

**INTERIM REPORT OF THE**

**JOINT SUBCOMMITTEE TO STUDY  
MENTAL HEALTH SERVICES  
IN THE COMMONWEALTH  
IN THE 21st CENTURY (SJ 47, 2014)**

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



**REPORT DOCUMENT NO. \_\_\_\_\_**

**COMMONWEALTH OF VIRGINIA  
RICHMOND  
2018**

## **Joint Subcommittee Members**

### **General Assembly Members**

The Honorable R. Creigh Deeds, Chairman  
The Honorable Robert B. Bell III, Vice-Chairman  
The Honorable Janet D. Howell  
The Honorable Emmett W. Hanger, Jr.  
The Honorable George L. Barker  
The Honorable Linda T. Puller (2014-2015)  
The Honorable John A. Cosgrove (2015-present)  
The Honorable T. Scott Garrett  
The Honorable Peter F. Farrell (2014-2017)  
The Honorable John M. O'Bannon III (2017-2018)  
The Honorable Joseph R. Yost (2014-2018)  
The Honorable Margaret B. Ransone  
The Honorable Vivian E. Watts  
The Honorable Luke E. Torian (2014-2017)  
The Honorable Patrick A. Hope (2017-present)

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## EXECUTIVE SUMMARY

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

The Joint Subcommittee was originally 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 now scheduled to issue its final report on December 1, 2019.

Senator R. Creigh Deeds and Delegate Robert B. Bell III serve as the Joint Subcommittee's chair and vice-chair, respectively. The Joint Subcommittee held five meetings during the 2016 Interim and four meetings during the 2017 Interim.

In the course of its meetings during the 2016 and 2017 Interims, the Joint Subcommittee received extensive testimony from numerous individuals with expertise in the field of mental health, including representatives from the Department of Behavioral Health and Developmental Services, sheriffs and other law-enforcement personnel, representatives of various advocacy groups, mental health service providers, and the general public. The Joint Subcommittee also received regular reports from the expert advisory panels formed by the Joint Subcommittee to advise and assist the Joint Subcommittee in its work.

During the 2016 and 2017 Interims, the Joint Subcommittee continued its evaluation of the current state of the mental health services system in the Commonwealth and how mental health services are provided. The Joint Subcommittee made numerous statutory and budgetary recommendations for reforming the current system and will continue its evaluation of the current system with the goal of making recommendations for reform of the existing system to ensure consistent delivery of high-quality mental health treatment and recovery support services in a timely and effective manner throughout the Commonwealth.

**INTERIM REPORT OF  
THE JOINT SUBCOMMITTEE TO STUDY  
MENTAL HEALTH SERVICES  
IN THE COMMONWEALTH  
IN THE 21st CENTURY  
TO  
THE GOVERNOR AND THE GENERAL ASSEMBLY OF VIRGINIA  
RICHMOND, VIRGINIA  
2018**

To: Governor of Virginia  
and  
The General Assembly of Virginia

**I. Origin of the Study**

**A. Study Resolution**

The Joint Subcommittee to Study Mental Health Services in the Commonwealth in the 21st Century was established pursuant to SJ 47 (patron: Deeds) passed during the 2014 Regular Session of the General Assembly. The 12-member Joint Subcommittee comprised Senators R. Creigh Deeds, Janet D. Howell, Emmett W. Hanger, Jr., George L. Barker, and Linda T. Puller and Delegates Robert B. Bell III, T. Scott Garrett, Peter F. Farrell, Joseph R. Yost, Margaret B. Ransone, Vivian E. Watts, and Luke E. Torian. On April 20, 2015, Senator John A. Cosgrove was appointed to replace Senator Puller. On June 20, 2017, Delegate John M. O'Bannon III was appointed to replace Delegate Farrell. On October 13, 2017, Delegate Patrick A. Hope was appointed to replace Delegate Torian.

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 now 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.

**B. Study Directive**

The enabling resolution notes that the provision of mental health services has been a core responsibility of the Commonwealth since 1776. However, the resolution notes, the resources available to provide mental health care have not kept pace with the increasing number of persons in need of services, and many persons in need of crisis intervention and emergency mental health treatment have been unable to access treatment and support services on a timely basis. The resolution also notes that a significant number of persons with mental illness commit various offenses bringing them within the criminal justice system; in July 2013, an estimated 23.5 percent of Virginia's local and regional jail population were estimated to be mentally ill, and 56 percent

of these offenders were estimated to be seriously mentally ill. In light of significant recent changes to the legal and regulatory framework governing mental health services, public and private delivery systems of mental health care, and the consequences of the increasing involvement of persons with mental illness in the criminal justice system, the resolution identifies a need for the General Assembly to consider the types of facilities, programs, and services and the appropriate funding mechanisms that will be needed in the twenty-first century to provide mental health care, both in traditional mental health delivery systems and in the criminal justice system.

## **II. Background**

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

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

## **III. Activities of the Joint Subcommittee: 2016**

### **A. Meeting of April 19, 2016**

#### **1. Overview**

The Joint Subcommittee held its first meeting of 2016 on Tuesday, April 19, 2016, at the General Assembly Building in Richmond, Virginia.

#### **2. Presentations**

##### **a. Update on Certified Community Behavioral Health Clinics**

Dr. Jack Barber, Acting Commissioner of the Department for Behavioral Health and Developmental Services (DBHDS), provided an overview of the DBHDS Certified Community Behavioral Health Clinics initiative. Dr. Barber first described the landscape of behavioral health services, noting national and state trends in spending on behavioral health services and some of the positive results and negative consequences of those trends. Dr. Barber also pointed out some issues affecting the Commonwealth's system of publicly funded behavioral health services, noting

that the Commonwealth's behavioral health services system is heavily oriented toward emergency services, that the system of services is still biased toward institutional rather than community-based care, that access to and quality of services varies considerably through the Commonwealth, and that many uninsured Virginians are unable to access or pay for services. To address these issues, DBHDS is adopting the Certified Community Behavioral Health Clinics model of service delivery.

The Certified Community Behavioral Health Clinics model is a new mode of behavioral health services delivery described in the federal Excellence in Mental Health Act (the Act). This model of services delivery provides a comprehensive range of mental health and substance use disorder services, prioritizes underserved and special populations, includes quality and performance measures to enhance quality of services, utilizes a prospective payment system, and requires ongoing oversight over service delivery to ensure uniform access to a full range of behavioral health services. The Act establishes a grant program to facilitate adoption of the model by participating states. Currently, Virginia is receiving a planning grant. As part of the grant process, DBHDS is working with eight community services boards (i) to determine what changes to the community services boards' existing array of services and operational procedures may be necessary to comply with the requirements of the Act and (ii) to develop plans that comply with those requirements. The next step for the eight community services boards participating in the planning grant process is to apply for the federal demonstration grant. If selected, community services boards receiving the federal demonstration grant would receive an increased Medicaid match of 65 percent federal funds for behavioral health services provided.

Dr. Barber noted that even if the Commonwealth does not receive the demonstration grant, DBHDS will continue to move toward adoption of the Certified Community Behavioral Health Clinics model of behavioral health services delivery. Further, once the model has been implemented at the eight community services boards currently participating in the program, DBHDS will work with the remaining 32 community services boards to implement the model in those areas as well. Dr. Barber stated that the DBHDS focus on this model will shape final budget requests, operational priorities, alignment of clinical and fiscal incentives, data collection and analysis, and capital expenditures in the coming years.

At the end of the presentation, members of the Joint Subcommittee expressed support for the model, noting the need to focus on community-based services, address differences in local financial contributions to behavioral health services spending, and facilitate coordination of behavioral health and other health care services, including services delivered by and through public schools.

#### **b. Report on the Investigation of the Death of Jamycheal Mitchell**

June W. Jennings, State Inspector General, and Ms. Priscilla Smith reported on the Office of the Inspector General's investigation into the death of Jamycheal Mitchell while in the custody of the Hampton Roads Regional Jail. Mr. Mitchell was found dead in his cell at the jail on August 19, 2015. On August 24, 2015, the Office of the Inspector General received a complaint regarding Mr. Mitchell's death and launched an investigation. Ms. Jennings stated that the objectives of the investigation were to (i) examine the sequence of events surrounding the death of Mr. Mitchell, the processes in place related to referral and admission of Hampton Roads Regional Jail inmates

to Eastern State Hospital, and preparation of the DBHDS Office of Internal Audit Investigation Report; (ii) identify potential risk points; and (iii) provide recommendations for systemic improvements to prevent similar events in the future. In conducting the investigation, staff of the Office of the Inspector General reviewed multiple agencies and facilities, including the Hampton Roads Regional Jail; Portsmouth Department of Behavioral Health Services; Eastern State Hospital; Department of Behavioral Health and Developmental Services; Portsmouth General District Court; NaphCare, Inc.; and Bon Secours Maryview Medical Center.

According to findings set out in the report prepared by the Office of the Inspector General, Mr. Mitchell, who had been arrested and charged with petit larceny and trespassing, had been incarcerated in the Hampton Roads Regional Jail since April 22, 2015, and at the time of his death was awaiting transfer to Eastern State Hospital in Williamsburg for services for restoration of competency. Records obtained by the Office of the Inspector General showed that an initial Competency Restoration Order (CRO) requiring that Mr. Mitchell be transferred from the jail to Eastern State Hospital for mental health services was entered by the Portsmouth General District Court on May 21, 2015, after receipt of the results of a court-ordered psychological evaluation of Mr. Mitchell. While documents obtained from the Portsmouth General District Court indicate that copies of the order were faxed and mailed to Eastern State Hospital, no records exist to show that the order was ever received by Eastern State Hospital. Records show that a subsequent order was faxed to and received by Eastern State Hospital on July 31, 2015. However, Mr. Mitchell's name did not appear on any of the weekly Forensic Logs prepared by Eastern State Hospital to track individuals awaiting admission to the hospital between the faxing of the second Competency Restoration Order on July 31 and his death on August 19.

At the conclusion of the investigation, the Office of the Inspector General made five observations:

- The process for transfers from the Hampton Roads Regional Jail to Eastern State Hospital had multiple decision points, risk points, and opportunities for variation, all of which had the potential to create risks through which unanticipated and egregious outcomes could occur. No evidence existed of any standards, protocols, decision trees, required time frames, or monitoring. In the absence of written and agreed-upon protocols with responsible parties, timelines, and monitoring systems, the root causes of the death of Mr. Mitchell remained at risk of reoccurrence.
- While Eastern State Hospital is the state facility most significantly affected by the 2014 civil commitment law changes requiring state hospitals to provide a bed of last resort in cases involving emergency custody orders, during the period in which Mr. Mitchell was under a CRO, bed availability was not an issue and a bed was available. While Eastern State Hospital did undertake a revision of policies governing admissions to streamline the process and improve efficiency in August 2015, following Mr. Mitchell's death, the revised plan did not address the completion or updating of the Jail Transfer Waiting List or the development of a monitoring system to ensure that the list remains up-to-date.
- DBHDS has convened or participated in numerous work groups, committees, and subcommittees in the past several years centering on improving services for individuals



with mental illness who are involved with the criminal justice system. All of these bodies, including the DBHDS Transformation Team for the Justice Involved, have made recommendations for additional funding, ongoing committee work, oversight, training, and system redesign, many of which have not been implemented.

- While DBHDS did undertake an investigation into Mr. Mitchell's death, its report omitted some information and failed to identify the possible root causes of the event. Failure to identify the root causes results in recommendations that have little chance of achieving the goal of preventing similar events in the future.
- Records provided by NaphCare, Inc., the organization contracted to provide medical care at the Hampton Roads Regional Jail at the time of Mr. Mitchell's death, to the Office of the Inspector General were incomplete and inconsistent, but did show that little action was taken to address Mr. Mitchell's medical and psychiatric symptoms. This failure to provide care is in conflict with the Hampton Roads Regional Jail's direct responsibility to provide quality medical and mental health care for those in its custody. While the contract with NaphCare has not been renewed, the change in provider offers limited promise of improvement in care or documentation in the absence of a change in oversight practices.

The Office of the Inspector General also provided five recommendations related to these observations:

- DBHDS should take the lead on development of a regional protocol relevant to the management of individuals in the Hampton Roads Regional Jail with mental illness, working together with the Hampton Roads Regional Jail, local police departments, Eastern State Hospital, the Portsmouth Department of Behavioral Health Services, and the Health Planning Region V Reinvestment Project Office, which should focus on cross systems mapping sequential intercepts, crisis intervention teams, jail diversion, court orders, Eastern State Hospital admissions and discharges, and mental health contact in the Hampton Roads Regional Jail by the Portsmouth Department of Behavioral Health Services and other Health Planning Region V community services boards and Eastern State Hospital staff. The protocol should identify responsible parties, timelines, and process flows and should address gaps and opportunities for improvement. DBHDS should consider the applicability of this protocol to other regions across the state.
- Eastern State Hospital should revise the process for the development, management, and oversight of the Jail Transfer Waiting List. A system for consistently reviewing the individuals on the list should be created and should include staff from the local court system, community services boards, the Health Planning Region V Reinvestment Project Office through the Facilities Management Committee, and the Hampton Roads Regional Jail.
- The recommendations of the DBHDS Transformation Team for the Justice Involved were substantive and, had they been implemented prior to August 2015, would have had a significant impact on the handling of cases involving justice-involved individuals

with mental illness. This situation should be considered urgent, and implementation plans should be developed immediately.

- DBHDS's investigation of critical events should be conducted independently by professionals trained and experienced in conducting health care root cause analyses and who have experience working in the behavioral health services systems in question. Reports should include all relevant risk points and analysis of root causes with specific recommendations targeting those root causes.
- The Hampton Roads Regional Jail should revise the process for overseeing the quality and outcomes of any contract agency that provides medical and mental health care in the jail. This process should ensure regular monitoring, direct oversight, and direct feedback and correction for areas of concern.

Following Ms. Jennings' report, members of the Joint Subcommittee asked several questions about the findings and recommendations. Delegate Farrell inquired about changes to the admissions process at Eastern State Hospital. Ms. Smith confirmed that despite the fact that the safety net law had been in place for some time, and there had been prior warning of the need to prepare for increased demand for beds, Eastern State officials had not made any changes to admissions practices and did not make changes to the jail admission process even in the wake of Mr. Mitchell's death. Senator Deeds inquired about other cases of individuals not included on the Jail Transfer Waiting List. Ms. Smith stated that there were others who had not been included on the list, but that the Office of the Inspector General had been limited to investigation of the case for which it had received a complaint. Delegate Yost inquired why recommendations described in observation 3 had not been implemented. Ms. Smith noted that some of the delay was the result of failure of the General Assembly to act, but that other changes could have been undertaken without General Assembly action and were not. Delegate Ransone asked about inspections, investigations, and oversight of the Hampton Roads Regional Jail and other jails. Ms. Jennings noted that jails are subject to some inspection and oversight requirements. She also pointed out that due to statutory language, the Office of the Inspector General does not have authority to investigate the jails and that the Office was not able to access the Hampton Roads Regional Jail's internal investigation of Mr. Mitchell's death.

### **3. Discussion of Work Plan**

Following presentations, Senator Deeds announced the creation of four work groups and the purpose and membership of each work group:

- **Work Group 1: Service System Structure and Financing:** To evaluate the existing public mental health services system (the system), including the types of services provided, the organization and structure of the system by which such services are provided, and the oversight and control of the system, and to make recommendations for reform of the existing system to ensure consistent delivery of a full array of high-quality mental health prevention, treatment, and recovery support services across the age range in a timely and effective manner throughout the Commonwealth.

Members: Senator Hanger (Chair), Senator Deeds, Delegate Farrell

- **Work Group 2: Criminal Justice Diversion:** To evaluate any existing mechanisms in the Commonwealth for diverting individuals with mental illness who have committed criminal offenses into available mental health services rather than into the criminal justice system and to make recommendations for reform of any existing mechanisms or for the adoption of additional mechanisms for the diversion of such individuals into mental health services that are consistent with the need to address both the mental health needs of such individuals and the safety of the community.

Members: Delegate Bell (Chair), Senator Cosgrove, Delegate Watts

- **Work Group 3: Mental Health Crisis and Emergency Services:** To evaluate the existing crisis response and emergency services system and provide recommendations for reform of such system to provide high-quality services to individuals experiencing an acute mental health crisis while ensuring the safety of such persons and the community.

Members: Delegate Garrett (Chair), Senator Barker, Delegate Yost

- **Work Group 4: Housing:** To evaluate the existing system for providing access to housing and surrounding services to individuals with serious mental illness who have housing needs and to make recommendations for reform of the existing system to ensure that such individuals receive such access and services and are able to maintain housing stability.

Members: Senator Howell (Chair), Delegate Ransone, Delegate Torian

Senator Deeds also announced the creation of expert advisory panels to advise and assist the work groups.

#### **4. Public Comment**

Following the work groups discussion, the Joint Subcommittee received public comment from several family members of individuals with mental illness as well as advocates for individuals in need of mental health services.

#### **B. Meeting of June 23, 2016**

##### **1. Overview**

The Joint Subcommittee held its second meeting of 2016 on Thursday, June 23, 2016, at the Capitol in Richmond, Virginia.

##### **2. Presentations**

###### **a. Update on Certified Community Behavioral Health Clinics**

Dr. Jack Barber, Interim Commissioner of the Department of Behavioral Health and Developmental Services (DBHDS), provided an update on the recent improvements in Virginia's

behavioral health services system and on the DBHDS Certified Community Behavioral Health Clinics (CCBHC) model of mental health services delivery. The CCBHC model is a mode of behavioral health services delivery described in the federal Excellence in Mental Health Act (the Act). This model of services delivery provides a comprehensive range of mental health and substance use disorder services, prioritizes underserved and special populations, includes quality and performance measures to enhance quality of services, utilizes a prospective payment system, and requires ongoing oversight over services delivery to ensure uniform access to a full range of behavioral health services. The Act establishes a grant program to facilitate adoption of the model by participating states. Currently, Virginia is receiving a planning grant. As part of the grant process, DBHDS is working with eight community services boards (CSBs) (i) to determine what changes to their existing array of services and operational procedures may be necessary to comply with the requirements of the Act and (ii) to develop plans that comply with those requirements.

Dr. Barber described the services that each of the eight CSBs would be required to provide under the CCBHC model. The required services are behavioral health crisis services; screening, assessment, and diagnosis, including risk assessment; person-centered treatment planning, risk assessment, and crisis planning; outpatient mental health and substance use services; outpatient clinic primary care screening and monitoring; targeted case management; psychiatric rehabilitation services; peer support and family support, including parent peer support for children; intensive community-based mental health care for members of the armed forces and veterans; and care coordination. Dr. Barber explained that each of the eight CSBs is mostly ready to implement or ready to implement with remediation the required services.

Dr. Barber then described what he termed the Virginia model for behavioral health. The Virginia model would integrate the CCBHC model recommendations with those of the Transformation Team. The Virginia model would encompass the required services under the CCBHC grant and would also include medication-assisted treatment for opiate addiction; in-home children's services; and housing, employment, education, and social services in addition to primary care to provide true care coordination. The model would provide critical support for individuals at risk for incarceration, those in crisis, and those in need of stable housing. Implementation of the Virginia model would require building in services over several biennia beginning with same-day access and primary care screening.

Dr. Barber explained that under the Virginia model the behavioral health needs of jail inmates would be the responsibility of CSBs. In addition, the model would include diversion, screening, assessment, and release planning. Diversion and planning for services post-release require that services are accessible and sufficiently comprehensive to meet individual needs. To provide such services, every jail should have at least one staff member to aid in coordinating release planning, and each CSB should have at least one staff member to coordinate release planning for individuals.

Dr. Barber noted that a crisis system that relies on inpatient beds or crisis stabilization units is expensive and not recovery oriented. A true crisis system has the capacity to make acute medications available and provide next-day referrals for assessment and establishment of a plan of care, emergency housing, and direct referrals for social supports. Such system requires a robust community behavioral health services system that is well integrated with the crisis response system.

Dr. Barber then spoke about access to housing as an integral component of a community behavioral health services system. The lack of stable housing reflects psychosocial distress and impedes individuals from getting past such distress. Dr. Barber explained that housing is a key determinant of health and that individuals who are homeless are at greater risk for poor health. Homelessness is correlated with high health care costs, and the high proportion of complex health needs and co-occurring health and behavioral health disorders increases the number, intensity, and scope of the services needed. Homelessness also increases the likelihood of excessive use of hospitals and crisis services. In addition to the relationship to poorer health outcomes and higher costs, lack of housing can be a key factor in recurrent arrests, loss of sobriety, and lack of adherence to prescribed medications for psychiatric or medical reasons.

Finally, Dr. Barber noted that Virginia must continue to focus on building a system of responsive, consistent community-based services that go beyond responding to each crisis. The system Virginia builds needs to connect critical partners in housing and the criminal justice system and needs to be closely integrated with crisis services. The basic framework of the CCBHC model, tailored to meet current and future needs of the Commonwealth, will give Virginia the opportunity to build the system it needs.

#### **b. Update on the Activities of the Work Groups**

The four work groups met in the morning prior to the Joint Subcommittee meeting and reported the results of their meetings to the full Joint Subcommittee.

Senator Hanger updated the Joint Subcommittee on the activities of Work Group 1 (Service System Structure and Financing). Dr. Richard Bonnie, Director of the Institute of Law, Psychiatry and Public Policy at the University of Virginia School of Law and Chairman of the System Structure and Financing Expert Advisory Panel (the Panel), provided an update on the Panel's activities. Daniel Herr, Assistant Commissioner of Behavioral Health Services, DBHDS, provided information about CSB performance contracts. In addition, Mike Tweedy, Legislative Fiscal Analyst, Health and Human Resources, Virginia Senate Finance Committee, provided an overview of public mental health services financing in the Commonwealth.

Delegate Bell updated the Joint Subcommittee on the activities of Work Group 2 (Criminal Justice Diversion). The work group received an update on activities of the criminal justice diversion expert advisory panel. The work group also received a summary of recommendations of justice-involved transformation teams from Dr. Michael Schaefer, Assistant Commissioner for Forensic Services, DBHDS.

Delegate Garrett updated the Joint Subcommittee on the activities of Work Group 3 (Crisis and Emergency Services). The work group received an update on activities of the Crisis and Emergency Services Advisory Panel from John Oliver of the Institute of Law, Psychiatry and Public Policy at the University of Virginia. The group also heard presentations from John Jones of the Virginia Sheriffs' Association and Will Frank of DBHDS.

Senator Howell updated the Joint Subcommittee on the activities of Work Group 4 (Housing). The work group heard a presentation on permanent supportive housing from Kristin

Yavorsky of DBHDS. The work group also received an update on the activities of Work Group 4's expert advisory panel. In addition, the work group discussed the group's work plan.

### **3. Public Comment**

Jill Hankin of the Virginia Poverty Law Center asked the Joint Subcommittee to consider the opportunity to improve the mental health services system by expanding the Medicaid program. Ms. Hankin indicated that thousands of low-income adults need better access to care and that Medicaid expansion offers the opportunity to provide that service. She noted that expansion is not a silver bullet, but it is a financing mechanism that would provide federal funding to pay at least 90 percent of the cost of behavioral health services for low-income adults.

### **C. Meeting of August 22, 2016**

#### **1. Overview**

The Joint Subcommittee held its third meeting of 2016 on Monday, August 22, 2016, at the Capitol in Richmond, Virginia.

#### **2. Presentations**

##### **a. Update on the Activities of the Work Groups**

Each of the four work groups met in the morning prior to the Joint Subcommittee meeting and reported the results of its meeting to the full Joint Subcommittee. Sarah Stanton of DLS, on behalf of Work Group 1 (Service System Structure and Financing), reported that Work Group 1 first heard an update on the activities of the expert advisory panel. The group then received a presentation on the steps taken toward the implementation of the Certified Community Behavioral Health Clinics (CCBHC) model that involved discussion of certain service definitions and service descriptions, a community services boards (CSBs) needs assessment, and various data collection models. Next, Work Group 1 heard a presentation regarding the local government perspective on publicly funded mental health services.

Delegate Bell and Delegate Watts updated the Joint Subcommittee on the activities of Work Group 2 (Criminal Justice Diversion). Following an update on the activities of Work Group 2's expert advisory panel, the Honorable Jacqueline F. Ward Talevi, Chief Judge, General District Court, 23rd Judicial District, presented on the mental health dockets in the Roanoke and Salem General District Courts. Michelle Albert of the Alexandria Department of Community and Human Services then presented on the Collaboration for Recovery and Reentry Program based in Alexandria. Finally, Work Group 2 heard from Bobby Russell, Superintendent of the Western Virginia Regional Jail and President of the Virginia Association of Regional Jails. Mr. Russell presented information regarding how in-custody deaths in regional jails are investigated.

Delegate Yost updated the Joint Subcommittee on three presentations heard at the Work Group 3 (Crisis and Emergency Services) morning meeting, the focus of which was telepsychiatry. First, Dr. Richard Merkel and Dr. Anita Clayton from the University of Virginia School of Medicine presented an overview of telepsychiatry and spoke about the University of Virginia's telepsychiatry program. Next, Work Group 3 heard from Ted Stryker and Dr. Stephanie Loveridge

of Centra Health, who spoke generally about the overwhelming need for mental health services in the Commonwealth and how telepsychiatry may help meet that need. Finally, the work group heard from Stephanie Lynch of the Virginia Association for Health Plans and Dr. Renee Miskimmin of Virginia Premier Health, Inc., on the biggest challenges in the psychiatry field generally and how telepsychiatry may assist in addressing those challenges. Delegate Yost noted that much of the discussion in the morning meeting focused on existing barriers to the expansion of telepsychiatry.

Senator Howell reported on behalf of Work Group 4 (Housing). The work group first heard from Brian Campbell and Karen Kimsey of the Department of Medical Assistance Services, who addressed, among other points, possible ways to access more federal funding for housing assistance for the mentally ill. Marti Knisley of the Technical Assistance Collaborative then presented on the North Carolina settlement agreement with the Department of Justice. Finally, Work Group 4 received an update on the activities of the expert advisory panel.

### **b. Update on Certified Community Behavioral Health Clinics**

Dr. Jack Barber, Interim Commissioner of the Department for Behavioral Health and Developmental Services (DBHDS), provided an update on the recent improvements in Virginia's behavioral health services system and on the DBHDS Certified Community Behavioral Health Clinics (CCBHC) model of mental health services delivery. The CCBHC model is a mode of behavioral health services delivery described in the federal Excellence in Mental Health Act (the Act). The model provides a comprehensive range of mental health and substance use disorder services, prioritizes underserved and special populations, includes quality and performance measures to enhance quality of service, utilizes a prospective payment system, and requires ongoing oversight over service delivery to ensure uniform access to a full range of behavioral health services.

Dr. Barber first updated the Joint Subcommittee on recent progress improving Virginia's behavioral health services system. He noted, among other improvements, improvements in the jail waiting list. In September 2015 the list included 85 individuals, 75 of whom had been waiting more than seven days. As of August 15, 2016, the list included only 22 individuals, only six of whom had been waiting more than seven days. He also noted that a planning grant for the CCBHC model had been completed and that a plan had been developed for a multiyear, stakeholder-involved transformation initiative for system change. Dr. Barber pointed out that although there has been a dramatic increase in emergency admissions at state hospitals in the last two years, a hospital bed has been provided for everyone needing one under a temporary detention order since July 1, 2014.

Dr. Barber then touched on new standards and processes for emergency evaluators, a joint effort of DBHDS and the Virginia Association of Community Services Boards. He noted that all new emergency evaluator hires must have a master's degree or a doctorate and that all supervisors must be licensed and have at least two years of experience. He then indicated that DBHDS is working with state hospitals, including Eastern State Hospital (ESH) and the Commonwealth Center for Children & Adolescents (CCCA), to strengthen operations and improve processes and staffing. He noted that ESH has an 18-month goal for restoration of its acute psychiatric certification. The current CCCA 18-month goal includes a change in processes to reduce the average length of stay for an individual to 14 days.

Dr. Barber then updated the Joint Subcommittee on the CCBHC model of DBHDS. He noted that DBHDS has been working with eight CSBs to determine what changes to the existing array of CSB services and operational procedures may be necessary to comply with the requirements of the Act. He presented the results of a CCBHC service ranking survey evaluating the eight CSBs in 11 different service areas to assess the readiness for CCBHC certification. On the basis of the survey results, none of the eight CSBs are yet ready for CCBHC certification. He noted that the one-time cost to achieve CCBHC certification is estimated to be \$6.52 million; ongoing costs are estimated to be \$38.02 million.

He reported that 24 states, including Virginia, received federal grant funds to plan for the CCBHC model. Out of these states, eight may be awarded funds for a federal demonstration grant; CSBs would receive an increased match of 65 percent federal funds for behavioral health services provided if selected for the demonstration grant. However, some states are determining that the costs to the states to achieve CCBHC certification are greater than the enhanced 65 percent federal match. DBHDS has learned that, due to this determination, up to half of the 24 states have stated that they do not plan to apply for the demonstration grant.

Dr. Barber then noted that the CCBHC planning grant provided an opportunity to promote access, consistency, and accountability in Virginia. He highlighted major accomplishments achieved during the process, including developing a comprehensive definition of core services for Virginia and developing cost models to provide specific services at each of the eight evaluated CSBs. He stated that Virginia still needs ongoing improvements, emphasizing that there is an overreliance on crisis services in Virginia and a considerable variation among CSBs across Virginia in terms of the services offered.

Dr. Barber then spoke about the System Transformation, Excellence and Performance in Virginia (STEP-VA) model. The STEP-VA model builds on federal CCBHC requirements and transformation team recommendations with services Virginians specifically need. He noted that STEP-VA would provide essential support for individuals at risk of being incarcerated, in crisis, and in need of stable housing. Among other inclusions, Dr. Barber noted that the STEP-VA model adds to CCBHC requirements same-day access for assessment at CSBs, medication assistance treatment, and primary care screening requirements. Dr. Barber presented an example of a funding timeline with cost estimates for these additional STEP-VA requirements, based on a needs assessment. Dr. Barber also noted that a similar plan should be developed for jail-based services; he noted that, much like the STEP-VA model for CSBs, a basic array of mental health services should be agreed upon.

Finally, Dr. Barber presented on CSB data collection options. Currently, the collection process is difficult and prone to delays. Moreover, the data gathered does not offer CSBs meaningful insight into their own efficiency or effectiveness. DBHDS has identified alternative data collection options and recommends executing a project to move to standard metrics, measures, and data transmissions. The project would involve engagement of a consulting firm, with the end goal of adopting a meaningful use outcome measure and collecting useful data to inform the CSBs and DBHDS and support the needs of individuals in their care.

### **c. Overview of the Center for Behavioral Health and Justice**



Joe Flores, Deputy Secretary of Health and Human Resources, then gave a presentation on the Center for Behavioral Health and Justice (the Center). He explained that the Center is an interagency collaborative designed to better coordinate behavioral health and justice services in the Commonwealth. The Center was established at the recommendation of the Governor's Task Force for Improving Mental Health Services and Crisis Response. The recommendation included 25 specific recommendations centered around expanding access, strengthening administration, and improving quality of services.

Mr. Flores then reported on Center activities. The Center has drafted a strategic implementation plan, created a Center Advisory Group, convened a Behavioral Health and Justice Summit, established a special subcommittee to assist its efforts, finalized a website, and assigned dedicated staff to the Center.

In addition, three Action Committees have been established, composed of members of the Center Advisory Group and co-chaired by a member of such group and the Executive Committee. Action Committee 1 is the Technology, Data, and Information Sharing Committee, focusing on an expansion of the use of technology, providing guidelines to communities regarding information sharing, tracking interventions and criminal justice contact to improve handoffs between systems, and tightening the guidelines on transmission of judicial treatment orders. Action Committee 2, the Committee on Diversion and Re-entry, will focus on expanding diversion options; supporting judicial involvement in ongoing diversion efforts; improving access to Medicaid, the Governor's Access Plan, Social Security, and other benefits available to those being released from incarceration; and expanding use of outpatient restoration. Action Committee 3, the Criminal Justice and Behavioral Health Facilities Committee, will address inequities in jail mental health services, ensure jail and prison screening for veterans, and work to improve access to benefits available to those being released from incarceration.

Mr. Flores explained the Center's next steps. The Center will continue to refine the Action Committee work plans and provide technical assistance to localities to promote the use of best practices for justice-involved behavioral health consumers. Mr. Flores anticipates that the Center's website will go live in September 2016.

### **3. Proposals for the 2017 Session**

The Joint Subcommittee had initial conversations about potential legislative proposals for the 2017 Session. Senator Cosgrove began by discussing potential legislation addressing a provision in the Code of Virginia that allows a minor over the age of 14 to refuse inpatient therapy. Delegate Bell spoke about potential legislation addressing the perceived problem of getting the Office of the State Inspector General in to investigate incidents occurring in the jails. Finally, Senator Howell discussed potentially amending the Housing Trust Fund so that 20 percent of that Fund goes towards funding permanent supportive housing and similar housing programs.

### **4. Public Comment**

Senator Deeds then invited members of the audience to offer public comment. No public comment was offered.

### **D. Meeting of October 26, 2016**

## **1. Overview**

The Joint Subcommittee held its fourth meeting of 2016 on Wednesday, October 26, 2016, at the General Assembly Building in Richmond, Virginia.

## **2. Presentations**

### **a. Update on the Activities of Work Group 2: Criminal Justice Diversion**

Delegate Bell, the chair of Work Group 2, updated the Joint Subcommittee on its activities. He noted that at its meeting earlier in the day, the work group heard testimony from three former employees of the Office of the State Inspector General (OSIG) concerning deficiencies in the investigation conducted by OSIG into the death of Jamycheal Mitchell while in the custody of the Hampton Roads Regional Jail. The work group then discussed what entity would be best equipped to investigate in-custody deaths of inmates in jails with relevant stakeholders, including representatives of the sheriffs and the regional jails. Delegate Bell reported that the work group is exploring the possibility of providing the Board of Corrections (BOC) with the authority to conduct such investigations but that discussions were still ongoing.

Delegate Bell then enumerated the three legislative proposals developed in conjunction with the expert advisory panel assisting the work group that would be presented at the final meeting of the Joint Subcommittee in December:

- Provide authority to an appropriate entity, possibly BOC, to investigate in-custody deaths in jails.
- Require the use of a standardized instrument upon intake of persons into jails to screen for mental illnesses.
- Require the Department of Behavioral Health and Developmental Services (DBHDS) to develop a plan for the provision of discharge planning services for persons being released from jail that ensures that each jail in the Commonwealth has access to such services. The plan shall include an estimate of the cost of providing discharge planning services as well as an estimate of any cost savings that may result from the provision of such services.

Delegate Bell concluded by noting that the work group plans to focus on specific models for diverting persons with mental illness from the criminal justice system during the 2017 Interim.

### **b. Update on the Activities of Work Group 3: Mental Health Crisis and Emergency Services**

Delegate Garrett, the chair of Work Group 3, updated the Joint Subcommittee on its activities. Delegate Garrett explained that the work group, with the assistance of its expert advisory panel, had concentrated on three topics:

- The use of alternative transportation providers for persons subject to the emergency custody and involuntary admission processes.

- The use and availability of telemental health services.
- The establishment of psychiatric emergency services units.

With regard to telemental health services, Delegate Garrett noted that the work group strongly recommends expansion of the use of such services, particularly in areas of the Commonwealth where the needs of the community for mental health services outstrip the number of mental health service providers available. However, the work group has identified several impediments to expanding the use of telemental health services, the most problematic of these being federal laws affecting the ability of medical professionals to prescribe medication for a patient without a face-to-face interaction.

Turning to alternative transportation, Delegate Garrett described the existing pilot program established pursuant to a DBHDS grant in the Mt. Rogers community services board (CSB) service area and remarked that the program has successfully transported numerous individuals without incident during its operation.

Finally, as to the establishment of psychiatric emergency services units, Delegate Garrett explained that such units are designed as an alternative to hospital emergency departments as a means for individuals experiencing mental health crises to obtain treatment. Delegate Garrett noted that such units may reduce the costs associated with psychiatric boarding (i.e., the length of time an individual experiencing a mental health crisis waits in a hospital emergency department for a psychiatric inpatient bed); however, the work group and its expert advisory panel are still attempting to determine the costs associated with psychiatric boarding in the Commonwealth and the potential cost benefits that may result from the establishment of psychiatric emergency services units.

Delegate Garrett then stated that the work group would be presenting two legislative proposals at the final meeting of the Joint Subcommittee in December:

- Require DBHDS and other relevant stakeholders to develop a model for the use of alternative transportation providers, including the criteria for the certification of such providers and the costs and benefits associated with the implementation of the model.
- Amend Virginia's laws to facilitate the use of telemental health services to the extent allowable under federal law.

### **c. Update on the Helping Families in Mental Health Crisis Act**

Stuart Gordon, Director of Policy, National Association of State Mental Health Program Directors, via conference call, provided an overview of the provisions of the federal legislation currently before the U.S. Congress that establishes the Helping Families in Mental Health Crisis Act (the Act). Mr. Gordon stated that the U.S. House of Representatives version of the Act (H.R. 2646) has passed the House while the U.S. Senate version (S. 2680) has been voted out of the Senate Health Education Labor and Pensions Committee but has not been acted on by the full Senate.

Mr. Gordon highlighted the provisions of both versions of the Act as well as the differences between the two versions. Among the Act's provisions are the following:

- Creation of a National Treatment Referral Routing Service to assist individuals in locating mental health treatment providers.
- Grants for states to enhance community-based crisis response systems and to develop and maintain a database of available beds at inpatient and other facilities.
- Requirement that a state receiving mental health block grants include in its plan a description of how the state will provide a community-based system of care for persons with mental illness and coordinate the delivery of services to such persons.
- Grants to states for treatment and recovery for homeless persons with substance use disorders.
- Grants for jail diversion programs.
- Grants for training of mental health professionals for underserved communities.
- Requirement that the Office of Civil Rights of the U.S. Department of Health and Human Services ensure that mental health providers and patients and their families have adequate information on the appropriate uses and disclosures of protected health information under the Health Insurance Portability and Accountability Act.

After Mr. Gordon completed his presentation, Senator Deeds asked if the Act could be characterized as primarily dealing with funding changes instead of making substantive changes to the law. Mr. Gordon agreed with that characterization. Senator Deeds also inquired if the Act reformed the Substance Abuse and Mental Health Services Administration (SAMHSA) in any way, and Mr. Gordon explained that the Act elevated the position of administrator of SAMHSA to the level of an assistant secretary. In response to Senator Deeds' question regarding whether the Act would pass, Mr. Gordon replied that there will be efforts to pass something during the lame duck congressional session but that he could not predict whether those efforts would be successful.

#### **d. Update on the Activities of Work Group 4: Housing**

Senator Howell, the chair of Work Group 4, updated the Joint Subcommittee on its activities. Senator Howell stated that it is well established that the best practices for reducing hospitalization and criminal justice utilization and improving stability for persons with serious mental illness is permanent supportive housing. He laid out four legislative proposals developed by the work group in conjunction with its expert advisory panel, all of which relate to permanent supportive housing and will be presented at the final meeting of the Joint Subcommittee in December:

- Provide \$10 million in new funding for permanent supportive housing targeted to address frequent users of high-cost systems (i.e., state psychiatric hospitals and jails).

- Amend the Virginia Housing Trust Fund to require that 20 percent of the Fund be used for (i) supportive services and predevelopment assistance for permanent supportive housing for the homeless and (ii) temporary rental assistance.
- Require the Department of Housing and Community Development, in consultation with other agencies and stakeholders, to develop and implement strategies for housing individuals with serious mental illness.
- Require the Department of Medical Assistance Services (DMAS), in consultation with other agencies and stakeholders, to research and recommend strategies for financing permanent supportive housing through Medicaid reimbursement.

Senator Howell stressed that the \$10 million in new funding for permanent supportive housing is only a first step and that \$100 million would be required to cover the estimated 5,000 individuals in the Commonwealth who are in need of permanent supportive housing.

#### **e. Update on the Activities of Work Group 1: Service System Structure and Financing**

Senator Hanger, the chair of Work Group 1, updated the Joint Subcommittee on its activities. Senator Hanger began by noting that the work group was considering a mechanism for continuing the work of the Joint Subcommittee after it concludes its study in 2017.

Senator Hanger then proceeded to explain that the work group, with the assistance of its expert advisory panel, has developed four legislative proposals that will be presented at the final meeting of the Joint Subcommittee in December:

- Endorse the goal of the Commonwealth's public mental health services system providing access to 10 services that would ensure that all individuals with mental illness receive needed services and fully fund the statewide implementation of two of these 10 services: same day access to mental health screening and timely access to assessment, diagnostic, and treatment services (estimated cost: \$1.5 million in FY 2017, \$12.3 million in FY 2018, and \$17.3 million annually thereafter) and outpatient primary care screening and monitoring services (estimated cost: \$3.72 million in FY 2019 and \$7.44 million annually thereafter). The 10 service goals are as follows:
  - Same-day access to mental health screening and timely access to assessment, diagnostic, and treatment services;
  - Outpatient primary care screening and monitoring services;
  - Crisis services;
  - Person-centered mental health treatment planning services;
  - Outpatient mental health and substance abuse services;
  - Targeted mental health case management;

- Psychiatric rehabilitation services;
  - Peer support and family support services;
  - Mental health services for members of the armed forces and veterans; and
  - Care coordination services.
- Request the Joint Commission on Health Care (JCHC) to review the work group's report on telemental health services and develop recommendations for increasing the use of telemental health services.
  - Amend Va. Code § 37.2-818 to allow transmission of records related to involuntary admission proceedings to DBHDS to enable it to maintain statistical archives and conduct research on the consequences and characteristics of such proceedings.
  - Manage the utilization of Virginia's state hospitals through the following:
    - Implementation of the census reduction initiatives adopted by DBHDS and the CSBs;
    - Development of budget requests by DBHDS for FY 2018 to stabilize and maintain state hospital utilization at no more than 90 percent of capacity;
    - Continued study by the work group of the statutory, policy, financing, and administrative elements of the current mental health services system that are not aligned with the work group's strategic and operational objectives; and
    - Study by DBHDS and DMAS of the potential use of the Involuntary Mental Commitment Fund for both involuntary and voluntary temporary detention.

Senator Hanger noted that during the 2017 Interim the work group would be studying restructuring the catchment areas of the CSBs, the financing of Virginia's mental health services system, and the potential for the provision of mental health services by private providers.

Upon completion of the reports from the work groups, Senator Deeds discussed the need for a continuing entity to continue the work of the Joint Subcommittee after the expiration of its four-year charge and expressed his preference that JCHC be given sufficient resources to continue the work on an ongoing basis.

### **3. Public Comment**

The Joint Subcommittee then received public comment from several family members of individuals with mental illness as well as advocates for individuals in need of mental health services.

### **E. Meeting of December 6, 2016**

## **1. Overview**

The Joint Subcommittee held its fifth and final meeting of 2016 on Tuesday, December 6, 2016, at the General Assembly Building in Richmond, Virginia.

## **2. Review of Recommendations for 2017 Session**

### **a. Work Group 1: Service System Structure and Financing**

Senator Hanger, the chair of Work Group 1, explained that the work group, with the assistance of its expert advisory panel, has developed four legislative proposals:

- Endorse the goal of the Commonwealth's public mental health services system providing access to 10 services that would ensure that all individuals with mental illness receive needed services and fully fund the statewide implementation of two of these 10 services: same day access to mental health screening and timely access to assessment, diagnostic, and treatment services (estimated cost: \$1.5 million in FY 2017, \$12.3 million in FY 2018, and \$17.3 million annually thereafter) and outpatient primary care screening and monitoring services (estimated cost: \$3.72 million in FY 2019 and \$7.44 million annually thereafter). The 10 service goals are as follows:
  - Emergency services;
  - Same-day access to mental health screening services;
  - Outpatient primary care screening and monitoring services;
  - Crisis services;
  - Outpatient mental health and substance abuse services;
  - Psychiatric rehabilitation services;
  - Peer support and family support services;
  - Mental health services for members of the armed forces and veterans;
  - Care coordination services; and
  - Case management services, including targeted mental health case management services.
- Request the Joint Commission on Health Care (JCHC) to review the work group's report on telemental health services and develop recommendations for increasing the use of telemental health services.
- Amend Va. Code § 37.2-818 to allow transmission of records related to involuntary admission proceedings to the Department of Behavioral Health and Developmental

Services (DBHDS) to enable it to maintain statistical archives and conduct research on the consequences and characteristics of such proceedings.

- Manage the utilization of Virginia’s state hospitals through the following:
  - Implementation of the census reduction initiatives adopted by DBHDS and the community services boards;
  - Development of budget requests by DBHDS for FY 2018 to stabilize and maintain state hospital utilization at no more than 90 percent of capacity;
  - Continued study by the work group of the statutory, policy, financing, and administrative elements of the current mental health services system that are not aligned with the work group’s strategic and operational objectives; and
  - Study by DBHDS and the Department of Medical Assistance Services (DMAS) of the potential use of the Involuntary Mental Commitment Fund for both involuntary and voluntary temporary detention.

The Joint Subcommittee voted unanimously to support the Work Group 1 proposals, with Delegate Garrett abstaining from voting on the first proposal.

### **b. Work Group 2: Criminal Justice Diversion**

Delegate Bell, the chair of Work Group 2, enumerated three legislative proposals for the 2017 Session:

- Provide authority to the Board of Corrections to investigate in-custody deaths in jails.
- Require the use of a standardized instrument upon intake of persons into jails to screen for mental illnesses.
- Require DBHDS to develop a plan for the provision of discharge planning services for persons being released from jail that ensures that each jail in the Commonwealth has access to such services. The plan shall include an estimate of the cost of providing discharge planning services as well as an estimate of any cost savings that may result from the provision of such services.

The Joint Subcommittee voted unanimously to support the Work Group 2 proposals.

### **c. Work Group 3: Mental Health Crisis and Emergency Services**

Delegate Garrett, the chair of Work Group 3, presented two legislative proposals for the 2017 Session:

- Require DBHDS and other relevant stakeholders to develop a model for the use of alternative transportation providers, including the criteria for the certification of such providers and the costs and benefits associated with the implementation of the model.



- Amend Virginia’s laws to facilitate the use of telemental health services to the extent allowable under federal law.

The Joint Subcommittee voted unanimously to support the Work Group 3 proposals.

#### **d. Work Group 4: Housing**

Delegate Ransone and Mira Signer, chair of the Housing work group’s expert advisory panel, discussed four legislative proposals:

- Provide \$10 million in new funding for permanent supportive housing targeted to address frequent users of high-cost systems (i.e., state psychiatric hospitals and jails).
- Amend the Virginia Housing Trust Fund to require that 20 percent of the Fund be used for (i) supportive services and predevelopment assistance for permanent supportive housing for the homeless and (ii) temporary rental assistance.
- Require the Department of Housing and Community Development, in consultation with other agencies and stakeholders, to develop and implement strategies for housing individuals with serious mental illness.
- Require DMAS, in consultation with other agencies and stakeholders, to research and recommend strategies for financing permanent supportive housing through Medicaid reimbursement.

As to the proposal to amend the Virginia Housing Trust Fund, several questions arose about what that 20 percent of the Fund is now used for. The Joint Subcommittee decided to postpone discussion on this proposal until they received more information. The first and third proposals were adopted unanimously by the Joint Subcommittee. The fourth proposal was adopted with a 9-2 vote, with Senator Cosgrove and Delegate Garrett voting against it.

### **3. Discussion of a Resolution Extending the Joint Subcommittee**

Senator Deeds then presented a proposal that would require the Joint Commission on Health Care to continue to make recommendations on issues related to the organization, delivery, financing, management, and oversight of publicly funded behavioral health care services in the Commonwealth at the expiration of the Joint Subcommittee’s four-year charge. Alternative recommendations were made to instead request that the General Assembly approve a resolution extending the Joint Subcommittee’s charge for another two years. This alternative proposal garnered unanimous support from the Joint Subcommittee.

### **4. Public Comment**

Senator Deeds then invited members of the audience to offer public comment, and one member of the public spoke.

### **F. Activities of the Joint Subcommittee’s Work Groups**

## **1. Work Group 1: Service System Structure and Financing**

Work Group 1 held six meetings during 2016 on the following dates: Tuesday, May 17, 2016; Thursday, June 23, 2016; Monday, August 22, 2016; Friday, September 30, 2016; Wednesday, October 26, 2016; and Tuesday, December 6, 2016. Over the course of these meetings, Work Group 1 received presentations on the following topics:

- The activities of the Service System Structure and Financing Expert Advisory Panel.
- The financing of Virginia's public behavioral health system.
- The core services to be provided by Virginia's public behavioral health system.
- The utilization rate of the state hospitals.
- The performance contracts entered into by community services boards.

At the conclusion of its 2016 meetings, Work Group 1 made several recommendations to the Joint Subcommittee. These recommendations are set forth in Part III E 2 a, *supra*.

## **2. Work Group 2: Criminal Justice Diversion**

Work Group 2 held four meetings during 2016 on the following dates: Thursday, June 23, 2016; Monday, August 22, 2016; Wednesday, October 26, 2016; and Tuesday, December 6, 2016. Over the course of these meetings, Work Group 2 received presentations on the following topics:

- The activities of the Criminal Justice Diversion Expert Advisory Panel.
- The recommendations of the Justice-Involved Transformation Teams by the Department of Behavioral Health and Developmental Services.
- The use of mental health dockets by courts.
- The conduct of in-custody death reviews in local and regional correctional facilities.
- The use of a standardized mental health screening instrument by local and regional correctional facilities.
- The Alexandria jail diversion program.

At the conclusion of its 2016 meetings, Work Group 2 made several recommendations to the Joint Subcommittee. These recommendations are set forth in Part III E 2 b, *supra*.

## **3. Work Group 3: Crisis and Emergency Services**

Work Group 3 held three meetings during 2016 on the following dates: Thursday, June 23, 2016; Monday, August 22, 2016; and Wednesday, October 26, 2016. Over the course of these meetings, Work Group 3 received presentations on the following topics:

- The activities of the Crisis and Emergency Services Expert Advisory Panel.

- The use of alternative transportation for individuals in the involuntary commitment process.
- The expansion of the use of telemental health.
- Care coordination improvement in emergency departments.

At the conclusion of its 2016 meetings, Work Group 3 made several recommendations to the Joint Subcommittee. These recommendations are set forth in Part III E 2 c, *supra*.

#### **4. Work Group 4: Housing**

Work Group 4 held three meetings during 2016 on the following dates: Thursday, June 23, 2016; Monday, August 22, 2016; and Wednesday, October 26, 2016. Over the course of these meetings, Work Group 4 received presentations on the following topics:

- The activities of the Housing Expert Advisory Panel.
- The availability of permanent supportive housing by the Department of Behavioral Health and Developmental Services.
- The *Olmstead* decision, requiring that individuals be placed in the least restricting setting, and the settlement agreement between North Carolina and the U.S. Department of Justice.

At the conclusion of its 2016 meetings, Work Group 4 made several recommendations to the Joint Subcommittee. These recommendations are set forth in Part III E 2 d, *supra*.

### **IV. Activities of the Joint Subcommittee: 2017**

#### **A. Action on Subcommittee Recommendations in the 2017 Session**

The Joint Subcommittee endorsed 12 legislative or budgetary proposals that had been developed by the Joint Subcommittee's work groups during the 2017 Session of the General Assembly. In addition, the Joint Subcommittee endorsed a proposal to extend its work by two years. The overwhelming majority of these proposals were enacted into law during the 2017 Session of the General Assembly.

##### **1. Proposal from the Joint Subcommittee**

- Extend the work of the Joint Subcommittee for two years.

**Passed:** Item 1(V) of the 2017 Appropriation Act extends the work of the Joint Subcommittee until December 1, 2019, and Item 6(D) appropriates \$250,000 to support the work of the Joint Subcommittee.

##### **2. Proposals from Work Group 1: Service System Structure and Financing**

- Expand CSB-mandated services to include the core services included in the STEP-VA model and fully fund same-day access to mental health screening and outpatient primary care screening and monitoring services.

**Passed:** Chapters 607 and 683 of the Acts of Assembly of 2017 require the provision of same-day access and outpatient primary care services effective July 1, 2019, and the remaining services in the STEP-VA model effective July 1, 2021.

Item 315(GG) of the 2017 Appropriation Act appropriates \$4.9 million in FY18 to implement same-day access.

- Request the Joint Commission on Health Care (JCHC) to study options for increasing the use of telemental health services.

**Passed:** Item 30(B) of the Appropriation Act requires JCHC to conduct a study and report its findings on November, 1, 2018.

- Allow transmission of records related to involuntary admission proceedings to DBHDS to enable it to maintain statistical archives and conduct research on the consequences and characteristics of such proceedings.

**Passed:** Chapters 188 and 719 of the Acts of Assembly of 2017.

- Request DBHDS and the Department of Medical Assistance Services to study the potential use of the Involuntary Mental Commitment Fund for both involuntary and voluntary temporary detention.

**Did Not Pass:** House Bill 1550 and Senate Bill 1007.

### **3. Proposals from Work Group 2: Criminal Justice Diversion**

- Authorize the State Board of Corrections to conduct reviews of in-custody deaths in jails.

**Passed:** Chapter 759 of the Acts of Assembly of 2017. In addition, the law imposes specific qualifications for membership on the State Board of Corrections.

Item 394(O) of the 2017 Appropriation Act appropriates \$100,000 to fund a position to conduct in-custody death reviews.

- Require the use of a standardized instrument upon intake of persons into jails to screen for mental illnesses.

**Passed:** Item 70(J)(2) and (J)(3) of the 2017 Appropriation Act requires screening and mandates that the Compensation Board review its jail staffing standards to determine the costs and benefits of providing an assessment of the need for mental health services within 72 hours of the conduct of a screening.

- Require DBHDS and other relevant stakeholders to develop a plan for the provision of forensic discharge planning services for persons with serious mental illness being released from jail.

**Passed:** Chapters 137 and 192 of the Acts of Assembly of 2017. Report received on November 1, 2017.

#### **4. Proposals from Work Group 3: Mental Health Crisis and Emergency Services**

- Require DBHDS and other relevant stakeholders to develop a model for the use of alternative transportation providers, including the criteria for the certification of such providers.

**Passed:** Chapters 94 and 97 of the Acts of Assembly of 2017. Report received on October 1, 2017.

- Amend Virginia's laws to facilitate the use of telemental health services to the extent allowable under federal law.

**Passed:** Chapters 58 and 110 of the Acts of Assembly of 2017.

#### **5. Proposals from Work Group 4: Housing**

- Provide \$10 million in new funding for permanent supportive housing targeted to address frequent users of high-cost systems (i.e., state psychiatric hospitals and jails).

**Passed:** Item 315(AA) of the 2017 Appropriation Act appropriates an additional \$4.9 million in FY18 for permanent supportive housing.

Item 313 of the 2017 Appropriation Act appropriates \$100,000 to fund a position at DBHDS to oversee the Permanent Supportive Housing program.

- Require the Department of Housing and Community Development (DHCD), in consultation with other agencies and stakeholders, to develop and implement strategies for housing individuals with serious mental illness.

**Passed:** Item 108(H) of the Appropriation Act requires DHCD to develop and implement such strategies, including the use of potential Medicaid financing.

- Require DMAS, in consultation with other agencies and stakeholders, to research and recommend strategies for financing permanent supportive housing through Medicaid reimbursement.

**Did Not Pass:** Budget amendment offered by Delegate Yost.

#### **B. Meeting of April 5, 2017**

##### **Overview**

The first Joint Subcommittee meeting for 2017 was scheduled for Wednesday, April 5, 2017, at the General Assembly Building in Richmond. Due to the need for some members to attend meetings scheduled at the same time as the Joint Subcommittee's, a quorum of the Joint Subcommittee was not present, and the meeting was not convened. However, the chair of the Joint Subcommittee, Senator R. Creigh Deeds, announced that the Mental Health Crisis and Emergency Services work group would be incorporated into the Service System Structure and Financing work group and that the Housing work group would be incorporated into the Criminal Justice Diversion work group. Senator Deeds stated that the two work groups would likely meet at least four times during 2017. Senator Deeds noted that the House Courts of Justice Committee referred five bills introduced during the 2017 Regular Session to the Joint Subcommittee for study and that each bill will be assigned to the appropriate work group. Finally, Senator Deeds noted that the Joint Subcommittee had been appropriated funds in the 2017–2018 budget that will enable the engagement of a consultant to assist the work of the Joint Subcommittee, if necessary.

### **C. Meeting of September 28, 2017**

#### **1. Overview**

The Joint Subcommittee held its second meeting of 2017 on Thursday, September 28, 2017, at the Pocahontas Building in Richmond, Virginia.

#### **2. Presentations**

##### **a. Update on Department of Behavioral Health and Developmental Services Initiatives**

Dr. Jack Barber, Interim Commissioner, Department of Behavioral Health and Developmental Services (DBHDS), provided an update on behavioral health services system reform efforts. Dr. Barber described progress toward implementing same-day access to mental health screening services and primary care screening and monitoring services in the Commonwealth; activities to ensure access to behavioral health services for uninsured Virginians, including steps to align services delivered through managed care behavioral health programs managed by the Department of Medical Assistance Services with the STEP-VA model of service delivery; current state hospital bed utilization and projected increases in such utilization; rates of emergency custody and temporary detention and changes in the number of individuals subject to temporary detention orders treated in private hospitals; activities around development of the plan for financial realignment of services delivered by DBHDS and community services boards required by Item 284 E.1. of the 2017 Appropriation Act; workforce challenges affecting DBHDS; and plans for development of community capacity to reduce demand for state hospital beds. Dr. Barber ended his presentation by noting that the jail waiting list for services has been reduced to a total of nine individuals, with no individuals waiting more than seven days for services.

##### **b. Update on Activities of the Expert Advisory Panels**

Dr. Richard Bonnie, chair of the Service System Structure and Financing Expert Advisory Panel, provided a brief overview of the work of the Expert Advisory Panels and requested funding from the amount appropriated to the Joint Subcommittee to fund a position to carry out research

and coordinate the studies. The Joint Subcommittee voted to allocate between \$60,000 and \$64,000 for such purpose, pursuant to a contract to be finalized between the Joint Subcommittee and the Institute for Law, Psychiatry and Public Policy.

On behalf of Leslie Weisman, chair of the Criminal Justice Diversion Expert Advisory Panel, Dr. Heather Zelle from the Institute of Law, Psychiatry and Public Policy provided an update on the activities and future plans of the panel. She noted that members of the panel have been visiting jails throughout the Commonwealth and have conducted a survey of the localities to determine which localities have mental health/criminal justice stakeholder groups in operation. She also stated that the panel is monitoring (i) the use of mental health dockets in the wake of the recent Supreme Court of Virginia rule allowing courts to establish such dockets, (ii) the forensic discharge planning study being completed by DBHDS, and (iii) the implementation of the requirement that inmates entering all jails in the Commonwealth be screened for mental illness using a uniform instrument.

As to future panel activities, Dr. Zelle stated that the panel is in the process of identifying rural areas that need assistance with launching crisis intervention team and jail diversion efforts and the resources needed to do so as well as developing a tool to measure the readiness of rural areas to launch such efforts. She also described the panel's interest in developing a method for calculating the cost savings that could be achieved through jail diversion programs. Finally, she noted that the panel will be reviewing the state of the law relating to medicating inmates over their objections.

John Oliver, chair of the Mental Health Crisis and Emergency Services Expert Advisory Panel, provided an update on that panel's recent activities. He noted that the panel is monitoring the work of the Alternative Transportation Work Group and that the work group's final report is due October 1. The panel is also monitoring the work of the Joint Commission on Health Care with regard to a study of options to expand use of telemental health services. The Joint Commission on Health Care's final report is due November 1, 2018. Mr. Oliver also described the panel's work around development of a description of core services that should be available to individuals in a mental health crisis no matter where the individual is located in the Commonwealth. The work group focused on this topic has met several times by conference call and is drafting a description of the proposed core services. Finally, Mr. Oliver stated that the work group that is focused on development of psychiatric emergency centers continues to review options but that additional work is required before recommendations can be made. In closing, Mr. Oliver requested input from the members of the Joint Subcommittee regarding the types of information and data the Joint Subcommittee members would like the panel to collect.

Mr. Jim Martinez described two studies the panel is undertaking: (i) a review of the oversight authority and responsibilities of DBHDS regarding the delivery of mental health services in the Commonwealth generally and (ii) the work of the community services boards specifically.

### **3. Discussion of Referred Bills**

Senator George Barker, Delegate Roxann Robinson, and Jennifer Wicker, Director of Intergovernmental Affairs, Virginia Hospital and Healthcare Association, provided information about Senate Bill 1222 and House Bill 1918, creating the Acute Psychiatric Patient Registry. The

speakers noted that during the 2017 Session of the General Assembly, several concerns were raised about the form and function of the proposed registry but that during the course of discussions among the stakeholders a solution had been identified and that implementation of a system for sharing data and information about patients in need of psychiatric beds could be implemented without additional legislation.

Senator R. Creigh Deeds provided an overview of Senate Bill 1064 and House Bill 1480 (Helsel), requiring mental health awareness training for law-enforcement officers, firefighters, and emergency medical services personnel. Mr. Art Lipscomb, Director of Government Affairs, Virginia Professional Fire Fighters, noted that the bill had been revised during the course of the session before being referred to the Joint Subcommittee and that the Virginia Professional Fire Fighters preferred the original version of the bill. He noted that the organization would be working with Senator Deeds and Delegate Helsel to reintroduce the bill during the 2018 Regular Session. Senator Deeds stated that he would like to have the Joint Subcommittee review the proposed legislation once a draft is prepared.

#### **4. Public Comment**

Ms. Amanda Woodward, a psychiatric nurse from Amissville, Virginia, provided comments on her experiences and the need for mental health reform in the Commonwealth.

#### **D. Meeting of November 28, 2017**

##### **1. Overview**

The Joint Subcommittee held its third meeting of 2017 on Tuesday, November 28, 2017, at the Pocahontas Building in Richmond, Virginia.

##### **2. Presentations**

###### **a. Update on the Work of the Farley Health Policy Center and the Department of Medical Assistance Services**

Dr. Ben Miller from the Farley Health Policy Center presented to the Joint Subcommittee on the work of the Farley Health Policy Center with the Department of Medical Assistance Services (DMAS) to advance mental health in Virginia. The presentation centered around the Medicaid-eligible population in the Commonwealth, with an emphasis on the alignment and integration of the Commonwealth's mental health services system, standards and accountability for the system, and multiple entry points for easy access to the system. Dr. Miller noted that Medicaid is the single largest payer in the United States for behavioral health services, including mental health and substance abuse services. Recent numbers show that Medicaid accounts for 26 percent of behavioral health spending nationally. In 2011, one in five Medicaid beneficiaries had behavioral health diagnoses but accounted for almost half of total Medicaid expenditures.

Dr. Miller and the Farley Health Policy Center analyzed Medicaid data from DMAS, the Department of Behavioral Health and Developmental Services (DBHDS), and the Department of Health. The average cost per Medicaid enrollee in Virginia was \$8,597, and there were a total of



1.37 million Medicaid recipients in Virginia during fiscal year 2017. Of those recipients, 386,305 individuals received behavioral health services.

Dr. Miller asserted that the alignment and integration of state agencies providing behavioral health and related services is paramount in a successful system in the Commonwealth, and he provided a map outlining the various regions of the Commonwealth measured by DMAS, DBHDS, and the Department of Health. Such regions are not uniform across the three agencies, which is a barrier to collecting accurate service and outcome data. Dr. Miller emphasized the importance of shared accountability and collaboration from the agencies.

Dr. Miller noted that, in FY 2017, the Commonwealth spent \$ 862,339,335 on fees for behavioral health services. He further broke down such expenditures into categories of behavioral health services and noted that an increase in services provided in a certain category was not necessarily driven by patient needs or outcomes but was often driven instead by reimbursement rates. The lack of good measurements for quality of care and patient outcomes for Medicaid spending further exacerbated such problem.

Dr. Miller again stressed that a fundamental cultural change is needed in the Commonwealth to advance its behavioral health services system. Such cultural change needs to be rooted in the alignment and integration of the Commonwealth's mental health services system, standards and accountability measures for the system, and multiple entry points for easy access to the system.

### **b. Report on Financial Realignment**

Dr. Jack Barber, Interim Commissioner, DBHDS, provided an update on the financial realignment of Virginia's public behavioral health services system. According to Dr. Barber, the basic intent of the financial realignment was to shift to the community services boards (CSBs) the funding that had previously gone directly to the state hospitals, so that the CSBs would pay for hospital bed days. Dr. Barber described the progress made toward implementing the financial realignment, which included implementing a community integration plan to prepare for the realignment. Some of the expected benefits of realignment are a reduction in the number of persons needing hospital-level care, a decrease in the amount of time persons wait on the extraordinary-barriers-to-discharge list, a reduction of state hospital utilization to the best practice rate of 85 percent, and the ability to avoid spending excessive amounts of money on more hospital beds, which are an impediment to building the capacity of community treatment. Dr. Barber stated that the expected time frame to implement full realignment was four years.

### **c. Report on Forensic Discharge Planning**

Dr. Michael Schaefer, Assistant Commissioner, DBHDS, provided a report on forensic discharge planning. The report was mandated by Chapters 137 and 192 of the Acts of Assembly of 2017. Jail discharge planning for individuals with severe mental illness includes the screening for and assessment of psychiatric, medical, social services, employment, and residential needs as soon as possible after the individual's admission to jail. Discharge planning also includes the development of a discharge plan that prioritizes goals and objectives that reflect the assessed needs. It includes care coordination with community providers and community supervision agencies,

including the exchange of treatment records, communication of treatment needs, and linkage of clients with available services and support options upon release. Traditionally, discharge planning has resulted in increased public safety measurements, improved quality of life for discharge planning participants, and a reduction in costs for jails. According to Dr. Schaefer, of those jails that responded to his survey, 75 percent reported insufficient staffing or other resources to provide a comprehensive discharge planning service. Dr. Schaefer recommended a three-phase approach to implement a comprehensive discharge planning system with jails across the Commonwealth, with the appropriate phases being implemented according to which jails have the highest percentage of severe mental illness.

### **3. Public Comment**

Following discussion of the recommendations, the Joint Subcommittee received two public comments, one from a psychiatric nurse on her experiences in the mental health field and the need for mental health reform in the Commonwealth and the other from a physician on the need for alternative treatments to be included in the Commonwealth's mental health reform.

#### **E. Meeting of December 19, 2017**

##### **1. Overview**

The Joint Subcommittee held its fourth and final meeting of 2017 on Tuesday, December 19, 2017, at the Pocahontas Building in Richmond, Virginia.

##### **2. Review of Recommendations for 2018 Session**

###### **a. Work Group 1: Service System Structure and Financing**

John Oliver presented several recommendations proposed by the Service System Structure and Financing Work Group, including:

- **Study of temporary detention.** The work group recommended establishment of a work group to conduct a collaborative study on measures needed to facilitate effective emergency intervention services and reduce admissions pursuant to temporary detention orders at state hospitals. The work group should include relevant stakeholders and should develop legislative and budget proposals intended to reduce overall admissions and reduce the burden on state hospitals.

The Joint Subcommittee adopted this recommendation; a letter will be drafted setting out the details of the proposed study.

- **Telemental health services.** The work group recommended a budget amendment to provide \$1.1 million per year for three years to Appalachian Telemental Health Network Initiative.

The Joint Subcommittee adopted this recommendation.

- **Alternative transportation.** The work group recommended a budget amendment to provide \$1.7 million per year to support and expand alternative transportation pilot programs in the area served by the Mount Rogers Community Services Board and the area served by the Region 10 Community Services Board.

After some discussion of the benefits of a pilot program or establishment of a statewide program, the Joint Subcommittee adopted a recommendation that a budget amendment be introduced to provide \$10.2 million to fund statewide implementation of the alternative transportation model proposed in RD 337 (2017) - Virginia Department of Behavioral Health and Developmental Services and Virginia Department of Criminal Justice Services: Alternative Transportation Workgroup Final Report.

Staff then presented additional recommendations adopted by the Service System Structure and Financing Work Group, including the following:

- **STEP-VA.** The work group recommended continued support for ongoing efforts to implement STEP-VA in accordance with the provisions of Chapters 607 and 683 of the Acts of Assembly of 2017. The Governor's proposed budget included \$11.8 million in general funds to expand access to same-day mental health screening and evaluation to every community services board in the Commonwealth and an additional \$6.4 million to complete implementation of same-day access and \$11.2 million in general funds to support outpatient clinics to provide primary health care screenings for individuals receiving services at community services boards.

The Joint Subcommittee adopted this recommendation.

- **Community Integration Plan.** The work group recommended continued support for the efforts of the Department of Behavioral Health and Developmental Services to reduce the census at state hospitals by improving community integration of individuals with mental illness. The Governor's proposed budget included \$4.8 million in general funds to support needed community services as a result of the mental health facility census and \$6.9 million in general funds to provide discharge planning assistance (DAP) to assist in discharging approximately 80-90 people on the extraordinary barriers list currently awaiting discharge from state hospitals.

The Joint Subcommittee adopted this recommendation.

- **Plan for fiscal realignment.** The work group recommended continued support for the development of the Secretary of Health and Human Resources plan for fiscal realignment of the public behavioral health services system in accordance with Item 284 of the Appropriation Act of 2017.

The Joint Subcommittee adopted this recommendation.

- **Funding options.** The work group recommended continued exploration of options for funding the public behavioral health services system, including options available under the Affordable Care Act.

The Joint Subcommittee adopted this recommendation; the Service System Structure and Financing Work Group will continue to explore options and provide information to the Joint Subcommittee during the 2018 Interim.

## **b. Work Group 2: Criminal Justice Diversion**

Heather Zelle presented the following recommendations of the Criminal Justice Diversion Work Group related to expansion of criminal justice diversion:

- **CIT programs in rural communities.** The work group recommended a budget amendment to provide the Department of Behavioral Health and Developmental Services with \$657,648 to make grants to support development, implementation, and operation of CIT training programs in up to six rural communities and \$1,925,400 to make grants to support development, implementation, and operation of CIT assessment centers in six rural communities.

The Joint Subcommittee adopted this recommendation.

- **Jail diversion programs.** The work group recommended a budget amendment to provide \$1,417,326 in general funds to support creation of diversion programs at Intercept 2 (initial detention/initial court appearance) in up to six rural communities.

The Joint Subcommittee adopted this recommendation.

- **Forensic discharge planning.** The work group recommended a budget amendment to provide \$4,109,900 in general funds to make forensic discharge planning available at five jails in the Commonwealth for persons with serious mental illness upon their release from jails to allow for better coordination of care, enhance public safety by linking individuals to needed care, and reduce the risk of future criminal justice involvement.

The Joint Subcommittee adopted this recommendation.

Sim Wimbush presented the following recommendation of the Criminal Justice Diversion Work Group related to permanent supportive housing:

- **Virginia Housing Trust Fund.** The work group recommended a budget amendment to provide \$4.5 million in general funds per year to the Virginia Housing Trust Fund to increase capital investment in order to increase available rental housing and expand access to permanent supportive housing.

The Joint Subcommittee adopted this recommendation.

## **3. Public Comment**

Following discussion of the recommendations, the Joint Subcommittee received the following public comment:

- Rhonda Thissen, Executive Director of NAMI Virginia, spoke in support of efforts to expand alternative transportation for individuals experiencing mental health crisis and for access to permanent supportive housing. Ms. Thissen also stated NAMI Virginia's support for expanding the Medicaid program.
- Amy Woolard, Policy Coordinator, Legal Aid Justice Center, emphasized the need for alternative transportation for children experiencing mental health crisis.
- Sherri Neil, Manager of Intergovernmental Affairs, City of Portsmouth, expressed support for the mental health jail pilot program and encouraged additional funding for the program.
- John Jones, Executive Director, Virginia Sheriffs' Association, spoke in support of the alternative transportation proposal.

## **F. Activities of the Joint Subcommittee's Work Groups**

### **1. Work Group 1: Service System Structure and Financing**

Work Group 1 held two meetings during 2017 on the following dates: Monday, June 12, 2017, and Monday, November 27, 2017. Over the course of these meetings, Work Group 1 received presentations on the following topics:

- The activities of the System Structure and Financing Expert Advisory Panel.
- The activities of the Mental Health Crisis and Emergency Services Expert Advisory Panel.
- The implementation of STEP-VA and the financial realignment of Virginia's public behavioral health system by the Department of Behavioral Health and Developmental Services.
- The model for alternative transportation for individuals in the involuntary commitment process by the Department of Behavioral Health and Developmental Services and the Department of Criminal Justice Services.
- A presentation by Dr. Benjamin Miller, Director, Farelly Health Policy Center, University of Colorado School of Medicine.

At the conclusion of their 2017 meetings, Work Group 1 made several recommendations to the Joint Subcommittee. These recommendations are set forth in Part IV E 2 a, *supra*.

### **2. Work Group 2: Criminal Justice Diversion**

Work Group 2 held two meetings during 2017 on the following dates: Tuesday, June 20, 2017, and Tuesday, November 28, 2017. Over the course of these meetings, Work Group 2 received presentations on the following topics:

- The activities of the Criminal Justice Diversion Expert Advisory Panel.
- An overview of the Hampton-Newport News Jail Diversion Program.
- An update on the conduct of in-custody death reviews in local and regional correctional facilities by the Board of Corrections.
- An update on the mental health screening of jail inmates.
- The model for forensic discharge planning from correctional facilities by the Department of Behavioral Health and Developmental Services.
- An update on permanent supportive housing.
- The quality of health care services in Virginia's correctional facilities and the impact of requiring Community Services Boards to provide mental health services in jails by the Joint Commission on Health Care.

At the conclusion of their 2017 meetings, Work Group 2 made several recommendations to the Joint Subcommittee. These recommendations are set forth in Part IV E 2 b, *supra*.

#### **V. Interim Recommendations of the Joint Subcommittee**

During the four years of its existence, the Joint Subcommittee has reviewed the current state of the mental health services system and the provision of mental health services in Virginia. To that end, the Joint Subcommittee has received extensive testimony from numerous experts in the field of mental health from both inside and outside the governmental sector. In addition, the Joint Subcommittee has received regular reports from the expert advisory panels created by the Joint Subcommittee to advise and assist it.

On the basis of the information it has gathered throughout its review, the Joint Subcommittee has made numerous recommendations as to what services should be provided and the statutory or regulatory changes necessary to improve access to such services by persons who are in need of mental health care. The Joint Subcommittee intends to continue its work with the goal of fashioning a mental health services system in the Commonwealth capable of delivering the services necessary to meet the needs of Virginia's citizens.