

**Advisory Panel on System Structure and Financing**  
**Interim Report on Core Services**  
**October 26, 2016**

It is sobering to review the reports undertaken at the General Assembly's behest over the past half century studying the Commonwealth's mental health system. The reports repeatedly highlight the same deficiencies: a fragmented system that allows many adults and children to fall through the cracks, inconsistent availability of services because of variability among CSBs (size, structure, local funding, personality/interests of leadership, etc), and lack of clear accountability and oversight.

In 1971, shortly after deinstitutionalization, the Hirst Commission reported that even though 66% of the state's population had access to some community-based services, the catchment area receiving services was limited to just 41 cities and counties. This was due mostly to the fact that most rural localities either could not afford to support local boards, or did not have the local workforce capacity to do so. Local boards, at the time known as "Chapter 10" boards, were broadly empowered to plan and coordinate mental health services. However, the State had no specific or consistent expectations beyond that. To begin to address these deficiencies, the Hirst Commission recommended that the State clarify the role and responsibilities of the local boards and more clearly define the relationship between the boards and other mental health agencies.

In 1979, a JLARC report emphasized the disconnect between state institutions and community services. This broken relationship was characterized by a lack of centralized leadership, misunderstandings over responsibility for service delivery, and an inability to assess client needs. A year later in 1980, the Bagley Commission highlighted the lack of any centralized control over the statewide system, which led to a lack of coordination between the state and local levels. Without coordination, local agencies were often providing inconsistent or redundant services. The commission also identified dramatic funding disparities between local boards. In general, boards that were established earlier and received local matching funds had drastically higher funding levels than newer boards.

The Emick Commission, which published its report in 1986, elaborated on JLARC's 1979 findings by stating that Virginia's mental health system was in reality two, bifurcated systems operating independently. Because the state and community systems were not well coordinated, it was difficult to hold either system accountable. Further, the community-based system received far less funding in part because the existing funding mechanisms encouraged state hospital utilization. Senator Elmon T. Gray (D-Sussex), one of the members of the Emick Commission, wrote in a statement appended to the report that he was "disturbed by the differences in the

resources and capabilities of the various Community Service Boards [sic]” and that he was “not convinced that they are uniformly qualified to provide the necessary services.”

A 1997 report on the effects of deinstitutionalization chaired by Delegate Anne G. Rhodes, found that the major challenge faced by state policymakers was to fill the persisting gaps in the system and that the state’s funds were not aligned to do so. Community services received a far smaller share of state funding, despite shouldering a much greater share of patients. At the time the report was published, 93.9% of patients were served by CSBs, while CSBs accounted for just 26.6% of the state’s mental health budget.

Later reports by the Gartlan Commission (2000) and JLARC (2004) echoed the sentiment of the earlier commissions: that since deinstitutionalization, the state had never fully committed to funding community-based services resulting in inconsistent levels of service across the state. These same deficiencies continue to exist. Half of the state general funds allocated to mental health are directed to state hospitals (see Figure 1), while large gaps remain in access to community services and supports for people with mental illness in many parts of the state. (See Appendix A, Institute of Law, Psychiatry and Public Policy, CSB Services Across the Commonwealth, October, 2016).

The deep flaw in the current system is starkly evident in the fact that the only services that all CSBs are mandated to provide by state law are emergency services and case management as funds allow and that even these services are differentially accessible across the Commonwealth.

Attempts to fix the system up to this point have been largely piecemeal:

- filling in gaps by population (e.g. those in crisis) or by a particular service (PACTs) only as very limited funds allow;
- responding to crises (e.g. legislation to fix problems in ECO/TDO process);
- and trying new models in only a few areas (e.g. drop-in centers).

Another consequence of the underdeveloped community-based services system is the overwhelming number of individuals with behavioral health needs in jails. Recent deaths of incarcerated person with serious mental illness have brought attention to the precariousness of the current situation. Additionally, Virginia faces a growing opioid crisis, which causes myriad negative consequences for those addicted and their families, including an increased number of children entering foster care due to parental substance use disorders.

Virginia has begun some promising endeavors in behavioral health that should remain and be incorporated into the current transformation effort. For example, funding over the last five years from the General Assembly has enhanced the capacity of certain CSBs to provide crisis services for children, additional PACTs, as well as services for transition-aged youth experiencing a first

psychotic episode. Additionally, the General Assembly has authorized DMAS to greatly enhance the substance use disorder benefits in Medicaid through a waiver, the newly created Addiction Recovery and Treatment Services (ARTS) program.

At this time what is needed most is a road map for comprehensive, statewide reform in Virginia, one that provides a clear vision of the behavioral health system we are seeking and that identifies a sequence of specific steps designed to achieve that vision. First and foremost, the system must provide a consistent array of services and supports – which need to be spelled out specifically -- throughout the state for individuals of all ages with mental health and substance use disorders. Second, those services must be of high quality, based on evidence of what works. Third, the behavioral health system must be aligned with the transformative changes now underway in the overall health care sector, including integration of primary and behavioral healthcare, data-driven decision making, and outcome-based care.

#### STEP-VA as a Road Map for Core Services

The Advisory Panel has studied the System Transformation, Excellence and Performance in Virginia (STEP-VA) plan developed by DBHDS and the CSBs and believes that it offers the needed vision. STEP-VA incorporates a comprehensive array of services and supports. It includes the “9+1” services that were identified as components of excellence in the Certified Community Behavioral Health Clinic (CCBHC) federal planning grant Virginia received, as well as additional elements deemed essential by the CSBs and DBHDS:

- 1) outpatient clinic that includes primary care screening and monitoring
- 2) crisis services: 24-hour mobile crisis intervention and stabilization
- 3) targeted case management
- 4) outpatient mental health and substance abuse services
- 5) patient-centered treatment planning
- 6) screening, assessment and diagnosis (including risk assessment)
- 7) psychiatric rehabilitation services
- 8) peer support and family support
- 9) care for members of the armed forces and veterans
- 10) care coordination that encompasses linkages to housing, employment, education and social services
- 11) medication assisted treatment
- 12) in-home children’s services
- 13) same day access

DBHDS has provided a potential timeline for funding STEP-VA in stages, over time, based on the needs assessment and gap analysis it has conducted with CSBs. DBHDS has prepared a series of estimates of the cost of implementing the STEP-VA vision in phases, beginning with same-day access to services. The Panel as reviewed these estimates and the methods used to generate them and believes that they provide a reasonable basis for action.

Beyond committing itself to the STEP-VA vision of a full array of “core” services available to all Virginians over a period of years, the Panel also recommends that the state make the first step toward achieving this vision. The cost of developing a fully functional behavioral health system is substantial, but also creates opportunities for savings in juvenile and criminal justice systems, foster care, and other social services. It will take commitment from the legislative and executive branches to work together to fund this system, as well as establish accountability for its ongoing development and implementation.

Beginning with same-day access would place emphasis on the “front door” of the behavioral health system, rather than continuing to focus solely on crises at the most intensive, restrictive and expensive end of the system, whether that is inpatient hospitalization or juvenile/criminal justice system involvement. Establishing same day access has the potential to increase engagement of individuals needing treatment by providing ready access rather than long waiting lists, and also has the potential to improve CSB efficiency by introducing a scheduling system that greatly reduces the likelihood of missed appointments.

The second priority would be to substantially beef up outpatient services in order to respond successfully to the expectations and needs identified by implementing same day access. Closing the huge gap in access to timely outpatient treatment will pay off many times in the long run by promoting stable functioning and preventing crises. Another early priority would be primary care screening, a service that highlights the need for the CSB to identify and responds to the person’s medical needs as well as their behavioral health needs. Indeed, they are inseparable. The Work Group and the Joint Subcommittee, and eventually the General Assembly as a whole, will have to decide whether funds are available for these three core service priorities.

The Panel also recommends that the following commitments be made as part of a step-by-step plan of implementing the STEP-VA plan:

1. Virginia must use all available funding sources to make the vision a reality: state general funds, existing Medicaid dollars, new Medicaid dollars, existing local funds, federal block grants, CSA funds, and all other funding opportunities, including efficiencies that can be achieved by pooling funds across systems.
2. Virginia must establish a cross-cutting accountability structure, involving both the legislative and executive branches of state government, to monitor the implementation of the plan and provide timely response to new issues that arise in that implementation.