

**Joint Subcommittee to Study Mental Health Services
in the Commonwealth in the 21st Century**

September 24, 2015

Suffolk City Hall

Suffolk, Virginia

The Joint Subcommittee to Study Mental Health Services in the Commonwealth in the 21st Century met on Thursday, September 24, 2015, at the Suffolk City Hall in Suffolk, Virginia.

Presentation: Mental Health Services in Jails — Sheriff Gabriel Morgan, Newport News

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% 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% of his deputies have received the training, which is above average for the area. The Commonwealth provided sufficient funds to train about 25% 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% 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% 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.

Presentation: Mental Health Services in Jails — Sheriff Ken Stolle, Virginia Beach

Sheriff Ken Stolle, Virginia Beach, provided additional information about mental health services in jails. He stated that 100% 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.

Presentation: Overview of Mental Health Services Funding — Susan Massart, Legislative Fiscal Analyst, House Appropriations Committee, and Mike Tweedy, Legislative Analyst, Senate Finance Committee

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% 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% since Fiscal Year 2012, with increases attributed to increased funding for the discharge assistance program (DAP), programs of assertive community treatment (PACT), 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, tele-psychiatry equipment, Mental Health First Aid training, suicide prevention efforts, additional local inpatient purchase of services (LIPOS), 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% 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 is 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 is due November 1, 2015.

Presentation: Department of Behavioral Health and Developmental Services Update and STEP VA: System Transformation, Excellence, and Performance in Virginia — Dr. Jack Barker, Interim Commissioner, Department of Behavioral Health and Developmental Services

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 (SAMHSA) 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:

1. 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;
2. Require reimbursement for case management services;
3. Strengthen the community-based system of services and supports statewide;
4. Standardize quality of care expectations statewide;
5. Align and maximize effectiveness of available funding streams;
6. Harness the power of data across agencies in the Secretariat to utilize and improve health outcomes;
7. Integrate behavioral health with physical health and social services;
8. Strengthen the workforce to ensure access to services;
9. 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
10. 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 must 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 had 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.

Presentation: 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

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:

1. Comprehensive;
2. Integrated;
3. Adequately funded;
4. Focused on recovery, health promotion, and morbidity reduction;
5. Composed of safe and respectful treatment environments;
6. Accessible;
7. Culturally competent;
8. Consumer-centered and consumer- and family-driven;
9. Well-staffed and trained; and
10. 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 in 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:

1. Fund peer support specialists and parent support partners.
2. Determine the base level of community services and how to deliver them.
3. Articulate the roles and expectations of public and private providers.
4. Expand early intervention and "First Episode" models.
5. Expand the array of services for people under 18.
6. Expand permanent supportive housing.
7. Address the problem of uninsured clients.
8. Address challenges with private hospitals.
9. Strengthen jail diversion (i.e., specialty dockets and Crisis Intervention Team training).
10. Improve usage of mandatory outpatient treatment.

Public Comment

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 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.