Executive Summary

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

Executive Summary of 2019 Interim Activity

http://dls.virginia.gov/interim_studies_MHS.html

The Joint Subcommittee to Study Mental Health Services in the Commonwealth in the 21st Century (the Joint Subcommittee) was established pursuant to SJ 47 (Deeds) (2014). The Joint Subcommittee was originally authorized to hold meetings in 2014 through 2017 and scheduled to issue its final report on December 1, 2017. In 2017, the work of the Joint Subcommittee was extended for two years in the Appropriation Act (Chapter 836 of the Acts of Assembly of 2017), with the Joint Subcommittee authorized to hold meetings through 2019 and scheduled to issue its final report of December 1, 2019, to the Governor and the 2020 Regular Session of the General Assembly. During the 2019 Session of the General Assembly, Senate Joint Resolution 301 (Deeds) again continued the Joint Subcommittee, authorizing the Joint Subcommittee to continue its work through the end of the 2021 interim.

The Joint Subcommittee met seven times during the 2019 interim and one time in January 2020 to prepare for the 2020 Session of the General Assembly.

Meeting # 1 - April 2, 2019

The Joint Subcommittee met in Richmond with Senator R. Creigh Deeds, chair, presiding. Members present included Senator George L. Barker, Senator John A. Cosgrove, Jr., Senator Emmett W. Hanger, Jr., Senator Janet D. Howell, Delegate Robert B. Bell, Delegate Nick Rush, and Delegate Vivian E. Watts. Delegate T. Scott Garrett, Delegate Patrick A. Hope, Delegate Todd E. Pillion, and Delegate Margaret B. Ransone were absent. Following opening remarks and an overview of the agenda, the Joint Subcommittee received presentations.

Overview of the Work of the Joint Subcommittee and Update on 2018 Recommendations

Staff provided an overview of the work of the Joint Subcommittee during the 2018 interim, noting that the Joint Subcommittee toured six state mental health facilities and received information and monitored major behavioral health initiatives underway in the Commonwealth, including implementation of STEP-VA, financial realignment of the Department of Behavioral Health and Developmental Services (DBHDS), the Medicaid Behavioral Health Redesign, and activities to address the state hospital bed crisis.

Work Group 1 (Service System Structure and Financing) reviewed the existing publicly funded behavioral health system, receiving presentations on the organization and functions of DBHDS; the role and function of the State Board of Behavioral Health and Developmental Services; DBHDS community services boards (CSBs) performance contract requirements and process; organization and functions of CSBs; CSB services and funding; DBHDS licensing of private

behavioral health service providers; private behavioral health service providers' perspectives on the existing publicly funded behavioral health system; and organization and functions of the Department of Medical Assistance Services (DMAS). Work Group 1 also received information on alternative models of service delivery, including presentations on service system structure and financing in other states and other state/local cooperative service delivery systems in the Commonwealth, which include the Virginia Department of Health and local departments of health and the Virginia Department of Social Services and local departments of social services, and received updates on the work of the Service System Structure and Financing Expert Advisory Panel and the work of the stakeholder work group on the state hospital bed crisis.

Work Group 2 (Criminal Justice Diversion) reviewed mental health services in local correctional facilities, including presentations on the quality of health care services in Virginia's jails and prisons and the impact of requiring CSBs to provide mental health services in jails; the 2017-2018 Healthcare Study in Virginia's Jails provided by the L. Douglas Wilder School of Government and Public Affairs, Virginia Commonwealth University; a survey of mental health services in Virginia's jails provided by the Criminal Justice Diversion Expert Panel; an overview of mental health services in Virginia's jails provided by the Virginia Sheriffs' Association; and an overview of mental health services in Virginia's regional jails provided by the Virginia Association of Regional Jails. Work Group 2 also received information about jail diversion efforts in the Commonwealth, including presentations on mental health specialty dockets, the Virginia Department of Corrections' Secure Diversionary Treatment Program, and DBHDS's Criminal Diversion Programs.

Presentation: Update on 2019 Behavioral Health Reviews by the JLARC Health and Human Resources Unit

Mr. Jeff Lunardi, Unit Director, Health and Human Resources, Joint Legislative Audit and Review Commission (JLARC), provided an update on 2019 behavioral health reviews by JLARC. The 2017 Appropriation Act requires JLARC to conduct ongoing reviews and evaluations of agencies and programs of the Health and Human Resources (HHR) secretariat. JLARC's HHR Unit was created in response to the Appropriation Act requirement. The HHR Unit studies topics referred to it by JLARC. Members of the General Assembly and legislative commissions, committees, joint committees, subcommittees, and joint subcommittees may request studies. JLARC considers input from the Joint Subcommittee for HHR Oversight when determining which studies to refer to the HHR Unit. During the 2018 interim, JLARC referred two studies to the HHR Unit: a review of CSB funding requested by the Joint Subcommittee and a review of implementation of STEP-VA. In addition to these studies, the HHR Unit will also continue to monitor and provide oversight of expansion of the Commonwealth's program of medical assistance (Medicaid) and will support work on individual insurance market reforms conducted by the Joint Subcommittee for HHR Oversight.

The HHR Unit's study of STEP-VA will evaluate the extent to which initial implementation enables CSBs to meet STEP-VA's overall goals and whether adequate steps have been taken to support full implementation of STEP-VA by 2021, as required by the enabling legislation. The HHR Unit has conducted interviews with DBHDS staff, reviewed STEP-VA planning and

budget documents, collected CSB perspectives on implementation and planning through a survey, interviews, and site visits, and reviewed other states' implementation of similar transformations. The HHR Unit's final report on the study of implementation of STEP-VA is expected in June.

The HHR Unit's review of CSB funding will provide an inventory of all funding sources for each CSB, identify criteria used by DBHDS to allocate funds to CSBs, identify alternative models for funding public behavioral health services in other states and other public services in the Commonwealth, and evaluate the potential impact of adopting alternative models to fund public behavioral health services in the Commonwealth. In conducting its study, the HHR Unit will analyze budget and spending data from all 40 CSBs in the Commonwealth, review documents related to funding and structure, conduct interviews with program staff to understand other states' approaches to funding behavioral health services and other models for funding public services in the Commonwealth, and conduct a sensitivity analysis on how adoption of alternative funding approaches for behavioral health services would impact the Commonwealth's CSBs. The HHR Unit's final report on CSB funding is expected in June of 2019.

Presentation: Proposed Plan to Replace Central State Hospital

Mr. Joe Flores, Deputy Secretary of Finance, presented information on the Governor's proposed plan to replace Central State Hospital. Joe Damico, Director of the Department of General Services, and Dr. S. Hughes Melton, Commissioner of Behavioral Health and Developmental Services, provided additional information.

The Governor's proposed budget for fiscal year 2019 included language requiring development of a detailed design to replace Central State Hospital. The proposed facility included 300 beds, with 111 designated maximum security beds and 189 designated civil beds for acute care and nonviolent forensic patients. The Governor's proposed budget included $16 million for development of the design, with a requirement that the facility be completed and online within seven years.

The budget conference report agreed to by both houses of the General Assembly eliminated the planning requirement and funding for the new Central State Hospital and instead included a requirement that DBHDS convene a work group to, among other things, develop a conceptual plan to "right size" the state hospital system. DBHDS was tasked with determining future capacity requirements and appropriate distribution of capacity and developing a proposal for the construction of a new Central State Hospital that fit within the requirements of the "right-sized" system. DBHDS was directed to report its conclusions and the details of the plan by November 1, 2019. No additional funds were included for the planning or construction of the new Central State Hospital.

The Governor's proposed amendment to the conference report retained language requiring DBHDS to develop a plan to "right size" the state hospital system and added language authorizing construction of a new Central State Hospital. The new proposal called for a 252-bed facility, including 111 maximum security beds and 141 civil beds for acute care and nonviolent forensic patients, with infrastructure to accommodate 48 additional acute care beds if necessary.

The new proposal also required DBHDS to address the feasibility of relocating forensic beds to state-owned property other than Central State Hospital. The proposed amendment did include funds for detailed design, construction, and furniture, fixtures and equipment within a $315 million bond authorization, and called for completion of the project in a shorter, five-year timeframe. The proposed new Central State Hospital would consist of a single new building, similar to Eastern State Hospital, with new utility connections and systems, consolidating living units, programs, and support in a single facility. Currently, Central State Hospital consists of 23 aging buildings on a 600-acre campus, creating a number of logistical challenges. The proposed facility would require 30 to 40 acres, making the balance of the property available for surplus declaration and sale.

Presentation: Update on Activities of the Department of Behavioral Health and Developmental Services

Dr. S. Hughes Melton, Commissioner, Department of Behavioral Health and Developmental Services, provided an update on DBHDS's activities related to behavioral health. He described activities related to implementation of STEP-VA; the Medicaid Behavioral Health Redesign; DBHDS crisis services; the state hospital bed census; convening of the work group required by SB 1488 (Hanger); the community needs assessment; the financial realignment; CSB general fund reductions; mental health services in jails; and implementation of alternative transportation for individuals subject to emergency custody orders.

Implementation of STEP-VA

Implementation of STEP-VA is underway, with same-day access available statewide in March 2019 and primary care integration on track to be launched July 1, 2019, as required by the enabling legislation. Statewide access to crisis services and outpatient behavioral health services will also launch July 1, 2019, two years ahead of schedule, while planning for psychiatric rehabilitation, peer and family support, veterans' behavioral health, care coordination, and targeted case management services already underway with a goal of implementation by July 1, 2021. To facilitate implementation, DBHDS has established a STEP-VA Advisory Council tasked with planning for a guiding implementation and coordinating with stakeholders.

Behavioral Health Redesign

DBHDS is working with DMAS to redesign behavioral health services funded by the Commonwealth's program of medical assistance (Medicaid). The Farley Center report describing a comprehensive continuum of behavioral health services that will provide long-term financial stability for STEP-VA and align with behavioral health initiatives of multiple state agencies, transitioning from a crisis-driven system to a system focused on prevention and early intervention, was presented to stakeholders in January 2019. DBHDS and DMAS are currently engaged in planning and preparation for implementation of the proposed plan.

Crisis Services

The Governor's proposed budget for fiscal year 2019 included $7.8 million for mental health crisis services. The proposed services would align with national best practices, reduce use of

hospital emergency departments, dramatically reduce unnecessary jail time, reduce trauma to individuals, and result in fewer unnecessary hospitalizations and fewer state psychiatric admissions for competency restoration. Key elements of the proposed program include a mobile crisis hotline, centrally deployed mobile crisis services available at all times, residential crisis stabilization programs, and comprehensive crisis services for children.

State Hospital Bed Census

As of April 1, 2019, the census at each of the Commonwealth's state hospitals was over 85 percent of capacity, the level considered safe for patients and staff. The census at seven of the nine facilities was greater than 90 percent, with the census at Catawba at 95 percent of capacity, Eastern State Hospital at 98 percent of capacity, and Piedmont Geriatric Hospital at 100 percent of capacity. While funding for additional beds has been provided, average bed needs are increasing at a rate of 28.4 beds per year and will quickly exceed the new capacity if nothing is done to change the trend.

SB 1488 (Hanger) Work Group

SB 1488 (Hanger) (Chapter 609, 2019) directed the Secretary of Health and Human Resources to convene a stakeholder work group to examine the causes of the high census at the Commonwealth's state hospitals for individuals with mental illness, including (i) the impact on such census of the practice of conducting evaluations of individuals who are the subject of an emergency custody order in hospital emergency departments, the treatment needs of individuals with complex medical conditions, the treatment needs of individuals who are under the influence of alcohol or other controlled substances, and the need to ensure that individuals receive treatment in the most appropriate setting to meet their physical and behavioral health care needs and (ii) the potential impact on such census of extending the timeframe during which an emergency custody order remains valid, revising security requirements to allow custody of a person who is the subject of an emergency custody order to be transferred from law enforcement to a hospital emergency department, diverting individuals who are the subject of an emergency custody order from hospital emergency departments to other, more appropriate locations for medical and psychological evaluations, and preventing unnecessary use of hospital emergency department resources by improving the efficiency of the evaluation process. The work group is directed to analyze how such issues affect both adults and children and develop recommendations for both long-term and short-term solutions to the high census at the Commonwealth's state hospitals for individuals with mental illness. The work group will report its recommendations to the Chairmen of the Joint Subcommittee to Study Mental Health Services in the Commonwealth in the Twenty-First Century, the House Committee on Appropriations, the House Committee for Courts of Justice, the Senate Committee on Finance, and the Senate Committee for Courts of Justice by November 1, 2019. DBHDS is working with the Secretary's office to convene the work group. The first meeting will be held on April 22, 2019.

Community Needs Assessment

DBHDS is working with JBS International to conduct a comprehensive Virginia Behavioral Health System Needs assessment focusing on publicly funded behavioral health services at both the state and local level. The goal of the assessment is to assess the need for publicly funded behavioral health services, assess the capacity of the current behavioral health system to meet those needs, recommend systems changes to increase access to care and monitor programs toward the goal of meeting behavioral health needs in the Commonwealth, and support STEP-VA and broader system initiatives, such as the behavioral health redesign and efforts to reduce the state hospital census. Ultimately, the assessment will identify community needs, identify workforce needs, highlight effective elements of the publicly funded behavioral health system that can be scaled up statewide, as well as gaps in the system and current needs, and facilitate and help determine costs for implementation of STEP-VA and the financial realignment.

Financial Realignment

DBHDS will use findings from the community needs assessment to guide development of community-based services and redistribution of a portion of state hospital funds to the community, allowing CSBs to purchase appropriate services for individuals in need of services while providing funding to CSBs to build and sustain additional capacity in the community. The financial realignment will change the trajectory of hospital utilization and future choices by building out community discharge services and decreasing the Extraordinary Barriers to Discharge list, changing the financial dynamic to support best practices and cost effectiveness, and transferring funds from state hospitals to CSBs to align costs with service and support needs, ultimately avoiding overspending on hospital beds and improving community capacity.

CSB General Fund Reductions

As a result of the expansion of the Commonwealth's program of medical assistance (Medicaid), the Appropriation Act of 2018 included a general fund replacement reduction offset for anticipated new Medicaid funding for CSBs. DBHDS is working together with the Virginia Association of Community Services Boards and the CSB Executive Council to develop a methodology to spread the replacement allocation among CSBs. The methodology will take into account anticipated revenue generation with a potential shortfall in revenue distributed based on total CSB revenues. The conference report for HB 1700 requires DBHDS to monitor the impact of Medicaid expansion on CSBs. If the amount of new revenue generated as a result of expansion of the Commonwealth's program of medical assistance is at least 10 percent less than the savings assumed in the Act, the Commissioner is authorized to allocate and disburse up to $7 million in special funds to replace the unrealized revenue. Additional proposed language will eliminate the $25 million special cap in fiscal year 2019, allowing DBHDS to carry forward funding to support this potential obligation.

Mental Health Services in Jails

HB 1942 (Bell, Robert B.) (Chapter 827, 2019) directs the State Board of Corrections (the Board) to establish minimum standards for behavioral health services in local correctional

facilities, including (i) requirements for behavioral health screening and assessment for all individuals committed to local correctional facilities, the delivery of behavioral health services in local correctional facilities, and the sharing of medical and mental health information and records concerning individuals committed to local correctional facilities; (ii) requirements for discharge planning for individuals with serious mental illness assessed as requiring behavioral health services upon release from local correctional facilities; (iii) requirements for at least one unannounced annual inspection of each local correctional facility to determine compliance; and (iv) provisions for billing the sheriff in charge of a local correctional facility or superintendent of a regional correctional facility by a community services board that provides behavioral health services in the local or regional correctional facility. The bill also allows the person in charge of a state, regional, or local correctional facility, or his designee, to receive from a health care provider medical and mental health information and records concerning a person committed to such correctional facility, even when such committed person does not provide consent or consent is not readily obtainable, when such information and records are necessary (a) for the provision of health care to the person committed, (b) to protect the health and safety of the person committed or other residents or staff of the facility, or (c) to maintain the security and safety of the facility. The bill clarifies that the administrative personnel of a state, regional, or local correctional facility may receive medical and mental health information and records from any health care provider concerning any person committed to such correctional facility as necessary to maintain the safety of the facility, its employees, or other prisoners. DBHDS is working together with the Board to carry out the requirements of HB 1942.

SB 1644 (Boysko) (Chapter 685, 2019) directs DBHDS to convene a work group to study the issue of and develop a plan for sharing protected health information of individuals with mental health treatment needs who have been confined to a local or regional jail in the Commonwealth and who have previously received mental health treatment from a community services board or behavioral health authority in the Commonwealth. The bill requires DBHDS to report by October 1, 2019, to the Governor and the General Assembly on (i) development of the plan, (ii) the content of the plan, and (iii) the steps necessary to implement the plan, including any statutory or regulatory changes and any necessary appropriations. DBHDS is preparing to convene the work group as directed.

Alternative Transportation

DBHDS is receiving $2.5 million in fiscal year 2019 and $4.5 million in fiscal year 2020 to implement a statewide alternative transportation program for individuals under a temporary detention order. DBHDS is currently in contract negotiations with a vendor for a phased implementation of alternative transportation, beginning in rural communities, with the goal of statewide implementation in two years. DBHDS hired an Alternative Transportation Coordinator to oversee implementation in March 2019 and is working with stakeholders, including CSBs, law enforcement, magistrates, special justices, and hospitals, to implement the program.

Discussion of Work Plan for 2019

Following presentations, the Joint Subcommittee discussed its work plan for the 2019 interim. Staff provided a list of the various reports to be made to the Joint Subcommittee during the 2019

interim. Members of the Joint Subcommittee agreed that mental health services for children and school-based mental health services should be a priority. Other potential topics for further study include mandatory outpatient treatment, housing, and the impact of Medicaid expansion.

Public Comment

Rhonda Thissen, Executive Director, NAMI-Virginia, thanked the Joint Subcommittee for its work and noted that the Department of Education was taking steps to include mental health in the Standards of Learning.

A citizen thanked the Joint Subcommittee for its work and its proposed focus on children's mental health services. She noted that early intervention in childhood can have significant positive impacts for children and families. She also spoke about the benefits of programs to provide support for family members of individuals with mental illness and noted the detrimental impacts of restraint and seclusion of children with mental health issues in schools.

Meeting # 2 - May 22, 2019

The Joint Subcommittee met in Richmond with Senator R. Creigh Deeds, chair, presiding. Members present were Senator George L. Barker, Senator Emmett W. Hanger, Jr., Senator Janet D. Howell, Delegate Robert B. Bell, Delegate Patrick A. Hope, Delegate Margaret B. Ransone, and Delegate Vivian E. Watts. Senator John A. Cosgrove, Jr., Delegate T. Scott Garrett, Delegate Todd E. Pillion, and Delegate L. Nick Rush were absent. The meeting began with introductions and opening remarks, followed by presentations and discussion.

Presentation: Comments on Children's Mental Health Services

Ms. Margaret Nimmo Holland, Executive Director, Voices for Virginia's Children, described the need for mental health services for children in the Commonwealth and highlighted several factors the General Assembly should consider when making decisions about mental health services for children. She explained that the child population in Virginia has grown since 1990 and that this increase has mostly been in minority populations, such as Hispanic and Asian populations. She noted that diversity in Virginia's child population continues to increase. Ms. Holland posed several questions to the members, encouraging them to consider the effects of policy change on children, the expertise informing decision-making, the priorities behind policy decisions, the workforce capacity required to implement policy changes, and the interconnectivity of policy changes across systems.

Presentation: Overview of the SB 1488 Work Group

Mr. Marvin Figueroa, Deputy Secretary of Health and Human Resources, provided an update from the stakeholder work group convened in accordance with SB 1488 (Hanger, 2019). He said that state-operated hospitals are under tremendous strain and operating at near-full capacity on a daily basis. There has been a 294 percent census increase over the last five years at the Commonwealth's state hospitals for individuals with mental illness and the census continues to rise at an annual increase of about 2 percent. The SB 1488 work group (the work group) was convened in the 2019 Session with the purpose of examining the causes of the high census while also focusing on the evaluation process for those under an emergency custody order (ECO),

individuals with medically complex conditions, individuals who are intoxicated, and evidence for the most appropriate setting for treatment. The work group will consider extending the period for an ECO, devising ways to deal with the transfer of custody for an individual under an ECO, diverting people from emergency rooms, and assessing the current evaluation process. Additionally, according to Budget Item 310 CC.1 of the 2019 Appropriation Act (HB 1700), the work group is charged with developing options for diverting more admissions to private hospitals, increasing community services to reduce temporary detention orders (TDOs), and developing a plan to "right-size" the state hospital system. The work group consists of law-enforcement officials, private hospitals, community service boards, advocates, and state agencies. The work group has expanded to include a wide variety of members so that no one organization is shouldering a disproportionate responsibility for any issue identified and in order to foster understanding among the different groups and stakeholders.

The work group has held two meetings in 2019. The April meeting focused on the role of the bed registry. One major takeaway was the recognition of a need for more comprehensive data, and the work group is now assessing what data will be useful and reviewing any helpful data that already exists. At the May meeting, the work group heard from a national expert who spoke about the roles of public psychiatric facilities in other states and how other states are leveraging Medicaid funds to assist mental health hospitals and facilities. A recurring topic of discussion is the need to ensure individuals are taken care of before they are in crisis in their communities and how to provide the care individuals need and deserve throughout the process. At the next meeting, the work group plans to evaluate the issue of law-enforcement officers maintaining custody of individuals during the ECO period. The work group will be looking for ways to shorten the time law-enforcement officers are involved and how other states are currently handling this situation. The goal is for the work group to have a final report for the General Assembly by October 15.

Following the presentation, the Joint Subcommittee members suggested the work group consider inviting the Department of Criminal Justice Services (DCJS) to join future meetings, given their role in training law-enforcement officers, so that DCJS can gain a better perspective on mental health issues affecting the Commonwealth and share any issues they are encountering in the training process. Members also inquired about whether the work group is looking at overcrowding at children's facilities. There is currently only one state facility for children and Mr. Figueroa reported that the work group is looking at developing solutions to ensure their appropriate care.

Members of the Joint Subcommittee also inquired about the process by which hospitals in other states take custody of individuals who are subject to emergency custody orders and the differences in systems based on a medical rather than a legal model of emergency custody. Mr. Figueroa noted that states' models differed with regard to the emergency custody process, but said that the work group would examine different approaches to the custody and commitment issues.

Members also noted that they had heard from law-enforcement officers that the bed registry is not useful, partly because the information in the registry is not accurate. Representatives of the

work group responded that they had heard similar concerns from law-enforcement officers and community service boards and would continue to explore the issue. Joint Subcommittee members also noted concerns, voiced by law-enforcement officers, that alternative transportation contractors may be located too far away from some localities. Mr. Figueroa noted that agreements with the contractors required contractors to respond to requests for transportation within certain time limits and that contractors would be required to be located accordingly.

Presentation: Children's Services: Current System and Opportunities

Ms. Nina Marino, Director, Office of Child and Family Services, Department of Behavioral Health and Developmental Services, described the existing children's mental health service system in the Commonwealth. She noted that Virginia ranks 23rd in the country overall for mental health care for children under 18 years of age, which is an improvement from past years. Virginia ranks 41 out of 51, however, for mental health workforce availability, indicating a major deficiency and the importance of integrating behavioral health into primary health care.

Ms. Marino noted that the existing system is very complex, with many different agencies involved. The majority of funding for our current community based services provided by the Department of Behavioral Health and Developmental Services (DBHDS) is for treatment services, generally for children served through the Department of Juvenile Justice or children receiving crisis. In addition, the Commonwealth has a robust tertiary prevention part C program for children from birth to three years old who are already showing some sort of cognitive, behavioral, or developmental delay. Other initiatives focused on improving children's mental health services include the Virginia Mental Health Access Program, Behavioral Health Redesign, Families First Prevention Services Act, STEP-VA, and other applications of evidence-based practices.

With regard to inpatient mental health services for children, Ms. Marino noted that there is only one state psychiatric hospital for children in the Commonwealth: the Commonwealth Center for Children & Adolescents (CCCA). Similar to Virginia's state hospitals for adults with mental illness, inpatient admissions have increased at CCCA. The number of readmissions at CCCA has also increased, prompting the question of what services or programs are missing to prevent readmissions. Involuntary admissions are also increasing at CCCA, which are driven by civil TDOs. Members commented on the stark difference in voluntary admissions from 33 percent in 2013 to 0 percent in 2018 and asked if there is any indication where those voluntary admissions are now going. DBHDS does not currently have data on children admitted outside of CCCA, but Ms. Marino said the Department could try to get information from other hospitals. There has also been a dramatic decrease in the average length of stay at CCCA. The hospital used to be a place for kids to go if they needed a longer time to get stable, but now the average length of stay is much shorter. These shorter stays might indicate that there are children admitted to CCCA who have benefited from other programs or services, preventing them from needing to go to the psychiatric facility. The fact that state-funded inpatient services for children are provided at a single location in the Commonwealth creates several challenges. The fact that many families must travel long distances to be with children receiving care creates financial and other burdens for families, resulting in a lack of family engagement and difficulties around discharge planning.

With regard to emergency services for children, Ms. Marino noted that the number of children receiving emergency services has increased substantially since 2016. However, the availability of services for children in crisis is limited. Lack of mental health service providers is a major issue. Ms. Marino stated that DBHDS is working to determine the scope of need with regard to mental health services providers. DBHDS is also working to establish a more robust and comprehensive crisis continuum of care to help connect children to services in their communities. DBHDS believes this can be accomplished with a system that includes a single point of access with a "no wrong door" approach, a robust triage process, mobile response and stabilization services, and robust community services and community collaboration. DBHDS recommendations on priorities for children's services include support and funding for Behavioral Health Redesign, continued support and funding for mobile crisis services, additional funding to fully implement Pediatric Mental Health Access programming, and expansion of early intervention and prevention programs.

Presentation: Update on the Medicaid Behavioral Health Redesign

Dr. Alyssa M. Ward, Behavioral Health Clinical Director, Department of Medical Assistance Services (DMAS), provided an update on the implementation of the Behavioral Health Redesign (Redesign). She noted that Medicaid is the largest payer of behavioral health claims in Virginia and has a membership with a high need for mental health services. The vision for Redesign is focused on incorporating evidence-based programs from a trauma-informed perspective that will be cost effective. The Redesign is focused on integrating services into environments where people already show up for care, such as schools or pediatric clinics. The long-term goal is to increase investment in prevention and early intervention services, eventually reducing demand for crisis services. The STEP-VA program has served as a good foundation for Redesign, Dr. Ward said, which will align with other successes in Virginia's children's health services system and build on current momentum.

Dr. Ward and Ms. Marino highlighted key overall changes to the continuum of services and to specific services, which included new partial hospitalization and intensive outpatient programs. The new partial hospitalization and intensive outpatient programs may provide alternatives to TDOs and inpatient hospitalization. A member asked how the future Therapeutic Day Treatment Services program would differ from what is currently in place and inquired whether there would be placement into school systems or private entities. The presenters noted that this is a question on the mind of many stakeholders and would be one of the greatest challenges to the implementation process. The presenters and DBHDS staff have been working with a school-based service task force run through the Governor's Children's Cabinet to devise specifics. A member asked whether there had been any pushback from the school system against implementing more mental health care into public schools. The presenters and their staff have started conversations with the Department of Education and various school systems and understand that different localities have different capacities requiring different strategies to achieve reforms.

Presentation: Family First Prevention Act

Mr. Carl Ayers, Director, Division of Family Services, Department of Social Services, presented on the Family First Prevention Act (Family First). He noted that our foster care system was designed to elicit a response after something such as abuse has already happened and has sought ways to treat the family to ensure it does not happen again. Family First is intended to shift the child welfare system to a new model focused on preventing children from entering foster care in the first place. The Family First model will accomplish this goal by providing services to children and families, including (i) mental health prevention and treatment services, (ii) substance abuse prevention and treatment services, and (iii) in-home parent skill-based programs. The Department of Social Services (DSS) is working withdraws and DBHDS to align its Family First program with the Behavioral Health Redesign in order to improve the quality and effectiveness of service.

Public Comment

Several citizens addressed the Joint Subcommittee and expressed various concerns regarding mental health services at private hospitals. One citizen noted the disparity of resources between state and private hospitals and stated that while state facilities must accept patients, private hospitals are able to deny admission for any reason at all. She was personally aware of several instances in which consumers across Virginia were denied the truth about the availability of beds in hospitals. Other citizens were also concerned about transportation services and situations in which consumers find themselves in hospitals far away from where they live with no way to get home. Another citizen suggested that the Deeds Commission create an expert panel to look at workforce development.

Meeting # 3 - July 1, 2019

The Joint Subcommittee met in Richmond with Senator R. Creigh Deeds, chair, presiding. Members present were Senator George L. Barker, Senator Emmett W. Hanger, Jr., Senator Janet D. Howell, Delegate Robert B. Bell, Delegate Patrick A. Hope, Delegate Margaret B. Ransone, Delegate L. Nick Rush, and Delegate Vivian E. Watts. Senator John A. Cosgrove, Jr., and Delegate T. Scott Garrett were absent. The meeting began with introductions and opening remarks, followed by presentations and discussion.

Presentation: CSB Funding and Implementation of STEP-VA

Mr. Jeff Lunardi, HHR Unit Director, Joint Legislative Audit and Review Commission (JLARC), presented two JLARC reports: (i) Community Services Board (CSB) Funding and (ii) the Implementation of STEP-VA.

CSB Funding

The Joint Subcommittee tasked JLARC with identifying the total amount and sources of CSB funding and evaluating the methods of allocating state funds. This identification and evaluation included development of an inventory of funding sources and amounts and a description of the criteria used to allocate funding, the alternative models for funding behavioral health services based on other states and other public services, and the potential impacts of adopting alternative funding models.

Currently, the Department of Behavioral Health and Developmental Services (DBHDS) allocates most state and federal funding based on historical CSB budgets rather than the current need for services. Current DBHDS funding allocations do not account for Medicaid reimbursements or local CSB funding. Mr. Lunardi suggested that several different funding formulas could be considered to better support Virginia's goal of effective and efficient CSB funding, including a funding formula model, a reimbursement model, and a grant model. Funding formulas use population and other data to estimate the need for services, reimbursement models pay providers for services delivered, and grants enable providers to request funding to meet unique needs. Mr. Lunardi reviewed each of these models in detail and discussed the advantages and disadvantages of each from the perspective of alignment with need, ease of implementation, transparency, and budget stability.

Mr. Lunardi recommended that, at a minimum, DBHDS should work with the Department of Medical Assistance Services (DMAS) to analyze whether CSBs are maximizing Medicaid reimbursements and should begin to factor in potential Medicaid reimbursements when allocating state funds to CSBs. Additionally, he suggested that the General Assembly consider establishing goals that determine whether CSB services should be consistent statewide or meet unique community needs and then direct DBHDS to submit a plan to adjust the state's allocation strategy to support these goals.

Throughout the presentation, Mr. Lunardi responded to numerous questions from the Joint Subcommittee members regarding the specifics of funding formulas, CSB funding expenditures per citizen, services offered in specific CSB regions, and specific CSB spending.

Implementation of STEP-VA

The General Assembly tasked JLARC with reviewing the implementation of STEP-VA by DBHDS and the CSBs. This review included evaluating the progress toward providing same-day access to behavioral health clinical assessments and reducing wait times for follow-up services (Step One), evaluating progress toward providing primary care screening (Step Two), and evaluating planning for future phases of STEP-VA.

STEP-VA was initiated in 2017 to improve access, consistency, quality, and accountability of community-based behavioral health services at Virginia's 40 CSBs. STEP-VA requires that nine core services be provided by all CSBs by July 2021. These core services include same-day access, primary care screening, outpatient services, crisis services, peer/family supports, psychiatric rehabilitation, veterans' behavioral health, case management, and care coordination. Mr. Lunardi asserted that successful implementation of STEP-VA will require an operational definition for each step that clearly communicates to CSBs the level of services they need to provide and the collection of data that will be tracked to assess CSB progress in implementing each step. In addition, each CSB should be required to create an implementation plan detailing how it will meet the requirements of each step.

Mr. Lunardi reported that same-day access (Step One) has reduced wait times for behavioral health assessments but availability of same-day assessments varies among CSBs. He stated that CSBs are on track to begin providing primary care screenings (Step Two) by the implementation

deadline. Mr. Lunardi asserted that DBHDS has not dedicated sufficient leadership to the oversight of STEP-VA implementation, resulting in fragmented communication between DBHDS and CSBs. He concluded that initiation of the remaining seven steps will require more time than the General Assembly's current July 2021 deadline. Mr. Lunardi recommended that remaining steps be prioritized by each CSB based on community needs and that additional funds not be released until DBHDS demonstrates that sufficient planning is complete for each step.

Throughout the presentation, Mr. Lunardi responded to numerous questions from the Joint Subcommittee members regarding costs of implementing STEP-VA, the specifics of same-day assessments, and qualifications required to perform behavioral health assessments.

Presentation: Response to JLARC Findings and Conclusions Related to CSB Funding Formulas and Implementation of STEP-VA

The Joint Subcommittee heard presentations from the Virginia Association of Community Services Boards (VACSB) and DBHDS in response to the JLARC reports on CSB funding and the implementation of STEP-VA.

Virginia Association of Community Services Boards

Ms. Jennifer Faison, Executive Director, VACSB, began by addressing JLARC's STEP-VA report and affirmed the dedication of the CSBs to full implementation of STEP-VA. She explained that implementation is in preliminary stages for many CSBs and stressed that it is too early in the process to classify implementation of STEP-VA as a success or failure. Ms. Faison detailed the importance of approaching implementation of the remaining steps in an integrated fashion, rather than attempting to implement them on an individual basis. In response to Joint Subcommittee members' concerns regarding current same-day access availability, Ms. Faison explained that each CSB received an expert consultation regarding implementing same-day access based on specific community needs.

Ms. Faison agreed with the JLARC report regarding a need for improved leadership, communication, and implementation oversight from DBHDS. She acknowledged that improvements have since occurred in this area. She explained that the current implementation timeline is concerning and that complete, effective implementation will likely require additional time.

Ms. Faison then briefly addressed the JLARC report on CSB funding. She cautioned the Joint Subcommittee that completely untying the historical funding model of CSBs would have significant implications. She stated that a base plus funding model may be effective because it would provide a set minimum amount of funding for each CSB and then additional targeted funding based on the specific needs of each CSB.

Throughout the presentation, Ms. Faison responded to questions from the Joint Subcommittee members regarding implementation of same-day access, the failure of certain CSBs to meet the local match funding requirements, and potential CSB funding formulas.

Department of Behavioral Health and Developmental Services

Dr. S. Hughes Melton, Commissioner, (DBHDS), began his presentation by explaining to the Joint Subcommittee that, in the summer of 2018, DBHDS formed the STEP-VA Advisory Committee (STAC) in an effort to ensure collaboration with VACSB in the effective implementation of STEP-VA. He stated that the purpose of STAC is for VACSB to advise DBHDS on step definitions, metrics, and funding formulas and to plan for STEP-VA implementation. Dr. Melton explained that STAC has met on a monthly basis since November 2018 and that the Committee consists of numerous CSB executive directors representing the five CSB regions and high-level DBHDS personnel, including himself, the Chief Deputy Commissioner Mira Signer, and the DBHDS senior leadership team.

Dr. Melton proceeded by reviewing STEP-VA milestones achieved to date. He explained that definitions, metrics, and funding formulas are complete for primary care screening and outpatient services. He stated that the CSBs have submitted primary care screening and outpatient service implementation plans and the distribution of funds to implement these plans will begin this month. He asserted that work groups have formed or are in the process of forming for each of the remaining steps to provide subject matter expertise for implementation. Dr. Melton explained that STAC continues to meet on a regular basis to receive feedback and coordinate an effective and integrated implementation of the remaining steps. He then provided an overview and timeline of future tasks STAC plans to address. Dr. Melton continued by summarizing the implementation status of Step One and Step Two. He explained that same-day access has been a success but additional work remains. He advised that DBHDS will examine the number of hours that CSBs are currently providing same-day access and the impact on accessibility. He indicated that DBHDS will work with STAC to update performance measures to reflect the timeliness of assessments and determine whether same-day access hours are sufficient to meet demand. Dr. Melton explained that phase one of Step Two (primary care screening) has been implemented and must be monitored and evaluated prior to implementation of phase two of this step.

Dr. Melton then addressed the JLARC report conclusion regarding DBHDS's lack of leadership and oversight over implementation of STEP-VA. He noted that since the Department's internal reorganization, Chief Deputy Commissioner Singer has led the implementation of STEP-VA. He explained that a team of individuals throughout the agency specializing in project management, finance, information technology and data, community and behavioral health, and child and family services are facilitating the implementation efforts. Dr. Melton agreed that it would be helpful for the General Assembly to consider authorizing additional central office resources for oversight and implementation. Dr. Melton reiterated that an effective leadership, communication, and oversight plan is in place and the momentum of implementation is positive.

Dr. Melton continued by identifying ongoing DBHDS goals for aligning CSB capacity with implementation funding. DBHDS goals include assessing the needs of Virginians for publicly funded behavioral health services, assessing the current capacity of Virginia's behavioral health system to meet these identified needs, recommending system changes to increase access to care and monitor progress toward that goal, and supporting STEP-VA and broader system initiatives such as behavioral health redesign and the state hospital census.

Dr. Melton concluded by addressing the issue of future CSB funding. He remarked that CSBs are operating in a complex environment with several major system transformations underway and that any changes in funding allocations must be considered in this context. He asserted that DBHDS is undertaking several steps to enhance CSB accountability, including a major overhaul of the CSB Performance Contract for fiscal year 2021-2022, utilization of a Community Needs Assessment to align funding with local needs, and utilization of the Behavioral Health Equity Index. Dr. Melton recommended that DBHDS, the CSBs, and the General Assembly return to the issue of CSB funding after full implementation of STEP-VA and any implementation of the behavioral health redesign.

Dr. Melton responded to numerous questions from Joint Subcommittee members throughout the presentation regarding same-day access, leadership, communication, oversight challenges, and future STEP-VA implementation strategies.

Presentation: School-Based Mental Health Services in the Commonwealth

Martha Montgomery, Office of Student Services, Virginia Department of Education (VDOE), explained that VDOE is dedicated to improving access to school-based mental health supports and advocating for adequate staffing levels of specialized instructional support staff, including psychologists, social workers, counselors, and nurses. She explained that VDOE is also implementing the Virginia Tiered Systems of Supports (VTSS), which is a data-informed decision-making framework for establishing the academic, behavioral, and social-emotional supports needed for schools to be effective learning environments for all students.

Ms. Montgomery highlighted three areas within which VDOE is collaborating with schools as a part of the implementation of VTSS. These areas include mental wellness, promotion of trauma-sensitive practices, and Project AWARE. The mental wellness collaboration encourages schools to engage with community partners with expertise in mental health and wellness for staff education and student services. In order to promote trauma-sensitive practices, the VDOE offers a three-day professional learning opportunity that focuses on a foundational understanding of the prevalence of trauma, evaluating the impact trauma may have on an educational community, universal strategies to work with all students in a trauma-sensitive manner, self-care education, and fostering family, student, and community engagement. Finally, Project AWARE, currently being piloted in the Montgomery, Pulaski, and Fairfax county school divisions, involves the implementation of a comprehensive school-based mental health framework in collaboration with community partners. Ms. Montgomery also highlighted two mental health education tools VDOE utilizes for staff education: the Youth Mental Health First Aid training curriculum and the Kognito behavior change model.

Ms. Montgomery stressed the reality that mental health services are not prioritized when there is not adequate specialized staffing in schools. She indicated that recent legislation lowering the school counselor to student ratio and requiring that school counselors spend 80 percent of their time providing direct services to students are steps in the right direction for ensuring student mental health needs are met. Ms. Montgomery concluded by informing the Joint Subcommittee of some specific next steps VDOE plans to take to improve mental health services for students. These steps include revising VDOE's Suicide Prevention Guidelines, revising the Health

Education Standards of Learning to add mental health standards for grades kindergarten through 10, and partnering with the Collaborative for Academic, Social, and Emotional Learning (CASEL) to expand social-emotional learning for all Virginia students.

Public Comment

Several citizens addressed the Joint Subcommittee and shared their personal experiences, expressed various concerns, and made suggestions regarding mental health services in the Commonwealth.

Meeting # 4 - September 23, 2019

The Joint Subcommittee met in Richmond with Senator R. Creigh Deeds, chair, presiding. Members present were Senator George L. Barker, Delegate Lashrecse D. Aird, Delegate Robert B. Bell, Delegate T. Scott Garrett, Delegate Patrick A. Hope, Delegate Margaret B. Ransone, Delegate L. Nick Rush, and Delegate Vivian E. Watts. Senator John A. Cosgrove, Jr., Senator Emmett W. Hanger, Jr., and Senator Janet D. Howell were absent. The meeting began with introductions and opening remarks, followed by presentations and discussion.

Presentation: Department of Behavioral Health and Developmental Services Update

Ms. Mira Signer, Acting Commissioner, Department of Behavioral Health and Developmental Services (DBHDS), presented an update on pending projects within DBHDS. These projects include the implementation of STEP-VA, modifications to the provision of crisis services, addressing the hospital census, the addition of beds at Catawba State Hospital, and the progress of the SB 1488 Work Group.

Ms. Signer began by reviewing the status of implementation of each step of STEP-VA, including milestones to date and future tasks for completion. She highlighted the formulation of the STEP-VA Advisory Committee (STAC), successes of implementation of same-day access, and investments made in building staff capacity for interventions that are evidence-based and trauma-informed. She discussed the shortcomings of the current crisis system in Virginia. She reviewed the planned future crisis system key elements, including development of a crisis hotline and a mobile crisis response mechanism. Hallmarks of the planned future crisis response system include allowing the caller to define the crisis, 24-hour, seven-day-a-week availability, the ability to serve individuals in their natural environments and to build on natural support structures, the utilization of specialized trained staff, and the ability to connect individuals to follow-up services and supports. Ms. Signer highlighted how other states have benefited from implementing best practices in their crisis response systems.

She then addressed the hospital census crisis and how the census pressures may be addressed. She reviewed statewide temporary detention order and hospital admission trends and explained that, in response to this emergent crisis, DBHDS is temporarily adding 56 beds over the next two years at Catawba State Hospital. Ms. Signer concluded by highlighting the topics covered by the SB 1488 Work Group and providing an overview of the work group's meetings to date, as well as topic plans for future meetings.

Throughout the presentation, Ms. Signer responded to questions from the Joint Subcommittee members regarding the effectiveness of the current implementation of same-day access, the potential role of telemedicine services in the implementation of STEP-VA, and the costs associated with adding beds at Catawba State Hospital.

Presentation: Behavioral Health Redesign Update: Advancing Proactive, Evidence-Based Solutions

Dr. Alyssa M. Ward, Department of Medical Assistance Services (DMAS), and Dr. Lisa Jobe-Shields, Deputy Director, Community Behavioral Health, DBHDS, co-presented on the status of the Behavioral Health Redesign (BH Redesign) on behalf of DMAS and DBHDS. Dr. Ward described the goals and vision of the BH Redesign. These goals include establishing a full continuum of mental health services from prevention services to acute services, adopting solutions with measurable effectiveness and quality, and ensuring the coordination of systems across state agencies. The overall vision of the BH Redesign is to provide high-quality, evidence-based, trauma-informed, and cost-effective mental health care to Medicaid members.

Dr. Ward highlighted BH Redesign efforts since May 2019. She explained that more than 20 stakeholder work group meetings have occurred, a Mercer Rate Study and Fiscal Impact Analysis is being completed, and efforts are underway to align the BH Redesign with other key initiatives. Dr. Ward described six critical BH Redesign services: the Partial Hospitalization Program (PHP), Multi-Systemic Therapy (MST), the Program of Assertive Community Treatment (PACT), the Intensive Outpatient Program (IOP), Functional Family Therapy (FFT), and Comprehensive Crisis Services.

Dr. Jobe-Shields discussed these service priorities in more detail and explained how a mobile response mechanism could be more successful in linking members to appropriate services. She explained how a lack of alternative crisis services has contributed to the increasing number of temporary detention orders and explained how programs like PACT can help to permanently decrease capacity and reliance on state psychiatric beds. Dr. Jobe-Shields explained how the BH Redesign leverages Medicaid dollars to support the alignment of multiple behavioral health efforts, including the implementation of the Family First Prevention Act, the Juvenile Justice Transformation, and the Governor's Children's Cabinet Work Group on Trauma-Informed Care.

Dr. Ward concluded by summarizing how BH Redesign implementation will support Virginia's ability to apply for the § 1115 Serious Mental Illness Waiver Opportunity. This waiver would provide new federal dollars to pay for an adult psychiatric residential treatment benefit, creating new capacity and alternatives to temporary detention orders. Dr. Ward stressed that Virginia must first implement the BH Redesign to be considered eligible for the waiver.

Public Comment

Several citizens and advocates addressed the Joint Subcommittee and shared their personal experiences, expressed various concerns, and made suggestions regarding mental health services in the Commonwealth.

Meeting # 5 - October 7, 2019

The Joint Subcommittee met in Richmond with Senator R. Creigh Deeds, chair, presiding. Members present were Senator Emmett W. Hanger, Jr., Delegate Robert B. Bell, Delegate Patrick A. Hope, and Delegate Vivian E. Watts. Senator George L. Barker, Senator John A. Cosgrove, Jr., Senator Janet D. Howell, Delegate Lashrecse D. Aird, Delegate T. Scott Garrett, Delegate Margaret B. Ransone, and Delegate L. Nick Rush were absent. Though a quorum was not present, the Joint Subcommittee convened to receive presentations. The meeting began with introductions and opening remarks, followed by presentations and discussion.

Presentation: Virginia's Behavioral Health System: Community Hospitals' Perspective

Jennifer Wicker, Director of Intergovernmental Affairs, Virginia Hospital and Healthcare Association, presented to the members on the community hospitals' perspective on Virginia's behavioral health system and, specifically, the state hospital bed shortage. She stated that, at first blush, it may seem like an easy solution for community hospitals to take more temporary detention orders (TDO) in response to this shortage but she said she would explain why that is not an easy solution, nor the only solution.

Ms. Wicker noted that the "bed of last resort" legislation was passed into law in 2014 in order to ensure that individuals who needed inpatient care received the care they needed and were not "streeted." She stated the legislation has been successful in that effort; however, it has also revealed some weaknesses in our behavioral health system. Ms. Wicker suggested that some of those weaknesses include an overreliance on inpatient care and a tendency to focus on the needs of behavioral health patients when they are in crisis. She said the changes and development of community services through STEP-VA and the full continuum of care that has been imagined through the Behavioral Health Redesign will help meet those challenges. Ms. Wicker reported that the Virginia Hospital and Healthcare Association (VHHA) remains committed to being part of the solution and optimizing the role of community hospitals.

Ms. Wicker noted that Virginia's behavioral health system serves people who are under a TDO and showed that, in fiscal year 2015, community hospitals admitted 90 percent of TDOs, and in fiscal year 2018, they admitted 80 percent. She reported that there has been an overall decrease of 2,477 TDO admissions by community hospitals. Virginia's behavioral health system also serves people who meet the criteria for inpatient care and are willing to do so voluntarily. Ms. Wicker added that, currently, community hospitals admit 100 percent of the voluntary patients. In fiscal year 2015, there were 25,526 voluntary admissions, and in fiscal year 2018, there were 29,278 voluntary admissions, meaning an overall increase of 3,752 voluntary admissions. Asked by members about the average length of stay for voluntary admissions, Ms. Wicker reported that the average stay at a community hospital is between seven and 10 days long, but she did not have the specifics for voluntary admissions. She concluded that, even considering the decrease in TDO admissions from fiscal year 2015 to fiscal year 2018, because of the increase in voluntary admissions, community hospital admissions increased by 1,275 patients between fiscal year 2015 and fiscal year 2018.

Ms. Wicker advised that, as of fiscal year 2018, community hospitals are meeting 90 percent of Virginia's behavioral health needs, including involuntary and voluntary admissions. Members noted that the number of TDOs have remained steady for the last four cycles, but it appears there has been an increase in voluntary admissions and asked why that is. She explained that there are no concrete answers, but she cited more people receiving insurance through Medicaid and thus more people having access to services, as well as the work being done to reduce the stigma of mental illness and increased awareness of mental illness. Looking at the Department of Behavioral Health and Developmental Services (DBHDS) Crisis Report from 2018, she remarked that, between fiscal year 2015 and fiscal year 2018, the number of emergency evaluations increased by over 8,000. She stated this is indicative of more people seeking services and the increasing need for mental health services. Members asked whether the increase in behavioral health needs is unique to Virginia; Ms. Wicker stated that the trend is seen nationwide.

She reported that 70 percent of emergency evaluations do not become TDOs. The final disposition varies and the individual may be voluntarily admitted, admitted in a crisis stabilization unit (CSU), discharged, or jailed. Ms. Wicker also listed the top reasons a bed may not be available for a person who is subject to a TDO: staffing, bed blocks, longer lengths of stay for many patients, and anti-ligature renovations. She said hospitals are licensed for a certain number of beds but not all are operating at their fully licensed capacity because of staffing difficulties, adding that community hospitals make up 1,799 of the licensed psychiatric beds in Virginia and that, out of 43 facilities, six operate at full licensed capacity. Ms. Wicker stated that the industry standard for psychiatric bed occupancy is 85 percent. In Virginia, 54 percent of community hospitals are operating at or above that standard and 69 percent are operating at or above 80 percent occupancy.

Asked by members about how community hospitals are using the term "voluntary admissions," Ms. Wicker explained that they cover an array of patient types. She noted that just because someone is a voluntary admission, it does not necessarily mean he or she requires a lower level of care compared to a patient who is under a TDO. She added that whether a person decides to become a voluntary patient might change throughout the process. She did not have specific information about the population of voluntary admissions but told members she can work to get more concrete data.

In looking at the psychiatric bed discharges by payor mix from 2018, Ms. Wicker showed that about 43 percent came from Medicaid and Medicare, 29 percent were from commercial insurers, and close to 16 percent were self-paid and uninsured.

Ms. Wicker talked to the members about VHHA's short-term and long-term opportunities and goals. For short-term opportunities, VHHA will work with its membership to come up with a plan to increase admissions to facilities operating below the 85 percent occupancy rate. She stated that VHHA is also currently working with the Virginia Association of Community Services Boards (VACSB) to improve access to CSUs and identify shared patients/clients with high rates of readmissions for intervention. Regarding long-term opportunities, Ms. Wicker talked about VHHA working with DBHDS to increase admissions for special populations in

community hospitals, increasing community supports to reduce reliance on inpatient services, and increasing community supports to improve safe discharges for geriatric patients, which would alleviate some pressure from inpatient settings. Ms. Wicker also reported the following proposals VHHA presented to DBHDS and the Secretary of Health and Human Resources: reduce inpatient admissions by establishing a Medicaid benefit for mental health partial hospitalization (PHP) and intensive outpatient (IOP), improve access to crisis services for patients with a substance use disorder, and a hospital/community services board (CSB) collaborative for intellectual disabilities and developmental disabilities (ID/DD) Dually Diagnosed Beds. Members inquired about more specifics about the various alternatives that would be provided for ID/DD and geriatric patients. Ms. Wicker reported that 159 additional inpatient beds have come or will be coming online between fall 2018 and the middle of 2022.

Members told Ms. Wicker they would like more information on the total number of psychiatric bed days from 2013 to present to see if there has been a significant change, and they requested a breakdown of the numbers of TDOs versus voluntary admissions, including the length of stay for each. Members also asked if she had any data on whether the number of readmissions was related to patients being released too soon. She stated that hospitals are experiencing denials for extended admission stays from insurance partners, so it is an issue and something that needs to be discussed. They have reached out to DMAS to have a conversation about this issue.

Presentation: Hospital Census Update

The Honorable Daniel Carey, M.D., Secretary of Health and Human Resources, discussed the current hospital census status, the need for temporary beds at Catawba Hospital, and the extraordinary barriers list (EBL). He explained that the sustained operation of facilities at 96 to 97 percent capacity is unsafe and leads to staff burnout, which is the main reason for DBHDS initiating action to add temporary beds to Catawba in order to meet its legal obligations under the "bed of last resort" requirement pursuant to § 37.2-809. There will be 56 beds added in total: 28 in fiscal year 2020 and 28 in fiscal year 2021. DBHDS will use $4.15 million of special funds in fiscal year 2020 and will request additional general funds of $9.3 million in fiscal year 2021 and $10.3 million in fiscal year 2022 to operate the beds. Secretary Carey explained that Catawba was chosen because there are already beds there, so almost all of the money will be going toward operational needs, such as staffing. Members asked if the goal is to reduce money spent, then why not focus on speeding up the redesign and providing wraparound services rather than adding more beds to Catawba? Secretary Carey explained they are in agreement with the long-term goal of moving moneys allocated to inpatient hospitals into the community; however, it became apparent to them they needed to provide temporary beds in order to meet their statutory requirement.

Secretary Carey said adding beds at Catawba is temporary and the beds would be in place until the state hospital census decreases through STEP-VA, mobile crisis, additional step-down levels of care and diversion alternatives such as IOP and PHP, and crisis stabilization units, and other short-term and long-term actions recommended by the SB 1488 work group.

Members asked whether DBHDS considered speeding up redesign and advancing money for intensive outpatient and PHP, rather than creating temporary beds. Secretary Carey reported that

the state hospital census meant they needed a solution as quickly as possible to take care of people. He stated they could not wait to build out those things with the emergent need for more beds. Members noted that it is going to take nine months to build out 28 beds and another year to build out the other 28 beds and inquired about an estimate for how long the temporary beds will be open. Secretary Carey stated the beds will be open only as long as they are needed. Members also asked whether the temporary beds at Catawba will be enough to lower the state hospital census or if it is just the first step. Secretary Carey responded that it is difficult to make predictions, but they anticipate the beds will be adequate.

Regarding the EBL, Secretary Carey explained that an individual is placed on the EBL 14 calendar days after they are clinically ready for discharge, but they are not able to be discharged due to the lack of needed residential programs, supports, and services. He presented that the EBL is a result of the need to build a comprehensive community-based system to prevent and divert inpatient admissions and reduce the overall need for inpatient care in state hospitals. It is also related to the growing number of people admitted to state hospitals. The SB 1488 work group is addressing these issues.

Presentation: Development of an Information Sharing Process between Jails and Community Services Boards (SB 1644)

Dr. Michael Schaefer, Assistant Commissioner-Forensic Services, DBHDS, discussed the development of an information sharing process between jails and CSBs. During the 2019 Session, SB 1644 (Boysko) became law, which required DBHDS to convene a work group, study the issue of information sharing between CSBs and jails, develop a plan for the sharing of protected health information (PHI) for individuals in jails who have previously received treatment from a CSB, and provide a status report to the Governor and General Assembly by October 1, 2019. Dr. Schaefer explained that information sharing with jails is critical because national research shows that 70 percent of offenders have a substance use disorder, 17 to 34 percent of inmates have some form of mental illness, and the prevalence rate for serious mental illness at a point in time in the community is 4.5 percent. In Virginia, 19.84 percent of inmates are known or suspected of having a mental illness and 10.42 percent are known or suspected of having a serious mental illness. He explained that jails admit new individuals year-round, 24 hours a day, and many of those admitted are in crisis. He advised that jails are not generally staffed to assess and respond to behavioral health disorders all the time, so access to prior treatment records is critical.

Dr. Schaefer spoke of some cautions to keep in mind when talking about information sharing, such as being mindful of the expectation of privacy in patient/health care provider relationships, the rule of sharing the minimum information necessary to accomplish the desired task, the stigma surrounding mental illness, the potential unintended consequences of keeping individuals away from treatment, and the possible differential treatment of individuals who access the public behavioral health treatment system versus those who access private services.

He also pointed out the laws currently regulating health information sharing. The applicable federal laws include the Health Insurance Portability & Accountability Act (HIPAA) and 42 C.F.R. § 2.2. Dr. Schaefer noted that HIPAA does allow for some sharing without signed release

to other providers involved in an individual's care when it is in the patient's best interest. There are other exceptions, but they generally do not apply to individuals in jails. He noted that the law concerning sharing of information with other providers is permissive, not obligatory, and there are often differing interpretations of HIPAA. He stated that, in general, a health provider in a jail is viewed as a provider involved in an individual's care, but a jail superintendent is not. Dr. Schaefer also highlighted 42 C.F.R. § 2.2, which covers health records related to substance abuse treatment and prohibits sharing without a signed release. The applicable Virginia laws include § 53.1-133.03, which provides that a person in charge of a jail is entitled to obtain medical and mental health information and records even without consent. Dr. Schaefer noted it does not address the community provider's obligation to release information. He also pointed out that § 37.2-804.2, which requires community providers to release, upon request, prior treatment records, only applies to individuals subject to involuntary commitment pursuant to Chapter 8 (§ 37.2-800 et seq.) of Title 37.2 and is not applicable to jails.

Dr. Schaefer shared with the members the process DBHDS went through to develop a plan for information sharing. They explored already existing information-sharing platforms, including the Emergency Department Care Coordination (EDCC) Program; however, not all CSBs are currently using EDCC and it would only contain information on a subset of CSB clients, he said. To use such a platform, they would have to broaden the user pool to include jail medical providers. He told the members they also consulted with Texas, which has a robust information-sharing system. Dr. Schaefer explained that all CSBs in Texas utilize one electronic health record (EHR) system and that the state's jails all utilize the same jail management system. That is not the case in Virginia. Thus, he explained, DBHDS could not use Texas's system as a model because the state does not currently have the right data systems. Dr. Schaefer advised that DBHDS also researched publicly available data-matching systems, but they would have to build such a system from scratch, which would be expensive, enter into a Business Associate Agreement (BAA), and write code from each EHR to be able to get data into such platform.

Next, Dr. Schaefer presented the option of using existing systems for a new purpose. He explained that DBHDS has a data warehouse that can match datasets. DBHDS already receives data from the CSBs about clients served (CCS3) and receives data from the State Compensation Board about individuals in jail (LIDS). They could write an inquiry to match these two data systems to identify individuals in jail who have previously received services from the CSB. There are several limiting factors, such as a two-month delay in CCS3 data being downloaded into the data warehouse and the fact that DBHDS only receives the LIDS download once a month. Additionally, he noted that the data warehouse does not currently have the ability to push data out to multiple sources. They would have to hire someone to send notifications to the CSBs. In addition, he stated this approach would only identify CSB consumers and not those who received services from a private provider.

Dr. Schaefer shared that the work group had differing opinions about how much data to share, but the prevailing opinion was to share information concerning clients who have been receiving case management services or psychiatric services, who have been pre-screened for hospital admission/crisis services, or who have received services within the last year. The work group

also discussed what type of information to share, such as diagnoses, current medications, incidents of self-injury, and types of services being provided.

Dr. Schaefer talked about how such a system would work. He stated DBHDS would run cross-matching intervals and that the data warehouse would identify individuals in jail who have previously received services from a CSB and who meet the specified criteria. DBHDS would then notify respective CSBs of clients who are currently in jail and who received the identified types of services within the last year. The CSB would either share information with the jail, and/or go see the client, and/or get the client to sign a release. DBHDS would then follow up with the CSBs to ensure such action was taken. In order to accomplish such a system, DBHDS would need one-time funds of approximately $144,000 to write computer code to facilitate the automatic download of LIDS data to allow for more frequent downloads and would need ongoing funds of about $65,000 for one full-time employee at DBHDS to perform the notifications to CSBs and follow up. He told the members that the work group suggested a "pilot" of this process to determine if the information shared is useful and to work out any issues. Dr. Schaefer noted that the alternative would be to build out a new platform, which would likely better meet needs but would be more costly and challenging to do.

Dr. Schaefer concluded by submitting to the members that, regardless of which system is used, the differing interpretations of HIPAA will continue to be a barrier to information sharing and that the members may want to consider amending § 53.1-133.01 to address such issues or codify DBHDS's responsibility to cross-match and the responsibility of CSBs to share information. Members inquired about the price estimate of building out an entirely new data platform. Members also asked about the percentage of inmates who received services from CSBs versus private providers. Dr. Schaefer said he would work to get that information for the work group.

Public Comment

Several citizens and advocates addressed the Joint Subcommittee and expressed various concerns including the money going toward the temporary beds at Catawba.

Meeting # 6 - November 12, 2019

The Joint Subcommittee met in Richmond with Senator R. Creigh Deeds, chair, presiding. Members present were Senator George L. Barker, Senator Emmett W. Hanger, Jr., Delegate Robert B. Bell, Delegate Patrick A. Hope, Delegate Margaret B. Ransone, Delegate L. Nick Rush, and Delegate Vivian E. Watts. Senator John A. Cosgrove, Jr., Senator Janet D. Howell, Delegate Lashrecse D. Aird, and Delegate T. Scott Garrett were absent. The meeting began with introductions and opening remarks followed by presentations and discussion.

Presentation: Overview of the SB 1488 Work Group

The Honorable Daniel Carey, M.D., Secretary of Health and Human Resources, began by discussing the purpose of the SB 1488 work group, which is examining the causes of the high census in state hospitals so that it can develop short-term and long-term solutions to benefit individuals with mental illness. Dr. Carey stated that state agencies, law-enforcement officials, provider groups, community services boards, and advocates have discussed the causes of the high state hospital census, diverting admissions from state hospitals, caring for intoxicated and

medically complex individuals, emergency custody orders (ECO), alternatives to emergency departments for evaluation and assessment, improving data collection and quality, and increasing community-based services.

Dr. Carey continued by presenting the group's consensus and nonconsensus recommendations. Consensus recommendations included supporting the continued build-out of community-based services and supports, addressing behavioral health workforce challenges, improving the civil commitment process, providing additional resources to treat individuals with medically complex conditions, and providing additional resources for individuals who are intoxicated or require detoxification. Nonconsensus recommendations included extending the ECO period, improving the temporary detention order (TDO) evaluation process, enhancing data collection, clarifying the role of Virginia's state psychiatric hospitals, and modifying the Bed of Last Resort legislation.

Dr. Carey concluded by highlighting how Virginia's investment in community-based mental health services compares to the nation, comparing state hospital and private hospital capacity and admission statistics, and summarizing the need to clearly define the role of state hospitals in Virginia going forward. Dr. Carey stated that the SB 1488 work group report is forthcoming and in its final revision. Throughout the presentation, Dr. Carey responded to numerous questions from the members. Specifically, many members expressed concern over the plan to add additional beds to Catawba Hospital.

Presentation: Middle Peninsula Northern Neck CSB Hybrid CIT Program Proposal

Mr. Charles R. Walsh, Jr., Executive Director, Middle Peninsula Northern Neck Community Services Board (the Board), presented on its proposal to the Department of Behavioral Health and Developmental Services (DBHDS) to create a mobile crisis intervention team (CIT) pilot program. The proposed pilot program is a hybrid model that will involve an on-call, CIT-trained law-enforcement officer and an on-call peer support specialist to assist individuals in mental health crisis. Mr. Walsh stated that the proposal was submitted to DBHDS approximately 10 days prior to the meeting. Mr. Walsh and his colleagues fielded numerous questions from the members regarding the proposal and the logistical challenges faced by the Board.

Discussion: Preliminary Recommendations for 2020 Session

The members engaged in a preliminary discussion regarding potential Joint Subcommittee recommendations for the 2020 legislative session. The members discussed the need for more detailed information regarding the Behavioral Health Redesign and STEP-VA, specifically surrounding funding needs. The members discussed the need to develop a specific recommendation regarding funding formulas for community services boards. Additionally, the members discussed potential policy options surrounding mandatory outpatient treatment.

Public Comment

Several individuals addressed the Joint Subcommittee and shared their personal experiences, expressed various concerns, and made suggestions regarding mental health services in the Commonwealth.

Meeting # 7 - December 6, 2019

The Joint Subcommittee met in Richmond, with Senator R. Creigh Deeds, chair, presiding. Members present were Senator George L. Barker, Senator Emmett W. Hanger, Jr., Senator Janet D. Howell, Delegate Lashrecse D. Aird, Delegate Robert B. Bell, Delegate Patrick A. Hope, and Delegate Vivian E. Watts. Senator John A. Cosgrove, Jr., Delegate T. Scott Garrett, Delegate Margaret B. Ransone, and Delegate L. Nick Rush were absent. The meeting began with introductions and opening remarks, followed by presentations and discussion.

Discussion: Implementation of Behavioral Health Redesign and STEP-VA

Dr. Alyssa M. Ward, Behavioral Health Clinical Director, Department of Medical Assistance Services; Ms. Mira Signer, Acting Commissioner, Department of Behavioral Health and Developmental Services (DBHDS); Dr. Alexis Aplasca, Chief Clinical Officer, DBHDS; and Dr. Lisa Jobe-Shields, Deputy Director, Community Services, DBHDS, provided information on the implementation of Behavioral Health Redesign and STEP-VA.

Dr. Ward and Dr. Aplasca presented to the members on the plan and vision of Behavioral Health Redesign (the Redesign) and how the Redesign and STEP-VA work together. Dr. Ward noted that Medicaid is currently the largest payer of behavioral health services in the Commonwealth and that Medicaid expansion includes populations that have not had access to mental health care for a long time. She also noted that Virginia is currently paying for mental health services that have not been updated for almost 20 years and the current rates are outdated. She further pointed out the lack of availability, access, and alternatives to inpatient treatment in Virginia have contributed to the rising state hospital census. Considering all of this, Dr. Ward said, the Redesign is a natural response to all of the different system needs Virginia has at this time.

Dr. Aplasca discussed the current priorities for the Redesign, which involve helping with the state inpatient bed crisis. She talked about how many Virginians are seeking mental health care through emergency rooms while in a state of crisis because there is a lack of community-based crisis response services. The lack of such services contributes to a cycle of emergency room visits and inpatient hospitalization. She talked about how addressing the needs of individuals currently admitted to inpatient hospitals is a priority, and Redesign services in the proposed budget include high acuity, intensive services that are effective in reducing admission and recidivism. The current budget proposal for the Redesign seeks permission to implement six evidence-based services that provide options for diversion from or step-down out of inpatient hospitals: (i) partial hospitalization programs (PHP); (ii) intensive outpatient programs (IOP); (iii) Program of Assertive Community Treatment; (iv) multi-systemic therapy; (v) functional family therapy; and (vi) comprehensive crisis services. Dr. Ward gave an overview of each of those services to the members of the General Assembly, who remarked that it seems like the PHP and IOP may be the most urgent for Virginia right now, and they inquired about increasing the focus on those services. Dr. Ward expressed that while the PHP and IOP are critical, they view each of the services as equal parts to solving the puzzle.

Next, Dr. Ward and Dr. Aplasca provided a look at how the STEP-VA and Redesign initiatives are similar and different. STEP-VA addresses only people who are served through community

services boards (CSBs), and Redesign addresses any of the 1.4 million people in Virginia who are served through Medicaid. STEP-VA ensures that all 40 CSBs provide access to nine core service categories, and Redesign ensures that all public and private health care providers who accept Medicaid, including CSBs, will have rates established or refreshed for various behavioral health services. Services in STEP-VA are defined within nine distinct steps and may encompass one or more types of services and are based on service categories in the CSBs. Redesign includes individual services that are part of a comprehensive continuum. For STEP-VA, service categories have been defined and an implementation timeframe is laid out in the Code of Virginia. For Redesign, implementation is multi-phased and can be modified to align with the priorities of Virginia.

Dr. Ward and Dr. Aplasca further described how STEP-VA and Redesign support each other and work together. They said continuing to work on these two initiatives through a combined effort will provide various benefits, including Medicaid rates that provide sustainability for STEP-VA services and other CSB services, maximizing state general funds in the mental health system, and avoiding development of differential public and private systems of care. The presenters exhibited how the two initiatives support each other by illustrating crisis services provided by each and by walking the members through a hypothetical. Members noted how the various services discussed would be ideal, but they asked how long it would take to actually implement them across Virginia. Dr. Ward stated that the regulatory process would require about an 18-month timeframe.

Commissioner Signer and Dr. Jobe-Shields then provided a brief update to the members on the current status of the implementation of STEP-VA and the projections for the implementation timeline. The projected activities between December 2019 and June 2020 include monitoring and supporting implementation of same day access and primary care screening, supporting CSBs in installation of outpatient and crisis services, utilizing the results of the comprehensive needs assessment and gathering additional feedback to improve the implementation process, and collaborating with the executive and legislative branches to acquire funding for STEP-VA.

Discussion: Recommendations for 2020 Session

The Joint Subcommittee discussed various items and suggestions that were proposed during the interim. The Joint Subcommittee agreed to continue discussions on the following items:

- Behavioral Health Redesign
- STEP-VA
- Providing additional resources to treat individuals with behavioral health needs and acute, medically complex health care needs, including:
    - Development of a funding stream and mechanism similar to the Local Inpatient Purchase of Services Funds to allow community services boards to pay for admission to private hospitals for a combination of medical and psychiatric services;
    - Evaluation of the need for specialized beds for geriatric and medically complex patients; and

    - Creation of a specialized inpatient rate for individuals with intellectual disabilities and developmental disabilities (ID/DD) and mental health treatment needs and designation of additional resources to support specialized training for individuals providing services to this population.
- Providing additional resources for individuals who are intoxicated or require detoxification and who are experiencing a mental health crisis, including:
    - Evaluating the Crisis Intervention Team Assessment Center (CITAC) model as an option for diverting individuals from state hospitals; and
    - Amending statutory provisions for involuntary temporary detention of individuals in need of medical services to include intoxicated individuals;
- Establishing a Civil Commitment Work Group to continue to examine the Commonwealth's civil commitment process to identify ways to improve the process and reduce trauma for those involved in the process.
- Extending the emergency custody period to up to 24 hours for all individuals or for individuals with acute medical conditions or who are intoxicated;
- Improving the evaluation process to facilitate quicker access to services by expanding the categories of individuals who may conduct an evaluation pursuant to § 37.2-808;
- Enhancing data collection, including:
    - Mandating the reporting of daily bed utilization by psychiatric wards and hospitals, additional patient diagnosis information, staffed capacities, and reasons for denial of admissions;
    - Revising the bed registry to allow for better data collection and monitoring of the emergency custody process; and
    - Leveraging emergency department care coordination technology to improve care for individuals with psychiatric needs through better linkages and coordination;
- Virginia Behavioral Health Practitioner Student Loan Forgiveness Program to address behavioral health care workforce shortages.
- Legislation creating a pilot program to facilitate the sharing of data regarding individuals in jails who have received services from a CSB that would utilize existing data from diverse systems, match data about individuals who have received services from CSBs and individuals who are in jails, and notify CSBs regarding the need to communicate information about identified individuals to the jail in which the individual is located. Implementation of the pilot program would require:
    - A one-time $144,000 appropriation to pay for development of computer code to facilitate the automatic collection of data from the Department of Behavioral Health and Developmental Services' LIDS system to allow cross-matching of data to identify individuals in jails who have previously received services from a community services board and who meet the criteria for sharing of data between systems.
    - An appropriation of $65,000 per year for one full-time equivalent position at the Department of Behavioral Health and Developmental Services to facilitate notification of CSBs regarding clients who are currently in jail who meet the criteria for sharing of data between systems and about whom the CSB will need to share information with the jail.
- Amending § 53.1-133.03(1) to establish the obligation of health care providers who have been notified that an individual to whom they have provided services is incarcerated to

disclose to the jail any information necessary and appropriate for the continuation of care and to provide legal protections for health care providers who provide such information.

- Providing funding to fully implement the provisions of SB 1406 (2019), which required school boards to increase the number of school counselors employed by the board to ensure the following ratios for the 2019-2020 school year:
    - For elementary schools: one school counselor available for at least one hour for every 75 students; one school counselor available full time for schools with 375 students; for schools with more than 375 students, one additional school counselor available for one hour per day for every 75 students over 375.
    - For middle schools: one school counselor available for at least one hour for every 65 students; one school counselor available full time for schools with 375 students; for schools with more than 325 students, one additional school counselor available for one hour per day for every 65 students over 325.
    - For high schools: one school counselor available for at least one hour for every 60 students; one school counselor available full time for schools with 300 students; for schools with more than 300 students, one additional school counselor available for one hour per day for every 60 students over 300.
- Amending the Code of Virginia to further reduce staff-to-student ratios for school counselors to ensure one full-time school counselor for every 250 students in grades K through 12.
- Amending the Code of Virginia to establish staffing ratios for other specialized instructional support staff, including school psychologists, school social workers, and school nurses that reflect national recommendations, including:
    - One school psychologist for no more than 500 to 750 students (National Association of School Psychologists)
    - One school social worker for every 250 general education students (National Association of School Social Workers)
    - One school nurse for every 750 students (National Association of School Nurses)
- Taking steps to implement universal mental health screenings in schools statewide. As a preliminary step, a proposal would create a multidisciplinary team composed of school counselors, school psychologists, school social workers, school administrators, and others, including student family members, teachers, resource officers, and community partners to evaluate the need for, the benefits and risks of, and the barriers to implementing universal mental health screenings in schools, and it would develop plans for implementation.
- Recommendations developed by the work group convened by the Department of Health and Developmental Services and the Institute for Law, Psychiatry and Public Policy at the University of Virginia to study matters related to the use of mandatory outpatient treatment in the Commonwealth, including:
    - Increasing the length of the initial order for mandatory outpatient treatment from 90 days to 180 days.
    - Authorizing a judge or special justice to convene a status conference to review compliance with the mandatory outpatient treatment plan or discharge plan.
    - Eliminating the requirement that the person who will be subject to the mandatory outpatient treatment plan following discharge from a period of involuntary

inpatient treatment agree to the proposed outpatient treatment plan prior to discharge.
    - Clarifying that a mandatory outpatient treatment order remains in force until it is rescinded by the court or it expires, even if the person revokes his agreement.
    - Providing that a CSB petitioning the court for enforcement of a mandatory outpatient treatment (MOT) due to material noncompliance with the order must also allege that noncompliance occurred despite efforts by the CSB to assist the person.
    - Clarifying the scope of the examination that can be ordered by the court when a petition for review of a mandatory outpatient treatment order is filed.
    - Providing that the criteria used by the court to determine whether to continue, alter, rescind, or extend a mandatory outpatient treatment order are the same as those used by the court to determine whether to enter the initial order for mandatory outpatient treatment.
- Recommendations made by the work group established by Dr. Richard Bonnie of the Institute of Law, Psychiatry, and Public Policy at the University of Virginia to study issues related to the emergency custody and temporary detention processes in the Commonwealth, which include:
    - Extending the period of emergency custody to the time at which a temporary detention order is executed.
    - Requiring prompt execution of the temporary detention order.
    - Allowing a magistrate to change the designated alternative transportation provider at any time until transportation actually begins.
    - Allowing a law-enforcement officer to transport an individual when an alternative transportation provider becomes unable to continue to provide transportation for any reason within his jurisdiction.

Some members expressed concerns about moving forward with the proposal, specifically about universal mental health screening in schools.

Public Comment

Citizens addressed the Joint Subcommittee and shared their personal experiences, expressed various concerns, and made suggestions regarding mental health services in the Commonwealth.

Meeting # 8 - January 7, 2020

The Joint Subcommittee met in Richmond, with Senator R. Creigh Deeds, chair, presiding. Members present were Senator George L. Barker, Senator Emmett W. Hanger, Jr., Senator Janet D. Howell, Delegate Robert B. Bell, Delegate Patrick A. Hope, and Delegate Vivian E. Watts. Senator John A. Cosgrove, Jr., Delegate Lashrecse D. Aird, Delegate T. Scott Garrett, Delegate Margaret B. Ransone, and Delegate L. Nick Rush were absent. The meeting began with introductions and opening remarks, followed by presentations and discussion.

Presentation: Governor's Budget Proposals for Department of Behavioral Health and Developmental Services

Ms. Alison Land, FACHE, Commissioner, Department of Behavioral Health and Developmental Services (DBHDS, gave an overview of the Governor's budget proposal for the Department. She talked to the members about the budget priorities of DBHDS, which include addressing the high census at state hospitals, continuing implementation of STEP-VA, investing in children's mental health initiatives, providing resources needed to exit the Department of Justice settlement agreement, and providing for the treatment needs of the sexually violent predator population. She gave an overview of the budget items broken down into fiscal years 2021 and 2022. Commissioner Land also discussed the plans and associated budget items for community actions to increase discharges from hospitals, which include expanding forensic discharge planning programs in jails, increasing permanent supportive housing capacity, and increasing funding for statewide discharge assistance plans.

Commissioner Land also spoke to the members about the budget items for DBHDS, the Department of Medical Assistance Services (DMAS), and the Virginia Department of Health intended to stem state hospital census growth while longer-term solutions take effect, such as reviewing incentive payments for disproportionate share hospitals, encouraging private acute care hospitals to accept more temporary detention orders (TDOs), and mandatory reporting of TDOs by private hospitals. She also went over the budget items intended to increase capacity for child and adolescent hospital beds.

Commissioner Land also broke down the mental health hospital items included in the budget proposal, which include adding critical clinical staffing at the Commonwealth Center for Children and Adolescents, managing increased pharmacy costs at state hospitals, increasing funding for safety and security in state hospitals, annualizing new positions at Western State Hospital and new direct care positions at state hospitals, and adding temporary beds at Catawba Hospital. Regarding the additional temporary beds at Catawba, she explained they expected 28 beds to be available in 2020 and 28 beds in 2021, for a total of 56 additional temporary beds. The first six beds were added in November 2019, and six more beds are expected to be in operation by March 2020. All 28 beds are expected to be available by June 2020.

Additionally, she went over the budget items in the Governor's budget proposal that correspond to the continuing steps in STEP-VA and also talked about the community behavioral health budget items not related to STEP-VA, including increasing funding for Part-C-Early Intervention Services for children and toddlers with developmental delays and providing additional funds for the Virginia Mental Health Access Program. Lastly, Commissioner Land reviewed the budget items included in the proposal related to the Behavioral Health Enhancement (formerly known as the Behavioral Health Redesign), including funding workforce training in preparation for the behavioral health enhancement and aligning DBHDS licensing with Medicaid behavioral health services.

Presentation: Governor's Budget Proposals for DMAS

Dr. Alyssa Ward, Behavioral Health Clinical Director, DMAS, gave a brief overview to the members about the Governor's budget proposals for DMAS. She went over a timeline for the

planned implementation of the Behavioral Health Enhancement and talked about the budget items included in the budget proposal related to such implementation.

Discussion: Recommendations for 2020 Session

Finally, the members decided which recommendations to move forward with for the 2020 Session of the General Assembly and assigned members to patron the recommended bills. A copy of the final recommendations and patrons can be found on the Joint Subcommittee's website at: *http://dls.virginia.gov/interim_studies_MHS.html*.