COMMONWEALTH of VIRGINIA

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November 22, 2019

The Honorable Thomas K. Norment, Jr., Co-chair
The Honorable Emmett W. Hanger, Jr., Co-chair
Senate Finance Committee
The Honorable Chris S. Jones, Chair
House Appropriations Committee
900 East Main Street
Richmond, VA 23219

Dear Senator Norment, Senator Hanger, and Delegate Jones:

Item 310 CC.1 – 3 of the 2019 Appropriation Act requires the Department of Behavioral Health and Developmental Services (DBHDS) to develop and report on a plan to “right size” the state behavioral health hospital system. The language reads:

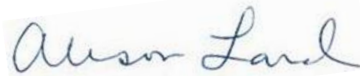
> *CC.1. The Department of Behavioral Health and Developmental Services shall establish a workgroup, which shall include the Virginia Hospital and Healthcare Association, other state agencies, and other stakeholders as deemed necessary by the department, to examine the impact of Temporary Detention Order admissions on the state behavioral health hospitals. The workgroup shall develop options to relieve the census pressure on state behavioral health hospitals, which shall include options for diverting more admissions to private hospitals and other opportunities to increase community services that may reduce the number of Temporary Detention Orders. The workgroup shall develop an action plan, that includes actions that can be implemented immediately and other actions that may require action by the 2020 General Assembly. The action plan shall take into account the need to take short-term actions to relieve the census pressure on state behavioral health hospitals in order to develop a plan for the right sizing of the state behavioral health hospital system. The department shall report its findings to the Governor and the Chairmen of the House Appropriations and Senate Finance Committees by October 15, 2019.*
>
> ***2. In conjunction with the workgroup in paragraph CC.1., the Department of Behavioral Health and Developmental Services shall develop a conceptual plan to***

"right size" the state behavioral health hospital system, including future capacity and distribution of capacity, that aligns with the action plan that is recommended by the workgroup. The department shall submit the plan to the Governor and the Chairmen of the House Appropriations and Senate Finance Committees by November 1, 2019.

3. As part of the plan in paragraph CC.2., the Department of Behavioral Health and Developmental Services shall include a proposal for construction of a new Central State Hospital. The plan shall establish the scope of the new hospital within a "right sized" system and the appropriate timeline to coincide with efforts to relieve census pressures on the state mental health hospital system.

In accordance with these items, please find enclosed the report for Item 310 CC of the 2019 Appropriations Act. Staff are available should you wish to discuss this request.

Sincerely,



Alison Land
Commissioner

Cc:
Marvin Figueroa
Susan E. Massart
Mike Tweedy

Report on Item 310 CC.2. Of the 2019 Appropriations Act

To the Governor and the Chairs of the Senate Finance and House Appropriations Committees

November 1, 2019

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Preface

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I. Introduction, Vision, and Guiding Principles for Virginia's Behavioral Health System

According to national prevalence rates, 352,724 (5.4 percent) Virginians aged 18 and older have a serious mental illness. [1] State behavioral health systems play a crucial role in providing mental health and substance use services to adults with mental illness and children with serious emotional disorders. In Virginia, behavioral health services are delivered through community services boards, state psychiatric hospitals, private hospitals, private providers of community-based services, and school-based providers.

The vision for Virginia's behavioral health system is to provide a comprehensive array of high quality, recovery-oriented, evidence-informed services to people with mental health disorders, to focus on early intervention and wellness across the lifespan, and to serve people in the least restrictive setting possible, according to their needs. A right sized system, as outlined in the language, must preserve several guiding principles:

- People with disabilities, including mental illness and behavioral health disorders, should be served in the **most integrated settings** as required under the *Olmstead* decision.
- A **comprehensive community-based system** of care focused on early intervention, prevention, and wellness across the lifespan is an essential component of a well-functioning mental health system.
- An **adequate and robust provider network** is critical for establishing a community-based system of care with levels of care across the continuum
- The **role of the state hospital** must be defined as a specific and targeted component of the overall system of care.
- The **current state hospital census challenge** does not lend itself to the concept of right-sizing the state hospitals; the state hospital census must plateau and or trend downward and remain that way for an extended period of time before any downsizing steps are taken.
- **Stakeholder involvement** is critical to the success of any right-sizing efforts.

DBHDS has considered several critical elements in a conceptual plan to right-size Virginia's behavioral health hospital system, including promising developments in treatment, policy, and philosophy, as well as data and trends in the ways states use psychiatric hospitals and funding.

II. History and Current Context: Promising Developments in Treatment, Policy, and Philosophy

Virginia's involvement with mental health treatment dates back to 1773 when Eastern State Hospital – the first public facility in the United States for people with mental illness – was founded. During that time, most people with mental disorders were institutionalized, some indefinitely, as there was little else effective treatment available. Nearly 200 years later, however, the United States as a whole began moving from institutionalized care to community-based care. New laws,

[1] SAMHSA, Adult Mental Health Prevalence, as provided by SAMHSA and the National Association of State Mental Health Program Directors (NASMHPD)

like the Community Mental Health Act of 1963, were passed to promote community-based services and the creation of community mental health services like outpatient services, psychiatric services, and case management. Passage of these laws very quickly and significantly decreased the number of individuals in institutional care, with many patients discharged from state mental hospitals and placed into community settings. Evidence-informed models such as Assertive Community Treatment (ACT), supportive housing, and new psychiatric medications helped spur the development of more community-based systems of care.

To align with the goals and objectives of the *Olmstead* ruling and Americans with Disabilities Act, Virginia must continue to move towards a community-based system of care for behavioral health to reduce overreliance on the state hospital system by expanding current reforms – like Coordinated Specialty Care programs, STEP-VA, permanent supportive housing (PSH), and ACT – and implementing new efforts – like creating a robust mobile crisis response system and adding lower levels of care in the Medicaid continuum. Without these, while it is worthwhile to contemplate and aspire to a right-sized hospital system, it is difficult to actualize.

STEP-VA

DBHDS and behavioral health system stakeholders are working on many levels to advance community-based mental health services across Virginia. In 2017, the General Assembly enacted Chapter 607[2] to expand the core services of community services boards by June 30, 2021 to include same day access, primary care screening, crisis services, outpatient services, psychiatric rehabilitation services, peer support and family services, veteran support services, care coordination, and case management. These nine services are collectively part of a multi-year initiative called System Transformation, Excellence and Performance (STEP-VA). To date, the General Assembly has funded or partially funded four steps (same day access, primary care screening, outpatient services, and crisis services). STEP-VA is foundational to creating the training and infrastructure necessary to ensure a complete continuum of evidence-based community based services that are effective in reducing behavioral health crises and diverting or preventing individuals from more costly levels of care, including inpatient admissions to state hospitals.

Full initiation and implementation of STEP-VA will support and complement any actions to reduce state hospital census by providing access to a critical continuum of these services to help people manage their symptoms before reaching a point of crisis that requires costly, restrictive hospitalization. In the long term, it serves as a key element in the platform for right sizing the state hospital system and is fundamental to that process. STEP-VA is part of a larger goal to reduce over-reliance on state psychiatric hospitals and inpatient care, while continuing to advance a system that is grounded in community-based services and supports that address prevention and needs well before crisis services or inpatient services are required.

Permanent Supportive Housing

Permanent supportive housing (PSH) is an evidence-based practice for adults with serious mental illness (SMI) that has been implemented, refined, and studied for more than thirty years. A notable subset of individuals with SMI are unstably housed or homeless and, as a result, have poor behavioral health outcomes and are high utilizers of costly treatment and criminal justice

[2] http://lis.virginia.gov/cgi-bin/legp604.exe?171+ful+CHAP0607+pdf

resources. Multiple peer-reviewed research studies, including seven randomized controlled trials, found that PSH is particularly effective in improving participants' housing stability and reducing emergency department and inpatient hospital utilization[3].

Outcomes for individuals served in DBHDS' PSH programs reflect significant improvements in housing stability and reductions in hospital utilization. In 2016, the top twenty percent of those accessing Crisis Stabilization, CSB Emergency Services, or State-Funded Inpatient Psychiatric Care (LIPOS) in Virginia were homeless or unstably housed, but data shows a 94 percent reduction in state hospital bed use for individuals after at least one year in permanent supportive housing.

Additionally, the statewide outcomes for the 950 individuals who were house between February 6, 2016 and July 1, 2019 demonstrate the value of investment in permanent supportive housing for people with serious mental illness who are frequent users of high-cost systems in Virginia such as emergency services and state hospitals:

- One hundred forty seven individuals were discharged from a state psychiatric hospital into DBHDS permanent support housing, and overall, 228 individuals in PSH had a state hospital admission the year before move-in.
- At least 95 individuals served in PSH were on the extraordinary barrier list (EBL) in the year before move-in.
- Eighty-six percent of individuals served in PSH remained stably housed.
- Only 6 percent of those service in the DBHDS PSH programs have been discharged to an institutional setting or higher level of care.
- State hospital utilization decreased 82 percent the year after PSH move-in, resulting in avoided costs of $9.5 milllion.
- A DBHDS cross-system cost impact analysis identified a 29 percent decrease in private hospital, state hospital, jail, and CSB costs after one year of PSH.

PSH is a critical component for reducing emergency departments, inpatient hospital care, and CSB emergency services, and is effective in reducing state hospital bed utilization for unstably housed individuals. Individuals who are enrolled in PSH experience dramatic improvements in housing instability and rely less on emergency, crisis, and inpatient care.

Programs of Assertive Community Treatment (PACT)

Assertive Community Treatment (ACT, or PACT as it is known in Virginia) is one of the oldest and most widely researched evidence-based practices in behavioral healthcare. Research shows that ACT reduces hospitalizations and incarceration, increases housing stability, and improves quality of life for people with the most severe symptoms of mental illness[4]. To do so, ACT utilizes a multidisciplinary, community-based team of medical, behavioral health, and rehabilitation professionals who work together to meet the needs of the individuals that they serve.

[3] https://doi.org/10.1176/appi.ps.201300261

[4] For a collection of relevant research, see: UNC Institute for Best Practices. (2019). *ACT* [Research]. Retrieved from http://www.institutebestpractices.org/act/research/

ACT is a cost-effective method of person-centered treatment. The average cost per client served by PACT teams across the Commonwealth is $15,754, with 78 percent of those clients served in FY2018 having zero local hospitalizations. All new PACT clients in FY2016 (324 individuals with SMI) accounted for 21,546 state hospital bed days in the two years before PACT admission and just 11,642 in the two years after PACT admission, which represents a 54% reduction in state hospital utilization or cost avoidance for that group of $8,061,856.

Coordinated Specialty Care (CSC)
First episode psychosis is often an indicator of the emergence of serious mental illness such as schizophrenia, and evidence indicates that high-intensity interventions provided at this stage of illness change the long term trajectory of the disorder towards reaching recovery goals effectively. Coordinated Specialty Care (CSC) is an evidence-based, standardized treatment for first episode psychosis. CSC is currently provided by eight CSBs to transitional age youth, aged 16 to 25 years, who have emerging serious mental illness. Virginia uses a combination of Mental Health Block Grant set-aside funds and state funds to support CSC programs.
States with strong CSC program implementation, such as Oregon and New York, have achieved statewide expansion through a combination of annual allocation of state funds, SAMHSA funding, commercial insurance, and Medicaid coverage. This impact of evidence-based, high intensity treatments for early stages of SMI will result in decreasing the overall burden on inpatient psychiatric facilities.

Proposed Medicaid Behavioral Health Redesign
Complementary to STEP-VA, DBHDS, the Department of Medical Assistance Services (DMAS), CSBs, and providers across the Commonwealth are proposing a redesign of the Medicaid community-based mental health services system. Medicaid behavioral health redesign seeks to shift Virginia's system for adults and children from its current state to a modern, evidence-based system of community-based services. If Medicaid Behavioral Health Redesign advances in the General Assembly, the proposed first six services will focus on services that directly address the hospital census. These services include: intensive outpatient, partial hospitalization, assertive community treatment, comprehensive crisis services, multi-systemic therapy, and functional family therapy (MST/FFT). Ensuring adequate reimbursement for these services will reduce reliance on costly inpatient psychiatric care and provide appropriate step down levels of care to divert individuals from inpatient admissions whenever appropriate.

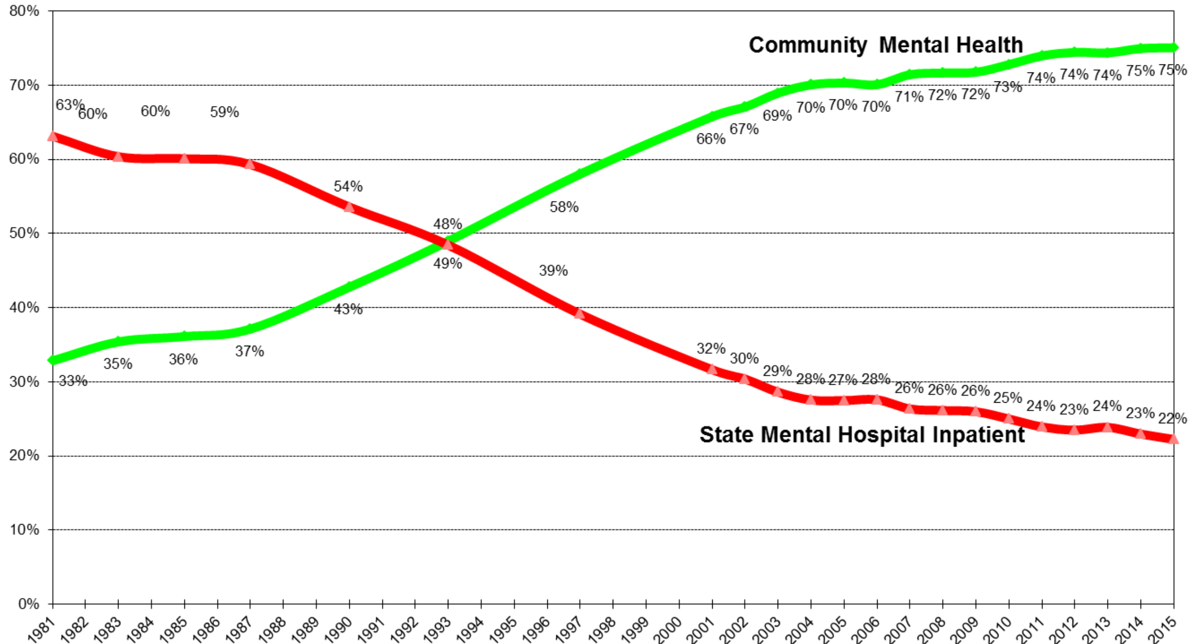
Mobile Crisis
The current crisis system is historically reactive in that it may not meet an individual's needs in their current setting, and has an inconsistent focus on proactive, preventative services. Rather than meeting the crisis needs of adults and children in their current setting, where there is familiarity and higher likelihood of mitigating further triggers, the adult or child is taken to the emergency department. Virginia is moving toward a more responsive system that support all individuals of all ages and disabilities in crisis. A pillar of this responsive system is mobile crisis. There is direct evidence that mobile crisis services disrupt the cycle of unnecessary hospitalizations for individuals with mental illness. If available statewide, mobile crisis can increase diversion from acute inpatient hospitalizations and will have an impact over time on

reducing hospital census. Any efforts to right size hospital the state hospital system should begin after regional implementation of mobile crisis supports for both children and adults.

III. National Data and Trends

On average, states use 23 percent of state mental health authority (SMHA) resources on state hospital care and 77 percent in the community (See Figure 1). (These figures exclude Medicaid expenditures.) [5] In contrast, Virginia spends roughly equal amounts for community-based services and state psychiatric hospital care. Hospital care is substantially more expensive and serves far fewer individuals than the community care. As a result, half of Virginia's general fund dollars allocated for its behavioral health system supports just three percent of the total individuals served each year. The imbalance in Virginia is exacerbated because it operates nine state hospitals, the majority of which are structurally and operationally outdated and require significant capital investment each year to maintain.

Figure 1: National Average of State Expenditures for State Hospitals and Community-Based Services as a Percent of Total Expenditures, FY 1981 to FY 2015



As SMHA resources have shifted from hospitals to community and the role of state hospitals has also changed, the number and size of state hospitals in each state has also changed. More than half of states have three or fewer state psychiatric hospitals, while only eleven states, including Virginia, have more than 6 state hospitals. Though the daily census at these hospitals averaged in the thousands in the 1950s and 1960s, the majority of these hospitals now average a census of 200 individuals per day. In addition and in contrast to Virginia, many other states do not provide treatment in state psychiatric hospitals for individuals under temporary detention. NASMPHD notes in its report, "The Vital Role of State Psychiatric Hospitals", that at least seventeen states require general and local hospitals be used as an initial admission site for psychiatric inpatient

[5] *The Vital Role of State Psychiatric Hospitals.* NASMPHD, July 2014

treatment before an individual uses state psychiatric facilities. If a patient still requires treatment after a defined length of stay, they will then be sent to a state facility for treatment.

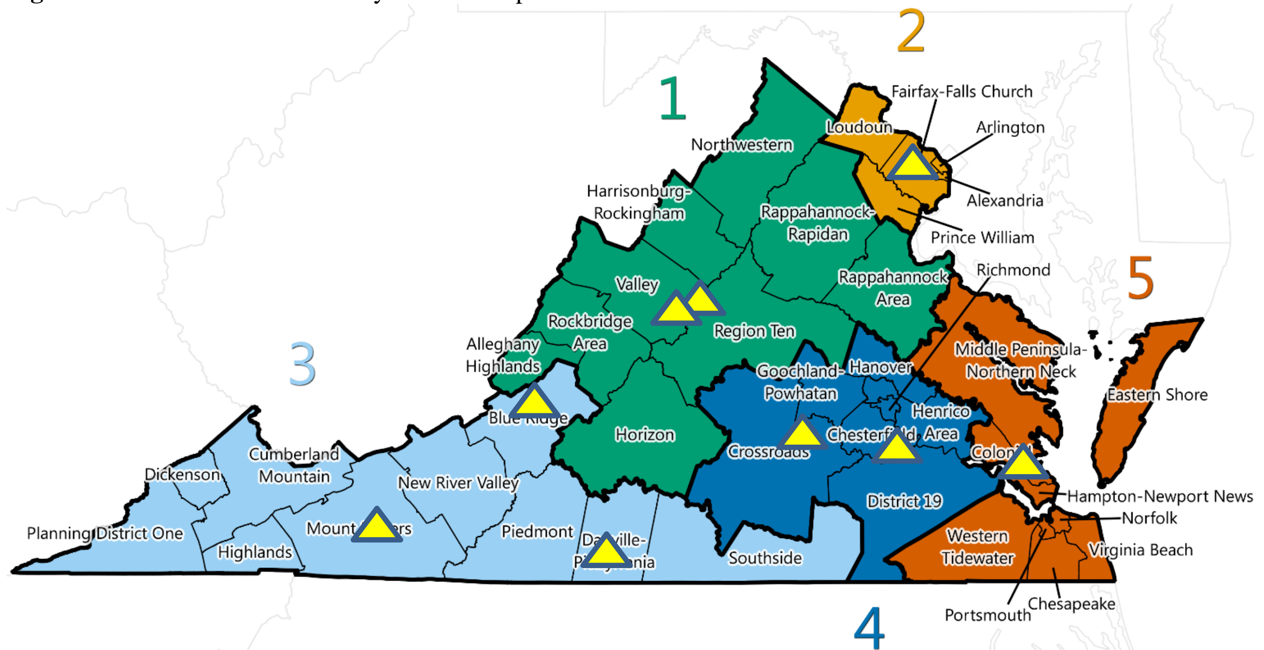
IV. Virginia State Psychiatric Hospitals: A Vital Part of the Continuum

Currently, DBHDS manages nine state psychiatric hospitals throughout the Commonwealth, one of which only treats children up to age 18. Additionally, Piedmont Geriatric Hospital is the only institution in the Commonwealth to exclusively treat patients 65 and older. There are three other hospitals – Catawba, Southwestern Virginia Mental Health Institute (SWVMHI) and Eastern State Hospital (ESH) – that have geriatric units. Figure 2 shows DBHDS' current state hospital structure, location, population, and number of beds, inclusive of 56 potential additional beds added to Catawba in FY 2020. Figure 3 shows the general location of each state hospital.

Figure 2: DBHDS State Operated Psychiatric Hospitals

Hospital	Location	Population	Beds
Catawba Hospital	Salem	Adult and Geriatric	166 (78 adult; 88 geriatric)
Central State Hospital	Petersburg	Adult	277 (166 civil; 111 maximum security forensic)
Commonwealth Center for Children & Adolescents	Staunton	Children	48
Eastern State Hospital	Williamsburg	Adult	302 (262 adult; 40 geriatric)
Northern Virginia Mental Health Institute	Fairfax	Adult	134
Piedmont Geriatric Hospital	Dinwiddie	Geriatric	123
Southern Virginia Mental Health Institute	Danville	Adults	72
Southwestern Virginia Mental Health Institute	Marion	Adult and Geriatric	179 (139 adult; 40 geriatric)
Western State Hospital	Staunton	Adults	246

Figure 3: Location of All State Psychiatric Hospitals



Before the Bed of Last Resort was enacted, Virginia had approximately 1,250 beds. According to the National Association of Mental Health Program Directors (NASMHPD), the national number of state operated beds per 100,000 population is 11.7 beds. Currently, across the nine hospitals, there are 1,547 inpatient psychiatric beds when including 56 additional beds at Catawba Hospital. Figure 4 provides a breakdown of these beds by type.

Figure 4: Psychiatric Beds in the Public System by Type

Type of Bed	Number	% Total Beds
Civil Adult	666	43.0
Forensics	431	29.7
Max Security	111	7.2
Children	48	3.1
Geriatric	291	18.8
Total	**1,547**	**100.0**

DBHDS hospitals have an important role in providing care for individuals who are mentally ill. Virginia's state psychiatric hospitals are statutorily required to provide treatment for individuals with criminal justice involvement by evaluating competency to stand trial and sanity at the time of the offense; restoring competency to stand trial; providing emergency treatment for individuals transferred from local and regional jails due to mental health crisis; and providing treatment for individuals who are not guilty by reason of insanity (NGRI). This group of individuals is not treated by private psychiatric hospitals due to the safety, security, and clinical expertise required to treat this population. These individuals comprise about 35 percent of hospital census, similar to the population in other states.[6]

Recent statutory changes have significantly increased state hospital census well beyond sustainable operating capacity, exacerbating the previous system imbalance in Virginia between community and institutional care. In 2014, the General Assembly passed "Bed of Last Resort" legislation, mandating state hospitals accept individuals under a temporary detention order (TDO) if a bed at a private psychiatric facility cannot be located within eight hours from the time that person is taken into custody. This change in law – and the impact of its implementation in the absence of a comprehensive system of community services – has increased the number of TDO admissions at state hospitals by 333 percent and pushed many state hospitals to a bed census well above industry standard operating capacity of 85 percent. In fact, state hospitals are currently operating at 96 percent with recent periods as high as 98 to 101 percent. Compounding the challenge, most state hospital beds are now used for TDOs instead of individuals requiring longer-term treatment and commitments, unlike in the years prior to "Bed of Last Resort". While the legislation ensures no person under a TDO will be without a bed, it is not yet fully supported by a comprehensive system of care to meet the needs of individuals who present in a mental health crisis. Without this system, individuals have few alternatives but inpatient treatment.

Figure 5 shows the increase in state hospital TDO admissions since FY 2013. Figure 6 shows average state hospital census by FY 2024 should effective actions not be in place to reverse the census trends. Figure 7 shows total TDOs issued each year and how many of those are admitted to state versus private hospitals.

[6] *The Vital Role of State Psychiatric Hospitals.* NASMPHD, July 2014

Figure 5: Number of State Hospital TDO Admissions in Virginia, FY2013 projected to FY2020

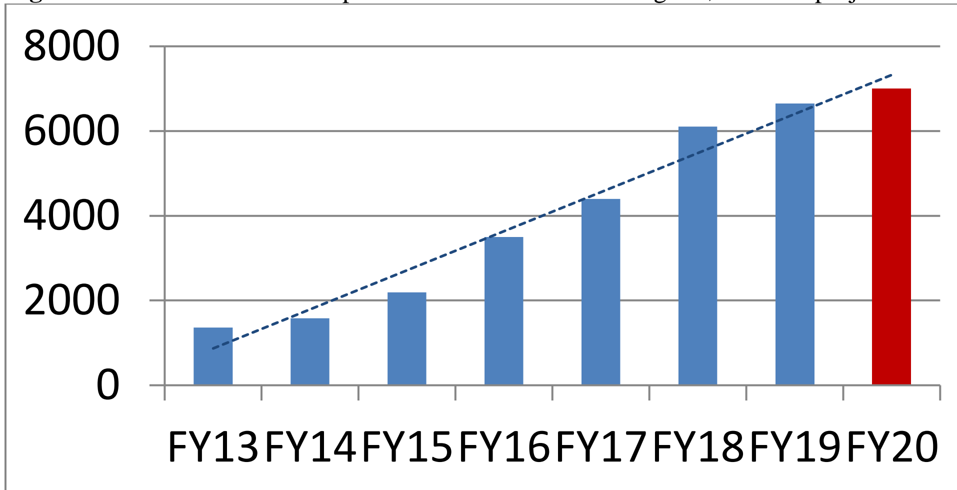


Figure 6: Projected Percent of State Hospital Beds Occupied by Patients, FY2019 to FY2024

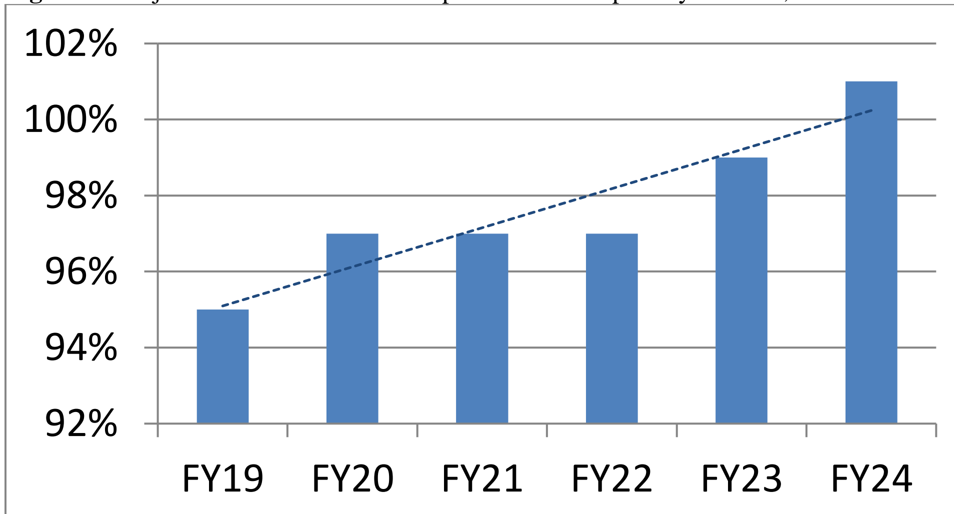
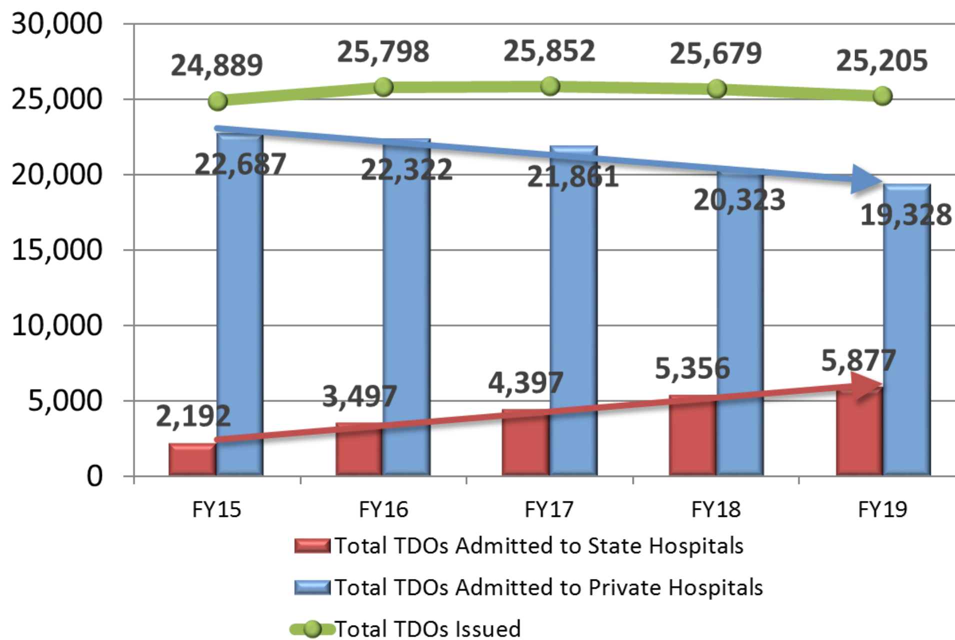


Figure 7: TDO Admissions to Private and State Hospitals in Virginia, FY2015 to FY2019



V. Conceptual Plan for a Right Sized State Hospital System in Virginia

Right sizing of Virginia's state behavioral health hospital system is, first and foremost, a commitment by Virginia for individuals to be served in the most integrated setting that is appropriate to their needs and as close to their home or community as possible. DBHDS' conceptual plan for right sizing establishes a clear mission for the role of the state hospitals in Virginia's public system of behavioral health care. According to NASMPHD, state psychiatric hospitals should provide treatment only to those "who cannot be safely and effectively treated in another setting", making the role of the state hospital in Virginia two-fold: (1) to serve individuals with criminal justice involvement who require inpatient psychiatric treatment or evaluation; and (2) to provide longer term treatment services for those individuals in the care of private psychiatric hospitals who are unable to be stabilized in an acute care setting and discharged to their home communities. Overall, right sizing will develop and sustain a comprehensive system of community-based services with appropriate levels of step down care and evidence based services, while clarifying the role of the state hospital.

Right sizing is not a cost savings endeavor in the short term, but it will reduce capital costs over time and provide more predictability around spending. Virginia has seen this happen with its efforts to close four of its five training centers since 2012. Over 1,100 individuals have transitioned from training centers to community-based care. Over time, capital costs have reduced as training centers close and individuals receive services through waiver funded programs.

The new state behavioral health hospital system as envisioned by this plan would offer a modern footprint operating on a regional basis. Each institution in the new footprint would operate at the

optimal bed size of 200 to 300 beds[7] and all facilities would be renovated to optimal efficiency or rebuilt to address the system imbalance and aging infrastructure of many of the current hospitals. Transitioning to a system with a smaller footprint is somewhat aspirational, but can be realized when STEP-VA is funded and investments are made in evidence-based services and models. These hospitals would provide care in a therapeutic environment with modern infrastructure that is safe and efficient. Figure 8 presents a potential conceptual plan for a "right sized" state hospital system. Figures 9 and 10 show concepts for locations and bed capacity of a smaller state hospital system.

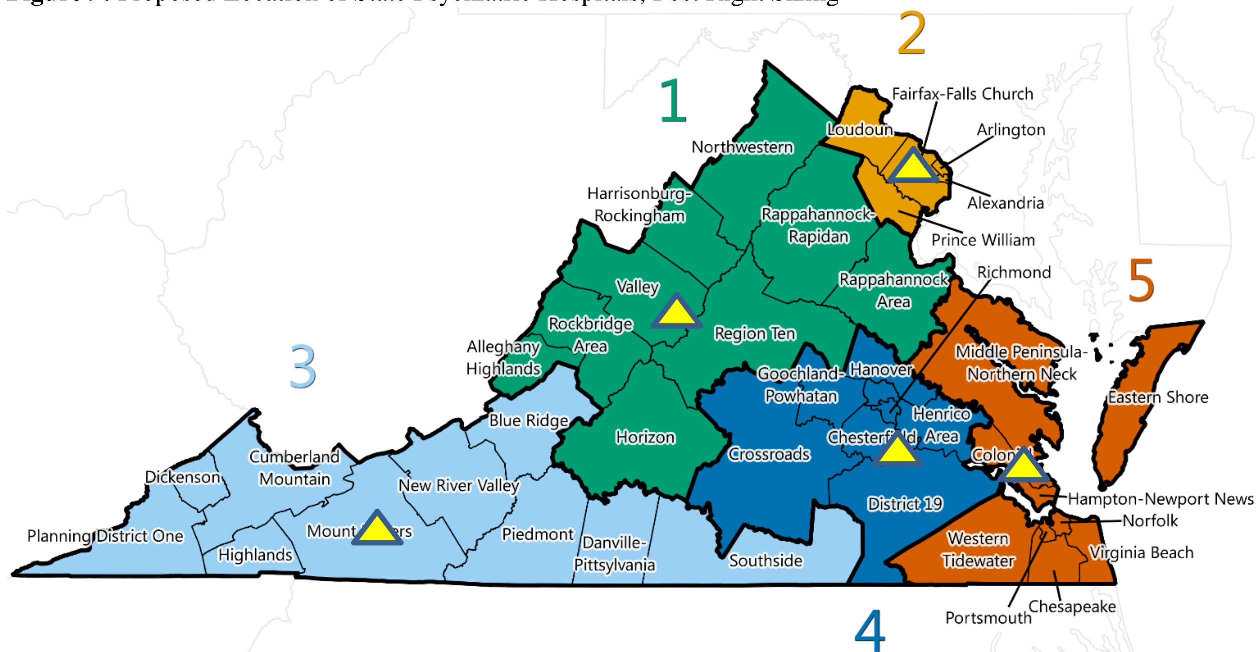
By providing a 200 to 300 bed footprint in five Virginia regions, beds at several smaller state hospitals – including those at Southern Virginia Mental Health Institute (Danville), Piedmont Geriatric Hospital (Dinwiddie), and Catawba Hospital (Salem) – will no longer be required. The transition from eight adult to five adult state hospitals will require the provision of geriatric services at two of the five regional hospitals, with units for both the acute and long-term needs of the population.

Figure 8: Right Sized State Hospital System

Facility	Beds	Region	Location	Capital
Western State Hospital	302	1	Staunton	Current Facility
Northern Virginia Mental Health Institute	200	2	Fairfax	New Facility
Southwestern Virginia Mental Health Institute	150	3	Marion	Renovate Facility
Central State Hospital	300	4	Petersburg	New Facility (Plans currently underway)
Eastern State Hospital	302	5	Williamsburg	Current Facility
CCCA*	24			
Total	**1,254**			

*Bed space for children and adolescents requires additional assessment

Figure 9: Proposed Location of State Psychiatric Hospitals, Post Right Sizing



[7] *Efficiency and Optimal Size of Hospitals: Results of systematic research.* (Giancotti, Guglielmo, Mauro, 2017).

Figure 10: Proposed Number of Psychiatric Beds by Type, Post Right Sizing

Type of Bed	Number	% Total Beds
Civil Adult	499	39.8
Forensics	480	38.3
Max Security	111	8.9
Children	24	1.9
Geriatric	140	11.2
Total	**1,254**	**100.0**

Virginia's state-operated child and adolescent beds will require more review before being incorporated into the right-sizing plan. Adolescents with high risks and criminal justice involvement could be served in one hospital with two units and a smaller number of beds. CCCA would likely close and a 24-bed unit would be opened in one of the five regional institutions to serve children. Additional discussion should be designated to determine the appropriate role of state hospitals in providing inpatient psychiatric care for children. NASMPHD notes that the majority of states do not operate state hospitals or state hospital units for adolescents or children.

During the 2019 Legislative Session, the General Assembly allocated $315 million to design and build a new Central State Hospital, with 111 maximum security beds and 141 civil beds. As part of the "right sizing" plan, the Appropriations Act required DBHDS to "*include a proposal for construction of a new Central State Hospital. The plan shall establish the scope of the new hospital within a "right sized" system and the appropriate timeline to coincide with efforts to relieve census pressures on the state mental health hospital system."*

DBHDS assessed the current needs for state hospital beds for the central Virginia region, which is CSH's service area. As part of its assessment, DBHDS applied the exponential smoothing algorithm to the five-year trends in admission. In order for CSH to operate at its funded and staffed capacity of 90 percent, CSH would need 174 civil beds in FY2020 and 202 civil beds by the time the new facility opens in 2024. Assuming a five percent decrease in admission trends beginning in FY2022, CSH would begin using 189 civil beds by FY 2024 just to serve the central Virginia region.

As previously noted, given the investment in a new physical pant for CSH, it is one of five regional hospitals in the right sized state hospital system. Within that system of care, CSH was envisioned as providing 189 civil bed for multiple regions, as well as 111 maximum security beds for the entire Commonwealth. Thus, DBHDS recommends that the new CSH be built to provide 111 maximum security beds and a minimum of 189 civil beds, with an included design that would support the addition of civil beds should they be needed. Importantly, Virginia will still be operating with 25 percent more state beds than the national average.

VI. Recommendations

As previously stated, current census pressures and need for a non-hospital based community services that focus on early intervention, prevention, and wellness preclude Virginia from right sizing its institutional footprint. To begin the right sizing process, specific conditions must be set from FY2020 to FY2022 to allow the safe closure of several facilities in the future:

- Initial implementation of all nine steps of STEP-VA by late FY2021;
- Initiation of the six priority services envisioned in proposed Medicaid Behavioral Health Redesign that provide diversion and step down options for adults and children by FY2021. These services are crisis services, intensive outpatient, partial hospitalization services, assertive community treatment, and child-services, such as MST and FFT;
- Initiation of an improved CSB Performance Contract to begin to enhance oversight and transparency of funding; and
- State hospital bed census falling below 85 percent and remaining below that threshold for a minimum of 12 months. To meet and sustain this census, the recommendations of the SB1488 Work Group should be considered, with special attention to the medically complex population and individuals who are intoxicated or require detoxification.

Any effort to right size Virginia's state mental health system will be insignificant without ensuring theses appropriate conditions are in place.

VII. Conclusion

Right sizing is a lofty goal to which the system should aspire. People with mental illness and behavioral health needs should be served in the community whenever possible, with the understanding that, at times, some service recipients will need access to state hospital inpatient care. Virginia spends nearly half of all state general fund mental health dollars on the state hospital system. This is out of sync with trends nationally. Virginia must continue to invest in a community-based system of care. DBHDS and the Commonwealth cannot sustain the current nine hospital footprint, with its aging infrastructure and increasing capital costs.

In contemplating a right sized system, a conceptual plan seeks to transition to a system with fewer state hospitals – from nine hospitals to possibly five regionalized institutions. These hospitals would provide care in a therapeutic environment with modern infrastructure that is safe and efficient. Movement to a regional five hospital footprint shifts the system to the appropriate size where individual hospitals can achieve economies of scale and meet regional needs.
More importantly, the plan seeks to ensure that state psychiatric hospitals provide necessary treatment to individuals who cannot be served in the community, with specific attention to serving individuals with criminal justice involvement and those individuals requiring longer term treatment.

This conceptual plan cannot be implemented until state psychiatric hospital capacity demonstrates plateaued growth or trend toward operating below 85 percent. It will require closing the front door to ever increasing TDO admissions, continued implementation of STEP-VA, and development of evidence based services and step down levels of care including proposed behavioral health redesign. With these actions, the community-based system of care will deliver preventive care, a robust provider network will develop and deliver community based care to individuals with complex mental health and other needs, and the inpatient admissions will decline. A developed and sustainable community-based system of support will align Virginia with national best practice and minimize overall capital costs and resources associated with operating state facilities.