

**Joint Subcommittee to Study Mental Health Services
in the Commonwealth in the 21st Century
Meeting #2 Summary
September 9, 2014
General Assembly Building, Richmond, Virginia**

Members Present: Senator R. Creigh Deeds (Chair), Delegate Robert B. Bell, III (Vice Chair), Senator George L. Barker, Senator Emmett W. Hanger, Jr., Senator Janet D. Howell, Senator Linda T. Puller, Delegate Peter F. Farrell, Delegate T. Scott Garrett, Delegate Margaret B. Ransone, Delegate Luke E. Torian, Delegate Vivian E. Watts, Delegate Joseph R. Yost.

The Joint Subcommittee to Study Mental Health Services in the Commonwealth in the 21st Century (the Joint Subcommittee) met for the second time on Tuesday, September 9, 2014, at the General Assembly Building in Richmond.

PRESENTATION: Mental Health Disorders and Treatment

Dr. Debra Ferguson, Commissioner, Department of Behavioral Health and Developmental Services, and Dr. Jack Barber, Medical Director, Department of Behavioral Health and Developmental Services, provided an overview of common mental health disorders and treatment.

Commissioner Ferguson began by describing a 2003 report by the New Freedom Commission on Mental Health that provided information on gaps in mental health services and made concrete recommendations for immediate improvements. The report identified three specific barriers to improving mental health services: stigma around mental illness, unfair limitations and financial requirements placed on mental health benefits in private insurance, and the fragmented mental health services delivery system. The report also identified several specific problems with the current system of mental health services, including fragmentation and gaps in services for children and adults with serious mental illness, high levels of unemployment and disability among individuals with serious mental illness, a lack of care for older adults with mental illness, and a lack of national priority for mental health and suicide prevention. Commissioner Ferguson reported that the New Freedom Commission identified six goals as the foundation for transforming mental health care in America. These were as follows:

1. Americans understand that mental health is essential to overall health.
2. Mental health care is consumer-driven and family-driven.
3. Disparities in mental health services are eliminated.
4. Early mental health screening, assessment, and referral services are common practice.
5. Excellent mental health care is delivered and research is accelerated.
6. Technology is used to access mental health care and information.

Commissioner Ferguson also stated that the report stressed recovery as the expectation and goal of the mental health services system. Recovery refers to the process whereby people are able to live, work, learn, and participate fully in their communities and to access health care, gainful employment, and adequate and affordable housing. In closing, Commissioner Ferguson stated

that the report could serve as a roadmap to developing a system of mental health services for the Commonwealth, because the system described by the report is grounded in best practices, is oriented to recovery, promotes access and early intervention, and emphasizes excellence in mental health.

Dr. Barber provided an overview of common mental illnesses, including schizophrenia, bipolar disorder, schizoaffective disorder, depression, anxiety disorders, mental health disorders in children and adolescents, conduct disorder, and substance use disorders, and information about the treatment thereof. He noted that mental illnesses are generally characterized as irregular mood, thought, or behavior; that mental illness becomes a concern when symptoms cause frequent distress and affect one's ability to function; and that individuals with mental illness are likely to experience co-morbidities that substantially negatively impact their life expectancy. He noted that the National Institute of Mental Health estimates that 18.6 percent of adult Americans experience some form of mental illness during the course of a year and that in any single year, an estimated four percent of Americans will experience serious mental illness. Approximately one-half of individuals with mental illness are diagnosed by the age of 24.

Dr. Barber highlighted some best practices for the treatment of mental illness, including early identification and treatment; holistic assessment, treatment, and support customized to the individual; use of the right medications for symptom control and side effect tolerance; a focus on recovery principles of hope, choice, purpose, and connection to helpful others; a focus on psychosocial rehabilitation; inclusion of peer support services and Wellness Recovery Action Plans; an emphasis on family involvement, support, and advocacy; prompt response to increasing symptoms; and establishing stable living arrangements. In closing, Dr. Barber emphasized that treatment is effective when it is available and tailored to the individual's needs and that people do recover from mental illness.

PRESENTATION: Governor's Taskforce on Mental Health

The Honorable Bill Hazel, Secretary of Health and Human Resources, and the Honorable Brian Moran, Secretary of Public Safety and Homeland Security, provided an overview of the Governor's Taskforce on Improving Mental Health Services and Crisis Response. The taskforce was created on December 10, 2013, by Executive Order 68 (McDonnell) to seek and recommend solutions that will improve Virginia's mental health crisis services and help prevent mental health crises from developing. Executive Order 12 (McAuliffe) continued the taskforce. The taskforce is composed of 42 members, including leaders in the mental health field, law enforcement, the judicial system, and the private hospital system, as well as individuals receiving mental health services and their family members. The taskforce is chaired by the Lieutenant Governor and co-chaired by Secretary Hazel and Secretary Moran. Several work groups and sub-work groups have assisted the taskforce in its work. During the spring and summer of 2014, the taskforce met several times to review existing services and challenges in the mental health system and made recommendations, including legislative and budget proposals, for critical improvements to procedures, programs, and services.

On January 1, 2014, the taskforce made a number of initial recommendations. These included:

- A 12-hour ECO period that includes tiered levels of notification every four hours;

- Notification of the community services board responsible for conducting the evaluation by the law-enforcement agency that executes an emergency custody order; and
- A two-year sunset on any statutory changes to ensure the new laws are meeting the needs of the Commonwealth.

At that time, the taskforce also endorsed several of the Governor's proposals, including:

- A 72-hour temporary detention period with a minimum of 24 hours of temporary detention prior to a commitment hearing;
- Additional funding for mental health services;
- Expanding secure assessment centers and crisis stabilization units for children and adults across the Commonwealth as the highest priority for funding;
- Expanding the use of telepsychiatry; and
- Expanding funding for crisis intervention team training for law-enforcement officers throughout the Commonwealth.

In June 2014, the taskforce made several additional recommendations, including recommendations for:

- Establishment of a "center of excellence" to use public and private resources to address behavioral health needs, including criminal justice, substance use disorder, housing, and employment. Each community should establish a position/committee/group to ensure best practices are actually implemented and analyze instances when programs do not work as intended;
- Investment in crisis intervention team training and assessment centers so that every community in the Commonwealth has a functional crisis intervention team program and assessment center;
- Development of a mechanism to ensure access to and use of alternative transportation providers in all communities. This may require additional funding and amendments to the Code of Virginia to give transportation providers the authority to detain individuals to be transported;
- Development of a single, consistent statewide process for data and oversight to maximize the use of telepsychiatry and video technology;
- Improvement of access to consistent, timely psychiatric services using a benchmark standard, as exists in other health care fields, and making resources available to accomplish this goal;
- Alteration of the Certificate of Public Need process to more effectively address needs for any additional psychiatric beds in some areas of the Commonwealth;
- Improvement of the service delivery system across the Commonwealth, including emergency services when a mental health crisis occurs and services to intervene early and prevent crises from developing, such as expanded crisis intervention teams, implementation of mental health first aid programs in every planning district, and

improved behavioral health resources for veterans, service members, and their families and children;

- Increased flexibility in the administration of the mental health system and increased communication among participants in the mental health services system;
- Improved mental health services in jails, including ensuring all jails have readily accessible evidence-based, trauma-informed services for people with mental illness, and developing a system to notify community providers when an individual with behavioral health needs is discharged from jail, to enhance the continuity of care;
- Improved education and incentives for primary care providers and a focus on recruiting and retention of mental health services providers; and
- Improved resources for families of individuals with mental illness.

Secretary Hazel noted that the final report of the taskforce will be submitted to the Governor by October 1, 2014, but that the taskforce will continue to meet into 2015.

PRESENTATION: Mental Health Services, a National Perspective

Mr. Ted Lutterman, Senior Director of Government and Commercial Research, National Association of State Mental Health Planning Directors (NASMHPD) Research Institute, Inc., presented on Virginia's state mental health system, comparisons with mental health systems in other states, and trends in state mental health systems. Mr. Lutterman discussed the impact of mental illness on America, provided an overview of state mental health service systems in the United States, and provided information on state mental health expenditures and financing in the United States and the role of state psychiatric hospitals in Virginia and neighboring states.

Mr. Lutterman reported that approximately one in five Americans will have a mental health problem in any given year, yet only one-third of those individuals will receive services. The direct cost of treatment for those who do seek treatment is approximately \$147 billion nationally each year, or approximately 6.3 percent of all health care spending. Most mental health services are publicly funded, and private insurance covers only about one percent of the costs of treatment. Approximately 50 percent of those individuals with mental health problems who did not receive services did not do so because of the high cost of mental health treatment. Individuals experiencing mental health problems are at higher risk of suicide, premature mortality, high medical co-morbidity, unemployment, homelessness and unstable living arrangements, and involvement with the corrections system. Individuals with mental illness can also create significant burdens for family members and caregivers.

Mr. Lutterman described several models of mental health services delivery used in states throughout the country. He noted that Virginia is like many states in that the state mental health authority is part of an agency that combines mental health and developmental and substance abuse services. The Commonwealth employs a county-based or city-based system in which the state mental health agency provides funds for mental health services to counties or cities, which then deliver or contract for services. Other states operate models in which the state mental health agency contracts directly with providers for services, or in which the state mental health agency provides services directly using its own staff. In 24 states, community mental health providers control admissions to state psychiatric hospitals, while in others admissions determinations are made by the courts or by medical professionals at hospitals.

In Virginia, approximately 1.4 percent of the total population receives mental health services from the publicly funded mental health system, as compared with 2.3 percent of the national population. Virginia serves more people in psychiatric inpatient settings than the national average but also transitions more people to community-based services. Approximately 20 percent of adults who receive services are employed, as compared with the national average of 18 percent, and approximately 55 percent had some Medicaid coverage to help pay the cost of services, as compared with 63 percent nationally.

Mr. Lutterman noted that while every state has involuntary commitment laws, the process of involuntary commitment varies substantially from state to state. For example, 23 states allow temporary holds of up to 72 hours, as does Virginia, while 21 allow holds of longer duration and eight have holds of shorter duration. Most involuntary holds are not at state psychiatric hospitals but are at general hospital psychiatric beds or private psychiatric hospitals. Virginia is one of 40 states that allow mandatory outpatient commitment.

At the end of his presentation, Mr. Lutterman described trends in state mental health expenditures and financing. He noted that state mental health systems had been negatively affected by recent state budget shortfalls and that many states had closed state hospitals and psychiatric beds in recent years. A number of states, including Virginia, have reported shortages of psychiatric inpatient beds and increased waits for state psychiatric beds. Mr. Lutterman reported that Virginia's overall spending on mental health services ranked in the middle of that of surrounding states but that the Commonwealth's spending skewed more toward inpatient and less toward community-based services than surrounding states. The largest category of state hospital expenditures in the Commonwealth was for civil status adults (81.2 percent of total spending); however, spending on forensic clients is growing quickly.

PUBLIC COMMENT

Following the scheduled presentation, the Joint Subcommittee received public comment.

- Dr. Jim McCullough, a professor of psychology at Virginia Commonwealth University, noted that Virginia needs a prevention strategy and needs to shift from a reactive to a proactive system.
- Ms. Barbara Brown recommended that the Joint Subcommittee consider ways to use adult foster care providers to provide safe and stable housing to individuals receiving community-based mental health services who are at risk of homelessness.
- Ms. Karen Duffy described her son's mental illness and the circumstances surrounding his death, and she recommended that the Joint Subcommittee consider requiring reporting of adverse drug reactions, including suicides.
- Ms. Sonia de la Cruz described her experience with mental illness and the mental health treatment system and reminded the Joint Subcommittee that it is important to recognize that mental illness, like any other illness, requires treatment and care and can result in recovery.
- Mr. Damien Cabezas, Chief Executive Officer of Horizon Behavioral Health, the community services board serving Lynchburg, described the services provided by the community services board and noted that crisis intervention teams and assessment centers are good options for reducing the impact of mental illness on the community. He also

noted that community services boards and law enforcement continue to learn to work together around issues like transportation and that community services boards require some clarification on recent changes to the laws.

- Ms. Sandy Sale asked the Joint Subcommittee to be aware of the mental health needs of individuals in jails and to take steps to ensure the availability of services for individuals in jails.
- Ms. Bonnie Neighbor, Executive Director of VOCAL (Virginia Organization of Consumers Asserting Leadership), suggested that the Joint Subcommittee hear testimony from individuals who have been involved with and received services through the publicly funded mental health services system.
- Ms. Sherry Sweet noted that medications to treat some mental illnesses are very expensive and that follow-up care is often difficult to obtain.

DISCUSSION: Work Groups

At the end of the meeting, Senator Deeds announced the focus and membership of the work groups:

- Crisis Intervention Work Group: Delegate Robert B. Bell, III (Work Group Chair), Senator George L. Barker, Delegate Margaret B. Ransone, Delegate Vivian E. Watts.
- Continuum of Care Work Group: Senator Emmett W. Hanger, Jr. (Work Group Chair), Senator Janet D. Howell, Delegate T. Scott Garrett, Delegate Luke E. Torian.
- Children and Other Special Populations Work Group: Delegate Joseph R. Yost (Work Group Chair), Senator Linda T. Puller, Delegate Peter F. Farrell.