

INTERIM REPORT OF THE

**Joint Subcommittee to Study
Mental Health Services in the
Commonwealth in the 21st
Century (SJR 47, 2014)**

**TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA**



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**COMMONWEALTH OF VIRGINIA
RICHMOND
2016**

Joint Subcommittee Members

General Assembly Members

The Honorable R. Creigh Deeds, Chairman
The Honorable Robert B. Bell, III, Vice-Chairman
The Honorable Janet D. Howell
The Honorable Emmett W. Hanger, Jr.
The Honorable George L. Barker
The Honorable Linda T. Puller (2014-2015)
The Honorable John A. Cosgrove (2015-present)
The Honorable T. Scott Garrett
The Honorable Peter F. Farrell
The Honorable Joseph R. Yost
The Honorable Margaret B. Ransone
The Honorable Vivian E. Watts
The Honorable Luke E. Torian

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EXECUTIVE SUMMARY

At the 2014 Regular Session of the General Assembly, the Joint Subcommittee to Study Mental Health Services in the Commonwealth in the 21st Century was established pursuant to Senate Joint Resolution 47. The 12-member Joint Subcommittee was directed to review the laws of the Commonwealth governing the provision of mental health services, including involuntary commitment of persons in need of mental health care, and recommend statutory or regulatory changes to improve access to services, the quality of services, and outcomes for individuals in need of services.

The Joint Subcommittee elected Senator R. Creigh Deeds and Delegate Robert B. Bell, III, as its chairman and vice-chairman, respectively. The Joint Subcommittee held three meetings during the 2014 Interim and five meetings during the 2015 Interim.

During the course of its meetings, the Joint Subcommittee received extensive testimony from numerous individuals with expertise in the field of mental health, including representatives from the Department of Behavioral Health and Developmental Services, employees from community services boards, sheriffs and other law-enforcement personnel, representatives of various advocacy groups, mental health service providers, and the general public. The Joint Subcommittee also toured numerous facilities around the Commonwealth that provide mental health services.

During the first two years of its study, the Joint Subcommittee concentrated on reviewing the works and recommendations of previous studies and educating its members as to the current state of the provision of mental health services in the Commonwealth. In the second two years of its study, the Joint Subcommittee will utilize this information in order to inform its recommendations as to what services should be provided and the statutory or regulatory changes necessary to improve access to such services by persons who are in need of mental health care.

**INTERIM REPORT OF
THE JOINT SUBCOMMITTEE TO STUDY
MENTAL HEALTH SERVICES
IN THE COMMONWEALTH
IN THE 21st CENTURY
TO
THE GOVERNOR AND THE GENERAL ASSEMBLY OF VIRGINIA
RICHMOND, VIRGINIA
2015**

To: The Honorable Terry R. McAuliffe, Governor of Virginia
and
The General Assembly of Virginia

I. Origin of the Study

A. Study Resolution

The Joint Subcommittee to Study Mental Health Services in the Commonwealth in the 21st Century was established pursuant to Senate Joint Resolution (SJR) 47 (patron: Deeds) passed during the 2014 Regular Session of the General Assembly. The 12-member Joint Subcommittee was comprised of Senators R. Creigh Deeds; Janet D. Howell; Emmett W. Hanger, Jr.; George L. Barker; and Linda T. Puller and Delegates Robert B. Bell, III; T. Scott Garrett; Peter F. Farrell; Joseph R. Yost; Margaret B. Ransone; Vivian E. Watts; and Luke E. Torian. On April 20, 2015, Senator John A. Cosgrove was appointed to replace Senator Puller.

The Joint Subcommittee is authorized to hold meetings from 2014 through 2017 with the direct costs of the study not to exceed \$72,560 per year. The Joint Subcommittee is required to submit its final report by December 1, 2017, to the Governor and the 2018 Regular Session of the General Assembly.

B. Study Directive

The enabling resolution noted that the provision of mental health services has been a core responsibility of the Commonwealth since 1776. However, the resolution noted, the resources available to provide mental health care have not kept pace with the increasing number of persons in need of services, and many persons in need of crisis intervention and emergency mental health treatment have been unable to access treatment and support services on a timely basis. The resolution also noted that a significant number of persons with mental illness commit various offenses, which bring them within the criminal justice system; in July 2013, an estimated 23.5 percent of Virginia's local and regional jail population were estimated to be mentally ill, and 56 percent of these offenders were estimated to be seriously mentally ill. In light of significant recent changes to the legal and regulatory framework governing mental health services, public and private delivery systems of mental health care, and the consequences of the increasing involvement of persons with mental illness in the criminal justice system, the resolution noted

that there was a need for the General Assembly to consider the types of facilities, programs, and services and the appropriate funding mechanisms that will be needed in the 21st century to provide mental health care, both in traditional mental health delivery systems and in the criminal justice system.

II. Background

As a result of the movement away from providing mental health treatment in state institutions in favor of community-based mental health services, the provision of such services has been the focus of numerous studies, beginning with the issuance of the *Report of the Commission on Mental, Indigent and Geriatric Patients* in 1971. Other recent studies include reports issued by the Joint Subcommittee Studying the Future Delivery of Publicly Funded Mental Health, Mental Retardation and Substance Abuse Services, the Virginia Tech Review Panel, the Commonwealth of Virginia Commission on Mental Health Law Reform established by the Supreme Court of Virginia, and the Task Force on Improving Mental Health Services and Crisis Response established by Governor Robert F. McDonnell and continued by Governor Terence R. McAuliffe. In response to the reports of these commissions, as well as other events, the General Assembly enacted a major overhaul of the involuntary commitment process in 2008 and enacted further refinements to that process in 2014.

In light of importance of the ability of Virginia citizens to access mental health services, the Joint Subcommittee was established to review the laws of the Commonwealth governing the provision of mental health services, including involuntary commitment of persons in need of mental health care, and recommend statutory or regulatory changes to improve access to services, the quality of services, and outcomes for individuals in need of services.

III. Activities of the Joint Subcommittee-2014

A. Meeting of July 21, 2014

1. Overview.

The Joint Subcommittee held its first meeting of 2014 on Monday, July 21, 2014, at the General Assembly Building in Richmond, Virginia. Senator R. Creigh Deeds was elected chairman, and Delegate Robert B. Bell, III, was elected vice-chairman of the Joint Subcommittee.

Sarah Stanton, Senior Attorney, Division of Legislative Services, provided a brief overview of the scope and purpose of the Joint Subcommittee. SJR 47 (Deeds) (2014) established the Joint Subcommittee for a period of four years and directed the Joint Subcommittee to:

- (i) Review the work of and coordinate with the Governor's Task Force on Improving Mental Health Services and Crisis Response;
- (ii) Review the laws of the Commonwealth governing the provision of mental health services, including involuntary commitment of persons in need of mental health care;
- (iii) Assess the systems of publicly funded mental health services, including emergency, forensic, and long-term mental health care and the services provided by local and regional jails and juvenile detention facilities;

- (iv) Identify gaps in services and the types of facilities and services that will be needed to serve the needs of the Commonwealth in the 21st century;
- (v) Examine and incorporate the objectives of House Joint Resolution (HJR) 240 (Hall) (1996) and HJR 225 (Hall) (1998) into its study;
- (vi) Review and consider the report *The Behavioral Health Services Study Commission: A Study of Virginia's Publicly Funded Behavioral Health Services in the 21st Century*; and
- (vii) Recommend statutory or regulatory changes to improve access to services, the quality of services, and outcomes for individuals in need of services.

In reviewing the need for facility beds at the community level, the Joint Subcommittee is directed to consider whether the current fiscal incentives for expanding regional jail capacity should be eliminated and replaced with a new incentive for construction, renovation, or enlargement of community mental health facilities or programs, which may or may not be co-located with selected jails on a regional basis.

The Joint Subcommittee is also directed to consider the appropriate location of such facilities; cooperative arrangements with community services boards, behavioral health authorities, and public and private hospitals; licensing, staffing, and funding requirements; and the statutory and administrative arrangements for the governance of such facilities. The Joint Subcommittee shall give consideration to the development of such facilities or programs on a pilot basis.

The Office of the Executive Secretary of the Supreme Court of Virginia, the Office of the Attorney General, the Offices of the Secretaries of Health and Human Resources and Public Safety, and the staffs of the Senate Finance and House Appropriations Committees are directed to provide technical assistance to the Joint Subcommittee. All other agencies of the Commonwealth shall provide assistance to the Joint Subcommittee upon request.

The Joint Subcommittee is required to submit an interim report to the Governor and the General Assembly by December 1, 2015, and a final report to the Governor and the General Assembly by December 1, 2017. The interim and final reports shall be submitted to the Division of Legislative Automated Services for processing and shall be posted on the General Assembly's website.

2. Presentations

a. Recent Changes in Laws Governing Involuntary Commitment and the Delivery of Mental Health Services

Allyson Tysinger, Senior Assistant Attorney General, Office of the Attorney General, provided an overview of the current emergency custody, temporary detention, and involuntary commitment processes in the Commonwealth and recent changes in the laws governing those processes enacted during the 2014 Session of the General Assembly, which included:

- Increasing the period of time during which an emergency custody order must be executed from six hours after issuance to eight hours after issuance and extending the duration of an emergency custody order from four hours with an optional two-hour extension to a period of up to eight hours with no provision for an extension. (SB 260 (Deeds)/HB 478 (Villanueva))

- Requiring the law-enforcement agency executing an emergency custody order to notify the community services board responsible for conducting the evaluation as soon as is practicable after taking the person into custody. (SB 260 (Deeds)/HB 478 (Villanueva))
- Requiring that every person who is subject to emergency custody or temporary detention be given a written summary of the emergency custody or temporary detention process and the statutory protections associated with those processes. (SB 260 (Deeds)/HB 478 (Villanueva))
- Establishing a web-based acute psychiatric bed registry to contain information about available acute beds in public and private inpatient psychiatric facilities and residential crisis stabilization units to facilitate identification and designation of facilities for temporary detention of individuals who meet the temporary detention criteria. All state facilities, community services boards, and private inpatient providers licensed by the Department of Behavioral Health and Developmental Services (DBHDS) must report data to the bed registry, and the registry must provide access to information about available beds for individuals who meet the criteria for temporary detention to community services boards, inpatient psychiatric facilities, residential crisis stabilization units, and health care providers working in emergency rooms or other facilities rendering emergency medical care. (SB 260 (Deeds)/HB 1232 (Cline))
- Requiring a community services board, upon receiving notification of the need for an evaluation, to contact the state facility serving the area in which the community services board is located and notify the state facility that the individual will be transported to the facility upon issuance of a temporary detention order if an alternative facility cannot be identified within the eight-hour emergency custody period. Upon completion of the evaluation, the community services board must provide information about the individual to the state facility to allow the state facility to determine the services the individual will require upon admission. During the eight-hour emergency custody period, both the state facility and the community services board shall seek an alternative facility for temporary detention. If an alternative facility is identified, the community services board shall designate the alternative facility in the preadmission screening report. A state facility may not fail or refuse to admit an individual who meets the criteria for a temporary detention order unless an alternative facility agrees to accept the individual. No person for whom a temporary detention order has been issued shall be released prior to transfer to a state facility or other alternative facility. (SB 260 (Deeds)/HB 293 (Bell, R.B.))
- Requiring that DBHDS submit an annual report on June 30 of each year to the Governor and the Chairmen of the House Appropriations and Senate Finance Committees setting forth the number of notifications of individuals in need of facility services by community services boards, the number of alternative facilities contacted by community services boards and state facilities, and the number of temporary detentions provided by state facilities and alternative facilities, including the lengths of stay and the cost of such detentions. (SB 260 (Deeds)/HB 293 (Bell, R.B.))
- Allowing a community services board to change the designated facility of temporary detention at any point during the period of temporary detention, provided the community services board has determined that the alternative facility is a more appropriate facility given the specific security, medical, or behavioral needs of the person. Transportation to

the newly designated facility shall be provided by the law-enforcement officer or alternative transportation provider who has custody of the person when the change is made. If the person has already been transported to an initial facility of temporary detention before the change is made, the community services board must require the magistrate to enter an order specifying an alternative transportation provider or local law-enforcement agency to transfer the individual to the new facility. (HB 1172 (Bell, R.B.))

- Allowing any willing law-enforcement agency, not just the primary law-enforcement agency of the jurisdiction where the person resides, to provide transportation for a person subject to an emergency custody order. (HB 323 (O'Bannon))
- Increasing the period of temporary detention from 48 to 72 hours (SB 260 (Deeds)/HB 574 (Yost))

During the 2014 Session, the General Assembly also:

- Directed the Governor's Task Force on Improving Mental Health Services and Crisis Response to identify and examine issues related to the use of law enforcement in the involuntary admission process and to consider options to reduce the amount of resources needed to detain individuals during the emergency custody period, including the amount of time spent transporting individuals. Options should include developing crisis stabilization units in all regions and contracting for retired officers to provide transportation. The Task Force was directed to report its findings to the Governor and the General Assembly by October 1, 2014. (SB 260 (Deeds)/HB 478 (Villanueva))
- Required DBHDS to review the requirements related to qualifications, training, and oversight of individuals performing preadmission screening evaluations and to make recommendations for increasing the qualifications, training, and oversight of evaluators. The Department was directed to report its findings to the Governor and the General Assembly by December 1, 2014. (SB 261 (Deeds)/HB 1216 (Bell, R.B.))
- Directed the Secretaries of Public Safety and Health and Human Resources to encourage the dissemination of information about specialized training in evidence-based strategies to prevent and minimize mental health crises. Such strategies shall include CIT training and Mental Health First Aid. Information shall be made available to law enforcement, first responders, emergency room personnel, school personnel, and other interested parties. (HB 1222 (Watts))

b. Overview of the Commonwealth's Publicly Funded Mental Health System

Debra Ferguson, Ph.D., Commissioner, Department of Behavioral Health and Developmental Services, provided an overview of the Commonwealth's publicly funded mental health system, including a statement of core principles and information on the number of public and private service providers, the distribution of service providers, and the services continuum. She stated that community services boards, which compose the public service system, are required by statute to provide emergency services, preadmission screening, and discharge planning services. When funds are available, community services boards must provide case management services. Community services boards may also provide a range of mental health and substance abuse services either directly or through contracts with private providers. Commissioner Ferguson noted that there is a lot of variation in the type of services provided by

community services boards in the Commonwealth and that performance contracts between the Department and community services boards are the main tool by which the Department oversees the work of the community services boards.

Commissioner Ferguson also described recent changes that have taken place at the Department. She noted that the Department's emphasis was on prevention and early identification of and intervention for individuals in need of mental health services as a method of reducing the need for emergency services. Other activities include tightening of regional protocols for admissions, revising medical screening and assessment guidance, extending the timelines for emergency custody and temporary detention, improving communication during the civil commitment process, launching the online psychiatric bed registry, and establishing regular mental health law "brown bag lunches" to discuss issues with stakeholders. The Department has also developed a process for reporting temporary detention order exceptions, requiring community services boards to submit data monthly. Commissioner Ferguson reported that between January 1 and April 30, 2014, there were 37 cases in which a temporary detention order was sought but not obtained because a willing facility could not be identified. Of these 37 individuals, approximately half were instead admitted for medical treatment instead of being taken into emergency custody, two were subjected to a second temporary detention order, two received an individual crisis plan rather than being taken into custody, and three were voluntarily admitted for services. Only six of the 37 left custody without any sort of follow-up or plan, with four leaving before a plan could be implemented and two leaving custody against medical advice. Commissioner Ferguson noted that with recent changes in the law, which became effective on July 1, these six individuals would not have been released from custody. Instead they would have been transferred to the state facility. Commissioner Ferguson also reported that during the same period there were a substantial number of cases in which a temporary detention order was obtained and executed, but only after more than six hours had elapsed. In many of these cases, she noted, the delay was due to the need for medical treatment before the order could be executed. The Department will continue to monitor these situations.

In closing, Commissioner Ferguson described a number of challenges facing the Department and the publicly funded mental health service system, including an underdeveloped system of prevention and early intervention services; lengthy community waiting lists; inconsistency in the availability of intensive supports such as programs of assertive community treatment (PACT), housing, and employment services in the Commonwealth; an underdeveloped peer support services delivery system; limited availability of mid-level crisis supports such as crisis stabilization services and crisis intervention team (CIT) secure assessment centers; the low income threshold for Medicaid, which presents challenges for providing services for uninsured and underinsured; and limited funding for community mental health services.

c. Civil Commitment Laws: A Survey of the States

John Snook, Deputy Director, and Katheryn Cohen, Legislative and Policy Council, Treatment Advocacy Center, provided an overview of commitment laws in other states, including background on the commitment process in the United States, trends and developments in treatment laws nationally, how Virginia compares to other states, and opportunities for Virginia to improve its commitment process. Mr. Snook and Ms. Cohen noted that though Virginia has a "gravely disabled" standard for involuntary commitment, like most other states, anecdotal evidence indicates that involuntary commitment is not available until an individual is actually in crisis. They reported that many states are beginning to address this type of problem by

incorporating a “need-for-treatment” standard that can prevent crises from occurring and help stabilize individuals with mental health treatment needs. Mr. Snook and Ms. Cohen also spoke about mandatory outpatient treatment requirements. Virginia, like many of the 45 states that have mandatory outpatient treatment statutes, uses a single standard for both involuntary inpatient and mandatory outpatient treatment. Mr. Snook and Ms. Cohen noted that in states with this type of standard, mandatory outpatient treatment is less likely to be utilized. Some states have addressed this problem by implementing different standards for inpatient and outpatient treatment. As a result, the number of orders for mandatory outpatient treatment has increased while the number of involuntary commitments has decreased. States that have implemented this approach, including New York, Ohio, Tennessee, and Massachusetts, report that the change has freed up voluntary services by making the system more efficient and reduced the cost of mental health services.

Mr. Snook and Ms. Cohen ended their presentation with recommendations for the Commonwealth to clarify and consolidate its commitment standards, train service providers on and update treatment standards to promote consistent implementation, consider revising the mandatory outpatient treatment standards and procedures to increase use of mandatory outpatient treatment, and monitor the outcomes of recent changes to the emergency custody and temporary detention time frames to determine whether longer time periods reduce the number of involuntary commitments.

3. Other Business

Finally, the Joint Subcommittee discussed its work plan for the remainder of the 2014 interim. The Joint Subcommittee planned to establish a number of work groups to focus on a range of topics and issues. Additional information about the work groups was to be made available in advance of the next meeting.

B. Meeting of September 9, 2014

1. Overview

The Joint Subcommittee held its second meeting of 2014 on Tuesday, September 9, 2014, at the General Assembly Building in Richmond, Virginia.

2. Presentations

a. Mental Health Disorders and Treatment

Dr. Debra Ferguson, Commissioner, Department of Behavioral Health and Developmental Services, and Dr. Jack Barber, Medical Director, Department of Behavioral Health and Developmental Services, provided an overview of common mental health disorders and treatment.

Commissioner Ferguson began by describing a 2003 report by the New Freedom Commission on Mental Health that provided information on gaps in mental health services and made concrete recommendations for immediate improvements. The report identified three specific barriers to improving mental health services: stigma around mental illness, unfair limitations and financial requirements placed on mental health benefits in private insurance, and the fragmented mental health service delivery system. The report also identified several specific problems with the current system of mental health services, including fragmentation and gaps in services for children and adults with serious mental illness, high levels of unemployment and

disability among individuals with serious mental illness, a lack of care for older adults with mental illness, and a lack of national priority for mental health and suicide prevention. Commissioner Ferguson reported that the New Freedom Commission identified six goals as the foundation for transforming mental health care in America. These were as follows:

1. Americans understand that mental health is essential to overall health.
2. Mental health care is consumer- and family-driven.
3. Disparities in mental health services are eliminated.
4. Early mental health screening, assessment, and referral services are common practice.
5. Excellent mental health care is delivered, and research is accelerated.
6. Technology is used to access mental health care and information.

Commissioner Ferguson also stated that the report stressed recovery as the expectation and the goal of the mental health service system. Recovery refers to the process in which people are able to live, work, learn, and participate fully in their communities and to access health care, gainful employment, and adequate and affordable housing. In closing, Commissioner Ferguson stated that the report could serve as a roadmap to developing a system of mental health services for the Commonwealth. The system described by the report is grounded in best practices, is oriented to recovery, promotes access and early intervention, and emphasizes excellence in mental health.

Dr. Barber provided an overview of common mental illnesses including schizophrenia, bipolar disorder, schizoaffective disorder, depression, anxiety disorders, mental health disorders in children and adolescents, conduct disorder, and substance use disorders, and information about the treatment thereof. He noted that mental illnesses are generally characterized as irregular mood, thought, or behavior; that mental illness becomes a concern when symptoms cause frequent distress and affect one's ability to function; and that individuals with mental illness are likely to experience co-morbidities that have a substantial negative impact on their life expectancy. He noted that the National Institute of Mental Health estimates that 18.6 percent of adult Americans experience some form of mental illness during the course of a year and that in any single year, an estimated 4 percent of Americans will experience serious mental illness. Approximately one-half of all individuals with mental illness are diagnosed by the age of 24.

Dr. Barber highlighted some best practices for the treatment of mental illness, including early identification and treatment; holistic assessment, treatment, and support customized to the individual; use of the right medications for symptom control and side-effect tolerance; a focus on recovery principles of hope, choice, purpose, and connection to help others; a focus on psychosocial rehabilitation; inclusion of peer support services and Wellness Recovery Action Plans; an emphasis on family involvement, support, and advocacy; prompt response to increasing symptoms; and establishing stable living arrangements. In closing, Dr. Barber emphasized that treatment is effective when it is available and tailored to the individual's needs, and that people do recover from mental illness.

b. Governor's Task Force on Improving Mental Health Services and Crisis Response

The Honorable Bill Hazel, Secretary of Health and Human Resources, and the Honorable Brian Moran, Secretary of Public Safety and Homeland Security, provided an overview of the

Governor's Task Force on Improving Mental Health Services and Crisis Response. The task force was created on December 10, 2013, by Executive Order 68 (McDonnell), to seek and recommend solutions to improve Virginia's mental health crisis services and help prevent crises from developing. Executive Order 12 (McAuliffe) continued the task force. The task force is composed of 42 members, including leaders in the mental health field, law enforcement, the judicial system, and the private hospital system, as well as individuals receiving mental health services and their family members. The task force is chaired by the Lieutenant Governor and co-chaired by Secretaries Hazel and Moran. Several work groups and sub-work groups assisted the task force in its work. During the spring and summer of 2014, the task force met several times to review existing services and challenges in the mental health system and made recommendations, including legislative and budget proposals, for critical improvements to procedures, programs, and services.

On January 1, 2014, the task force made a number of initial recommendations. These included:

- A 12-hour emergency custody order (ECO) period that includes tiered levels of notification every four hours;
- Notification of the community services board responsible for conducting the evaluation by the law-enforcement agency that executes an emergency custody order; and
- A two-year sunset on any statutory changes to ensure the new laws are meeting the needs of the Commonwealth.

At that time, the task force also endorsed several of the Governor's proposals, including:

- A 72-hour temporary detention period with a minimum of 24 hours of temporary detention prior to a commitment hearing;
- Additional funding for mental health services;
- Expanding secure assessment centers and crisis stabilization units for children and adults across the Commonwealth as the highest priority for funding;
- Expanding the use of telepsychiatry; and
- Expanding funding for crisis intervention team (CIT) training for law-enforcement officers throughout the Commonwealth.

In June of 2014, the task force made several additional recommendations, including recommendations for:

- Establishment of a "center of excellence" to use public and private resources to address behavioral health needs, including criminal justice, substance use disorder, housing, and employment. Each community should establish a position/committee/group to ensure best practices are actually implemented and analyze instances when programs do not work as intended;
- Investment in CIT training and assessment centers so that every community in the Commonwealth has a functional CIT program and assessment center;
- Development of a mechanism to ensure access to and use of alternative transportation providers in all communities. This may require additional funding and amendments to

the Code of Virginia to give transportation providers the authority to detain individuals to be transported;

- Development of a single, consistent statewide process for data and oversight to maximize the use of telepsychiatry and video technology;
- Improvement of access to consistent, timely psychiatric services using a benchmark standard, as exists in other health care fields, and making resources available to accomplish this goal;
- Alteration of the Certificate of Public Need process to more effectively address needs for any additional psychiatric beds in some areas of the Commonwealth;
- Improvement of the service delivery system across the Commonwealth, including emergency services when a mental health crisis occurs and services to intervene early and prevent crises from developing, such as expanded crisis intervention teams; implementation of mental health first-aid programs in every planning district; and improved behavioral health resources for veterans, service members, and their families and children;
- Increased flexibility in the administration of the mental health system and increased communication among participants in the mental health service system;
- Improved mental health services in jails, including ensuring all jails have readily accessible, evidence-based, trauma-informed services for people with mental illness, and developing a system to notify community providers when an individual with behavioral health needs is discharged from jail, to enhance the continuity of care;
- Improved education and incentives for primary care providers and a focus on recruiting and retention of mental health service providers; and
- Improved resources for families of individuals with mental illness.

Secretary Hazel noted that the final report of the task force was to be submitted to the Governor by October 1, 2014, but that the task force would continue to meet into 2015.

c. Mental Health Services, a National Perspective

Mr. Ted Lutterman, Senior Director of Government and Commercial Research, National Association of State Mental Health Planning Directors Research Institute, presented on Virginia's state mental health system, national comparisons, and trends in state mental health systems. Mr. Lutterman discussed the impact of mental illness on America, provided an overview of state mental health service systems in the United States, and provided information on state mental health expenditures and financing in the United States and the role of state psychiatric hospitals in Virginia and neighboring states.

Mr. Lutterman reported that approximately one in five Americans will have a mental health problem in any given year, yet only one-third of those individuals will receive services. The direct cost of treatment each year for those who do seek treatment is approximately \$147 billion nationally, or approximately 6.3 percent of all health care spending. Most mental health services are publicly funded, and private insurance covers only about 1 percent of the costs of treatment. Approximately 50 percent of those individuals with mental health problems who did not receive services did not do so because of the high cost of mental health treatment. Individuals

experiencing mental health problems are at higher risk of suicide, premature mortality, high medical co-morbidity, unemployment, homelessness and unstable living arrangements, and involvement with the corrections system. Individuals with mental illness can also create significant burdens for family members and caregivers.

Mr. Lutterman described several models of mental health service delivery used in states throughout the country. He noted that Virginia is like many states in that the state mental health authority is part of an agency that combines mental health and developmental and substance abuse services. The Commonwealth employs a county- or city-based system in which the state mental health agency provides funds for mental health services to counties or cities, which then deliver or contract for services. Other states operate models in which the state mental health agency contracts directly with providers for services, or in which the state mental health agency provides services directly using its own staff. In 24 states, community mental health providers control admissions to state psychiatric hospitals, while in others admissions determinations are made by the courts or by medical professionals at hospitals.

In Virginia, approximately 1.4 percent of the total population receives mental health services from the publicly funded mental health system, as compared to 2.3 percent of the national population. Virginia serves more people in psychiatric inpatient settings than the national average, but also transitions more people to community-based services. Approximately 20 percent of adults who receive services are employed, as compared to the national average of 18 percent, and approximately 55 percent had some Medicaid coverage to help pay the cost of services, as compared with 63 percent nationally.

Mr. Lutterman noted that while every state has involuntary commitment laws, the process of involuntary commitment varies substantially from state to state. For example, 23 states allow temporary holds of up to 72 hours, as does Virginia, while 21 allow holds of longer duration and eight have holds of shorter duration. Most involuntary holds are not at state psychiatric hospitals but are at general hospital psychiatric beds or private psychiatric hospitals. Virginia is one of 40 states that allow mandatory outpatient commitment.

At the end of his presentation, Mr. Lutterman described trends in state mental health expenditures and financing. He noted that state mental health systems had been negatively affected by recent state budget shortfalls, and that many states had closed state hospitals and psychiatric beds in recent years. A number of states, including Virginia, have reported shortages of psychiatric inpatient beds and increased waits for state psychiatric beds. Mr. Lutterman reported that Virginia's overall spending on mental health services ranked in the middle of that of surrounding states, but that the Commonwealth's spending skewed more toward inpatient and less toward community-based services than surrounding states. The largest category of state hospital expenditures in the Commonwealth was for civil status adults (81.2 percent of total spending); however, spending on forensic clients is growing quickly.

3. Public Comment

Following the scheduled presentations, the Joint Subcommittee received public comment.

- Dr. Jim McCullough, a professor of psychology at Virginia Commonwealth University, noted that Virginia needs a prevention strategy and needs to shift from a reactive to a proactive system.

- Ms. Barbara Brown recommended the Joint Subcommittee consider ways to use adult foster care providers to provide safe and stable housing to individuals receiving community-based mental health services who are at risk of homelessness.
- Ms. Karen Duffy described her son’s mental illness and the circumstances surrounding his death, and recommended that the Joint Subcommittee consider requiring reporting of adverse drug reactions, including suicides.
- Ms. Sonia de la Cruz described her experience with mental illness and the mental health treatment system and reminded the Joint Subcommittee that it is important to recognize that mental illness, like any other illness, requires treatment and care and can result in recovery.
- Mr. Damien Cabezas, Chief Executive Officer of Horizon Behavioral Health, the community services board serving Lynchburg, described the services provided by the community services board and noted that crisis intervention teams and assessment centers are good options for reducing the impact of mental illness on the community. He also noted that community services boards and law enforcement continue to learn to work together around issues like transportation, and that community services boards require some clarification on recent changes to the laws.
- Ms. Sandy Sale asked the Joint Subcommittee to be aware of the mental health needs of individuals in jails and to take steps to ensure the availability of services for individuals in jails.
- Ms. Bonnie Neighbor, Executive Director of VOCAL (Virginia Organization of Consumers Asserting Leadership), suggested that the Joint Subcommittee hear testimony from individuals who have been involved with and received services through the publicly funded mental health services system.
- Ms. Sherry Sweet noted that medications to treat some mental illnesses are very expensive, and that follow-up care is often difficult to obtain.

4. Other Business

At the end of the meeting, Senator Deeds announced the focus and membership of the work groups:

- Crisis Intervention Work Group: Delegate Robert B. Bell, III (Work Group Chairman), Senator George L. Barker, Delegates Margaret B. Ransone and Vivian E. Watts.
- Continuum of Care Work Group: Senator Emmett W. Hanger, Jr. (Work Group Chairman), Senator Janet D. Howell, Delegates T. Scott Garrett and Luke E. Torian.
- Children and Other Special Populations Work Group: Delegate Joseph R. Yost (Work Group Chairman), Senator Linda T. Puller, Delegate Peter F. Farrell.

C. Meeting of December 16, 2014

1. Overview

The Joint Subcommittee held its third and final meeting of 2014 on Tuesday, December 16, 2014, at the General Assembly Building in Richmond, Virginia.

2. Presentation: Recommendations of the Governor's Task Force on Improving Mental Health Services and Crisis Response

The Honorable Bill Hazel, Secretary of Health and Human Resources, presented information on recommendations of the Governor's Task Force on Improving Mental Health Services and Crisis Response. The task force was created by Executive Order No. 68 (2013) (McDonnell) and continued by Executive Order 12 (2014) (McAuliffe), to seek and recommend solutions to improve Virginia's mental health crisis services and help prevent crises from developing. Responsibilities of the task force included:

- Recommending refinements and clarifications of protocols and procedures for community services boards, state hospitals, law enforcement, and receiving hospitals;
- Reviewing for possible expansion the programs and services that assure prompt response to individuals in mental health crises and their families, such as emergency services teams, law-enforcement crisis intervention teams (CIT), secure assessment centers, mobile crisis teams, crisis stabilization centers, and mental health first aid;
- Examining extensions or adjustments to the emergency custody order and the temporary detention order period;
- Exploring technological resources and capabilities, equipment, training, and procedures to maximize the use of telepsychiatry;
- Examining the cooperation that exists among the courts, law enforcement, and mental health systems in communities that have incorporated crisis intervention teams and cross-systems mapping;
- Identifying and examining the availability of and improvements to mental health resources for Virginia's veterans, service members, and their families and children;
- Assessing state and private provider capacity for psychiatric inpatient care, the assessment process hospitals use to select which patients are appropriate for such care, and explore whether psychiatric bed registries and/or census management teams improve the process for locating beds;
- Reviewing for possible expansion those services that will provide ongoing support for individuals with mental illness and reduce the frequency and intensity of mental health crises. These services may include rapid, consistent access to outpatient treatment and psychiatric services, as well as co-located primary care and behavioral health services, critical supportive services such as wrap-around stabilizing services, peer support services, programs of assertive community treatment (PACT) services, housing, employment, and case management;
- Recommending how families and friends of a loved one facing a mental health crisis can improve the environment and safety of an individual in crisis; and
- Examining the mental health workforce capacity and scope of practice and recommending improvements to ensure an adequate mental health workforce.

The task force met 23 times and delivered final recommendations to the Governor on October 1, 2014. Recommendations were categorized into three areas: (i) recommendations to strengthen administration, (ii) recommendations to expand access, and (iii) recommendations to improve

quality. The final recommendations can be found in the task force's final report on the Department of Behavioral Health and Developmental Services' website.

Following the presentation, the Joint Subcommittee voted to support the recommendations, with particular emphasis on the following:

Recommendation 1. Secure Assessment Centers and Crisis Stabilization Units - The task force supports expanding secure CIT assessment centers (drop-off centers) and crisis stabilization units for children and adults across the Commonwealth as the highest priorities for funding.

Recommendation 2. Crisis Intervention Teams - Expand funding for CIT program development, including training for law-enforcement officers throughout the Commonwealth. Virginia needs to invest in CIT programs (to include CIT assessment centers) so that every community in Virginia has a functional CIT program including an assessment center.

- Investment needs to include ongoing funding for CIT training, CIT coordinators, and related expenses associated with operating a CIT program.
- Communities should be encouraged to incorporate college and campus safety/ police departments into their CIT programs.
- In addition, DBHDS, the Department of Criminal Justice Services (DCJS), and others should work to develop a CIT-like training curriculum for jail personnel to enhance the identification and treatment of individuals with mental illness in jails. (See Recommendation 8.)

Recommendation 8. Center for Behavioral Health and Justice - The vision of the intergovernmental Center for Behavioral Health and Justice should be to identify and utilize Virginia's resources (both public and private) to more effectively address behavioral health needs within the Commonwealth.

- One significant initial focus would be to address the behavioral healthcare needs of individuals involved in all aspects of the criminal justice system.
- This Center would serve as a coordinating center utilizing a multisystems approach including lead staff from DBHDS and DCJS, as well as private and public universities, community services boards (CSBs), law enforcement, representatives from Virginia's court system, individuals with lived experience with the behavioral healthcare/criminal justice system(s), community members, and family members.
- In addition the Center for Behavioral Health and Justice would serve as a coordinating entity for communities that should be required to establish a position/ committee/group to liaise with the Center and ensure best practices are actually implemented, and analyze instances when treatment/criminal justice/diversion programs do not work as intended.
- The Center should also serve as a statewide oversight system to make sure communities are engaged in oversight review; and the state should make funding to a community contingent on demonstration that the community is providing oversight and utilizing evidence-based programs.
- The Center would also serve as a resource for programs such as family, veterans, and jail services and technological resources. (See Recommendations 2, 4, 6, 11, 12, 13, and 20.)

*Recommendation 10. **Alternative Transportation*** - Virginia needs to affect a paradigm shift away from having law enforcement be primary transporters for mental health issues (from emergency custody orders to temporary detention orders).

- Virginia should develop a mechanism whereby alternative transportation (via ambulance, EMS, secure cab, etc.) is available in all communities.
- Both law enforcement and the CSB emergency services clinician should make recommendations, and a magistrate would determine whether an individual should be transported by law enforcement or could safely be transported via alternative transportation.
- While the Code of Virginia currently allows for alternative transportation, it is restricted to occasions when the individual is incapacitated. Additionally, there is no funding mechanism to support alternative transportation.
- Virginia would need to invest in funding this service but would also need to ensure transportation providers are trained/qualified to provide services.
- The Code of Virginia would also need to give transportation providers the authority to detain individuals, and the Commonwealth would need to address liability issues.

*Recommendation 14. **Virginia Criminal Information Network (VCIN)*** - Enable first responders (police officers) to gain access to the TDO database already in VCIN. Add training requirements for VCIN.

*Recommendation 15. **Protected Health Information (PHI) Disclosures*** - Develop legislation that (i) authorizes sharing of PHI between CSBs, law-enforcement agencies, health care entities and providers, and families and guardians about individuals who are believed to meet the criteria for temporary detention (whether or not they are in custody or ultimately detained) and (ii) contains a “safe harbor” provision for practitioners and law-enforcement officers who make such disclosures and act in good faith. DBHDS should develop a disclosure “toolkit” for practitioners and law enforcement that can support effective, consistent understanding of disclosure and information sharing in the emergency context.

*Recommendation 20. **Resources for Families*** - Look at mechanisms of support for families and individuals in crisis and increase functionality, utilization, and support of psychiatric advanced directives, complete with education on what a model advanced directive should include.

- Educate as to other forms of support through technology like apps for mental health support, electronic brochures, resource information, mental health first aid, healthy lifestyles information, and other electronic forms of communication.
- Consider having all information available on existing web pages with links to other pages as needed.
- Consider a registry/clearinghouse for advanced directives. The Virginia Department of Health maintains a registry.
- Strive for no wrong door or path to get information.

Recommendation 25. Psychiatric Bed Registry Reporting - Fully utilize the data reporting capacity of the psychiatric bed registry and add data fields as necessary to automate data collection to better understand where the gaps or pressure points are.

D. Summary of 2014 Legislative Activities

Based upon the Joint Subcommittee's support of the task force recommendations, bills were filed by during the 2015 Session to implement recommendations 10, 14, and 25. All of these bills passed and became law effective July 1, 2015. The summaries for these bills are as follows:

Recommendation 10: SB 1263 (Deeds) HB 1693 (Bell, R.B.)

Civil admission process; alternative transportation. Provides that a magistrate may authorize alternative transportation for a person subject to an emergency custody order or temporary detention order when there exists a substantial likelihood that the person will cause serious physical harm to himself or others. Current law prohibits the use of alternative transportation when there exists a substantial likelihood that the person will cause serious physical harm to himself or others. The bill also provides liability protection for alternative transportation providers.

Recommendation 14: SB 1264 (Deeds)

Law-enforcement access to involuntary admission and incapacity information. Provides that certain information related to persons adjudicated incapacitated or ordered to involuntary inpatient or outpatient treatment or to persons who were subject to a temporary detention order who agreed to voluntary admission may be disseminated to a full-time or part-time employee of a law-enforcement agency for purposes of the administration of criminal justice.

Recommendation 25: SB 1265 (Deeds) HB 2118 (Cline)

Acute psychiatric bed registry; frequency of updating. Requires state facilities, community services boards, behavioral health authorities, and private inpatient psychiatric service providers to update information included in the acute psychiatric bed registry whenever there is a change in bed availability for the facility, board, authority, or provider or, if no change in bed availability has occurred, at least once daily.

IV. Activities of the Joint Subcommittee-2015

A. Meeting of February 24, 2015

1. Overview

The Joint Subcommittee held its first meeting of 2015 on Tuesday, February 24, 2015, at the General Assembly Building in Richmond, Virginia.

2. Presentation: Mental Health Services in the Commonwealth

Dr. Steven Sterns, Merrill H. Bankard Professor of Economics at the University of Virginia, presented information about a recently completed study of the availability of public mental health services in the Commonwealth. He described characteristics of individuals seeking public mental health services, including age, education level, average household income, and insurance coverage. He also gave an overview of the 40 community services boards providing public mental health services in the Commonwealth, including the size of the population in the

region served by each community services board, the types of services offered, and the total number of individuals served by year. Dr. Sterns also provided an estimate of the number of individuals in each community services board's service area that could be expected to need mental health services, based on mental health problem prevalence data that takes into account age, race, education, family income, and insurance status. He noted the deficit in the supply of mental health services as compared to the demand for mental health services provided by community services boards, with all but a few community services boards expected to demonstrate such deficits and a few expected to demonstrate substantial deficits. Dr. Sterns pointed out that individuals without insurance of any type were the most likely to experience difficulty in accessing mental health services.

3. Other Business

Following Dr. Sterns' presentation, the members of the Joint Subcommittee discussed the work plan for the 2015 interim. Senator Deeds encouraged the work groups to meet as needed to carry out their work. The members agreed that the work groups should meet on the same days as the full Joint Subcommittee, and that meetings would be held beginning in April.

B. Meeting of April 16, 2015

1. Overview

The Joint Subcommittee held its second meeting of 2015 on Thursday, April 16, 2015, at the General Assembly Building in Richmond, Virginia.

2. Presentation: 2015 Legislative Update

Staff gave an overview of mental health-related legislation from the 2015 General Assembly Session. Of particular interest to the Joint Subcommittee were its three recommendations adopted on December 16, 2014.

- HB 1693 (Bell, R.B.)/SB 1263 (Deeds)

Civil admission process; alternative transportation. Recommendation adopted at 12/16/14 meeting (based on Recommendation #10 of the Governor's Task Force on Improving Mental Health Services and Crisis Response). Both bills passed the House and Senate unanimously (Chapters 297 and 308, 2015 Acts of Assembly).

- HB 2118 (Cline)/SB 1265 (Deeds)

Acute psychiatric bed registry; frequency of updating. Recommendation adopted at the 12/16/14 meeting (based on Recommendation #25 of the Governor's Task Force on Improving Mental Health Services and Crisis Response). Both bills passed the House and Senate unanimously (Chapters 34 and 116, 2015 Acts of Assembly).

- SB 1264 (Deeds)

Law-enforcement access to involuntary admission and incapacity information. Recommendation adopted at the 12/16/14 meeting (based on Recommendation #14 of the Governor's Task Force on Improving Mental Health Services and Crisis Response). Passed the House and Senate unanimously (Chapter 540, 2015 Acts of Assembly).

3. Other Business

The members of the Joint Subcommittee discussed the work plan for the remainder of 2105. Senator Deeds discussed the need to determine what mental health services should be provided by the Commonwealth. After the Joint Subcommittee identifies those services it can then examine how to provide the services and how to pay for them.

The members discussed meeting dates and locations for the 2015 interim. The Joint Subcommittee agreed to have three two-day meetings in various locations across the Commonwealth. They agreed that in order to fully understand the issues the Joint Subcommittee has a duty to tour mental health facilities across the state. The members agreed to meet June 30-July 1, September 24-25, and November 12-13.

The members agreed to have the June 30-July 1 meeting in the Staunton area. They planned to tour the Commonwealth Center for Children and Adolescents and wanted to hear more about other mental health studies conducted over the years. In addition to the full Joint Subcommittee, the three work groups planned to meet. The September and November meetings were planned to take place in the Northern Virginia and Tidewater areas.

C. Meeting of June 30, 2015, and July 1, 2015

1. Overview-June 30, 2015

The Joint Subcommittee held its third meeting of 2015 on Tuesday, June, 30, 2015, at the Augusta County Government Center in Verona, Virginia, and on Wednesday, July 1, 2015, at Valley Community Services Board in Staunton, Virginia.

2. Presentation-June 30, 2015: Professor Richard J. Bonnie, Director, Institute of Law, Psychiatry and Public Policy, University of Virginia School of Law

Professor Bonnie provided an overview of the history of Virginia's laws governing involuntary commitment and the different legal models governing involuntary commitment used in the United States. Specifically, Professor Bonnie explained that states employ either the judicial certification model, in which the decision for emergency treatment is made by a judicial officer, or the medical certification model, in which the decision for emergency treatment is made by a medical professional and subsequently reviewed by a judicial officer. He noted that the two models differ in the strictness of the criteria employed and reflect differing substantive policy concerns (paternalistic vs. libertarian). However, as the focus of civil commitment law has shifted from long-term hospitalization to short-term emergency hospitalization, these differences have become less pronounced.

Professor Bonnie stated that between 1968 and the present day, Virginia transformed from a state that utilizes the medical certification model to one that utilizes the judicial certification model. Prior to 1974, a person could be involuntarily committed on the basis of a medical certification of need for hospitalization. Such person could be held for up to 60 days prior to a judicial review of the decision. Professor Bonnie noted that in 1974 Virginia adopted the judicial certification model, many elements of which are still in place today. Professor Bonnie also reviewed various reforms to the commitment laws during this period, including those made during the 2015 Session of the General Assembly. Professor Bonnie also detailed the priorities that remain for future reforms of Virginia's law, including (i) access to safe, nonstigmatizing transportation; (ii) alternatives to emergency departments for crisis evaluations;

(iii) removal of impediments to voluntary admission; (iv) facilitation of the use of advance directives; and (v) continued improvement in the collection of data regarding emergency evaluations, emergency custody orders (ECO), temporary detention orders (TDO), and commitment hearings to facilitate evidence-based policy decisions. Professor Bonnie also reviewed recent trends in ECOs, TDOs, and commitment orders, beginning in April 2014, that demonstrate an increase in the frequency of ECOs and TDOs and a decrease in the number of commitment orders.

Joint Subcommittee Discussion

In discussing Professor Bonnie's presentation, Delegate Farrell observed that the criteria for involuntary commitment and mandatory outpatient treatment (MOT) are identical and suggested that the Joint Subcommittee look at whether the MOT criteria should be different. Professor Bonnie noted that though the criteria for involuntary commitment and MOT in Virginia are identical, they differ somewhat from the criteria for "step-down" MOT (the release of an involuntarily committed person for MOT). Senator Deeds requested information on the number of persons ordered to MOT who have complied with the treatment. Professor Bonnie responded that a study would have to be done to answer that question and that it may be possible to access MOT orders and any judicial revocation of such orders. Delegate Watts requested more information on the responsibility of someone with custodial authority over a person to obtain treatment for such person; the issue arises out of the February 2015 death of a Fairfax County mentally ill woman associated with physical restraints used by deputies taking her into custody. Delegate Bell asked if any data suggests that the greater availability and use of early intervention, such as crisis stabilization units, reduces the numbers of commitments. Professor Bonnie stated that there is data in Virginia that shows that such early intervention can reduce the number of persons who need commitment or otherwise suffer a mental health crisis.

Senator Howell requested more information regarding the training of special justices used in the commitment process.

3. Other Business-June 30, 2015

Senator Deeds announced that the Joint Subcommittee would be taking an informational tour of the Commonwealth Center for Children and Adolescents after the meeting adjourned.

4. Presentation-July 1, 2015: David Deering, Executive Director, Valley Community Services Board

Mr. Deering provided an overview of the Valley Community Services Board, its organization, the services it provides, its facilities, and its priorities and challenges. Mr. Deering noted that there are 40 unique community services boards and behavioral health authorities in Virginia and that similar presentations from each would vary greatly.

Mr. Deering stated that the Valley CSB serves a population of 125,000 in Augusta County, Highland County, Waynesboro, and Staunton. The Joint Subcommittee inquired about the funding across localities. Mr. Deering noted that they have worked to find a fair allocation method across the localities. While they haven't always received the 10 percent mandated local match, things have gotten better as they have worked toward a fairer allocation. The Joint Subcommittee noted that receiving the 10 percent mandated local match has been a problem for many CSBs.

Mr. Deering discussed the qualifications needed to become a prescriber at the Valley CSB. Delegate Garrett inquired about the standardization of such qualifications. Valley staff noted that they required their prescribers to understand and be able to work within their system because prescribers are required to do more than prescribe.

Mr. Deering highlighted several services provided by the Valley CSB including the “My Action Plan” card. Individuals with the “My Action Plan” card can present it to law enforcement during an encounter, which allows the law enforcement officer to become familiar with the individual’s mental health needs.

Delegate Watts inquired about the mandatory outpatient treatment services (MOT) provided by the CSB. Mr. Deering noted that they haven’t had as much success with MOT as they would like but the region has had a lot of success with drug courts and therapeutic dockets.

Sheriff Timothy Duff of Highland County stated that the telemedicine services implemented by Valley CSB have saved him and his staff a significant amount of time transporting individuals to the emergency department. In addition, Sheriff Duff reported that 100 percent of his deputies and dispatch had received Crisis Intervention Training and such training had improved their response to individuals in mental health crisis.

Mr. Deering outlined the significant funding challenges the Valley CSB faces. The funding challenges have led the Valley CSB to close residential programs in favor of community-based programs. The Joint Subcommittee discussed the financial impact of additional Medicaid funding, the recently approved GAP program, and the possibility of standardizing services across community services boards.

D. Meeting of September 24, 2015

1. Overview

The Joint Subcommittee held its fourth meeting of 2015 on Thursday, September 24, 2015, at the Suffolk City Hall in Suffolk, Virginia.

2. Presentations

a. Mental Health Services in Jails

Sheriff Gabriel Morgan, Newport News, spoke about mental health services in jails in the Commonwealth. He noted that jails are the largest providers of mental health services in the Commonwealth. The demand for services is high, with an estimated 60 percent of individuals in jails having serious mental illness. Many of these individuals are in jails because there are insufficient community mental health resources to meet their needs. Many sheriffs work with local community services boards to meet the demand for mental health services in the jails. However, funding for mental health services is insufficient. Similarly, funding and service capacity for individuals with mental health needs exiting jails and returning to the community are insufficient, creating a situation in which those individuals are likely to end up back in jail.

Sheriff Morgan suggested that to meet the need for mental health services, the Commonwealth needs to invest in the public mental health system to increase capacity. Areas of focus should be increasing the availability of crisis stabilization and drop-off centers for individuals experiencing mental health crises and increased use of alternative transportation providers for individuals under emergency custody orders or temporary detention orders. He also

raised concerns about differences in drug formularies across mental health services providers in the Commonwealth, and recommended that a single-state formulary would be beneficial.

Senator Deeds asked Sheriff Morgan about Crisis Intervention Team (CIT) training. Sheriff Morgan stated that about 40 percent of his deputies have received the training, which is above average for the area. The Commonwealth provided sufficient funds to train about 25 percent of the deputies, and he paid for the remainder from his budget. Sheriff Morgan stated that funding for training has not been an issue, but that capacity and the ability to move a larger number of deputies through the training process has been an issue.

Senator Howell asked if Sheriff Morgan thought 40 percent of officers trained in crisis intervention was sufficient, or if all deputies should be required to receive training, as is recommended by the Memphis CIT model. Sheriff Morgan stated that training 100 percent of deputies was the goal.

Delegate Farrell asked about other opportunities to improve the mental health service system to reduce the burden on jails. Sheriff Morgan stated that establishing therapeutic centers to provide treatment and restoring competency services in the jails would be beneficial.

Sheriff Ken Stolle, Virginia Beach, provided additional information about mental health services in jails. He stated that 100 percent of his deputies have received Crisis Intervention Team training, which he believed should be standard throughout the Commonwealth, but that CIT training was just a small piece of what the Commonwealth should be doing. He noted that insufficient funding of mental health services in jails was a major problem and that the lack of adequate mental health services both in jails and in the community meant that many individuals with mental health problems continued to be involved with the criminal justice system rather than receiving necessary treatment. To address the problem, Sheriff Stolle suggested establishing drug and alcohol detox programs and dedicated mental health units for individuals who need treatment in jails. He noted the need to encourage and facilitate delivery of mental health services in jails by community services boards, a structure that would ensure a seamless continuation in services for individuals leaving jails and returning to the community. One option would be to require the community services boards to provide such services. Sheriff Stolle also suggested that the Joint Subcommittee consider requiring mandatory outpatient treatment for individuals leaving jails, to ensure access to and compliance with mental health treatment. In closing, Sheriff Stolle stressed the importance of transitional housing for individuals leaving jails, calling safe, stable transitional housing the number one need for individuals returning to the community.

b. Overview of Mental Health Services Funding

Susan Massart, Legislative Fiscal Analyst, House Appropriations Committee, and Mike Tweedy, Legislative Analyst, Senate Finance Committee, provided an overview of recent budget actions affecting behavioral health services. They reported that the General Assembly had added \$161 million in general funds over the 2014-2016 biennium to expand services for individuals with serious mental illness, with funds dedicated to creation of a new Medicaid waiver program, known as the GAP waiver, to provide targeted physical and behavioral health services to low-income adults with serious mental illness who are at or below 60 percent of the federal poverty level (\$96.5 million); to support targeted community-based programs (\$37.2 million); to provide additional adult bed capacity at Eastern State Hospital and to backfill loss of revenues from declining need for geriatric beds (\$14.4 million); to expand capacity at state facilities serving as

providers of last resort for individuals involved in the involuntary commitment process (\$8.5 million); to address expanded time periods for emergency custody and temporary detention (\$2.8 million); and to fund the acute bed registry (\$233,586). An additional \$642.1 million in general funds was included in the Medicaid forecast over the biennium to support the growing cost of Medicaid-funded mental health services.

Ms. Massart noted that, as of August 2015, 8,187 individuals had been screened to determine eligibility for the GAP waiver program and 4,736 had been approved and enrolled. She also noted that expenditures for Medicaid-funded community mental health services have grown 22.5 percent since fiscal year 2012, with increases attributed to increased funding for the discharge assistance program, programs of assertive community treatment, crisis intervention training for law-enforcement officers, and therapeutic drop-off centers. Additional funding has also been provided for children's and youth services, supportive housing, peer support recovery programs, telepsychiatry equipment, Mental Health First Aid training, suicide prevention efforts, additional local inpatient purchase of services, and expanded inpatient capacity at state facilities resulting from the reopening of 13 beds at Northern Virginia Mental Health Institute and added capacity at Eastern State Hospital. Ms. Massart also noted that expenditures for treatment costs related to involuntary commitments, which are funded through appropriations to the Department of Medical Assistance Services, have grown by 33 percent from fiscal year 2012.

Looking forward, Ms. Massart reminded the Joint Subcommittee that language in the Appropriations Act adopted during the 2014 Session directed the Department of Behavioral Health and Developmental Services to review the current services provided at the Commonwealth's mental health hospitals and consider options for consolidating and reorganizing the delivery of state services to include programmatic assessment and fiscal impact of long-term needs for inpatient services for geriatric, adult, and forensic populations and fiscal impact of the reduction in third-party payments from reducing the geriatric patient population served in state hospitals. This report was due October 1, 2015. Additional language added to the Appropriations Act in 2015 required the Department to review Piedmont Geriatric and Catawba hospitals and examine alternate options for care, especially geriatric psychiatric care. This report was due November 1, 2015.

c. Department of Behavioral Health and Developmental Services Update and STEP VA: System Transformation, Excellence, and Performance in Virginia

Dr. Jack Barber, Interim Commissioner, Department of Behavioral Health and Developmental Services, provided an update on the Department's System Transformation initiative. He noted that comprehensive behavioral health care that includes prevention, early intervention, and wellness, as well as integration of primary health care, with an increased focus on community-based services and supports and decreased reliance on institutional care is essential to both population health and cost containment. Currently, the Commonwealth is 35th in the nation for all behavioral health funding, 40th for the number of consumers served per capita, and 15th in the nation in terms of expenditures per client. Dr. Barber stated that, given this information, the Commonwealth is not maximizing its investment.

To address this problem, the Department has undertaken efforts to transform the behavioral health care system. The transformation will have the goal of establishing excellence in behavioral health care and integrating behavioral and primary health care, with an emphasis

on population health and wellness and sustained, strategic investment in community services and supports. A key element of the transformation will be the establishment of certified community behavioral health clinics (CCBHCs) in accordance with the federal Excellence in Mental Health Act (EMHA). CCBHCs will be established at eight community services boards throughout the Commonwealth, and will provide same-day access to mental health services, standardized community services, 24/7 mobile crisis services, veterans' services, robust mental health services for children, and connections to primary care, reducing geographic disparities in service offerings, improving access to care, eliminating inconsistencies in service quality, and improving system capacity. Key components of the system will include comprehensive outpatient services, robust crisis services including 24-hour mobile crisis intervention and stabilization services, permanent supportive housing, supported employment, children's mental health and trauma services, transition age services, geropsychiatric care, jail diversion and community reentry services, behavioral health services for veterans, acute detoxification services, and prevention and early intervention services. Dr. Barber reported that the Commonwealth has received a \$2 million planning grant from the federal Substance Abuse and Mental Health Service Administration and that the Department has set aside an additional \$2 million to implement the CCBHC model. If the Commonwealth can successfully establish the eight CCBHCs by October of 2016, it will be eligible to compete for the second phase of the grant, to fund service delivery through the CCBHCs over the following two years. Ultimately, Dr. Barber stated, the goal is to bend the cost curve for behavioral health services, reducing hospitalizations, emergency department visits, and psychiatric hospitalizations, while improving behavioral health and primary health integration, health outcomes, wellness, and patient experience.

Dr. Barber also provided an update on the work of the Adult Behavioral Health, Adult Developmental Services, Children & Adolescent Behavioral Health Services, and Services to Individuals Who Are Justice-Involved transformation teams. He reported that the teams had met several times and had received public comment at those meetings. Over the course of the meetings, ten themes had emerged across all of the recommendations. These included the need to:

- Formalize and fund core services and supports across a continuum of care—focus on the right services and the right place at the right time;
- Require reimbursement for case management services;
- Strengthen the community-based system of services and supports statewide;
- Standardize quality of care expectations statewide;
- Align and maximize effectiveness of available funding streams;
- Harness the power of data across agencies in the Secretariat to utilize and improve health outcomes;
- Integrate behavioral health with physical health and social services;
- Strengthen the workforce to ensure access to services;
- Promote through policy and reimbursement a person-centered approach to care, merging the activities and processes of mental health, substance abuse, and DD/ID with those of child welfare, juvenile justice, educational, and health services, and

- Develop and conduct customized trainings for organizations that interact with populations—employers, schools, jails, etc.

Recommendations of the transformation teams focused on efforts to: increase access to services, including screening and assessment; expand person-centered/patient-centered practices; improve the spectrum of crisis services; implement and fund more targeted case management; strengthen peer and family services; and ensure better integration of behavioral health care with primary care, employment, housing, education, and social services. Recommendations of the transformation teams had been reviewed by a stakeholder group comprised of providers, advocates, family members, and persons with lived experience. Dr. Barber noted that the transformation teams have started the Fall 2015 transformation cycle, which will include additional meetings with stakeholder groups, presentation of recommendations to the Commissioner, and public town hall meetings. Additional information on the transformation teams is available on the Department's website.

Dr. Barber also discussed the activities of the involuntary commitment work group established pursuant to Chapter 742 of the Acts of Assembly of 2015. Chapter 742 directed the Commissioner of Behavioral Health and Developmental Services to work together with relevant stakeholders to review the current practice of conducting emergency evaluations for individuals subject to involuntary civil admission and to develop a comprehensive plan to authorize psychiatrists and emergency physicians to evaluate individuals for involuntary civil admission where appropriate to expedite emergency evaluations. The review and recommendations were to be completed by November 15, 2015, and reported to the Governor; the Joint Subcommittee to Study Mental Health Services in the Commonwealth in the 21st Century; the House Committee on Health, Welfare and Institutions; and the Senate Committee on Education and Health. Dr. Barber stated that the group had met several times and would report recommendations in accordance with the requirements of Chapter 742.

At the end of Dr. Barber's presentation, members of the Joint Subcommittee posed several questions. Delegate Farrell asked about demographics of individuals who were the subject of temporary detention orders. Dr. Barber noted that many were younger individuals, in their teens and early twenties. Delegate Farrell asked for additional data about these individuals, which the Department will provide.

Delegate Watts asked about the use of advance medical directives by individuals experiencing mental health crisis. Dr. Barber stated that the Department was working to increase awareness and use of advance directives but that advance directives were not frequently used.

d. Strengths and Challenges of Virginia's Mental Health System: Perspectives from Individuals and Families

Mira Signer, Executive Director, National Alliance on Mental Illness of Virginia, described the strengths and challenges of Virginia's mental health services system from the perspective of individuals and families involved in the system. She stated that families and individuals who become involved with the system often have negative experiences but that improving the mental health system can reduce the negative impacts. She described the ten characteristics of a high-quality state mental health system:

- Comprehensive;
- Integrated;

- Adequately funded;
- Focused on recovery, health promotion, and morbidity reduction;
- Composed of safe and respectful treatment environments;
- Accessible;
- Culturally competent;
- Consumer-centered and consumer- and family-driven;
- Well-staffed and trained; and
- Transparent and accountable.

Ms. Signer stated that Virginia’s mental health system was moving in the direction of incorporating key principles of recovery, health promotion, and resilience and that the system was designed in a way that would allow for enactment of policy and accountability standards. Private providers offer options and capacity, while localized systems foster buy-in and support. However, the system is also fragmented, confusing to navigate, crisis-driven, inconsistent in terms of services and funding, and lacking in consumer choice. Community services boards generally face challenges in terms of access and capacity, and the lack of clarity and rules governing the relationship between public and private providers creates additional difficulties. Other challenges include difficulty in accessing inpatient care, barriers to discharge from state hospitals, uninsured patient populations, a high number of jail inmates with mental illness, and a lack of housing.

Ms. Signer stated that top priorities for improving the adult mental health system include: expanding permanent supportive housing, integrating mental health care with primary health care, improving access to emergency and crisis stabilization services, expanding intensive outpatient services, expanding Medicaid to provide coverage for the uninsured, and improving acute care access. Top priorities for improving mental health services for children include: implementing parent and youth peer support services in the child-serving systems, expanding the array of services to develop a true continuum of care for children and youth, expanding transition-aged youth services, and bringing Systems of Care values and principles to scale in Virginia. In closing, Ms. Signer offered ten recommendations:

- Fund peer support specialists and parent support partners.
- Determine the base level of community services and how to deliver them.
- Articulate the roles and expectations of public and private providers.
- Expand early intervention and “First Episode” models.
- Expand the array of services for people under 18.
- Expand permanent supportive housing.
- Address the problem of uninsured clients.
- Address challenges with private hospitals.
- Strengthen jail diversion (i.e., specialty dockets and crisis intervention team training).

- Improve usage of mandatory outpatient treatment.

3. Other Business

During the public comment period, Judge Bruce Wilcox and Nancy Wilcox of Norfolk described challenges they've faced in accessing the mental health services system and securing services for their adult son, who has suffered a traumatic brain injury, substance abuse, and mental illness. They noted that due to lack of services, including a lack of housing, their son has often ended up in jail. Judge and Mrs. Wilcox recommended improving education for those involved in the criminal justice system to enable them to assist individuals with behavioral health needs. Judge Wilcox also noted that the mental health docket in Norfolk has been a success and that it has saved money and lives.

E. Meeting of November 13, 2015

1. Overview

The Joint Subcommittee held its fifth meeting of 2015 on Friday, November 13, 2015, at the James J. McCoart Administration Building in Woodbridge, Virginia.

2. Presentations

a. Mental Illness in the Jails: The Challenge to Provide for Incarcerated Virginians with Behavioral Health Issues

Dr. Michael Schaefer, Assistant Commissioner for Forensic Services, Department of Behavioral Health and Developmental Services, spoke to the Joint Subcommittee about challenges to providing mental health services to individuals identified as having mental illness in jail. Dr. Schaefer noted that the recent report by the Compensation Board identified 16.81 percent of the total jail population as having some mental illness and 7.87 percent as suffering from serious mental illness. These numbers may misrepresent the actual number of individuals with mental illness in jails because the report captured a single point in time and the numbers are self-reported by jails. There is no standardized screening or assessment process across jails.

The Supreme Court has established that jails have a constitutional obligation to provide medical care, including psychiatric care, to individuals in the jail. Individual jails decide how they will meet this obligation. A jail may contract with a private agency, hire its own behavioral health staff, or contract with a community services board (CSB). Dr. Schaefer also noted that there is no consistent formulary across individual jails.

Currently there is no requirement that CSBs provide services in jails. The Code of Virginia does require that CSBs conduct prescreening assessments and "outpatient" competency restoration services. The DBHDS is required to provide competency to stand trial evaluations, sanity at the time of offense evaluations, inpatient treatment to restore competency to stand trial, emergency treatment orders, and post-not guilty by reason of insanity adjudication.

DBHDS has waiting lists for behavioral health services for individuals coming from jails. Most individuals on the waiting list are those who have been ordered for inpatient competency restoration. Most are served at Eastern State Hospital and Central State Hospital. The waiting list to get into Eastern State Hospital for services is about 67 days. This is lengthened by the delay in actually getting people on the waiting list created by delays in receiving orders. The waiting lists tend to grow when "civil" bed demand grows.

The Commonwealth has several jail diversion programs. The state has focused on the early stage of jail diversion such as Crisis Intervention Team (CIT) programs and assessment sites. CIT programs are based on the CSB service area, and 37 of 40 CSBs have programs. There is currently no general fund money for CIT training available. There is some general fund money available for CIT assessment sites.

Dr. Schafer presented DBHDS's recommendations to the Joint Subcommittee. The recommendations include funding for criminal justice diversion programs, discharge planning funds and permanent supportive housing funds, funding to expand availability of outpatient competency restoration service, establishing standards for behavioral health care across jails, establishing a standardized screening and assessment process, establishing a standard formulary, and Mental Health First Aid or CIT training for jail personnel.

b. Magistrate Involvement in Mental Health Processes

Mason Byrd, Magistrate System Coordinator and Jonathan Green, Magistrate Advisor, Supreme Court of Virginia, spoke to the Joint Subcommittee about the role of Magistrates in the mental health process. Magistrates may issue emergency custody orders or temporary detention orders if the statutory criteria are satisfied. The presenters noted that Magistrates have unique authority to issue these processes and may issue such processes based upon the sworn petition of a responsible party or on the magistrate's own motion.

Mr. Byrd noted that because magistrates play a unique role in the mental health system, mental health training is one of the largest components of instruction in magistrate certification school. The training is focused on application of Virginia law, including required findings and procedural matters. They are not trained to diagnose mental illness, as they rely on the testimony of the petitioner or other witnesses to establish mental illness. All magistrates participate in mock mental health hearings during their initial training. Additionally, magistrates receive supplemental training when there are changes to Virginia's mental health laws.

The two presenters noted that diversion is not an option for Magistrates to consider. A magistrate may not refuse to hear criminal complaints against mentally ill individuals, nor may he refuse to issue criminal process against a mentally ill individual if the magistrate has probable cause to believe the accused committed a crime. There aren't any exceptions for mental illness.

c. Mental Illness and the San Antonio Model

Gilbert Gonzales, Director, Mental Health Department, Bexar County, Texas, and Mike Lozito, Director, Judicial Services Office, Bexar County, Texas, gave a presentation to the Joint Subcommittee regarding the Bexar County mental health system. Bexar County has taken an integrated approach to mental health that focuses on diversion and treatment after realizing that such an approach is more cost-effective and results in better treatment outcomes to provide mental health services and supports to people on the front end, rather than pay for jail beds and prison time.

Bexar County has been focused on diversion since 2000. Law enforcement, the county jail, the courts, hospitals, and other county services have integrated their efforts to keep individuals out of jail and get them into treatment. The jails in Bexar County are currently under capacity and have realized significant savings since implementing the program.

Central to the program has been the development of crisis care community centers. The Rehabilitation Center in San Antonio offers inpatient psychiatric care, outpatient primary care,

and other psychiatric services. The Center can help individuals with mental illness, substance abuse, and housing needs, and it even provides job training. Around 18,000 individuals receive treatment at the Center each year.

3. Public Comment

Christy Gallagher, member of the board of the National Alliance on Mental Illness of Virginia, and mother of a child with mental illness, addressed the Joint Subcommittee. Virginia needs a comprehensive array of services. She said most areas of the Commonwealth don't have these services and those areas that do have the services don't have enough. NAMI's top priorities are to expand supportive housing, integrate primary and behavioral health care, strengthen round-the-clock services and crisis stabilization, expand outpatient care, cover the uninsured, expand Medicaid, improve acute care access, implement parent and youth peer support, ensure a full continuum of care, and expand transition to aged services.

V. Interim Recommendations of the Joint Subcommittee

During the first two years of its work, the Joint Subcommittee has concentrated on reviewing the works and recommendations of previous studies on the provisions of mental health services in the Commonwealth and on familiarizing itself as to the current state of the mental health system in Virginia. To that end, the Joint Subcommittee has received extensive testimony from numerous experts in the field of mental health, both from inside and outside the governmental sector. In addition, the Joint Subcommittee has toured numerous mental health facilities and service providers throughout the Commonwealth.

In the second two years of its work, the Joint Subcommittee will utilize the information it has collected regarding Virginia's mental health system and intends to make recommendations as to what services should be provided and the statutory or regulatory changes necessary to improve access to such services by persons who are in need of mental health care. In keeping with this goal, the Joint Subcommittee intends to reconfigure the membership and subject matter areas of its work groups in order to facilitate the making of such recommendations.

SENATE BILL NO. _____ HOUSE BILL NO. _____

1 A BILL to amend the Code of Virginia by adding in Chapter 3 of Title 37.2 an article numbered 5,
2 consisting of sections numbered 37.2-320 and 37.2-321, relating to the Virginia Behavioral
3 Health Practitioner Student Loan Repayment Fund and Program.

4 **Be it enacted by the General Assembly of Virginia:**

5 **1. That the Code of Virginia is amended by adding in Chapter 3 of Title 37.2 an article numbered**
6 **5, consisting of sections numbered 37.2-320 and 37.2-321, as follows:**

7 Article 5.

8 Virginia Behavioral Health Practitioner Student Loan Repayment Fund and Program.

9 **§ 37.2-320. Virginia Behavioral Health Practitioner Student Loan Repayment Fund.**

10 There is hereby created in the state treasury a special nonreverting fund to be known as the
11 Virginia Behavioral Health Practitioner Student Loan Repayment Fund, referred to in this section as "the
12 Fund." The Fund shall be established on the books of the Comptroller. All funds appropriated for such
13 purpose and any gifts, donations, grants, bequests, and other funds received on its behalf shall be paid
14 into the state treasury and credited to the Fund. Interest earned on moneys in the Fund shall remain in
15 the Fund and be credited to it. Any moneys remaining in the Fund, including interest thereon, at the end
16 of each fiscal year shall not revert to the general fund but shall remain in the Fund. Moneys in the Fund
17 shall be used solely for the purposes of awarding student loan repayment grants to eligible behavioral
18 health practitioners through the Virginia Behavioral Health Practitioner Student Loan Repayment
19 Program. Expenditures and disbursements from the Fund shall be made by the State Treasurer on
20 warrants issued by the Comptroller upon written request signed by the Commissioner.

21 **§ 37.2-321. Virginia Behavioral Health Practitioner Student Loan Repayment Program.**

22 A. As used in this section:

23 "Eligible behavioral health practitioner" means an individual licensed or certified to provide
24 behavioral health services in the Commonwealth.

25 "Fund" means the Virginia Behavioral Health Practitioner Student Loan Repayment Fund
26 established in § 37.2-320.

27 B. Beginning January 1, 2017, an eligible behavioral health practitioner may apply to the
28 Department for a grant from the Fund. Such grant shall be used for the purposes of student loan
29 repayments and shall not exceed \$10,000 per recipient per year. Prior to the award of any grant, the
30 applicant shall sign a contract in which he agrees to a 12-month employment obligation with a
31 community services board, behavioral health authority, or Department facility in the Commonwealth or
32 with an entity that has entered into a contract with a community services board, behavioral health
33 authority, or Department facility in the Commonwealth to provide behavioral health services.

34 C. Grants shall be issued by the Department in the order that each completed eligible application
35 is received. The Department shall award no more than 250 grants per year. In the event that the amount
36 of eligible grants requested in a fiscal year exceeds the funds available in the Fund, such grants shall be
37 paid in the next fiscal year in which funds are available.

38 D. The Department shall develop guidelines setting forth the general requirements of qualifying
39 for a grant including a grant application form, a certification form from the employing behavioral health
40 facility, and an obligation contract. Such guidelines shall be exempt from the Administrative Process
41 Act (§ 2.2-4000 et seq.). Specific provisions of the obligation contract shall be developed by the
42 Department in consultation with the Office of the Attorney General.

43

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SUMMARY

Virginia Behavioral Health Practitioner Student Loan Repayment Fund and Program.

Establishes the Virginia Behavioral Health Practitioner Student Loan Repayment Fund and Program to provide student loan repayment grants to eligible behavioral health practitioners who agree to a 12-month employment obligation with a community services board, behavioral health authority, or Department of Behavioral Health and Developmental Services facility or with an entity that has entered into a contract with a community services board, behavioral health authority or Department of Behavioral Health and Developmental Services facility to provide behavioral health services. Grants may be up to \$10,000 per recipient per year, and the Department of Behavioral Health and Developmental Services may award up to 250 grants per year.

- Recommendations fall under (2) categories: Services and Workforce
- **Services**
 - 4 base services that all CSBs should have:
 - Child psychiatry
 - Crisis Intervention
 - Intensive in-home services
 - Case management
 - The priority recommendation is the expand the number and capacity of services to provide for a consistent level of care for children and their families across Virginia.
 - Doing so would have the greatest impact on reducing reliance on inpatient and residential care.

Recommendations:

1. Fund the creation of (5) additional Crisis Stabilization Units (CSU) for Children in each of Health Planning Regions.
 - CSUs provide short-term residential crisis stabilization and provide almost immediate access to assessment, prescreening, temporary detention, treatment and care planning.
 - Currently, 2 CSBs report having adequate capacity with this service, 1 CSB reports providing this service with inadequate capacity and 37 do not provide this service.
 - Estimated cost is \$1.265 million per unit per region or \$6.326 million for all (5) HPRs.
2. Fund the creation of (5) pilot mobile crisis response teams.
 - Teams would be multidisciplinary and provide 24 hour crisis intervention services to families.
 - Estimated cost is \$2 million per team per region or \$10 million for all (5) HPRs.
3. Expand CSB children case management services to all CSBs.
 - Currently, 20 CSBs report having adequate capacity and 20 report having inadequate capacity.
 - Estimated cost is \$80,000 (salary, fringe and support) per case manager per CSB or \$1.6 million for (20) case managers
4. Continue to add additional children's psychiatric services in each HPR.

- Currently, \$6.65 million GF annually is allocated to these services
- Increase the annual funding amount for these services to \$10 million GF annually to bring it up to base funding .

- Workforce
 - Even if funding were available to expand services, finding qualified providers for all parts of the Commonwealth is still a challenge.
 - CSBs have stated numerous times that they really need help with workforce issues before more services are mandated.

Recommendations:

1. Propose the creation of the Virginia Mental Health Practitioner Student Loan Assumption Program
 - Provide funding to develop a loan forgiveness program in order to retain qualified mental health professionals working within our Community Services Boards (CSBs)/Behavioral Health Authorities (BHAs)/DBHDS facilities
 - Allocate \$2.5 million per year or \$5 million over the biennium
 - Up to 250 awardees per year
 - Awardees may receive up to \$10,000 per year
 - Must have a 12-month service obligation within a CSB/BHA/DBHDS facility

2014 SESSION

APPENDIX

ENROLLED

SENATE JOINT RESOLUTION NO. 47

Establishing a joint subcommittee to study mental health services in the Commonwealth in the twenty-first century. Report.

Agreed to by the Senate, March 8, 2014
Agreed to by the House of Delegates, March 8, 2014

WHEREAS, the provision of mental health services has been a core responsibility of the Commonwealth of Virginia since 1776, with the establishment of the nation's first publicly supported state mental institution in Williamsburg; and

WHEREAS, the Commonwealth appropriated \$585 million for behavioral health services provided through the Department of Behavioral Health and Developmental Services (the Department) in fiscal year 2013, and of this total amount, 52 percent was provided to serve 1,203 individuals treated in state mental health facilities and the remaining 48 percent provided services for 146,503 individuals living in the community; and

WHEREAS, the current system of care should be reexamined to ensure that resources are aligned to serve the most individuals with behavioral health issues in the most appropriate settings along the continuum of care funded by the Department; and

WHEREAS, in the twenty-first century, the Commonwealth is challenged to provide mental health care through a complex and often confusing array of facilities, programs, and services for individuals with a broad range of mental health needs, including persons requiring voluntary and involuntary, emergency, short-term, forensic, and long-term mental health care in both inpatient and outpatient settings in the public and private sectors; and

WHEREAS, the Commonwealth, since the report of the Hirst Commission over 40 years ago, has made a commitment to provide a system of community-based care for the mentally ill; and

WHEREAS, the fulfillment of that commitment requires that every individual and family experiencing a mental health crisis has access to emergency mental health services without delay; and

WHEREAS, the resources available to local and regional community services boards and behavioral health authorities have not kept pace with the increasing number of persons in need of services as, despite those increasing needs, the Department has reduced the number of beds in state facilities, and private hospitals have often lacked the resources and reimbursement mechanisms needed to fill the gaps when called upon; and

WHEREAS, many persons in need of crisis intervention and emergency mental health treatment have been unable to access treatment and support services on a timely basis, and at the same time a significant number of persons with mental illness commit various offenses, in many cases minor, nonviolent offenses, and are arrested by law-enforcement officers, brought before the courts, and held in jails or juvenile detention facilities rather than being provided with the necessary treatment in the most appropriate setting in order to prevent their entry into the criminal justice system; and

WHEREAS, in July 2013, an estimated 23.5 percent of Virginia's local and regional jail population, or 6,346 offenders, were estimated to be mentally ill, and of these offenders, 56 percent, or 3,555 offenders, were estimated to be seriously mentally ill, according to the annual jail mental health survey conducted by the State Compensation Board in cooperation with the Department; and

WHEREAS, the Commonwealth has provided significant resources to both local and regional community services boards and behavioral health authorities and to local and regional jails and juvenile detention centers, including a significant fiscal incentive through the reimbursement of up to one-half of the capital cost of construction or enlargement of regional jails, but no comparable incentive for the development of mental health facilities at the community level that may be needed to serve persons with serious mental illness has been provided; and

WHEREAS, significant changes have occurred in recent years in the legal and regulatory framework, federal and state reimbursement structures, and service delivery systems, both public and private, for mental health care, including the largely unintended consequences of the increasing involvement of persons with mental illness in the criminal justice system; and

WHEREAS, there is a need for the General Assembly to consider the types of facilities, programs, and services and appropriate financing mechanisms that will be needed in the twenty-first century to provide mental health care, both in traditional mental health delivery systems and in the criminal justice system; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That a joint subcommittee be established to study mental health services in the Commonwealth in the twenty-first century. The joint subcommittee shall consist of 12 legislative members. Members shall be appointed as follows: five

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members of the Senate, of whom two shall be members of the Senate Committee on Education and Health, two shall be members of the Senate Committee on Finance, and one shall be a member at-large, to be appointed by the Senate Committee on Rules; and seven members of the House of Delegates, of whom two shall be members of the House Committee on Health, Welfare and Institutions, two shall be members of the House Committee on Appropriations, and three shall be members at-large, to be appointed by the Speaker of the House of Delegates in accordance with the principles of proportional representation contained in the Rules of the House of Delegates. The joint subcommittee shall elect a chairman and vice-chairman from among its membership, who shall be members of the General Assembly.

The joint subcommittee may appoint work groups to assist it with its work. In conducting its study, the joint subcommittee shall (i) review and coordinate with the work of the Governor's Task Force on Improving Mental Health Services and Crisis Response; (ii) review the laws of the Commonwealth governing the provision of mental health services, including involuntary commitment of persons in need of mental health care; (iii) assess the systems of publicly funded mental health services, including emergency, forensic, and long-term mental health care and the services provided by local and regional jails and juvenile detention facilities; (iv) identify gaps in services and the types of facilities and services that will be needed to serve the needs of the Commonwealth in the twenty-first century; (v) examine and incorporate the objectives of House Joint Resolution 240 (1996) and House Joint Resolution 225 (1998) into its study; (vi) review and consider the report *The Behavioral Health Services Study Commission: A Study of Virginia's Publicly Funded Behavioral Health Services in the 21st Century*; and (vii) recommend statutory or regulatory changes needed to improve access to services, the quality of services, and outcomes for individuals in need of services.

In reviewing the need for facility beds at the community level, the joint subcommittee shall give consideration to whether the current fiscal incentives for expanding regional jail capacity should be eliminated and replaced with a new incentive for construction, renovation, or enlargement of community mental health facilities or programs, which may or may not be co-located with selected jails on a regional basis. The joint subcommittee shall consider the appropriate location of such facilities; cooperative arrangements with community services boards, behavioral health authorities, and public and private hospitals; licensing, staffing, and funding requirements; and the statutory and administrative arrangements for the governance of such facilities. The joint subcommittee shall give consideration to the development of such facilities or programs on a pilot basis.

Administrative staff support shall be provided by the Office of the Clerk of the Senate. Legal, research, policy analysis, and other services as requested by the joint subcommittee shall be provided by the Division of Legislative Services. Technical assistance shall be provided by the Office of the Executive Secretary of the Supreme Court of Virginia, the Office of the Attorney General, the Offices of the Secretaries of Health and Human Resources and Public Safety, and the staffs of the Senate Finance and House Appropriations Committees, upon request. All agencies of the Commonwealth shall provide assistance to the joint subcommittee for this study, upon request.

The direct costs of this study shall not exceed \$72,560 for each year without approval as set out in this resolution. Of this amount an estimated \$50,000 is allocated for speakers, materials, and other resources. Approval for unbudgeted nonmember-related expenses shall require the written authorization of the chairman of the joint subcommittee and the respective Clerk. If a companion joint resolution of the other chamber is agreed to, written authorization of both Clerks shall be required.

No recommendation of the joint subcommittee shall be adopted if a majority of the Senate members or a majority of the House members appointed to the joint subcommittee (i) vote against the recommendation and (ii) vote for the recommendation to fail notwithstanding the majority vote of the joint subcommittee.

The joint subcommittee shall submit its interim report by December 1, 2015, to the Governor and the General Assembly and its final report by December 1, 2017, to the Governor and 2018 Regular Session of the General Assembly. The interim and final reports shall be submitted as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents and reports and shall be posted on the General Assembly's website.

Implementation of this resolution is subject to subsequent approval and certification by the Joint Rules Committee. The Committee may approve or disapprove expenditures for this study, extend or delay the period for the conduct of the study, or authorize additional meetings during the 2014 and 2017 interims.

