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Overview of Virginia's Publicly-Funded Mental Health System:

Structure, Funding & Recent Changes

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

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Commissioner

Virginia Department of Behavioral Health and Developmental Services

Core Principles

- Individuals can and do recover from mental illness and substance use disorders.
- Across the entire Commonwealth, Virginians should have access to quality mental health services.
- Interventions should be focused on prevention and early intervention.
- Services must be individualized, consumer-driven and family-focused.
- To best promote recovery, interventions should be holistic, and include necessary primary health care, housing and employment supports.

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Structure of the Public Mental Health System in Virginia

- DBHDS as the state mental health authority.
- Provides services through 9 state-operated hospitals across the Commonwealth.
- Provides partial funding to 40 community services boards (CSBs) across the Commonwealth who serve as the single point of entry into the publicly-funded mental health system.

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Virginia's Publicly-Funded Behavioral Health Services Delivery System

Public and Private DBHDS-Licensed Community Providers:

	MH/SA Providers	MH/SA Locations
CSB (Public)	40	1,710
Private Providers	557	2,683
Total	**597**	**4,393**

State Mental Health Hospitals*:

Populations Served	Number of Hospitals
Adult • One all geriatric/3 with geriatric units • One with maximum security unit	8
Child/Adolescent	1
Total	**9**

* DBHDS also operates one medical center for people in MH hospitals or training centers with acute medical needs

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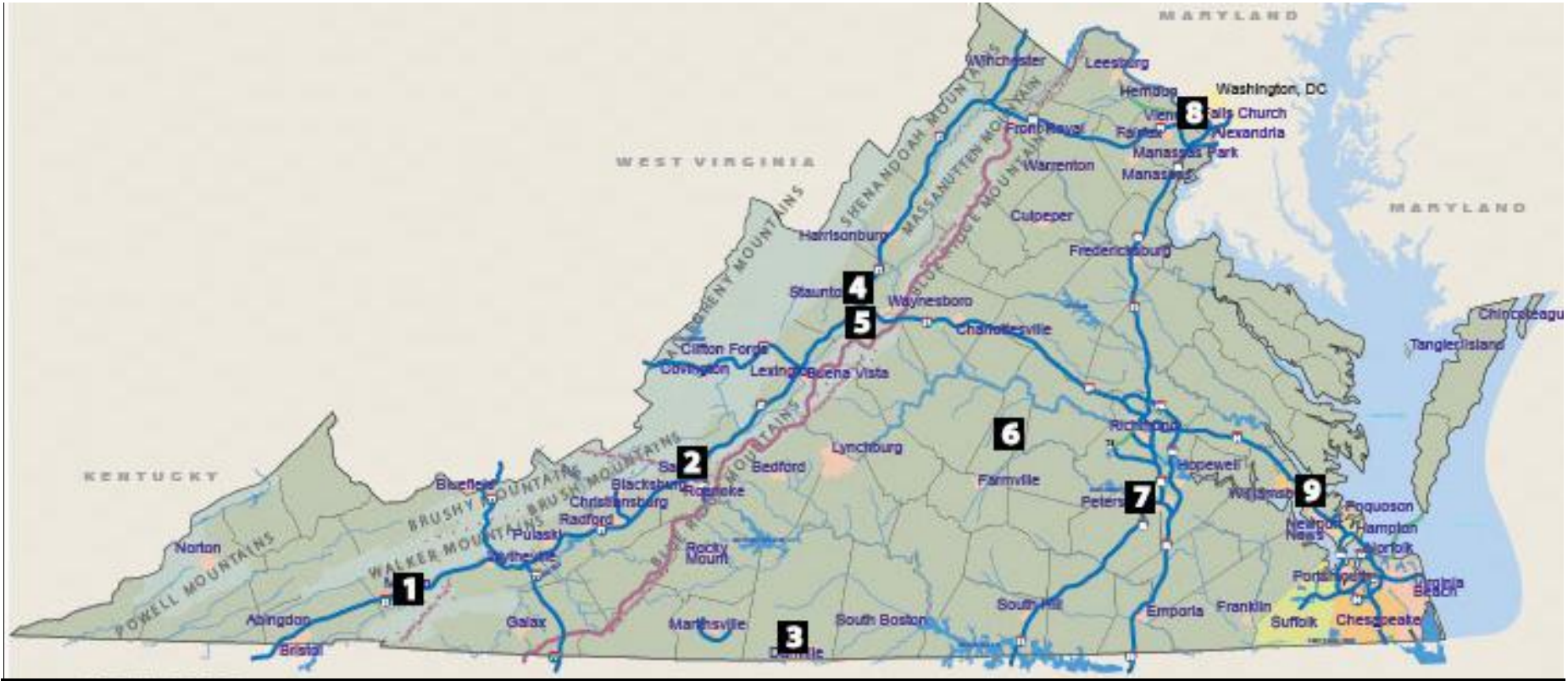
State Mental Health Hospitals



	Facility	Location			Facility	Location
1	Southwestern VA MH Institute	Marion		6	Piedmont Geriatric Hospital	Burkeville
2	Catawba	Catawba		7	Central State Hospital	Petersburg
3	Southern VA MH Institute	Danville		8	Northern VA MH Institute	Falls Church
4	Western State Hospital	Staunton		9	Eastern State Hospital	Williamsburg
5	Commonwealth Center for Children and Adolescents	Staunton				

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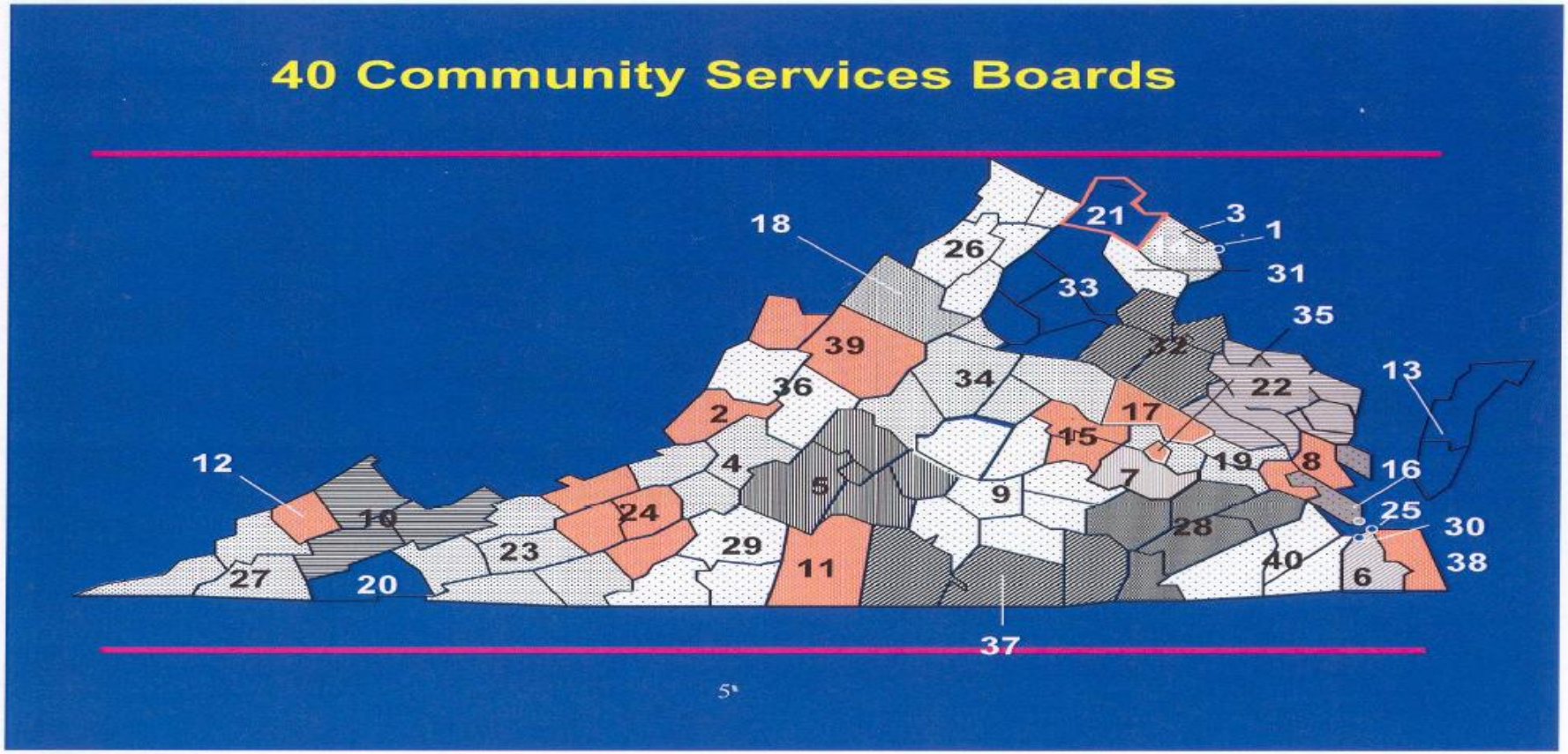
Community Services Boards



1. Alexandria
2. Allegheny-Highlands
3. Arlington County
4. Blue Ridge
5. Central Virginia
6. Chesapeake
7. Chesterfield
8. Colonial
9. Crossroads
10. Cumberland Mountain
11. Danville-Pittsylvania
12. Dickenson County
13. Eastern Shore
14. Fairfax-Falls Church
15. Goochland-Powhatan
16. Hampton-Newport News
17. Hanover County
18. Harrisonburg-Rockingham
19. Henrico Area
20. Highlands
21. Loudoun County
22. Mid Peninsula-Northern Neck
23. Mount Rogers
24. New River Valley
25. Norfolk
26. Northwestern
27. Planning District 1
28. Planning District 19
29. Piedmont Regional
30. Portsmouth
31. Prince William County
32. Rappahannock Area
33. Rappanannock-Rapidan
34. Region Ten
35. Richmond
36. Rockbridge Area
37. Southside
38. Virginia Beach
39. Valley
40. Western Tidewater

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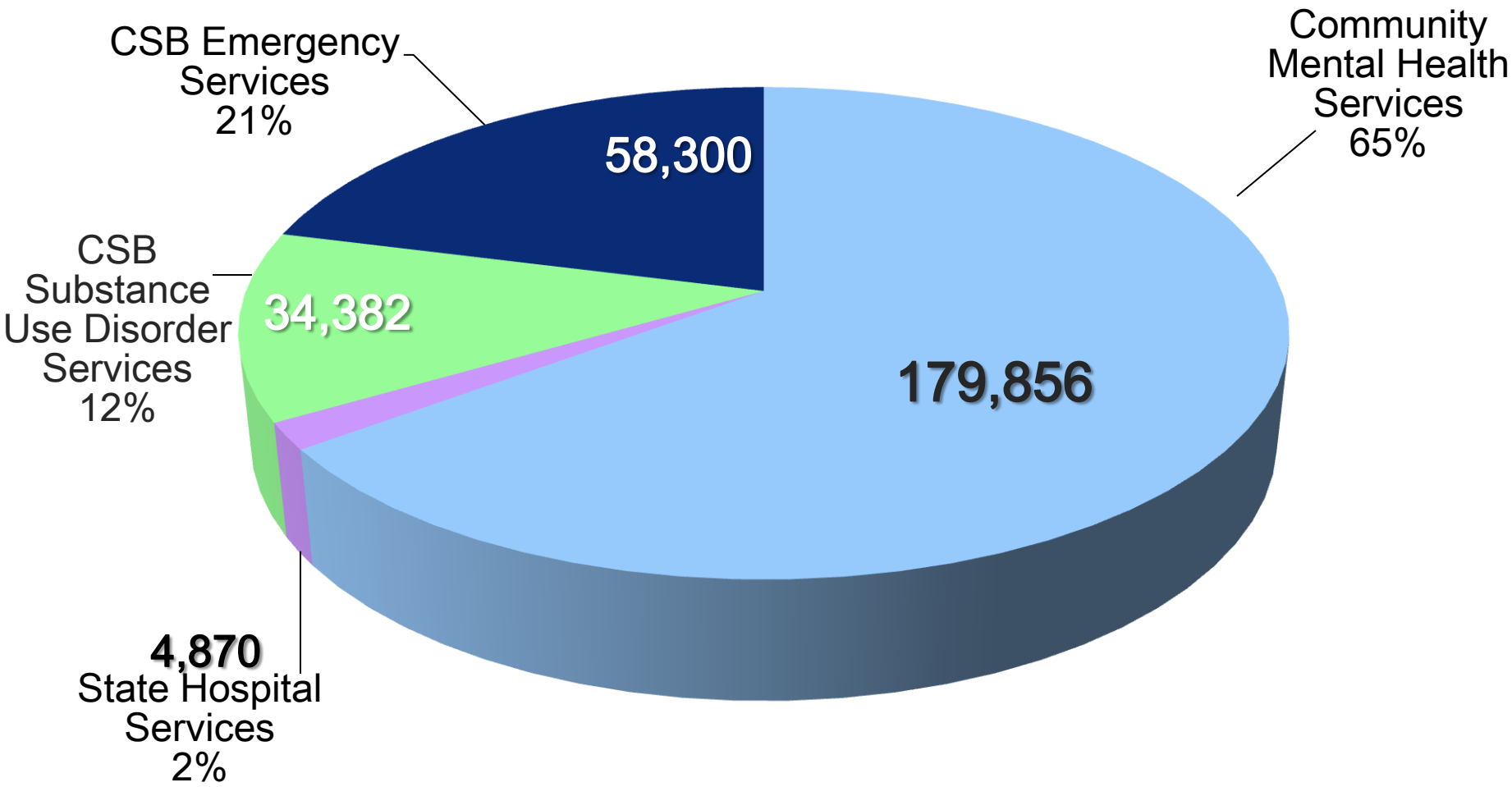
Individuals Receiving Public Behavioral Health Services in FY 2013



CSB Services

- **MANDATED to provide:**
  - Emergency services
  - Case management subject to the availability of funds
  - Preadmission screening and discharge planning
- **MAY provide a core of comprehensive services:**
  - MH/SA services can be provided directly by CSB
  - CSB may contract for services
  - Groups of CSBs may contract for services or provide them directly on a regional basis

CSB Oversight and Accountability

- CSB-DBHDS Performance Contract
- Finance and program audits
- Licensing by DBHDS
- Human Rights protection
- Certification by federal CMS for Medicaid
- Accreditation by national agencies
- Virginia Office of Inspector General

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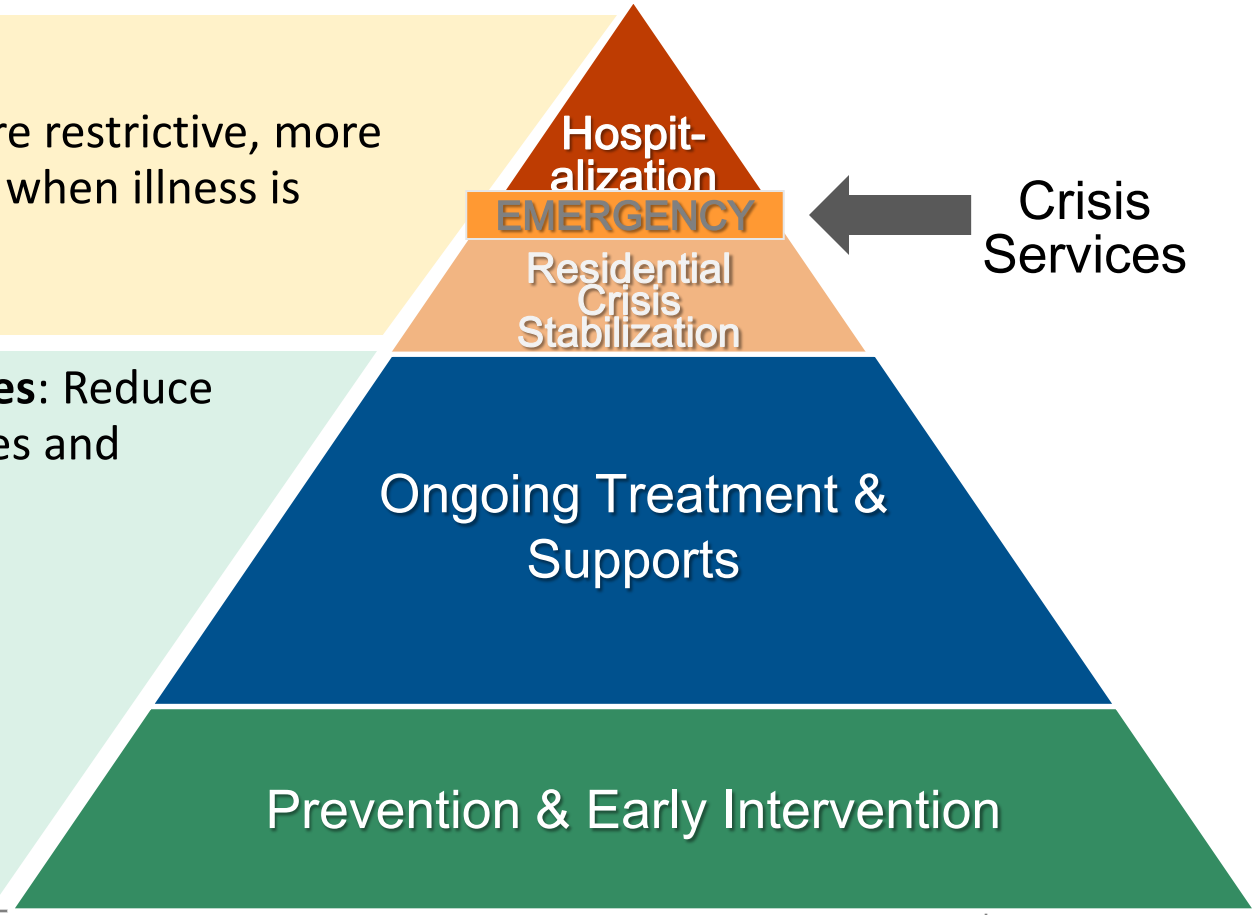
Services Continuum

Mid to low intensity services reduce demand for emergency interventions and intensive services

High Intensity Services: More restrictive, more expensive services provided when illness is more difficult to manage.

Mid to Low Intensity Services: Reduce demand for intensive services and emergency interventions:

- Outpatient Treatment
- Medication Management
- Individual & Group Therapy
- Therapeutic Day Services
- Psycho-social Rehabilitation
- Residential Services & Supports
- Telepsychiatry
- CIT
- MH Skill Building



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Total New MH/SA Funding FY 2005 – FY 2014

New Funding	Total (in millions)
Community Total	**$71.40**
Crisis Response	$24.12
Adults with Serious and Persistent Mental Illness	$23.33
Mental Health Treatment for Children & Adolescents	$12.15
Mental Health & Criminal Justice Interface	$4.77
Substance Abuse Services	$3.43
Outpatient Mental Health Treatment for Adults	$3.00
Prevention	$0.60
State Hospitals Total	**$20.52**
Total New Funding	**$91.92**
Total Reductions	**($57.50)***
Net Total Over Ten Year Period	**$34.42**

* The programmatic increase in MH since 2005 was $34.32 mil, however if adjusted for inflation and put into 2014 dollars the buying power is reduced to $22.79 mil.

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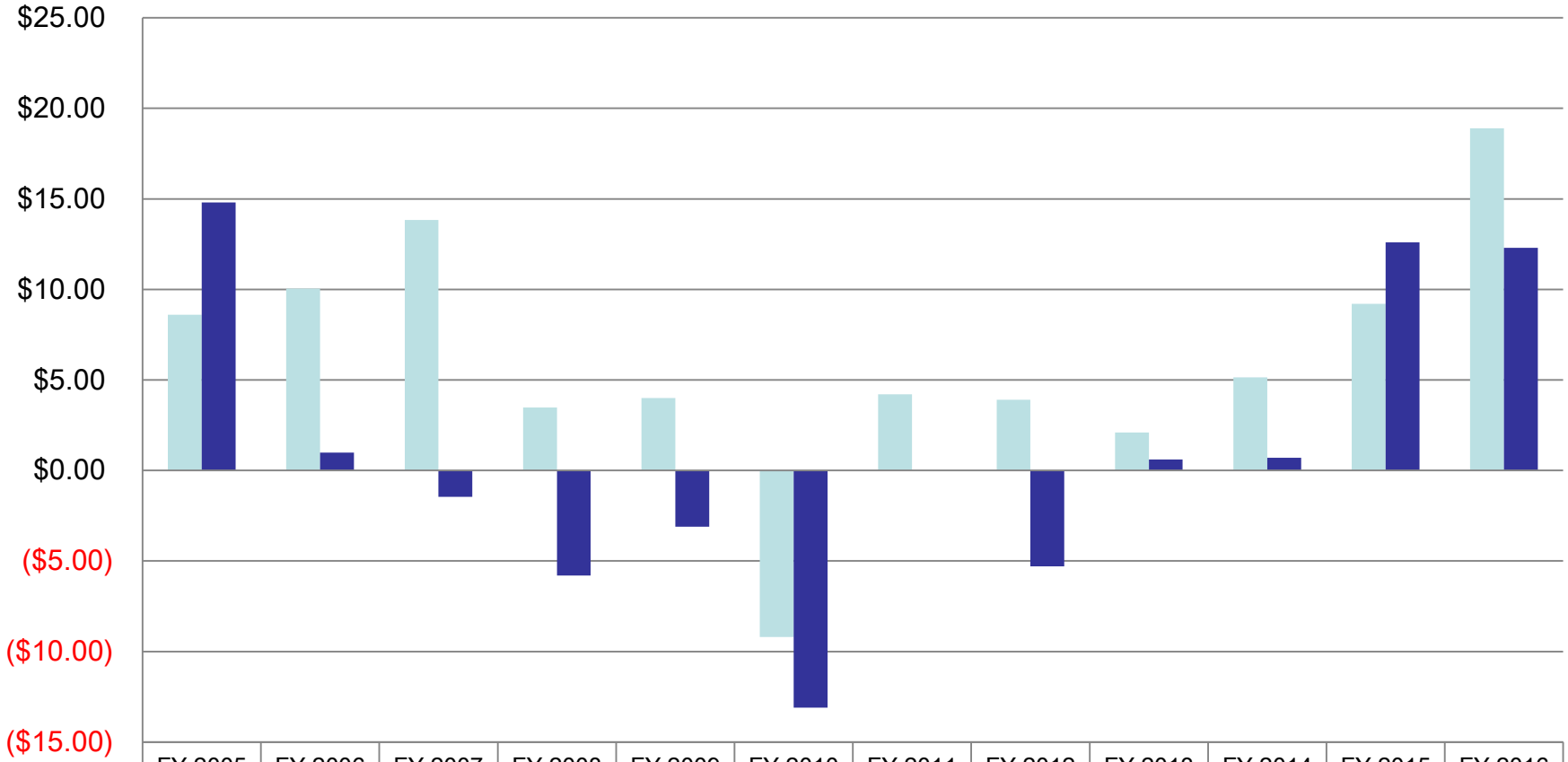
Mental Health Funding
FY 2005 – FY 2016 (in millions)



	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Community Net	$8.60	$10.05	$13.83	$3.47	$4.00	($9.20)	$4.20	$3.90	$2.10	$5.15	$9.20	$18.90
State Hospital Net	$14.80	$0.98	($1.46)	($5.80)	($3.10)	($13.10)	$0.00	($5.30)	$0.60	$0.70	$12.60	$12.30

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2014 Major Improvements

Effort	Description
Tightening of Regional Protocols	• CSBs, state facilities and their safety net partners (local hospitals, law enforcement agencies, and others) developed new regional admission protocols based on new laws. • Refers to primary state facility when alternative TDO facility cannot be found. • Use of alternative facilities when primary state hospital is full or cannot serve as "facility of last resort."
Revision of Medical Screening and Assessment Guidance	• Medical screening prevents someone with a medical condition from being sent to a treatment facility that cannot adequately manage the illness or condition. • Failure to adequately detect, diagnose, and treat medical conditions may result in significant and unnecessary morbidity and mortality, the advance of certain illnesses, and increased liability for providers across the system.

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2014 Major Improvements

Effort	Description
Extending ECO/TDO Period	• The maximum duration of an emergency custody order (ECO) has been changed from 4 to 8 hours. • There are no extensions of the ECO period. • The maximum period of temporary detention prior to a hearing is extended from 48 hours to 72 hours.
Improving Communication During Civil Commitment Process	• New statutory notification requirements, such as between law enforcement and CSBs at the time an ECO is executed, between CSBs and state hospitals when a CSB is notified of the need for an emergency evaluation, and between CSBs and state hospitals upon completion of an ECO evaluation. • CSBs are required to notify the primary state hospital serving the CSB's area when an emergency custody evaluation is needed. State hospitals are required to admit any individual for temporary detention who is not admitted to an alternative treatment facility prior to the expiration of the emergency custody period.

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2014 Major Improvements

Effort	Description
Launch of Online Psychiatric Bed Registry	Launched March 3, 2014. Provides descriptive information about each public and private inpatient psychiatric facility and each CSB and private residential crisis stabilization unit to CSB emergency services providers and psychiatric hospitals that need immediate access to inpatient or residential crisis services for individuals. Legislation requires that the PBR provide real-time information about the number of beds available at each facility.
Soft Launch of New Laws	Beginning June 16, DBHDS and CSBs began operating as if all aspects of new civil commitment legislation were in effect (except 8-hour ECO period).

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2014 Major Improvements

Effort	Description
Mental Health Law "Brown Bag" Meetings	Beginning on June 10, 2014, DBHDS began meeting with key representatives and stakeholders in emergency services. This group will continue to meet regularly to improve communication and address any problem areas.
Implemented TDO-Exception Reporting	Since January, CSBs must submit monthly data on TDO exceptions to DBHDS. Data is aggregated and posted on the DBHDS website.

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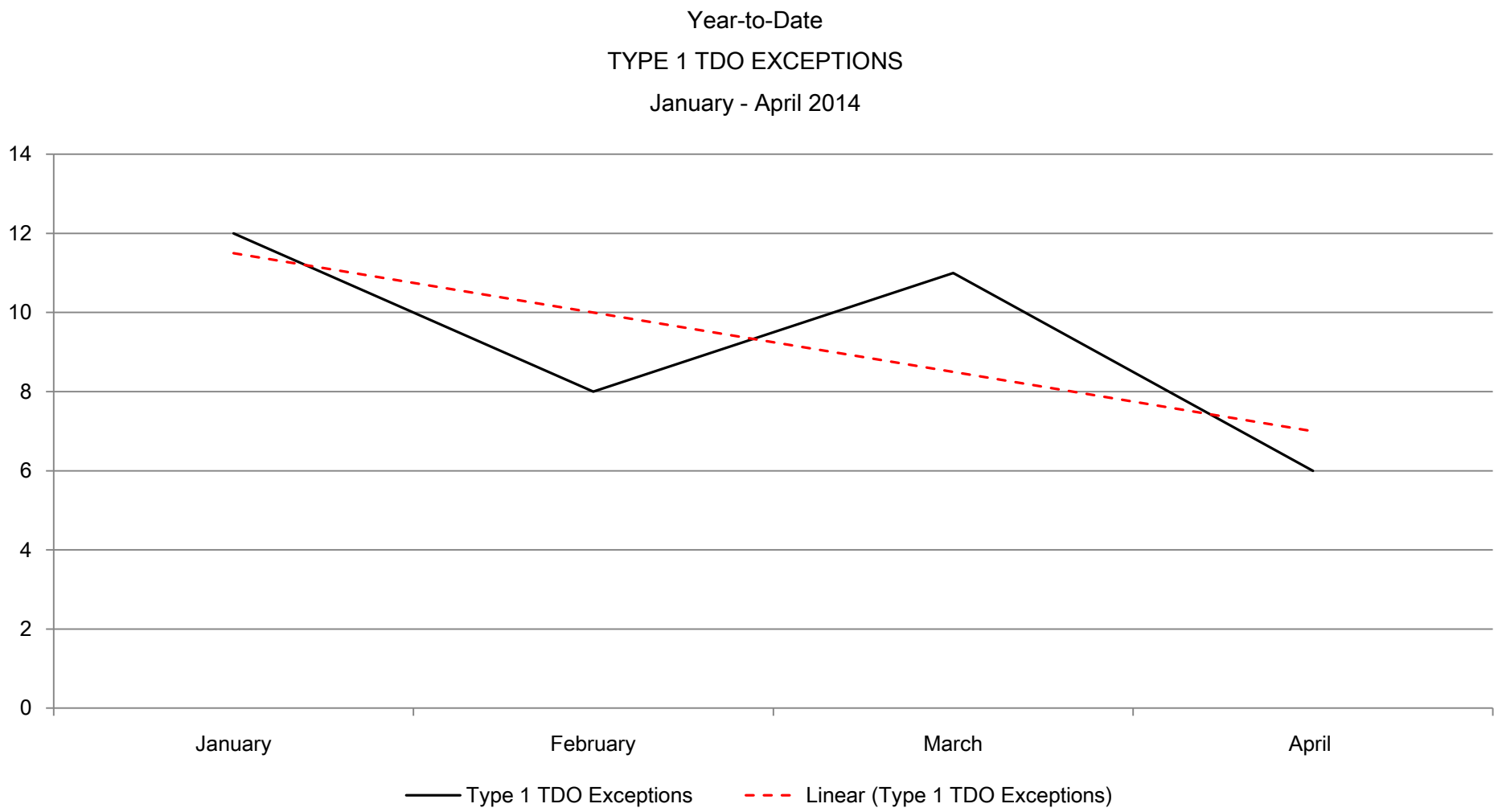
Reported Type 1 Events: TDO was sought but not obtained due to lack of willing facility



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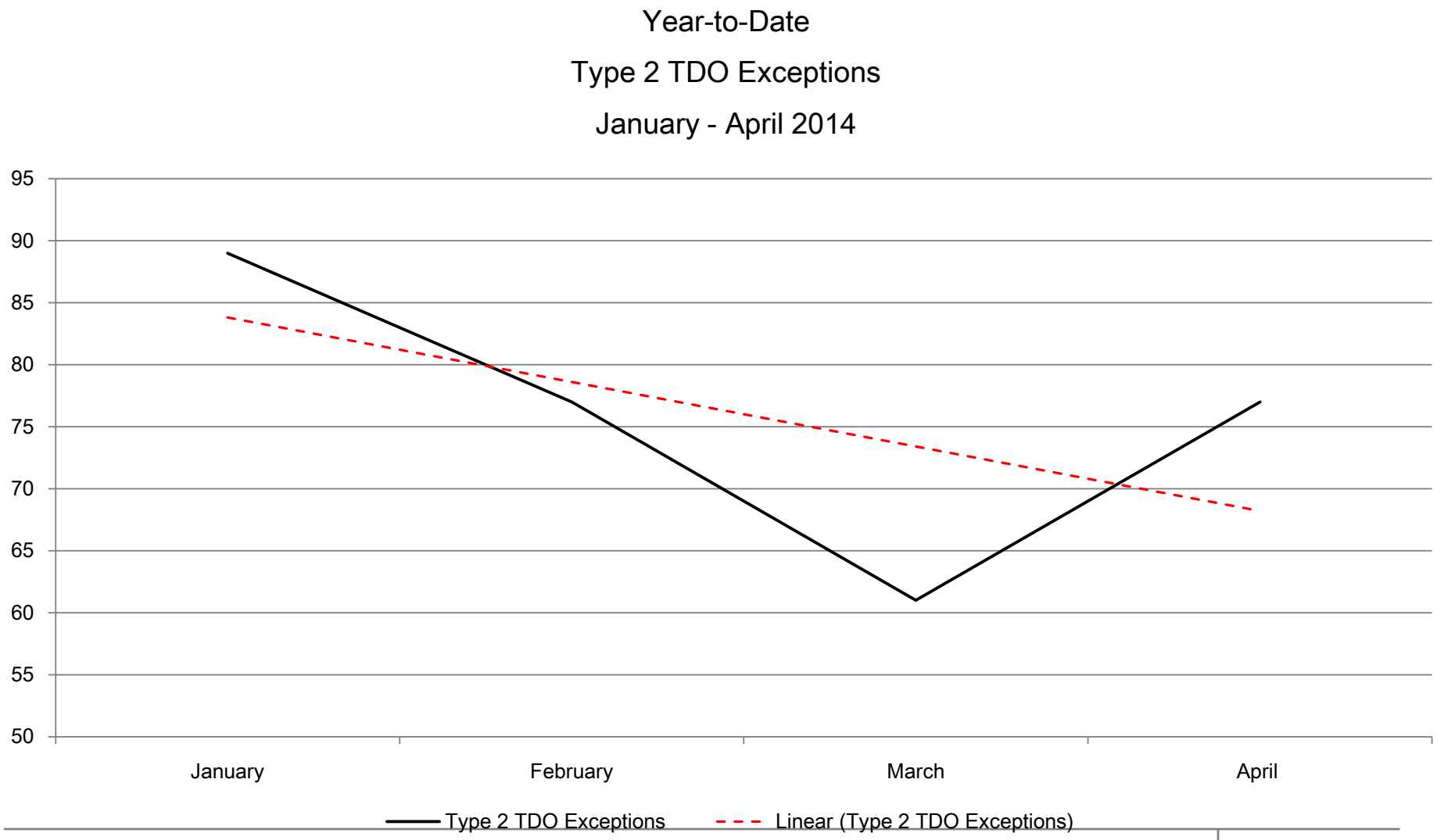
Reported Type 2 Events: TDO was obtained and executed but more than 6 hours elapsed



Major Challenges

- Prevention and early intervention system is underdeveloped.
- Lengthy community waiting lists – 3,200 adult mental health, 1,200 children/adolescents MH, 1,100 substance abuse.
- Intensive supports such as PACT, housing, and employment are inconsistently available across Virginia.
- Underdeveloped peer support services delivery.
- Limited availability of mid level crisis supports such as crisis stabilization services, CIT secure assessment centers.
- The low income threshold for Medicaid presents challenges for providing services for the uninsured and underinsured.
- Virginia ranks 39th in community funding and 10th in facility funding nationwide.

Recent Commissions and Task Forces

- **2006 – 2011** – Supreme Court Commission on MH Law Reform.
- **2007** – Gov. Kaine's Virginia Tech Review Panel.
- **2013** – Gov. McDonnell's Taskforce on School and Campus Safety (Mental Health Workgroup).
- **2013 – 2014** – Gov. McDonnell/Gov. McAuliffe's Taskforce on Improving Mental Health Services and Crisis Response.

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New Efforts: Shoring Up Virginia's Mental Health System

Focus Areas

Identifying a core set of mental health services to be consistently available across the Commonwealth.

Developing a consistent, multi-year, funding strategy.

Increasing system-wide accountability and performance management.

Embarking on full-scale transformation effort.

Transformation Effort

- Small, strategic "transformation teams" of DBHDS staff, agency partners, stakeholders and advocates to develop priorities.
- Complete examination of system infrastructure and delivery for behavioral health and developmental services.
- Key deliverables to strengthen the system after six, 12, 18 and 24 months.

Vision of a Reformed System

- Access to high quality mental health and substance abuse services across the Commonwealth.
- Consistent and effective emergency services.
- Emphasis on prevention and early intervention services across the lifespan.
- Increase in evidence-based practices such as permanent supportive housing and supportive employment.
- Strategic and consistent funding.
- System performance monitoring and increased accountability; contracting that ties funding to measurable outcomes.