be admitted for treatment in accordance with regulations adopted by the Board. If a person is refused admission to an approved treatment facility, the administrator shall refer the person to another approved treatment facility in accordance with regulations adopted by the Board for treatment, if possible and appropriate.

§ 37.1-223. Procedure for adoption of regulations.

Prior to the adoption, amendment, or repeal of any regulation, the Board shall, in addition to the procedures set forth in the Administrative Process Act (§ 9-6.14:1 et seq.)~~:~~

~~A. Present~~, *present* the proposed regulation to the ~~Virginia Advisory Council on Substance Abuse Problems~~ *Substance Abuse Services Council* at least thirty days prior to its adoption for the Council's review and comment.

~~B. [Repealed.]~~

2. That §§ 37.1-208, 37.1-209 and 37.1-214 through 37.1-218 of the Code of Virginia are repealed.

988991260

HOUSE BILL NO. 1293

Offered January 26, 1998

A BILL to amend and reenact §§ 19.2-389, 37.1-20.3, and 37.1-197.2 of the Code of Virginia and to amend the Code of Virginia by adding a section numbered 37.1-20.4, relating to criminal background checks; central registry.

Patrons—Christian, Blevins, Bloxom, Crittenden, Darner, Day, Deeds, Drake, Grayson, Hall, Hargrove, Harris, Hull, Jackson, Jones, S.C., Kilgore, McClure, McEachin, Melvin, Moran, O'Brien, Puller, Robinson, Shuler and Wagner; Senators: Hanger, Howell, Lucas, Miller, Y.B., Ticer and Williams

---

Referred to Committee on Health, Welfare and Institutions

Be it enacted by the General Assembly of Virginia:

1. That §§ 19.2-389, 37.1-20.3, and 37.1-197.2 of the Code of Virginia are amended and reenacted and that the Code of Virginia is amended by adding a section numbered 37.1-20.4 as follows:

§ 19.2-389. Dissemination of criminal history record information.

A. Criminal history record information shall be disseminated, whether directly or through an intermediary, only to:

1. Authorized officers or employees of criminal justice agencies, as defined by § 9-169, for purposes of the administration of criminal justice and the screening of an employment application or review of employment by a criminal justice agency with respect to its own employees or applicants, and dissemination to the Virginia Parole Board, pursuant to this subdivision, of such information on all state-responsible inmates for the purpose of making parole determinations pursuant to subdivisions 1, 2, 3, and 5 of § 53.1-136 shall include collective dissemination by electronic means every thirty days;

2. Such other individuals and agencies which require criminal history record information to implement a state or federal statute or executive order of the President of the United States or Governor that expressly refers to criminal conduct and contains requirements and/or exclusions expressly based upon such conduct, except that information concerning the arrest of an individual may not be disseminated to a noncriminal justice agency or individual if an interval of one year has elapsed from the date of the arrest and no disposition of the charge has been recorded and no active prosecution of the charge is pending;

3. Individuals and agencies pursuant to a specific agreement with a criminal justice agency to provide services required for the administration of criminal justice pursuant to that agreement which shall specifically authorize access to data, limit the use of data to purposes for which given, and ensure the security and confidentiality of the data;

4. Individuals and agencies for the express purpose of research, evaluative, or statistical activities pursuant to an agreement with a criminal justice agency which shall specifically authorize access to data, limit the use of data to research, evaluative, or statistical purposes, and ensure the confidentiality and security of the data;

5. Agencies of state or federal government which are authorized by state or federal statute or executive order of the President of the United States or Governor to conduct investigations determining employment suitability or eligibility for security clearances allowing access to classified information;

6. Individuals and agencies where authorized by court order or court rule;

7. Agencies of any political subdivision of the Commonwealth for the conduct of investigations of applicants for public employment, permit, or license whenever, in the interest of public welfare or safety, it is necessary to determine under a duly enacted ordinance if the past criminal conduct of a person with a conviction record would be compatible with the nature of the employment, permit, or license under consideration;

8. Public or private agencies when and as required by federal or state law or interstate compact to investigate applicants for foster or adoptive parenthood subject to the restriction that the data shall not

be further disseminated by the agency to any party other than a federal or state authority or court as may be required to comply with an express requirement of law for such further dissemination;

9. To the extent permitted by federal law or regulation, public service companies as defined in § 56-1, for the conduct of investigations of applicants for employment when such employment involves personal contact with the public or when past criminal conduct of an applicant would be incompatible with the nature of the employment under consideration;

10. The appropriate authority for purposes of granting citizenship and for purposes of international travel, including but not limited to, issuing visas and passports;

11. A person requesting a copy of his own criminal history record information as defined in § 9-169 at his cost, except that criminal history record information shall be supplied at no charge to a person who has applied to be a volunteer (i) with a Virginia affiliate of Big Brothers/Big Sisters of America, (ii) with a volunteer fire company or volunteer rescue squad, or (iii) with the Volunteer Emergency Families for Children;

12. Administrators and board presidents of and applicants for licensure or registration as a child welfare agency as defined in § 63.1-195 for dissemination to the Commissioner of Social Services' representative pursuant to § 63.1-198 for the conduct of investigations with respect to employees of and volunteers at such facilities, caretakers, and other adults living in family day-care homes or homes approved by family day-care systems, and foster and adoptive parent applicants of private child-placing agencies, pursuant to § 63.1-198.1, subject to the restriction that the data shall not be further disseminated by the facility or agency to any party other than the data subject, the Commissioner of Social Services' representative or a federal or state authority or court as may be required to comply with an express requirement of law for such further dissemination;

13. The school boards of the Commonwealth for the purpose of screening individuals who are offered or who accept public school employment and those current school board employees for whom a report of arrest has been made pursuant to § 19.2-83.1;

14. The State Lottery Department for the conduct of investigations as set forth in the State Lottery Law (§ 58.1-4000 et seq.);

15. Licensed nursing homes, hospitals and home care organizations for the conduct of investigations of applicants for compensated employment in licensed nursing homes pursuant to § 32.1-126.01, hospital pharmacies pursuant to § 32.1-126.02, and home care organizations pursuant to § 32.1-162.9:1, subject to the limitations set out in subsection E;

16. Licensed homes for adults, licensed district homes for adults, and licensed adult day-care centers for the conduct of investigations of applicants for compensated employment in licensed homes for adults pursuant to § 63.1-173.2, in licensed district homes for adults pursuant to § 63.1-189.1, and in licensed adult day-care centers pursuant to § 63.1-194.13, subject to the limitations set out in subsection F;

17. The Alcoholic Beverage Control Board for the conduct of investigations as set forth in § 4.1-103.1;

18. The State Board of Elections and authorized officers and employees thereof in the course of conducting necessary investigations with respect to registered voters, limited to any record of felony convictions;

19. The Commissioner of the Department of Mental Health, Mental Retardation and Substance Abuse Services for those individuals who are committed to the custody of the Commissioner pursuant to §§ 19.2-169.2, 19.2-169.6, 19.2-176, 19.2-177.1, 19.2-182.2, 19.2-182.3, 19.2-182.8 and 19.2-182.9 for the purpose of placement, evaluation, and treatment planning;

20. Any alcohol safety action program certified by the Commission on the Virginia Alcohol Safety Action Program for (i) assessments of habitual offenders under § 46.2-360, (ii) interventions with first offenders under § 18.2-251, or (iii) services to offenders under §§ 18.2-51.4, 18.2-266 or § 18.2-266.1;

21. Residential facilities for juveniles regulated or operated by the Department of Social Services, the Department of Education, or the Department of Mental Health, Mental Retardation and Substance Abuse Services for the purpose of determining applicants' fitness for employment or for providing volunteer or contractual services;

22. The Department of Mental Health, Mental Retardation and Substance Abuse Services and facilities operated by the Department for the purpose of determining an individual's fitness for

employment pursuant to departmental instructions;

23. Pursuant to § 22.1-296.3, the governing boards or administrators of private or parochial elementary or secondary schools which are accredited by a statewide accrediting organization recognized, prior to January 1, 1996, by the State Board of Education;

24. State-supported colleges and universities for the purpose of screening individuals who are offered or accept public employment;

25. Executive directors of community services boards for the purpose of determining an individual's fitness for employment pursuant to § 37.1-197.2;

26. Executive directors of behavioral health authorities as defined in § 15.1-1677 for the purpose of determining an individual's fitness for employment pursuant to § 37.1-197.2;

27. The Commissioner of the Department of Social Services for the purpose of locating persons who owe child support or who are alleged in a pending paternity proceeding to be a putative father, provided that only the name, address, demographics and social security number of the data subject shall be released; ~~and~~

28. Authorized officers or directors of agencies that provide services under contract with community services boards or behavioral health authorities for the purpose of determining an individual's fitness for employment or providing services pursuant to § 37.1-197.2; and

~~28.~~ *29.* Other entities as otherwise provided by law.

Upon an ex parte motion of a defendant in a felony case and upon the showing that the records requested may be relevant to such case, the court shall enter an order requiring the Central Criminal Records Exchange to furnish the defendant, as soon as practicable, copies of any records of persons designated in the order on whom a report has been made under the provisions of this chapter.

Notwithstanding any other provision of this chapter to the contrary, upon a written request sworn to before an officer authorized to take acknowledgments, the Central Criminal Records Exchange or the criminal justice agency in cases of offenses not required to be reported to the Exchange, shall furnish a copy of conviction data covering the person named in the request to the person making the request; however, such person on whom the data is being obtained shall consent in writing, under oath, to the making of such request. A person receiving a copy of his own conviction data may utilize or further disseminate that data as he deems appropriate. In the event no conviction data is maintained on the data subject, the person making the request shall be furnished at his cost a certification to that effect.

B. Use of criminal history record information disseminated to noncriminal justice agencies under this section shall be limited to the purposes for which it was given and may not be disseminated further.

C. No criminal justice agency or person shall confirm the existence or nonexistence of criminal history record information for employment or licensing inquiries except as provided by law.

D. Criminal justice agencies shall establish procedures to query the Central Criminal Records Exchange prior to dissemination of any criminal history record information on offenses required to be reported to the Central Criminal Records Exchange to ensure that the most up-to-date disposition data is being used. Inquiries of the Exchange shall be made prior to any dissemination except in those cases where time is of the essence and the normal response time of the Exchange would exceed the necessary time period. A criminal justice agency to whom a request has been made for the dissemination of criminal history record information that is required to be reported to the Central Criminal Records Exchange may direct the inquirer to the Central Criminal Records Exchange for such dissemination. Dissemination of information regarding offenses not required to be reported to the Exchange shall be made by the criminal justice agency maintaining the record as required by § 15.1-135.1.

E. Criminal history information provided to licensed nursing homes, hospitals and to home care organizations pursuant to subdivision A 15 shall be limited to the convictions on file with the Exchange for any offense specified in §§ 32.1-126.01, 32.1-126.02 and 32.1-162.9:1.

F. Criminal history information provided to licensed adult care residences, licensed district homes for adults, and licensed adult day-care centers pursuant to subdivision A 16 shall be limited to the convictions on file with the Exchange for any offense specified in §§ 63.1-173.2, 63.1-189.1 or § 63.1-194.13.

§ 37.1-20.3. Background check required.

A. As a condition of employment, the Department shall require any individual who (i) accepts a position of employment at a state facility as defined in § 37.1-1 and was not employed by that state facility prior to July 1, 1996; ~~or~~ (ii) accepts a position with the Department that receives, monitors or disburses funds of the Commonwealth and was not employed by the Department prior to July 1, 1996; *or (iii) accepts a position with any other program licensed by the Department and was not employed by that program prior to July 1, 1998,* to submit to fingerprinting and to provide personal descriptive information to be forwarded along with the applicant's fingerprints through the Central Criminal Records Exchange to the Federal Bureau of Investigation for the purpose of obtaining criminal history record information regarding such applicant.

The Central Criminal Records Exchange, upon receipt of an individual's record or notification that no record exists, shall submit a report to the state facility or to the Department. If an individual is denied employment because of information appearing on his criminal history record, the state facility or Department shall provide, upon written request, a copy of the information obtained from the Central Criminal Records Exchange that resulted in the denial of employment to the individual. The information provided to the state facility or Department shall not be disseminated except as provided in this section.

B. Those individuals listed in clause (i) of subsection A also shall provide the state facility or Department a copy of information from the central registry maintained pursuant to § 63.1-248.8 on any investigation of child abuse or neglect undertaken on him.

C. The Board may promulgate regulations to comply with the provisions of this section. Copies of any information received by the state facility or Department pursuant to this section shall be available to the Department and to the applicable state facility but shall not be disseminated further, except as permitted by state or federal law. The cost of obtaining the criminal history record and the central registry information shall be borne by the applicant, unless the Department, at its option, decides to pay such cost.

§ 37.1-20.4. Central registry; disclosure of information.

The central registry shall contain such information as shall be prescribed by State Board regulation. The information contained in the central registry shall not be open to inspection by the public. However, appropriate disclosure may be made in accordance with State Board regulations.

§ 37.1-197.2. Background checks required.

A. Every community services board ~~and~~, behavioral health authority, *and employing agency that provides services under contract with the community services board or behavioral health authority* shall, on and after July 1, 1997, require any applicant who accepts employment in any direct client care position with the community services board ~~or~~, behavioral health authority, *or employing agency that provides services under contract with the community services board or behavioral health authority* to submit to fingerprinting and provide personal descriptive information to be forwarded through the Central Criminal Records Exchange to the Federal Bureau of Investigation (FBI) for the purpose of obtaining national criminal history record information regarding such applicant.

The Central Criminal Records Exchange, upon receipt of an individual's record or notification that no record exists, shall submit a report to the requesting executive director of the community services board ~~or~~, the behavioral health authority, *or the authorized officer or director at the employing agency providing services under contract with the community services board or behavioral health authority*. If any applicant is denied employment because of information appearing on the criminal history record and the applicant disputes the information upon which the denial was based, the Central Criminal Records Exchange shall, upon request, furnish the applicant the procedures for obtaining a copy of the criminal history record from the Federal Bureau of Investigation. The information provided to the executive director of any community services board or behavioral health authority *or the authorized officer or director at any employing agency* shall not be disseminated except as provided in this section.

B. The community services boards ~~and~~, behavioral health authorities, *and employing agencies that provide services under contract with community services boards or behavioral health authorities* shall also require, as a condition of employment for all such applicants, written consent and personal information necessary to obtain a search of the registry of founded complaints of child abuse and

neglect maintained by the Department of Social Services pursuant to § 63.1-248.8.

C. The cost of obtaining the criminal history record and search of the child abuse and neglect registry record shall be borne by the applicant, unless the community services board ~~or~~, behavioral health authority *or employing agency that provides services under contract with a community services board or behavioral health authority*, at its option, decides to pay such cost.

D. As used in this section, the term "direct client care position" means any position with a job description that includes responsibility for (i) treatment, case management, health, safety, development or well-being of a client, or (ii) immediately supervising a person in a position with such responsibility.

Official Use By Clerks

Passed By The House of Delegates		**Passed By The Senate**	
without amendment	☐	without amendment	☐
with amendment	☐	with amendment	☐
substitute	☐	substitute	☐
substitute w/amdt	☐	substitute w/amdt	☐

Date: _____ Date: _____

_____ _____

Clerk of the House of Delegates Clerk of the Senate

986028260

HOUSE BILL NO. 1294

Offered January 26, 1998

A BILL to amend and reenact §§ 2.1-746, 9-268, 9-270, 9-271, and 9-272 of the Code of Virginia, relating to prevention services.

Patrons—Christian, Behm, Crittenden, Darner, Deeds, Grayson, Hargrove, Hull, Jackson, Jones, J.C., McEachin, Melvin, Moran, Robinson, Shuler and Wagner; Senators: Hanger, Howell, Lucas, Miller, Y.B., Ticer and Williams

---

Referred to Committee on Health, Welfare and Institutions

Be it enacted by the General Assembly of Virginia:

1. That §§ 2.1-746, 9-268, 9-270, 9-271, and 9-272 of the Code of Virginia are amended and reenacted as follows:

§ 2.1-746. State executive council; members; duties.

The members of the state executive council shall be the Commissioners of Health, of Mental Health, Mental Retardation and Substance Abuse Services and of Social Services; the Superintendent of Public Instruction; the Executive Secretary of the Virginia Supreme Court; the Director of the Department of Juvenile Justice; an elected or appointed local official, to be appointed by the Governor; a private provider representative as a nonvoting, ex officio member, to be appointed by the Governor, who may appoint from nominees recommended by the Virginia Coalition of Private Provider Associations; and a parent representative. The parent representative shall be appointed by the Governor for a term not to exceed three years and shall not be an employee of any public or private program which serves children and families. The council shall annually elect a chairman who shall be responsible for convening the council. The council shall meet, at a minimum, semiannually, to oversee the administration of this chapter and make such decisions as may be necessary to carry out its purposes.

The state executive council shall:

1. Appoint the members of the state management team in accordance with the requirements of § 2.1-747;

2. Provide for the establishment of interagency programmatic and fiscal policies developed by the state management team, which support the purposes of this chapter, through the promulgation of regulations by the participating state boards or by administrative action, as appropriate;

3. Oversee the administration of state interagency policies governing the use, distribution and monitoring of moneys in the state pool of funds and the state trust fund;

4. Provide for the administration of necessary interagency functions which support the work of the state management team;

5. Review and take appropriate action on issues brought before it by the state management team;

6. Advise the Governor and appropriate Cabinet Secretaries on proposed policy and operational changes which facilitate interagency service development and implementation, communication and cooperation;

7. Provide administrative support and fiscal incentives for the establishment and operation of local comprehensive service systems;

8. Oversee coordination of ~~prevention and~~ early intervention programs to promote comprehensive, coordinated service delivery, local interagency program management, and co-location of programs and services in communities. ~~Prevention and early~~ *Early* intervention programs include state programs under the administrative control of the state executive council member agencies; and

9. Biennially publish and disseminate to members of the General Assembly and community policy and management teams a state progress report on comprehensive services to children, youth and families and a plan for such services for the next succeeding biennium. The state plan shall:

a. provide a fiscal profile of current and previous years' federal and state expenditures for a comprehensive service system for children, youth and families;

b. incorporate information and recommendations from local comprehensive service systems with responsibility for planning and delivering services to children, youth and families;

c. identify and establish goals for comprehensive services and the estimated costs of implementing these goals, report progress toward previously identified goals and establish priorities for the coming biennium; and

d. include such other information or recommendations as may be necessary and appropriate for the improvement and coordinated development of the state's comprehensive services system.

§ 9-268. Virginia Council on Coordinating Prevention; members; terms.

The Virginia Council on Coordinating Prevention is hereby established. *There shall be four members of the House of Delegates to be appointed by the Speaker of the House and two members of the Senate to be appointed by the Senate Committee on Privileges and Elections.* There shall be one member each from the Advisory Board for the Aging, Board of Correctional Education, State Board of Corrections, State Board of Juvenile Justice, Criminal Justice Services Board, State Board of Education, State Board of Health, Board of Medical Assistance Services, State Mental Health, Mental Retardation and Substance Abuse Services Board, Virginia Board for People with Disabilities, ~~and~~ Board of Social Services, *Department of Motor Vehicles Medical Advisory Board, Alcoholic Beverage Control Board, Criminal Justice Services Board, Comprehensive Services State Executive Council, and the Substance Abuse Council and Prevention Task Force of the Virginia Association of Community Services Boards*, to be appointed by the chairman of the respective board or council. Persons appointed to the Council by virtue of their membership on a board or council listed above may serve on the Council only while a member of the respective board or council and may not serve on the Council for more than two consecutive terms.

Five members shall be representatives of the private sector who are interested in prevention, to be appointed by the Governor. Representatives of the private sector shall serve for terms of four years. Members appointed to the Council by the Governor shall not be eligible to serve more than two consecutive full terms.

The Secretary of Health and Human Resources shall be an ex officio member of the Council. ~~The Governor shall appoint a chairman from the membership of the Council.~~ *The Council shall elect a chairman from among its members.*

§ 9-270. Powers and duties.

A. The Council shall have the power and duty to:

1. Review and comment on the Comprehensive Prevention Plan and submit these comments to the Governor biennially prior to submission of the budget;

2. Recommend to the Governor policies, legislation, regulations, and funding that will further the purposes of the Council and local prevention programs;

3. Recommend, in order of priority, prevention issues to be addressed by government and the private sector;

4. Recognize outstanding prevention programs and initiatives;

5. Recommend methods by which the Commonwealth may provide technical assistance and training to state and local, public and private agencies, organizations or individuals to promote the development and implementation of prevention initiatives;

6. Develop recommendations for the establishment and operation of a clearinghouse for information pertinent to prevention initiatives, record keeping of existing prevention programs, and methods by which information concerning those programs may be communicated to the public; *and*

7. Recommend methods by which the Commonwealth may collect data on the effectiveness of prevention programs~~; and~~

~~8. Employ staff as necessary to carry out its duties~~.

B. In carrying out the purposes of this chapter, the Council shall consider prevention activities, issues and programs to be those governmental and private sector programs and/or services which promote the maximum independence of individuals and strengthen families; which avoid or minimize physical or mental disability or dysfunction; which reduce the likelihood of dependency on governmental and private sector support, treatment and rehabilitative services; and which encourage future cost savings through early intervention or treatment.

C. Staff support shall be provided by the Department of Mental Health, Mental Retardation and Substance Abuse Services.

§ 9-271. Comprehensive Prevention Plan.

A Comprehensive Prevention Plan shall be jointly developed biennially by the following agencies: Department for the Aging, *Department of Alcoholic Beverage Control,* Department of Correctional Education, Department of Corrections, Department of Juvenile Justice, Department of Criminal Justice Services, Department of Education, Department of Health, Department of Medical Assistance Services, Department of Mental Health, Mental Retardation and Substance Abuse Services, *Department of Motor Vehicles,* Department for Rights of Virginians With Disabilities, and Department of Social Services. The Secretary of Health and Human Resources shall designate an agency to coordinate development of the Plan. The Comprehensive Prevention Plan shall coordinate and integrate the planning efforts of the state agencies listed above and the private sector in order to provide a broad prevention agenda for the Commonwealth, enable communities to design and implement prevention programs that meet the identified needs of the community and facilitate the development of interagency and broad-based community involvement in the development of prevention programs. The Comprehensive Prevention Plan shall identify priority prevention issues and challenges, prevention goals and objectives and public and private strategies to achieve goals and objectives. For the purposes of the Plan, prevention activities, issues and programs shall be those activities which promote the objective identified in subsection B of § 9-270. The Plan with a cost analysis of the proposed strategies shall be submitted to the House Committee on Health, Welfare and Institutions and the Senate Committees on Rehabilitation and Social Services and Education and Health for the purpose of analysis, review and comment prior to implementation.

§ 9-272. State agency responsibilities.

The agencies listed in § 9-271 shall have the duty to:

1. Participate in the development of the Comprehensive Prevention Plan, *based on risk, protective factors, and clearly defined benchmarks, and* ~~to~~ *shall* include cost estimates for implementation and ~~long term~~ *long-term* cost savings;

2. Develop and implement, to the extent authorized by law, programs that support the Comprehensive Prevention Plan;

3. Facilitate the involvement of local service providers in interagency, broad-based community development and implementation of *local* prevention programs consistent with the Comprehensive Prevention Plan;

4. Require that the planning process for all agency programs that relate to the priority issues identified by the Council include an analysis of their prevention component or potential and their potential impact on budgetary requests; ~~and~~

5. Set funding priorities and recommend regulations and guidelines to the Council to administer the Community Prevention Initiative Grants Program;

6. Support the development of a state database on prevention activities that includes risk and protective factors;

7. Develop and implement a set of core elements to be used by state agencies that provide grant funding for prevention services;

8. Provide coordinated and comprehensive training and technical assistance to localities for prevention planning and implementation; and

9. Local agencies that receive prevention funding shall participate in the development and implementation of the community-based prevention plan as prepared by the local Prevention Advisory Team.

988993260

HOUSE JOINT RESOLUTION NO. 113

Offered January 22, 1998

Requesting the Department of Mental Health, Mental Retardation and Substance Abuse Services to continue to implement managed care technologies in the provision of publicly funded mental health, mental retardation and substance abuse services.

Patrons—Thomas, Bloxom, Christian, Clement, Cranwell, Croshaw, Darner, DeBoer, Deeds, Diamonstein, Dickinson, Hall, Jackson, Joannou, Johnson, Jones, J.C., Keating, Moran, Murphy, Phillips, Plum, Puller, Robinson, Spruill, Stump, Tate, Van Landingham, Van Yahres, Williams and Woodrum; Senator: Gartlan

---

Referred to Committee on Rules

WHEREAS, the need for and vast array of resultant services for mental health, mental retardation and substance abuse services is growing each day; and

WHEREAS, while new treatments make it possible for more consumers of mental health, mental retardation and substance abuse services to live independent lives, as well as provide a new quality of life for those who reside in institutions, it is inherent upon the Commonwealth to provide these services in a meaningful, cost efficient, and efficacious manner; and

WHEREAS, with the new emphasis on accountability and outcomes for the delivery of services, new technologies are necessary to implement such goals; and

WHEREAS, managed care technologies provide methods and tools to provide accurate and usable information and attain meaningful results; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Department of Mental Health, Mental Retardation and Substance Abuse Services be urged to continue to explore and implement managed care technologies in the delivery of mental health, mental retardation and substance abuse services to the citizens of the Commonwealth; and, be it

RESOLVED FURTHER, That the Clerk of the House of Delegates transmit a copy of this resolution to the Commissioner of the Department of Mental Health, Mental Retardation and Substance Abuse Services in order that he may be apprised of the sense of the General Assembly in this matter.

Official Use By Clerks

Passed By The House of Delegates		Passed By The Senate	
without amendment	☐	without amendment	☐
with amendment	☐	with amendment	☐
substitute	☐	substitute	☐
substitute w/amdt	☐	substitute w/amdt	☐

Date: _____ Date: _____

Clerk of the House of Delegates

Clerk of the Senate

986025260

HOUSE JOINT RESOLUTION NO. 114

Offered January 22, 1998

Requesting the Department of Education to administer a youth risk-behavior survey.

Patrons—Thomas, Bloxom, Christian, Clement, Cranwell, Croshaw, Darner, DeBoer, Deeds, Diamonstein, Dickinson, Hall, Hull, Jackson, Joannou, Johnson, Jones, J.C., Keating, Melvin, Moran, Murphy, Parrish, Phillips, Plum, Puller, Rhodes, Robinson, Spruill, Stump, Tate, Van Landingham, Van Yahres, Williams and Woodrum; Senator: Gartlan

---

Referred to Committee on Rules

WHEREAS, the National Public Health Service reports that people between the ages of 15 and 24 are at a special risk of developing behaviors that may later become permanent health hazards; and

WHEREAS, research demonstrates that youth problem behaviors are linked to specific, identifiable risk factors and can be prevented; and

WHEREAS, an ongoing measurement protocol for these health risk behaviors must be established in order to accurately monitor the incidence and prevalence of problem behaviors among Virginia's youth; and

WHEREAS, up-to-date statistics describing youth risk behavior are needed in every locality to accurately plan and evaluate the impact of prevention programs; and

WHEREAS, a youth risk-behavior survey administered in 1993 to 1,923 students in 35 Virginia high schools by the Department of Education provided localities with a preliminary snapshot of youth involvement in problem behaviors; and

WHEREAS, the survey was discontinued by the Department of Education in 1994; and

WHEREAS, in 1997, the Virginia Congress of Parents and Teachers endorsed the assessment of youth-risk behaviors "....provided that it protects the privacy of students, allows parents/guardians the right to opt-out their students, and participation is voluntary"; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Department of Education be requested to administer a youth risk-behavior survey in all localities of the Commonwealth and report the results of the survey and the Department's recommendations to the Governor and the General Assembly by November 1, 1999, as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

Official Use By Clerks			
Passed By The House of Delegates		**Passed By The Senate**	
without amendment	☐	without amendment	☐
with amendment	☐	with amendment	☐
substitute	☐	substitute	☐
substitute w/amdt	☐	substitute w/amdt	☐
Date: _____		Date: _____	
Clerk of the House of Delegates		Clerk of the Senate	

986026260

HOUSE JOINT RESOLUTION NO. 157

Offered January 26, 1998

Expressing the sense of the General Assembly on drug courts and the need for substance abuse services for offenders.

Patrons—Hall, Bloxom, Christian and Thomas; Senators: Gartlan and Martin

Referred to Committee on Health, Welfare and Institutions

WHEREAS, an estimated 60 to 85 percent of Virginia's criminal justice population has a substance abuse problem; and

WHEREAS, research shows that offenders who receive treatment and follow-up services for substance abuse problems are less likely to re-offend than those who do not receive treatment; and

WHEREAS, research also demonstrates that the effectiveness of treatment is undiminished when the criminal justice system coerces offenders into treatment prior to sentencing or as a post-conviction condition of probation and parole; and

WHEREAS, the number of drug commitments to Virginia's prisons continues to grow at alarming rates; and

WHEREAS, the current need for substance abuse services for offenders exceeds available resources; and

WHEREAS, the cost of treating offenders with substance abuse problems is less than half the cost of incarceration for one year; and

WHEREAS, in a recent study, the Virginia State Crime Commission recommended a system of identifying persons with substance abuse problems during the sentencing phase and integrating substance abuse treatment with criminal punishment; and

WHEREAS, the Virginia State Crime Commission also recommended funding for a drug court grant program to support the number of local courts which may be interested in establishing drug courts at either the general district, circuit, or juvenile court level; and

WHEREAS, the recidivism rate of persons participating in drug courts is substantially lower than the comparison groups; and

WHEREAS, a recent California Drug and Alcohol Treatment Assessment study indicated that the cost of treating offenders was a fraction of the cost of crime resulting from non-treatment, and that the level of criminal activity declined by two-thirds from pre-treatment to post-treatment; and

WHEREAS, there is a growing need for more local jail treatment programs, community residential treatment for juveniles and adults, and aftercare and transition services for offenders and their families to begin to meet the demand for these services and to reduce the cost of incarcerating substance abusing offenders in state prisons; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That it is the sense of the General Assembly that additional resources should be made available for substance abuse services for offenders and their families and that support should be provided to local efforts to establish drug courts; and, be it

RESOLVED FURTHER, That the Clerk of the House of Delegates transmit copies of this resolution to the Commissioner of the Department of Mental Health, Mental Retardation and Substance Abuse Services, the Directors of the Departments of Corrections, Juvenile Justice, and Criminal Justice Services, and the Sentencing Commission in order that they may be apprised of the sense of the General Assembly in this matter.

989096260

HOUSE JOINT RESOLUTION NO. 212

Offered January 26, 1998

Requesting the Secretary of Health and Human Resources, the Department of Mental Health, Mental Retardation and Substance Abuse Services, and the Department of Medical Assistance Services to report on the proposed implementation of a "carve out" of Medicaid-financed mental health, mental retardation, and substance abuse services from any managed care contracts negotiated with Health Maintenance Organizations or other networks of physical health care service providers.

Patrons—Bloxom, Christian, Darner, Hall and Thomas

Referred to Committee on Health, Welfare and Institutions

WHEREAS, as the Department of Medical Assistance Services (DMAS) moves the Medical Assistance Program into a managed care environment through Medallion II, the effects of this decision on mental health, mental retardation, and substance abuse services on those individuals receiving those services have attracted considerable interest; and

WHEREAS, the first phase of this move, in Tidewater, included mental health clinic services and psychiatric inpatient hospitalization services, but excluded certain other services, in capitated contracts negotiated with health maintenance organizations; and

WHEREAS, this continues to fragment service delivery, making it more difficult for consumers and their families to obtain needed services that are coordinated and integrated; and

WHEREAS, the current proposal for implementing Medallion II in Northern Virginia includes psychiatric inpatient hospitalization in the capitated contracts but excludes certain mental health clinic services, along with certain other services excluded in the Tidewater contracts; and

WHEREAS, different states have selected a variety of solutions to the question of how to fund, administer, and deliver mental health, mental retardation, and substance abuse services financed by Medicaid; and

WHEREAS, one approach involves "carving out" all of these services from any managed care contracts negotiated with Health Maintenance Organizations or other networks of physical health care service providers; and

WHEREAS, the Joint Subcommittee to Evaluate the Future Delivery of Publicly Funded Mental Health, Mental Retardation and Substance Abuse Services (HJR 240, 1996) has endorsed the concept of a "carve out" approach in which the Department of Medical Assistance Services would subcontract the administration of Medicaid-covered mental health, mental retardation, and substance abuse services to the Department of Mental Health, Mental Retardation and Substance Abuse Services; now, therefore, be it

RESOLVED the House of Delegates, the Senate concurring, That in order to have sufficient time to develop the data and evaluative foundation to manage the proposed "carve out," implementation of all subcontracting or "carve out" proposals, with the exception of replacing the match currently transferred from grants to localities, be deferred until the 2001 Session of the General Assembly. To provide guidance on such implementation, the Secretary of Health and Human Resources, the Department of Mental Health, Mental Retardation and Substance Abuse Services, and the Department of Medical Assistance Services should present recommendations prior to the 2001 Session of the General Assembly on the implementation of the "carve out" which would become effective July 1, 2001.

988994260

HOUSE JOINT RESOLUTION NO. 225

Offered January 26, 1998

Continuing the Joint Subcommittee to Evaluate the Future Delivery of Publicly Funded Mental Health, Mental Retardation and Substance Abuse Services.

Patrons—Hall, Bloxom, Christian and Thomas; Senators: Gartlan, Martin and Wampler

Referred to Committee on Rules

WHEREAS, the Joint Subcommittee to Evaluate the Future Delivery of Publicly Funded Mental Health, Mental Retardation and Substance Abuse Services was established by House Joint Resolution No. 240 in the 1996 Session of the General Assembly; and

WHEREAS, the resolution directed the joint subcommittee to examine (i) the current services system, (ii) the principles and goals of a comprehensive publicly funded system, (iii) the range of services and eligibility for those services, (iv) the methods of funding publicly supported community and facility services, (v) the relationship between the Department of Mental Health, Mental Retardation and Substance Abuse Services and the components of the service system, (vi) the information and technology needs to provide appropriate and enhanced accountability, (vii) changes needed in the Code of Virginia, (viii) ways to effectively involve consumers and families in planning and evaluating the publicly funded system, and (ix) recommendations of previous studies and the work of the Secretary of Health and Human Resources' Task Force; and

WHEREAS, the joint subcommittee has made recommendations to effect sweeping changes in the delivery of publicly funded services; and

WHEREAS, while numerous recommendations have been made, the joint subcommittee believes that many issues still need to be resolved and oversight is needed for the implementation of current recommendations; and

WHEREAS, the joint subcommittee identified two particular issues that will require review and resolution; and

WHEREAS, the first of these issues is determining the most effective structure and location of an external human rights protection system in Virginia, increased attention to which has been brought by the serious incidents and deaths in state mental health and mental retardation facilities; and

WHEREAS, two human rights programs now operate to protect consumers: one is the program operated by the Department of Mental Health, Mental Retardation and Substance Abuse Services, commonly known as the "internal" system since the Department also provides services to some of the same persons protected by its system; and the other program is operated by the Department for the Rights of Virginians with Disabilities under the federal Protection and Advocacy for Individuals with Mental Illness (PAIMI) Act and the Developmental Disabilities Assistance and Bill of Rights (DD) Act; and

WHEREAS, there is a perception that more needs to be done to (i) ensure complete independence of any external human rights system from the internal system, (ii) complement but not duplicate the internal system, (iii) ensure the system is supported by adequate levels of resources, (iv) increase consumer access, (v) increase oversight responsibility, and (vi) ensure the system is objective; and

WHEREAS, recommendations in a 1997 State Board of Mental Health, Mental Retardation and Substance Abuse report on human rights called for further study; and

WHEREAS, a second issue involves the need to study welfare reform and substance abuse policy, since public assistance recipients often experience a wide range of employment barriers, including the abuse of alcohol and other drugs; and

WHEREAS, a 1995 study by the U.S. Department of Health and Human Services concluded that substance abuse affected the ability of more than 15 percent of welfare recipients to find and maintain employment; and

WHEREAS, an integrated welfare reform and substance abuse policy will need to address issues concerning assessment, treatment capacity, funding, data collection and analysis, interagency coordination, work and treatment coordination, staff training, and outcome measurement; now, therefore, be it

986174260

HOUSE JOINT RESOLUTION NO. 254

Offered January 26, 1998

Expressing the sense of the General Assembly on substance abuse prevention and treatment and the appropriate strategies for State agencies that have responsibility for persons who have substance abuse problems.

Patrons—Christian, Behm, Blevins, Bloxom, Crittenden, Darner, DeBoer, Deeds, Drake, Grayson, Hall, Hargrove, Hull, Jackson, Jones, J.C., McEachin, Melvin, Moran, O'Brien, Robinson, Shuler and Thomas; Senators: Hanger, Howell, Lucas, Martin, Miller, Y.B. and Ticer

---

Referred to Committee on Health, Welfare and Institutions

WHEREAS, almost one-half of Americans report that either they, a family member, or a close friend have used illegal drugs; and

WHEREAS, illicit drug use is a primary contributor to property crimes and crimes of violence in homes and communities; and

WHEREAS, nationwide, absenteeism, lost productivity, and accident and medical claims due to alcohol and other drug use cost more than $140 billion per year; and

WHEREAS, as a result of aggressive prevention, interdiction and treatment efforts, the number of illegal drug users in the United States decreased by half between 1985 and 1996; and

WHEREAS, research demonstrates that substance abuse treatment in combination with incarceration is more effective for offenders than either treatment or criminal justice sanctions applied separately; and

WHEREAS, Section 37.1-194 of the Code of Virginia requires emergency services for persons with substance abuse problems, but, due to inadequate or unavailable community-based treatment options, some persons with substance abuse problems who exhibit acute psychiatric symptoms are admitted to state mental health facilities; and

WHEREAS, demographics, economics, ability to access treatment, and the nature of substance abuse problems vary widely across the Commonwealth; and

WHEREAS, many of Virginia's youth are at substantial risk of becoming involved in substance abuse, as well as the related problems of teen pregnancy, crime, youth violence, and school failures; and

WHEREAS, alcohol and other drug abuse are preventable and treatable conditions, but without prevention and treatment, addiction-related behaviors can create public health and safety concerns that affect the general welfare and economy of the Commonwealth; and

WHEREAS, Virginia faces an urgent challenge in designing integrated systems that will provide prevention and treatment services for pregnant women, parents with children, offenders with substance abuse problems, and youth who abuse or who are at risk of abusing alcohol and other drugs; and

WHEREAS, Virginia faces the equal challenge of providing prevention and treatment services for persons with substance abuse problems who are infected by HIV, AIDS, hepatitis, or other related communicable diseases, as well as persons who inject drugs and persons with substance abuse problems who suffer from serious and persistent mental illness; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That it is the sense of the General Assembly that, within available resources, (i) offenders in the criminal justice system shall have access to substance abuse treatment both in corrections facilities and the community; (ii) a continuum of care, consistent with minimum standards, shall be available to all persons with substance abuse problems and their families, so that these persons can lead a normal life as productive members of society; and (iii) the minimal continuum of care shall include prevention and education, comprehensive assessment, case management, outpatient counseling, detoxification, and residential treatment services; and, be it

RESOLVED FURTHER, That the General Assembly shall endeavor to ensure a minimal continuum of substance abuse prevention and treatment services in every region of the Commonwealth by 2004; and be it

RESOLVED FURTHER, That the General Assembly reaffirm that the Department of Mental

Health, Mental Retardation and Substance Abuse Services is the state agency responsible for planning, developing, and providing substance abuse prevention and treatment services, as cited in Chapter 11 (§ 37.1-203 et seq.) of Title 37.1 of the Code of Virginia; and be it

RESOLVED FURTHER, That the General Assembly request state agencies with responsibility for persons who have substance abuse problems to (i) give highest priority to effective strategies for prevention, intervention, and treatment alternatives to ameliorate substance abuse problems and (ii) work collaboratively with other agencies to form an integrated service system that avoids duplication, overcomes agency barriers to service delivery, and increases public awareness that the abuse of alcohol and other drugs is a major social and health problem affecting individuals and their families; and be it

RESOLVED FINALLY, That the Clerk of the House of Delegates transmit copies of this resolution to the Commissioner of the Department of Mental Health, Mental Retardation and Substance Abuse Services; the Commissioner of Health; the Superintendent of Public Instruction; and the Directors of the Departments of Corrections, Juvenile Justice, Criminal Justice Services, Social Services, and Motor Vehicles in order that they may be apprised of the sense of the General Assembly in this manner.

Official Use By Clerks

Passed By The House of Delegates		Passed By The Senate	
without amendment	☐	without amendment	☐
with amendment	☐	with amendment	☐
substitute	☐	substitute	☐
substitute w/amdt	☐	substitute w/amdt	☐

Date: _____ Date: _____

_____ _____

Clerk of the House of Delegates Clerk of the Senate

988987661

SENATE BILL NO. 494

Offered January 26, 1998

A BILL to amend the Code of Virginia by adding in Title 9 a chapter numbered 49, consisting of sections numbered 9-375 through 9-379, relating to the Joint Commission on Behavioral Health Care.

Patrons—Gartlan and Wampler; Delegates: Bloxom, Christian, Hall and Thomas

---

Referred to the Committee on Rules

Be it enacted by the General Assembly of Virginia:

1. That the Code of Virginia is amended by adding in Title 9 a chapter numbered 49, consisting of sections numbered 9-375 through 9-379, as follows:

CHAPTER 49.

JOINT COMMISSION ON BEHAVIORIAL HEALTH CARE.

§ 9-375. Joint Commission created.

There is hereby created, as a legislative agency, the Joint Commission on Behavioral Health Care, hereinafter referred to as the Commission. The purpose of the Commission is to study, report and make recommendations on all areas of behavioral health care provision, regulation, and delivery of services. Further, the Commission may make recommendations and coordinate the proposals and recommendations of all commissions and agencies as to legislation affecting the provision and delivery of behavioral health care.

§ 9-376. Membership; compensation.

The Commission shall be composed of sixteen legislative members: seven members of the Senate, to be appointed by the Senate Committee on Privileges and Elections, and nine members of the House of Delegates, to be appointed by the Speaker of the House.

The term of each appointee shall be for five years. Whenever any legislative member fails to retain his membership in the house from which he was appointed, his membership shall be vacated, and the vacancy shall be filled in the original manner. The members of the Commission shall elect a chairman and vice chairman.

Members of the Commission shall receive compensation as provided in § 14.1-18 and shall be paid their necessary expenses incurred in the performance of their duties. All such expense payments, however, shall come from existing appropriations to the Joint Commission on Behavioral Health Care.

§ 9-377. Duties and powers.

The Commission shall have the duty and power to study and to gather information and data to accomplish its purpose as set forth in § 9-375 and to report its recommendations to the Governor and the General Assembly.

The Chairman of the Commission shall have the authority to invite other interested parties to sit with the Commission and to participate in its deliberations.

The Commission shall study the operations, management, jurisdiction, powers and interrelationships of any department, board, bureau, commission, authority or other agency with any direct responsibility for the provision and delivery of behavioral health care in the Commonwealth.

The Commission shall examine matters relating to health services in other states and shall consult and exchange information with officers and agencies of other states with respect to behavioral health service problems of mutual concern. The Commission may maintain offices and may hold meetings and functions at any place within the Commonwealth as it may deem necessary.

§ 9-378. Staff and staff support.

The Commission shall be authorized to appoint, employ, and remove an executive director and such other persons as it may deem necessary and to determine their duties and fix their salaries or compensation within the amounts appropriated therefor. The Commission may also obtain such assistance as it may deem necessary from other legislative and executive agencies and may employ experts who have special knowledge of the issues before it.

§ 9-379. Annual report.

The Commission shall make an annual report to the Governor and the General Assembly which shall include its recommendations. The Commission shall make such further interim reports to the Governor and the General Assembly as it shall deem advisable or as shall be required by the Governor or the General Assembly.

Official Use By Clerks

Passed By The Senate		Passed By The House of Delegates	
without amendment	☐	without amendment	☐
with amendment	☐	with amendment	☐
substitute	☐	substitute	☐
substitute w/amdt	☐	substitute w/amdt	☐

Date: _____ Date: _____

_____ _____

Clerk of the Senate Clerk of the House of Delegates

984222661

SENATE BILL NO. 495

Offered January 26, 1998

A BILL to amend and reenact § 37.1-3 of the Code of Virginia, relating to membership on the State Mental Health, Mental Retardation and Substance Abuse Services Board.

Patrons—Gartlan and Wampler; Delegate: Christian

Referred to the Committee on Education and Health

Be it enacted by the General Assembly of Virginia:

1. That § 37.1-3 of the Code of Virginia is amended and reenacted as follows:

§ 37.1-3. Creation of Board; appointment of members; terms and vacancies.

There shall be a State Mental Health, Mental Retardation and Substance Abuse Services Board which shall consist of nine members to be appointed by the Governor, subject to confirmation by the General Assembly, if in session when such appointment is made, and if not in session, then at its next succeeding session. No less than one-third of the members shall be consumers of mental health, mental retardation or substance abuse services or family members of consumers of such services. At all times at least one member shall be a consumer ~~and~~, one shall be a family member of a consumer, *and one shall be an elected local government official*. Appointments shall be made for terms of four years each, except appointments to fill vacancies which shall be for the unexpired terms. No person shall be eligible to serve more than two ~~successive~~ full *four-year* terms.*; however, persons heretofore and hereafter appointed to fill vacancies may serve two additional full four-year terms.*

988996661

SENATE JOINT RESOLUTION NO. 151

Offered January 26, 1998

Requesting the Department of Rehabilitative Services and the Department of Mental Health, Mental Retardation and Substance Abuse Services to work together to address the employability needs of persons with serious mental illness.

Patrons—Gartlan, Martin and Wampler; Delegates: Christian, DeBoer, Hall and Thomas

Referred to the Committee on Rules

WHEREAS, a large number of Virginians each year seek help for a serious mental illness from a system of state facilities and community programs; and

WHEREAS, the goal of the mental health system is to provide consumers services in those settings that promote the highest quality of life for them and which complement natural family and community resources and supports that are adequate and continuing; and

WHEREAS, the provision of the least intrusive levels of support will increase opportunities for people to build upon natural abilities and supports and to take more control over their lives by making their own decisions about the services and supports they want and need; and

WHEREAS, new and effective programs, such as antipsychotic medications, intensive community treatment programs, and psychosocial rehabilitation programs have enabled numerous individuals to leave institutions and return to the community, family and jobs, and there is hope that many more will likewise benefit; and

WHEREAS, job skills and employment opportunities enable persons with serious mental illness to regain some independence and return to their families; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Department of Rehabilitative Services and the Department of Mental Health, Mental Retardation and Substance Abuse Services work together to address the employability needs of persons with serious mental illness.

The Departments of Rehabilitative Services and of Mental Health, Mental Retardation and Substance Abuse Services shall complete their work in time to submit their findings and recommendations to the Governor and 1999 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

Official Use By Clerks

Passed By The Senate		Passed By The House of Delegates	
without amendment	☐	without amendment	☐
with amendment	☐	with amendment	☐
substitute	☐	substitute	☐
substitute w/amdt	☐	substitute w/amdt	☐

Date: _____ Date: _____

Clerk of the Senate | Clerk of the House of Delegates

988988661

SENATE JOINT RESOLUTION NO. 152

Offered January 26, 1998

Expressing the sense of the General Assembly that the performance and outcome measurement system (POMS) pilots being conducted by the Department of Mental Health, Mental Retardation and Substance Abuse Services be continued and that such a system be included in community services boards and facility performance contracts and reports.

Patrons—Gartlan and Wampler; Delegates: Christian, Hall and Thomas

Referred to the Committee on Rules

WHEREAS, currently, accountability in the mental health, mental retardation and substance abuse services system is described and measured through audits, cost containment practices, collection of fees and other revenue, types and amounts of services provided, and the existence of particular policies and procedures; and

WHEREAS, the community services board (CSB) performance contracts and reports establish and measure mutually negotiated, very basic indicators such as types and amounts of services and the costs of services; and

WHEREAS, the absence of uniform cost accounting standards and systems, compatible management information systems, and consistent data bases across the state make analytical comparisons difficult, if not impossible; and

WHEREAS, there is no mechanism comparable to this performance contract process in place for state facilities that establishes up-front performance expectations; and

WHEREAS, while these types of process and output accountabilities are useful and necessary, they do not measure the impact or effect of services or agency efforts on the individuals who are served by those agencies or organizations; and

WHEREAS, there is now considerable interest in more meaningful measure of an organization's effectiveness and the efficacy of its services; and

WHEREAS, the CSBs, Department of Mental Health, Mental Retardation and Substance Abuse Services (the Department), and consumer and family advocacy groups have developed the Performance and Outcome Measurement System (POMS) in response to this interest, and the Department has initiated pilots at several selected CSBs and state facilities; and

WHEREAS, the results of the pilots will be available in December 1998; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Department of Mental Health, Mental Retardation and Substance Abuse Services continue the POMS pilot programs and, once POMS has been successfully piloted, revised, and implemented statewide, appropriate and relevant measures from it be included in the CSB and state facility performance contracts and reports; and, be

RESOLVED FURTHER, That the Clerk of the Senate transmit a copy of this resolution the Secretary of Health and Human Resources and the Director of the Department of Mental Health, Mental Retardation and Substance Abuse Services that they might be apprised of the sense of the General Assembly in this matter.

988995661

SENATE JOINT RESOLUTION NO. 153

Offered January 26, 1998

Requesting the Department of Mental Health, Mental Retardation and Substance Abuse Services to complete its pilot projects on priority populations and recommend legislation to implement priority populations for mental health, mental retardation and substance abuse services.

Patrons—Gartlan and Wampler; Delegates: Christian and Hall

Referred to the Committee on Rules

WHEREAS, historically, the Commonwealth of Virginia has assumed major responsibility for the provision of services for its citizens with mental disabilities and substance abuse problems; and

WHEREAS, provision of care has shifted away from the institutional setting to programs in the community and, between 1986 and 1996, the numbers of people receiving various services from community services boards grew from 208,453 to 294,882, an increase of 41.5 percent; and

WHEREAS, during its study, the Joint Subcommittee to Evaluate the Future Delivery of Publicly Funded Mental Health, Mental Retardation and Substance Abuse Services found that improvements in the services system are needed to increase opportunities for consumers and their representatives to become more involved in policy making, services planning, delivery and evaluation, and decisions about their treatment; and

WHEREAS, these services should complement, not replace, natural family and community resources and supports which are adequate and continuing; and

WHEREAS, although Virginia is currently experiencing economic growth, all of this must be accomplished in a time when current dollars have to be allocated to a growing number of programs and services; and

WHEREAS, the Virginia must also consider the most prudent method of providing services in those times when growth is not as vigorous; and

WHEREAS, the Department of Mental Health, Mental Retardation and Substance Abuse Services (the Department) has begun the process, through pilot projects, to develop mechanisms to ensure that individuals with the most serious mental illnesses, mental retardation, or alcohol or other drug abuse problems receive the highest priority for publicly-funded services; and

WHEREAS, this population includes adults with serious mental illnesses, children and adolescents with serious emotional disturbances, and individuals with mental retardation or alcohol or other drug abuse or dependence with lower levels of functioning, more intense services and supports needs, and life situations that increase their risk of abuse of exploitation; and

WHEREAS, the Joint Subcommittee to Evaluate the Future Delivery of Publicly Funded Mental Health, Mental Retardation and Substance Abuse Services (HJR 240, 1996) reviewed draft legislation which would direct the Department to allocate a significant proportion of its funds to priority populations and to provide funds for other populations to ensure that people are not turned away when they need help; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Department of Mental Health, Mental Retardation and Substance Abuse Services be requested complete the pilot projects on priority populations. The Department should use the results of the pilot projects on priority populations to develop policies that define priority populations, involving the Department, community services boards, the Virginia Hospital and Healthcare Association, the Virginia Network of Private Providers, and consumer and advocacy groups.

The Department of Mental Health, Mental Retardation and Substance Abuse Services shall complete the pilot projects on priority populations and develop proposed legislation to implement priority populations no later than December 1, 1999, for submission to the Governor and 2000 Session of the General Assembly according to the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

988997661

SENATE JOINT RESOLUTION NO. 154

Offered January 26, 1998

Requesting the Commissioner of the Virginia Department of Health, in cooperation with the Department of Mental Health, Mental Retardation and Substance Abuse Services, to conduct a comprehensive assessment of the primary health care needs of persons with mental illness, mental retardation and substance abuse problems.

Patrons—Gartlan and Wampler; Delegates: Christian, DeBoer, Hall and Thomas

---

Referred to the Committee on Rules

WHEREAS, publicly-funded primary health care is beginning to be provided increasingly through health maintenance organizations and other managed care entities; and

WHEREAS, this raises serious questions about the adequacy of the primary health care services afforded persons with mental disabilities and substance abuse problems; and

WHEREAS, persons with mental disabilities and substance abuse problems experience increasing health care needs as they age, develop chronic medical conditions, or suffer exposure to infectious diseases; and

WHEREAS, in many cases, such consumers are unable to adequately self-report symptoms to health care workers and, in cases of aging consumers, have experienced the loss of family members who previously provided continuity of medical information; and

WHEREAS, turnover in personnel who provide health care continuity poses a problem, as does the proposed community integration of consumers; and

WHEREAS, in some cases, specialized personnel are needed to provide certain services to clients with mental disabilities, and there are many underserved areas of the Commonwealth; and

WHEREAS, shifts in the population's age distribution and the early onset of chronic health problems will have important implications for financing of health services; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Commissioner of the Virginia Department of Health, in cooperation with the Department of Mental Health, Mental Retardation and Substance Abuse Services, be requested to conduct a comprehensive assessment of the primary health care needs of persons with mental illness, mental retardation and substance abuse problems.

The Commissioner of Health and the Department of Mental Health, Mental Retardation and Substance Abuse Services shall complete their assessment in time to submit their findings and recommendations to the Governor and 1999 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

Official Use By Clerks			
Passed By The Senate		**Passed By The House of Delegates**	
without amendment	☐	without amendment	☐
with amendment	☐	with amendment	☐
substitute	☐	substitute	☐
substitute w/amdt	☐	substitute w/amdt	☐
Date: _____		Date: _____	
_____		_____	
Clerk of the Senate		Clerk of the House of Delegates	

986027700

SENATE JOINT RESOLUTION NO. 156

Offered January 26, 1998

Expressing the sense of the General Assembly on drug courts and the need for substance abuse services for offenders.

Patrons—Martin, Gartlan and Wampler; Delegates: Bloxom, Christian, Hall and Thomas

Referred to the Committee on Rules

WHEREAS, an estimated 60 to 85 percent of Virginia's criminal justice population has a substance abuse problem; and

WHEREAS, research shows that offenders who receive treatment and follow-up services for substance abuse problems are less likely to re-offend than those who do not receive treatment; and

WHEREAS, research also demonstrates that the effectiveness of treatment is undiminished when the criminal justice system coerces offenders into treatment prior to sentencing or as a post-conviction condition of probation and parole; and

WHEREAS, the number of drug commitments to Virginia's prisons continues to grow at alarming rates; and

WHEREAS, the current need for substance abuse services for offenders exceeds available resources; and

WHEREAS, the cost of treating offenders with substance abuse problems is less than half the cost of incarceration for one year; and

WHEREAS, in a recent study, the Virginia State Crime Commission recommended a system of identifying persons with substance abuse problems during the sentencing phase and integrating substance abuse treatment with criminal punishment; and

WHEREAS, the Virginia State Crime Commission also recommended funding for a drug court grant program to support the number of local courts which may be interested in establishing drug courts at either the general district, circuit, or juvenile court level; and

WHEREAS, the recidivism rate of persons participating in drug courts is substantially lower than the comparison groups; and

WHEREAS, a recent California Drug and Alcohol Treatment Assessment study indicated that the cost of treating offenders was a fraction of the cost of crime resulting from non-treatment, and that the level of criminal activity declined by two-thirds from pre-treatment to post-treatment; and

WHEREAS, there is a growing need for more local jail treatment programs, community residential treatment for juveniles and adults, and aftercare and transition services for offenders and their families to begin to meet the demand for these services and to reduce the cost of incarcerating substance abusing offenders in state prisons; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That it is the sense of the General Assembly that additional resources should be made available for substance abuse services for offenders and their families and that support should be provided to local efforts to establish drug courts; and, be it

RESOLVED FURTHER, That the Clerk of the Senate transmit copies of this resolution to the Commissioner of the Department of Mental Health, Mental Retardation and Substance Abuse Services, the Directors of the Departments of Corrections, Juvenile Justice, and Criminal Justice Services, and the Sentencing Commission in order that they may be apprised of the sense of the General Assembly in this matter.

986031700

SENATE JOINT RESOLUTION NO. 157

Offered January 26, 1998

Expressing the sense of the General Assembly on substance abuse prevention and the appropriate strategies for State agencies that have responsibility for prevention services in each locality in the Commonwealth.

Patrons—Martin, Gartlan and Wampler; Delegates: Bloxom, Christian, DeBoer, Hall and Thomas

---

Referred to the Committee on Rules

WHEREAS, many of Virginia's youths are at substantial risk of becoming involved in substance abuse and the related problem behaviors of teen pregnancy, crime, delinquency, violence, and school failure; and

WHEREAS, research demonstrates that youth problem behaviors are linked to specific, identifiable risk factors and can be prevented; and

WHEREAS, research also indicates that the most effective prevention strategies are those which are planned and developed through local collaborative efforts and are linked to measurable community risk factors; and

WHEREAS, many Virginia localities lack a coordinated plan for implementing and evaluating prevention programs, which often results in services that are fragmented and less cost-effective; and

WHEREAS, prevention often commands a low priority as increasing demands for treatment require increasing levels of funding and local governments lack an advisory group that can advise on the positive impact of prevention services; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That it is the sense of the General Assembly that (i) each locality in the Commonwealth should designate a local Prevention Advisory and Planning Group inclusive of all agencies receiving prevention funding, as well as civic and social groups, local businesses, the faith community, private human service agencies, parents, and youths; (ii) each local Prevention Advisory and Planning Group should develop, implement, and monitor a Comprehensive Community Prevention Plan, based on measurable community risk factors and designed to provide a continuum of prevention services for youths and families across agencies and community groups; and (iii) the use of State agency prevention funds in localities should be guided by, and actively support, the goals and objectives outlined in the Comprehensive Community Prevention Plan; and be it

RESOLVED FURTHER, That the General Assembly request state agencies that receive prevention funding and have responsibility for prevention services in localities to (i) participate on their community Prevention Advisory and Planning Group to ensure a comprehensive and collaborative approach to prevention programming, use of local prevention resources, and the development of an evaluation protocol based on measurable community risk factors and (ii) develop prevention plans that are consistent with, and a part of, the Comprehensive Community Prevention Plan, which provides a continuum of prevention services for youths and families across agencies and community groups; and be it

RESOLVED FINALLY, That the Clerk of the Senate transmit copies of this resolution to the Commissioner of Mental Health, Mental Retardation and Substance Abuse Services, the Commissioner of Health, the Superintendent of Public Instruction, and the Directors of the Departments of Corrections, Juvenile Justice, Social Services, and Motor Vehicles in order that they may be apprised of the sense of the General Assembly in this matter.

988999661

SENATE JOINT RESOLUTION NO. 158

Offered January 26, 1998

Requesting the Department of Mental Health, Mental Retardation and Substance Abuse Services and the Department of Rehabilitative Services to develop an action plan for the appropriate treatment of persons with brain injuries who also have mental illness.

Patrons—Martin, Gartlan and Wampler; Delegates: Bloxom, Christian, Hall and Thomas

Referred to the Committee on Rules

WHEREAS, each year approximately 10,000 Virginians are reported to the Brain Injury Central Registry; and

WHEREAS, of the total number of brain-injured individuals residing in the Commonwealth, there are 163 reported individuals within the mental health hospital system, and, of those, 74 reside at Western State Hospital; and

WHEREAS, a recent study at a Virginia adult detention center found that 23 of 100 inmates had sustained brain injuries of some sort; and

WHEREAS, individuals with brain injuries often have disrupted cognitive functioning and, as a result, the ability to understand and control behavior is diminished and interventions that attempt to correct behavior fail; and

WHEREAS, further, medications given for traditional psychiatric diagnoses may not be appropriate for people with brain injury, but alternative neuropharmacology applications may be effective if appropriately prescribed and supported; and

WHEREAS, an array of services, similar to those proposed for other mental health clients, could enable persons with brain injuries complicated by mental illness to return to the community and function independently; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Department of Mental Health, Mental Retardation and Substance Abuse Services and the Department of Rehabilitative Services develop an action plan for the appropriate treatment of persons with brain injuries who also have mental illness. The Department of Mental Health, Mental Retardation and Substance Abuse Services shall serve as lead agency and provide staff support for the study.

All agencies of the Commonwealth shall provide assistance to the Department of Mental Health, Mental Retardation and Substance Abuse Services and the Department of Rehabilitative Services for this study, upon request.

The Department of Mental Health, Mental Retardation and Substance Abuse Services and the Department of Rehabilitative Services shall complete their work in time to submit their findings and recommendations to the Governor and the 1999 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

Official Use By Clerks			
Passed By The Senate		**Passed By The House of Delegates**	
without amendment	☐	without amendment	☐
with amendment	☐	with amendment	☐
substitute	☐	substitute	☐
substitute w/amdt	☐	substitute w/amdt	☐
Date: _____		Date: _____	
_____		_____	
Clerk of the Senate		Clerk of the House of Delegates	

988998661

SENATE JOINT RESOLUTION NO. 159

Offered January 26, 1998

Requesting the Secretaries of Administration, Commerce and Trade, and Health and Human Resources to study the feasibility of creating a residential alternatives capital fund to address the housing needs of persons with mental disabilities and substance abuse problems.

Patrons—Wampler; Delegates: Bloxom, Hall and Thomas

Referred to the Committee on Rules

WHEREAS, the Comprehensive State Plan for 1998-2004, as developed by the Department of Mental Health, Mental Retardation and Substance Abuse Services and the community services boards (CSB), indicates that over 11,700 individuals are on CSB waiting lists for residential services or are known by name as people who need housing; and

WHEREAS, there may be others who need housing who are not currently receiving CSB services or who have not attempted to access those services; and

WHEREAS, housing is critical to the current plans and goals to release from institutions those individuals who are identified as ready and willing to go to community programs, as well as to maintain those who are eligible for community programs; and

WHEREAS, in addition to adult care residences, Virginia has relied in large part on federal HUD resources to develop special-needs housing; and

WHEREAS, renewals of existing Section 8 (rental assistance) projects will consume most of HUD's budget over the next five years and the HUD 811 (housing for people with disabilities) program is dwindling; and

WHEREAS, Virginia needs to address these immediate housing shortage problems, as well as plan for housing thousands of people who currently need housing, are now living with aging caregivers, or will be discharged as state facilities are downsized; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Secretaries of Administration, Commerce and Trade, and Health and Human Resources be requested to study the feasibility of creating a residential alternatives capital fund to address the housing needs of persons with mental disabilities and substance abuse problems.

The Secretaries shall complete their study and make their recommendations to the Senate Finance and House Appropriations Committees prior to the 1999 Session of the General Assembly.

Official Use By Clerks

Passed By The Senate		Passed By The House of Delegates	
without amendment	☐	without amendment	☐
with amendment	☐	with amendment	☐
substitute	☐	substitute	☐
substitute w/amdt	☐	substitute w/amdt	☐

Date: _____ Date: _____

Clerk of the Senate | Clerk of the House of Delegates

Appendix 4

Issue Brief: Restructuring Medicaid Financing of Publicly-Supported Mental Health, Mental Retardation and Substance Abuse Services

The Joint Subcommittee Studying the Future Delivery of Publicly Funded Mental Health, Mental Retardation and Substance Abuse Services

General Assembly
Commonwealth of Virginia

"Issue Brief: Restructuring Medicaid Financing of Publicly-Supported Mental Health, Mental Retardation, and Substance Abuse Services Recommendations of the HJR 240 Joint Subcommittee"

FINAL DRAFT

As Amended
December 17, 1997

Introduction

- As the Department of Medical Assistance Services (DMAS) moves the Medical Assistance Program into a managed care environment through Medallion II, the effects of this decision on mental health, mental retardation, and substance abuse services and on the individuals receiving those services have attracted considerable interest.

- The first phase of this move, in Tidewater, included mental health (MH) Clinic services (e.g., outpatient therapy and medication management) and psychiatric inpatient hospitalization services in capitated contracts negotiated with health maintenance organizations (HMOs). This continues and, in some instances (e.g., MH Clinic services), exacerbates fragmentation of service delivery, making it more difficult for consumers and their families to obtain needed services that are coordinated and integrated. State mental health and mental retardation facility services, mental retardation (MR) home and community-based waiver services, community MR intermediate care facilities, and State Plan Option services were excluded from those contracts. These services continue to be reimbursed on a fee for service or prospective payment and cost settlement basis. The proposal for implementing Medallion II in Northern Virginia includes psychiatric inpatient hospitalization in the capitated contracts, but it excludes MH Clinic services along with the services excluded in the Tidewater contracts.

- Different states have selected a variety of solutions to the question of how best to fund, administer, and deliver mental health, mental retardation, and substance abuse services financed by Medicaid. One approach involves ***carving out*** all of these services from any managed care contracts negotiated with HMOs or other networks of physical health care service providers. That approach is the basis of the following recommendations.

- Since the Joint Subcommittee issued the first draft of this paper, significant concerns have been identified regarding highly variable cost information and inconsistencies in data provided by community services boards (CSBs). For example, these concerns have been documented by the Cost Analysis and Rate Review of Community Mental Health and Mental Retardation Services Covered by the Medicaid Program, presented to the General Assembly in September. Analysis of CSB-specific data reveals cost variances that are difficult to explain. This situation raises concerns about the ability and capacity of the CSB system to deliver the degree of reliable and consistent financial, consumer, and service data and accountability that are required by the recommendations that follow. Therefore, implementation of all subcontracting or carve-out recommendations,

but not the match replacement recommendations, should be deferred until Fiscal Year 2000, so that these concerns can be addressed and satisfactorily resolved, as determined by the DMAS and the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS).

Proposed DMAS-DMHMRSAS Structural Relationship

1. **Services:** The Department of Medical Assistance Services (DMAS) should contract (carve-out) the administration of Medicaid-covered mental health, mental retardation, and substance abuse (MH, MR, and SA) services to the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS).

   - The DMHMRSAS should administer and manage the provision of medically necessary MH, MR, and SA services to enrolled recipients who meet applicable service-specific eligibility criteria (e.g., a diagnosis of serious mental illness).

   - These medically-necessary MH, MR, and SA services should be excluded from any managed care contracts for the delivery of physical health services that the DMAS negotiates with HMOs, managed care organizations (MCOs), or other organized provider networks.

   - The DMAS must continue to be the **single state agency** for purposes of dealing with the federal Health Care Financing Administration (HCFA).

   - The DMHMRSAS shall be the **responsible state authority** for the delivery and financing of Medicaid-covered MH, MR, and SA services.

   - Medicaid-covered mental health, mental retardation, and substance abuse services are: MH Clinic Option services (outpatient therapy and counseling, medication management); MH, MR, and SA State Plan Option services; acute care mental health (inpatient psychiatric) services; MR Home and Community-based Waiver services; MR community ICF/MR services; ~~and~~ services in Medicaid-certified state-operated mental health facilities and mental retardation training centers; and mental health, mental retardation, and substance abuse services covered under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program.

- Atypical psychotropic medications should remain in the Medallion II program, rather than being carved out with covered mental health services. This would avoid administratively burdensome alternatives such as a mandatory formulary for Medallion II contractors. However, to insure that atypical medications are accessible by individuals who need them, DMAS contracts with Medallion II contractors should delineate a clear requirement that atypical psychotropic medications must be provided to enrollees who meet specific clinical and diagnostic criteria. These criteria should be developed jointly by the DMAS and the DMHMRSAS, with significant participation and involvement by consumers and family members.

  Given the relatively small number of enrollees involved, receipt of atypical psychotropic medications should be preauthorized and periodically reviewed. Medallion II contracts must also include specific, consumer-friendly appeals procedures to use in the event that provision of atypical medications is denied. Appropriate access to atypical medications needed by enrollees who meet these clinical and diagnostic criteria would be assessed through consumer satisfaction surveys conducted as part of the CSB Performance and Outcome Measurement System (POMS).

2. **Agency Roles and Responsibilities:** The two Departments should have the following roles and responsibilities.

   - The DMAS should:

     - continue to function as the **single state agency** in relation to the HCFA;
     - operate the claims payment system; and
     - hear final appeals of client and provider complaints and grievances.

   - As the single state agency for Medicaid, the DMAS must be the final arbiter on the content of state Medicaid regulations and the State Medical Assistance Plan. However, the DMAS should develop the regulations and state plan in close collaboration and consultation with the DMHMRSAS and consumers and family members.

   - The DMHMRSAS should function essentially as the Commonwealth's care and resources manager for all public and private Medicaid-financed mental health, mental retardation, and substance abuse services. The DMHMRSAS should contract for administrative services or employ additional staff to:

- ❒ enroll and disenroll all public and private providers;
- ❒ preauthorize (where appropriate) services by reviewing proposed individual plans of care for enrolled recipients who meet service eligibility and medical necessity criteria and authorizing specific types and amounts of services;
- ❒ conduct utilization reviews of covered MH, MR, and SA services;
- ❒ conduct look-behind surveys and random audits of local care managers and providers;
- ❒ monitor the subcontracted administration of Medicaid, including preauthorization and utilization review activities;
- ❒ develop, implement, and maintain necessary information technology supports (e.g., management information systems) at the local and state levels;
- ❒ conduct or review financial and data audits of all enrolled providers;
- ❒ establish mechanisms to handle client and provider complaints and grievances;
- ❒ develop comprehensive, long-range, statewide plans for covered services, identifying projected needs and demands for those services; and
- ❒ develop and submit budget requests for resources to address growth in service demand and any expanded services.

3. **Financing:** The current way in which matching funds are identified and provided for State Plan Option and MR Waiver services poses a major impediment to opening these services up to more competition and greater private provider participation and it also limits recipient choices of providers.

   - ❍ Match for all Medicaid-covered MH, MR, and SA services should be handled in the same way as match for other Medicaid services. It should be appropriated by the General Assembly as a separate item, rather than being converted from existing appropriations (now done with all SPO and many MR Waiver services).

   - ❍ Given the amount of matching funds for these two programs, appropriating the match separately should be phased in over four years. As the match is replaced by these new appropriations, the resulting freed-up state general funds should be earmarked to provide services for specific individuals in priority populations. Thus, as the existing match, which was transferred from the DMHMRSAS appropriation for community services boards (CSBs), is replaced with new state general funds, those new funds should be used to provide individualized packages of services

and supports to persons in priority populations who are not covered by Medicaid. The use of these new funds should be focused and monitored through appropriate managed care technologies, such as preauthorization and utilization review and management of individual plans of care.

- Match replacement should be phased in by type of service. For example, all of the match for psychosocial rehabilitation might be replaced in the first year. As the match for each service is replaced, private agencies, which may now be providing the service under contract to community services boards and receiving fee payments from the boards that are less than their costs or the amounts billed to the DMAS, could begin billing the DMAS directly, relieving the CSB of the administrative burden of billing for these services, and receiving the full fee.

- The DMHMRSAS, rather than the DMAS, should request matching funds as part of its routine budget submissions once subcontracting its part of the Medical Assistance Plan is transferred.

- Financing arrangements for covered MH, MR, and SA services should contain a medical cost inflator component, similar to that applied to other types of Medicaid providers, to accommodate predictable increases in such settings.

4. **Provider System:** The provider system for carved-out Medicaid-covered mental health, mental retardation, and substance abuse services should include the community services boards, private providers, and state mental health facilities and training centers.

   - CSBs should be responsible for preparing and managing individual plans of care for Medicaid-enrolled individuals who are seeking covered mental health, mental retardation, and substance abuse services. CSBs should submit these plans of care to the DMHMRSAS for review and approval, including authorizing the provision of specific services and payments. Plans of care should clearly document that clients have been afforded the opportunity to choose among available, qualified local service providers.

   - CSBs, through their Medicaid-funded case management services provided to Medicaid-enrolled individuals, should also be responsible for assuring appropriate access to needed physical health care services, which should be identified in the plans of care, but only for information purposes, for these individuals. Appropriate access to needed physical health care services would be assessed through consumer satisfaction

surveys conducted as part of the CSB Performance and Outcome Measurement System (POMS).

- Through this case management/care coordination function, CSBs should be responsible for managing and ensuring the appropriate use of state-operated and locally-run inpatient mental health and mental retardation facilities.

- While community services boards would be the local managers of access to care, CSBs should not have a monopoly on direct service provision. The appropriate paradigm is the MR Home and Community-Based Waiver. While CSBs have the responsibility to coordinate provision and receipt of services, they do not have a monopoly on serving enrolled individuals. In fact, one of the requirements of the Waiver is that clients must be afforded the opportunity to choose among local service providers, and this must be documented in the consumer's record.

- The role of state mental health and mental retardation facilities in this provider system may be affected by the State Mental Health and Mental Retardation System and Facility Master Plan, requested by the HJR 240 Joint Subcommittee. This Master Plan will determine the projected future needs for state facility beds over the next three biennia. This plan will be completed by December, 1998.

- Once subcontracting and financing arrangements described in previous sections are in place, any Medicaid-covered MH, MR, or SA service should be able to be provided by any qualified CSB, other public agency, or private provider.

5. **Accountability:** The CSBs and the DMHMRSAS should continue the shift initiated by the DMAS to convert the service delivery system to some form of managed care in order to restrain the growth in Medicaid expenditures while enhancing the quality, accessibility, and scope of Medicaid-funded mental health, mental retardation, and substance abuse services.

- Once they gain experience from the performance and outcomes measurement and priority populations and case rate pilot projects, the CSBs and the DMHMRSAS should explore converting current funding arrangements for State Plan Option and MR Waiver services to some form of payment mechanism other than fee for service within the overall framework of subcontracted Medicaid administration.
- The rationale for converting Medicaid to managed care through the

Medallion II program included controlling the growth of Medicaid expenditures while maintaining or enhancing the quality and accessibility of those services. The DMHMRSAS and the CSBs, as the local managers of mental health, mental retardation, and substance abuse services for Medicaid enrollees, should hold the risk for producing such cost savings. This should be part of the formal contract between the DMAS and the DMHMRSAS and part of the subcontracts (the CSB Performance Contracts) between the DMHMRSAS and individual CSBs. This risk could be phased in over several years, and CSBs could use their balances of unexpended revenues as contingency funds to cover the risk.

- Recent experience with the Comprehensive State Plan and the Medicaid rate survey point to the need for greater consistency, uniformity, and comparability in the data and information on all community services, including local inpatient services. The DMHMRSAS, DMAS, and CSBs should identify mechanisms to increase the consistency, uniformity, and face validity of community services, such as standardized cost accounting systems and client information data bases.

- As a condition of subcontracting the administration of Medicaid coverage for mental health, mental retardation, and substance abuse services to the DMHMRSAS, the Department and the CSBs must use a standardized cost accounting system and a common consumer information data base, both of which must be able to communicate easily and directly with those systems used by the DMAS.

6. **Consumer Issues:**

- The CSB Performance Contract requires CSBs and the Department to identify, design, and implement local, sub-regional, or regional dispute resolution mechanisms that enable clients or family members of clients to raise and resolve concerns, issues, or disagreements about services without adversely affecting their access to or receipt of appropriate types and amounts of services.

- Existing grievance and appeals mechanisms now in place under the DMAS should remain in place.

Appendix 5

Listing of HJR 240 Joint Subcommittee Recommendations

	Listing of HJR 240 Joint Subcommittee Recommendations Recommendation
1	The Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS), Community Services Boards (CSBs), and state facilities should increase the involvement and participation of consumers and family members in policy and decision-making; service development, operation, and evaluation; and decisions about their treatment, habilitation, and recovery. The "best practice" strategies being developed through the Consumer and Family Involvement Pilot Projects of the Department should be used to form future policies, directives, and actions of the State Board, DMHMRSAS, CSBs, other providers, and local governments.
2	The DMHMRSAS should work with the CSBs to expand the pool of service providers through incentives to private providers and by creating opportunities for consumers and family members to provide services.
3	The DMHMRSAS should ensure that performance measures included in the performance contracts for both state facilities and CSBs include consumer satisfaction indicators. These indicators should reflect the range and variety of services offered by providers and the consumer's perception of his or her ability to choose among appropriate and desirable local service providers.
4	The DMHMRSAS, CSBs, and state facilities should develop and implement easy-to-use instruments to assess consumer and family member satisfaction and disseminate reports presenting the results of such surveys.
5	The DMHMRSAS and the CSBs should develop and implement consumer dispute resolution mechanisms that enable consumers and family members to raise and resolve with DMHMRSAS (including facilities) and CSBs concerns, issues, or disagreements about services without adversely affecting their access to or receipt of appropriate levels and amounts of current or future services from DMHMRSAS or CSBs.
6	An education and advocacy network for the prevention and treatment of substance abuse should be created. This organization would educate the public and provide expertise for state and local policy development.
7	To ensure that issues of concern to local governments are resolved at the highest policy level, one member of the State Board should be an elected local government official.

8	Legislation on priority populations should not be enacted this year. However, the State Board should use the results of the pilot projects on Priority Populations to begin the development of policies that define priority populations. The State Board should involve the Department, CSBs, Virginia Hospital and Healthcare Association, Virginia Network of Private Providers, and consumer and advocacy groups in the development of these policies.
9	The State Board should provide oversight for the development and implementation of the Comprehensive State Plan.
10	The DMHMRSAS should establish statewide standards in areas of consumer access to services, outreach to consumers and families, service quality, consumer grievances and appeals, and consumer satisfaction. The Department should establish mechanisms for dealing with providers, including CSBs and state facilities, who do not comply with these standards.
11	The DMHMRSAS should be authorized to contract with other public agencies and with private non-profit or for-profit organizations for local services when a CSB, after remediation efforts have proven to be unsuccessful, remains in substantial non-compliance with its performance contract or when the CSB fails to serve certain populations.
12	The DMHMRSAS should establish a dispute resolution mechanism for private providers that contract with CSBs or state facilities to use if these providers cannot achieve a satisfactory resolution of issues, concerns, or problems with a CSB or state facility.
13	The DMHMRSAS should develop more sophisticated management oversight systems (e.g., management information systems, utilization review staff and processes, quality assurance, and consumer involvement mechanisms) and require adherence to these management practices through an enhanced Performance Contract with each CSB.
14	The DMHMRSAS, with input from CSBs, consumer and family groups, private providers, and local government representatives, should develop and implement an adult state psychiatric bed day allocation system through the CSB performance contract. This system should identify specific bed utilization targets for each CSB and include financial incentives or disincentives which should be applied through the CSB performance contracting mechanism.
15	The DMHMRSAS should obtain the assistance of knowledgeable and experienced professional consultants, well versed in public mental health and mental retardation facility census management, as it develops this bed utilization target mechanism.

16	The DMHMRSAS should implement strategies and procedures that are intended to increase services access, effectiveness, and choice through competition and other practices that foster competition. Such practices include contract negotiation, publication and dissemination of report cards, outcome and performance measures, and consumer satisfaction surveys. These practices will help to mediate potential role conflicts. Actual or perceived conflicts of interests should be addressed by identifying and correcting deficiencies in consumer choice and satisfaction through contracting mechanisms. Provider performance measures and consumer satisfaction indicators should be used to evaluate the degree to which a CSB has addressed these dual function concerns.
17	The DMHMRSAS should complete the pilot projects on Priority Populations and recommend to the Governor and General Assembly, by December 1, 1999, legislation to implement priority populations. The draft legislation of the joint subcommittee should serve as the basis for the Department's review and recommendations.
18	The DMHMRSAS should be required to develop and update a Comprehensive State Plan on a biennial basis. Before the next biennial update of the Comprehensive State Plan in 1999, the DMHMRSAS, with input from CSBs, state facilities, consumers and family members, advocacy groups, and local governments, should develop an easily applied, consistent, and quantifiable methodology to document the unmet needs for services. This methodology should clearly define what is included in the calculation of unmet needs and to which populations that methodology will be applied. The results of this methodology should be verifiable, at least on a sample basis.
19	The DMHMRSAS should re-establish a separate Office of Substance Abuse Services to strengthen leadership and system planning.
20	The DMHMRSAS should re-establish the Office of Prevention Services within the Department to provide leadership in planning, implementing, and evaluating prevention programs.

21	The DMHMRSAS should develop a Community and Facility Master Plan by December 1, 1998. The Community and Facility Master Plan should utilize nationally recognized private sector consultants to determine the future number of individuals that can be served in the communities, resources needed to provide appropriate community capacity, the numbers of individuals that will continue to require facility care, the optimum size, and location of facilities. The DMHMRSAS should ensure that representatives of consumers, families and advocacy groups participate in development of this Plan. Options for staff transition, economic impact on localities, and potential alternative uses for state facilities should be included in the final report. In addition, the master plan should determine the feasibility of utilizing other operating models for state facilities, such as operation of a facility or a specialized program area by a private contractor. As specific plans for downsizing or changing the use of facilities are formulated, the Department should work with the Virginia Municipal League and the Virginia Association of Counties to ensure that those local governments that will be most affected will be consulted and included in the formulation and implementation of any plans regarding state facilities.
22	The DMHMRSAS, with input from state facilities and CSBs, should examine and, where necessary, revise state facility catchment areas. This study should identify any proposed changes or realignments in facility catchment areas needed to improve CSB and state facility coordination, increase appropriate consumer access to state facility services nearer to home communities, and enhance predischarge planning and the best community placements for patients and residents in state facilities.
23	Given the current variability in admission and discharge criteria and protocols across state facilities, the DMHMRSAS, with input from facility directors and staff, CSBs, consumers and family members, and advocacy groups, should develop consistent and, where applicable, uniform clinical protocols for admission to and discharge from its facilities. The DMHMRSAS should seek consultation in the development of these protocols from managed care organizations or administrative services-only organizations that are experienced in the management of public mental health services.
24	Whenever possible, acute short-term psychiatric inpatient services should be provided in the community by private hospitals, which can receive Medicaid funding for this service. Local inpatient care for individuals who are not enrolled in Medicaid should be supported to the extent possible by state general funds allocated to the CSBs.
25	The DMHMRSAS, in consultation with state facility directors, should develop and implement a consistent, uniform methodology for determining the actual numbers of beds funded at and operated by each state facility. These figures should become the official capacity figures for the state facility system for planning, costing, and census management purposes.

26	The DMHMRSAS should develop and include options for state facility staff in any future planning regarding state mental health and mental retardation facilities. Among the options that should be considered are: • reasonable access to and priority for community services positions for which they are qualified by their training and experience; • access to a reasonable relocation package; • access to training; and • access to a reasonable severance packages, based on years of employment by the state.
27	CSBs that are actual departments of a city or county government should be distinguished from CSBs that function as autonomous operating boards.
28	Local governments should have flexibility to establish either a local government department with a policy-making board or an operating board. An operating board should function relatively independently of the local governments that created it.
29	CSBs should be local care coordinators and not the primary or only providers of services. Where this is not possible, the CSB, with the Department's authorization, may be the primary provider of services.
30	One-third of the appointments to CSBs shall be consumers or family members of consumers and at all times at least one member must be a consumer. Consumers and family members must be identified.
31	Local governments should be permitted but not required to appoint to the CSB no more than two elected or appointed local government officials from any city or county belonging to the CSB, one of whom may be a sheriff, when practical. Private providers may also be appointed to the board.
32	For CSBs that are not actual city or county government departments (operating CSBs), the DMHMRSAS should participate in the recruitment and approve the selection of the executive director before a final offer of employment has been made.
33	For operating CSBs, executive directors should be employed under contracts with clearly defined performance expectations. The DMHMRSAS should review and approve these employment contracts.
34	For operating CSBs, the compensation packages for executive directors and senior management staff (e.g., mental health, mental retardation, and substance abuse directors) should be reviewed and approved by the DMHMRSAS.
35	The CSBs' responsibilities for arranging discharge from state facilities should be clarified. CSB staff who prescreen individuals for temporary detention and commitment should be certified by the DMHMRSAS.

36	CSBs should contract with private providers for any service which can be provided effectively and at a reasonable cost.
37	CSBs should be contractually responsible for the effective and efficient use of all state-controlled funds. This should occur through the management of funding allocations from the DMHMRSAS for individualized packages of services and supports and for general access services, such as emergency services, that will be available to any resident of the community, and through the management of state facility resources (bed days) allocated to CSBs through mechanisms such as bed utilization targets.
38	Managed care practices such as pre-authorization, utilization review, consumer satisfaction surveys, and report cards should be integrated into CSB management practices and monitored by the DMHMRSAS through an enhanced performance contract.
39	The DMHMRSAS, with input from state facilities and CSBs, should examine the needs and opportunities for regional cooperation, existing models, and proposals for enhancing regional cooperation. The DMHMRSAS study should identify models that could be used when regional responses to an issue or situation are needed.
40	The DMHMRSAS, with input from CSBs and representatives of private providers, such as the Virginia Hospital and Healthcare Association, Virginia Association of Health Maintenance Organizations, and Virginia Network of Private Providers, should develop specific proposals and strategies for increasing the provision of community services, especially local acute psychiatric inpatient services, by private providers across the state.
41	The State Board and the DMHMRSAS should continue and expand efforts to involve and increase the participation of private providers in policy development, planning, service delivery, and oversight and evaluation activities.
42	The DMHMRSAS should continue to explore and, where feasible and desirable, institute or expand the provision of services by private providers at its state facilities. Such initiatives should be carefully developed, with close attention devoted to economic efficiency, effectiveness, service quality, and continuity of care criteria in making the decision of whether to contract services.
43	The DMHMRSAS should establish an informal forum of representatives from the institutions of higher education, CSBs, state facilities, and consumer and family advocacy groups to examine current and possible future roles for the academic community in the publicly funded mental health, mental retardation, and substance abuse services system. This forum should produce a report to the Commissioner that defines the appropriate roles for colleges and universities in the publicly funded services system. The report should also present proposals for expanding linkages between the academic community and the state facilities and CSBs, particularly for the disciplines and specialties mentioned.

44	The current CSB performance contract and report mechanism should be expanded and refined by adding a focus on provider performance and consumer outcomes by July 1, 1999. These include service accessibility, quality, and appropriateness standards; inter-system performance measures; and requirements for consumer and family member participation in policy development and service planning, delivery, and evaluation. Additionally, a mechanism to measure and report on consumer satisfaction should be added to the contract mechanism.
45	The CSB performance contracts should be voted on by each local governing body involved in the CSB.
46	The DMHMRSAS should negotiate annual performance contracts with each state facility, similar to the performance contracts between CSBs and the Department.
47	Once POMS has been successfully piloted, revised, and implemented statewide, appropriate and relevant measures from it should be included in the CSB and state facility performance contracts and reports. Changes in POMS should be based on the results of the POMS pilots.
48	The DMHMRSAS should explore the development and implementation of approaches to reward superior performance and deal with poor performance for inclusion in CSB and state facility performance contracts.
49	The DMHMRSAS, the Department of Medical Assistance Services, and the CSBs should identify mechanisms to increase the consistency, uniformity, and validity of community services information, including standardized cost accounting systems and client information data bases.
50	The DMHMRSAS and the CSBs should jointly develop an implementation plan that describe statewide costs on a phased, multi-year basis for the full implementation of POMS and the information systems required to support it. The DMHMRSAS should report to the Governor and General Assembly prior to the 2000 Session of the General Assembly on the status of and resources required for fully implementing POMS.
51	The State Board should ensure the consolidation of all existing human rights regulations governing facilities, CSBs, and private programs into one comprehensive regulatory framework as soon as possible. Once implemented, the DMHMRSAS should review these regulations regularly to assess their adequacy in affording human rights protections.
52	The human rights program in state facilities should be strengthened and expanded to assure adequate availability, accessibility, rights protections, and resources. The DMHMRSAS should redistribute facility advocates in proportion to facility censuses so that each consumer has equal access to an advocate.
53	The DMHMRSAS should study the adequacy of advocate positions in the state facilities and request additional resources in the next budget cycle, if needed, to assure that each consumer has sufficient access to an advocate.

54	The DMHMRSAS should remove immediately all potential for influence on human rights advocates by the state mental health and mental retardation facilities. All advocate and advocate support positions should be supported by the DMHMRSAS Central Office maximum employment level (MEL) positions and budget.
55	The DMHMRSAS should require facility directors to provide adequate office space, equipment, and supplies to support all day-to-day operations of the advocates within their facilities. The DMHMRSAS should ensure that state facility directors and staff play no role in the recruitment, hiring, supervision, or training of the advocates.
56	The State Board should revise the human rights regulations to prohibit the practice of facility directors serving as authorized representatives for medical and treatment decisions for patients and residents in state facilities.
57	The DMHMRSAS should arrange for training in the areas of mental disabilities and human rights for judges who hear cases involving consent to medical and psychiatric treatment decisions.
58	Decisions other than medical and treatment decisions (e.g., consent to release of records or participation in an outside activity) can continue to be made by facility directors, but only with adequate, consistent, and formal oversight by local human rights committees, and only when there is no alternative.
59	The human rights regulations should be revised to prohibit the use of seclusion and restraint for behavior modification purposes; place clear limitations on the use of seclusion and restraint for any other purpose; provide for adequate monitoring of each use of seclusion and restraint; and require that the DMHMRSAS develop, implement, and enforce a system-wide policy governing the use of seclusion and restraint.
60	The DMHMRSAS should study the adequacy of advocate positions in CSBs and request additional resources in the next budget cycle, if needed, to assure that consumers in CSB and other community programs have sufficient and equal access to advocates regardless of the location of the program in which they are receiving services.
61	The DMHMRSAS should be authorized to sanction programs for non-compliance with the human rights regulations. Mechanisms should include funds withdrawal, fines, and/or penalties. The DMHMRSAS should regularly monitor and enforce the human rights regulations in all public and private mental health, mental retardation, and substance abuse programs.
62	The practice of allowing CSBs and private providers to nominate persons for appointment to the Local Human Rights Committees that oversee the CSBs should be prohibited. Nominations to local human rights committees should be made through the advocates directly to the State Office of Human Rights.

63	The State Board should revise the human rights regulations to require CSBs and private programs to publicize, at least annually, information about the existence and purpose of the human rights program. CSBs should actively encourage interested citizens to contact the regional advocate for potential appointment to Local Human Rights Committees whenever there is a vacancy.
64	The DMHMRSAS and the State Human Rights Committee should implement a procedure to ensure inclusion of adequate consumer and family representation on all Local Human Rights Committees.
65	The human rights regulations should be revised to require consolidation of CSB, private provider, and facility Local Human Rights Committees into regional committees wherever appropriate and feasible, in order to strengthen membership, assist in recruitment, and promote consistency in decision-making. The DMHMRSAS should provide training to Local Human Rights Committees at least annually and should reimburse expenses incurred in carrying out their duties in accordance with state travel regulations.
66	The DMHMRSAS should provide statewide educational seminars on an annual basis for Local Human Rights Committee members and any other interested persons, on a cost basis for participants if funding is not otherwise available.
67	The DMHMRSAS should conduct a thorough review and revision of the current Departmental Instruction on reporting and investigating allegations of abuse, redouble efforts to require all facilities to abide strictly by the terms of the statewide policy, prohibit the development of alternative facility policies, and monitor and affirmatively enforce the statewide policy. Minimally, the statewide policy should provide that investigations into all allegations of abuse and neglect be conducted by highly trained and skilled neutral investigators who have no interest in the outcome of the investigation. The policy should be regularly reviewed and revised to assure its maximum effectiveness.
68	CSBs and private programs should be required to develop policies governing prevention, detection, reporting, and suspension of employees and investigation and follow up on all allegations of abuse or neglect, with such policies subject to the review and approval of the DMHMRSAS Commissioner. CSBs and private programs should be required to report to the DMHMRSAS Office of Human Rights all allegations of abuse or neglect.
69	All programs providing services to persons with mental disabilities should be authorized statutorily to access information about potential employees' criminal convictions of violent crimes or past abusive acts in other programs and to provide such information concerning their own employees. A central registry should be established. Immunity should be provided for program personnel who share information about current or past employees. The DMHMRSAS should examine the availability and utility of other mechanisms to assist in screening out potential employees who are likely to abuse consumers.

70	The DMHMRSAS should study the issues involved in the employee grievance procedure to develop solutions for prohibiting the reinstatement to work of facility employees who are terminated for acts of abuse or neglect.
71	The DMHMRSAS should assure that adequate human rights oversight mechanisms are built into any managed care system, including clearly articulated and enforced human rights standards, immediate advocate access, and an effective appeals mechanism for handling complaints from denials of care or treatment.
72	The DMHMRSAS should develop and implement statewide standards of care for the state facilities and for CSB programs.
73	The DMHMRSAS should design and implement a modern, reliable, current, and effective data collection system for human rights information.
74	The DMHMRSAS should provide the resources necessary to provide appropriate oversight of the internal human rights program.
75	The State Board, State Human Rights Committee, the Commissioner, and the State Human Rights Director should make a continuous effort to review and assess the effectiveness of the internal human rights system and make improvements where needed. Interaction and communication among these entities should increase.
76	The most effective structure and location for an external human rights protection system in Virginia should be studied. The study should explore whether an external system located within the executive branch of state government can adequately protect consumers and whether placement in the judicial branch of government would better serve consumers. The DMHMRSAS, the State Board, DRVD, the PAIMI Council, the Board for People with Disabilities, the Supreme Court, and representatives from consumer and advocacy groups, CSBs, and private providers should be included in the study.
77	The current practice of providing Medicaid SPO and Waiver match through transfers from CSB appropriations should be ended. Match funds should be appropriated in the DMAS budget, as is the case for all other health care providers in the Commonwealth.
78	State general funds currently being used by CSBs to match Medicaid dollars should be restored to the CSBs to provide individualized packages of services and supports to people who have been identified as ready for discharge from state facilities or who are on waiting lists in communities.
79	The DMHMRSAS should identify those CSBs that have not converted and expanded Medicaid Services. The performance contract and future level of state funding to CSBs should be adjusted to reflect, to the extent possible, a comparable degree of effort to convert existing services to Medicaid and to expand Medicaid-funded services.

80	The DMHMRSAS and DMAS should continue to review and expand Medicaid covered services for mental health, mental retardation, and substance abuse services as a budget and service policy to insure the maximum use of federal funds available for individuals eligible for Medicaid.
81	The DMHMRSAS should develop and implement a funding mechanism that reallocates a reasonable proportion of resources saved through state facility bed reductions to CSBs where patients or residents will return and incorporates managed care utilization review and management practices, provided the facility meets appropriate standards of quality.
82	The Secretary of Health and Human Resources, DMHMRSAS, and DMAS should present recommendations prior to the 2001 Session of the General Assembly on implementation of the carve-out which would be effective July 1, 2001.
83	The Department of Social Services (DSS) and the DMHMRSAS should develop pilot projects in areas that have high concentrations of ACRs. The pilot projects should determine and provide the appropriate treatment and supports for persons with mental illness, mental retardation, or substance abuse problems who reside in ACRs. The DSS and DMHMRSAS should submit a report to the House Appropriations and Senate Finance Committees on the pilot projects prior to the 1999 Session of the General Assembly.
84	The Secretaries of Administration, Commerce and Trade, and Health and Human Resources should study the feasibility of creating a residential alternatives capital fund to address the housing needs of persons with mental disabilities and substance abuse problems. The Secretaries should complete their study and report to the House Appropriations and Senate Finance Committees prior to the 1999 Session of the General Assembly.
85	The Department of Health, in cooperation with DMHMRSAS, should conduct a comprehensive assessment of the primary health care needs of persons with mental illness, mental retardation, or substance abuse problems. The assessment should include a review of patients and residents in state facilities and persons served by community services boards. The needs assessment should be presented to the Governor and General Assembly prior to the 1999 Session of the General Assembly.
86	As part of a comprehensive long-range plan for addressing the increasing aging population, the DMHMRSAS and DMAS should explore the feasibility of providing a supplement to private nursing homes and other alternatives to expand community-based services for elderly individuals with mental disabilities. This plan should be presented to the Governor and General Assembly prior to the 1999 Session of the General Assembly.
87	Atypical antipsychotic medications should be the first line of treatment for persons with serious mental illness in state facilities and community programs.
88	The DMAS should be directed to mandate the availability of atypical antipsychotic medications on all formularies used by Medicaid managed care companies (e.g., HMOs) in Virginia.

89	The DMHMRSAS and the CSBs should establish intensive and assertive community treatment teams in communities with the highest usage of state mental health facility beds per 100,000 population. The DMHMRSAS should establish targets to reduce state facility bed utilization as these teams become operational.
90	In a managed care environment, the DMHMRSAS, DMAS, and CSBs should ensure that psycho-social rehabilitation services continue to be available for consumers.
91	The Department of Rehabilitative Services and the DMHMRSAS should work together to address the employment needs of persons with serious mental illness and report their recommendations to the 1999 Session of the General Assembly.
92	The DMHMRSAS and the Department of Rehabilitative Services should develop a plan for the appropriate treatment of persons with acquired brain injuries who receive treatment in the publicly funded mental health system and present it to the 1999 Session of the General Assembly.
93	The DMHMRSAS should enhance and better coordinate facility and community services for persons who deaf or deaf and blind and have mental disorders. The special unit for the deaf and deaf-blind at Western State Hospital should not be included in plans for downsizing.
94	The State Board and DMHMRSAS should ensure that the service needs of children with or at risk of severe emotional disturbance are a primary consideration in the development and implementation of priority populations.
95	The Health Department should continue to be responsible for primary prevention strategies that target mental retardation. These activities should occur in collaboration with CSB efforts that address primary prevention activities related to alcohol and substance abuse. In addition, the Health Department should be responsible for developing and monitoring specific goals, strategies, and outcomes addressing the prevention of mental retardation in collaboration with the local coordinating councils for prevention.
96	A new plan for early intervention services should be developed by the Virginia Interagency Coordinating Council and the Local Interagency Coordinating Councils. It should emphasize more aggressive outreach efforts to identify more unserved infants and toddlers, and it should include expanded state support, and increased use of Medicaid as a funding source.
97	The DMHMRSAS, DMAS, and CSBs should maximize Medicaid funding for mental retardation services. A target should be an amount equivalent to at least 75 percent of the current state general funds which support community mental retardation services being used as Medicaid match.
98	The DMAS, DMHMRSAS, and the mental retardation field should work together to develop a more inclusive Waiver that reimburses flexible and informal supports.

99	Once the priority populations pilot projects are completed and the necessary legislation and policies have been passed, state general funds should be allocated for any consumer found to meet the highest priority emergency need category through the priority population assessment process.
100	The majority of State general funds should be allocated to CSBs on the basis of service rates with funding tied to individualized service plans.
101	The DMHMRSAS and the CSBs should implement five pilot projects: • Housing Development Pilots • Mobile Community Crisis Stabilization Team Pilots • Alternative Community Facilities for Medically Fragile Children • Center for Developmental Medicine/Ancillary Services • Regional Emergency Management Funds
102	The General Assembly should affirm a strong substance abuse policy for the Commonwealth and provide resources to increase capacity and reduce waiting lists for persons who need substance abuse treatment services.
103	The Governor's Council on Alcohol and Drug Abuse Problems should be reconstituted as the Governor's Substance Abuse Council and its powers and duties should be redefined. The twenty-three members of the new Council should include the heads of agencies that receive substance abuse funding and representatives of local government, community services boards, the Virginia Sheriff's Association, the General Assembly, consumer and advocacy organizations, and statewide provider associations.
104	The recommendations of the Crime Commission's study (HJR 443, 1997) concerning alcohol and other drug abuse screening and assessment for offenders should be adopted and implemented.
105	The General Assembly should establish drug courts in those judicial circuits that express interest and that have high drug offense case dockets and sufficient correctional and treatment services to support the drug court.
106	An incentive fund should be established to develop innovative local programs to treat offenders.
107	The Virginia Council on Coordinating Prevention should be fully implemented and strengthened.
108	All local agencies that receive prevention funding should be required to participate in local planning and advisory groups. Ten prevention projects should be established to demonstrate the effectiveness of research-based prevention strategies.
109	The Department of Education should be requested to administer a youth risk behavior survey.
110	The Department of Medical Assistance Services should be requested to study the costs and benefits of expanding Medicaid reimbursement for substance abuse services.

111	Further study should be made of the integration of welfare reform and substance abuse policy to determine what treatment programs will improve the functioning and employability of Virginia Initiative for Employment Not Welfare (VIEW) participants.
112	The General Assembly should establish a Behavioral Healthcare Commission or continue the joint subcommittee to conduct further analysis of the issues and provide oversight for implementation of the recommendations.