

The Virginia NEWS LETTER

Virginia's Mental Health System: How It has Evolved and What Remains to Be Improved

by Mira E. Signer

Introduction

The tragic death of State Senator Creigh Deeds' son, who severely wounded his father before taking his own life in the midst of a psychiatric crisis in November 2013, put a spotlight on Virginia's mental health system. The event stimulated debate about the features and adequacy of the state's mental health policies and was a major factor in the policy changes adopted in the 2014 session of the General Assembly. This article had been scheduled for release in late 2013, but was postponed so I could add to my earlier work a report on what was accomplished by new legislation and address problems that remain.

The issue of mental health is increasingly present in contemporary American life. There is new societal awareness about mental health and the role it plays in people's lives, and it is generally now more acceptable to discuss mental health problems and to seek mental health treatment. More is known now about the causes of mental illness, and over the past several decades there have been tremendous advances in the treatment for mental illness.

Mental illnesses, according to a standard definition, are "...medical conditions that disrupt a person's thinking, feeling, mood, ability to relate



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to others and daily functioning.”¹ Mental illnesses take many forms and range in severity and suffering. They include anxiety disorders, bipolar disorder, borderline personality disorder, depression, eating disorder, posttraumatic stress disorder, schizophrenia, and schizoaffective disorder,² among others.

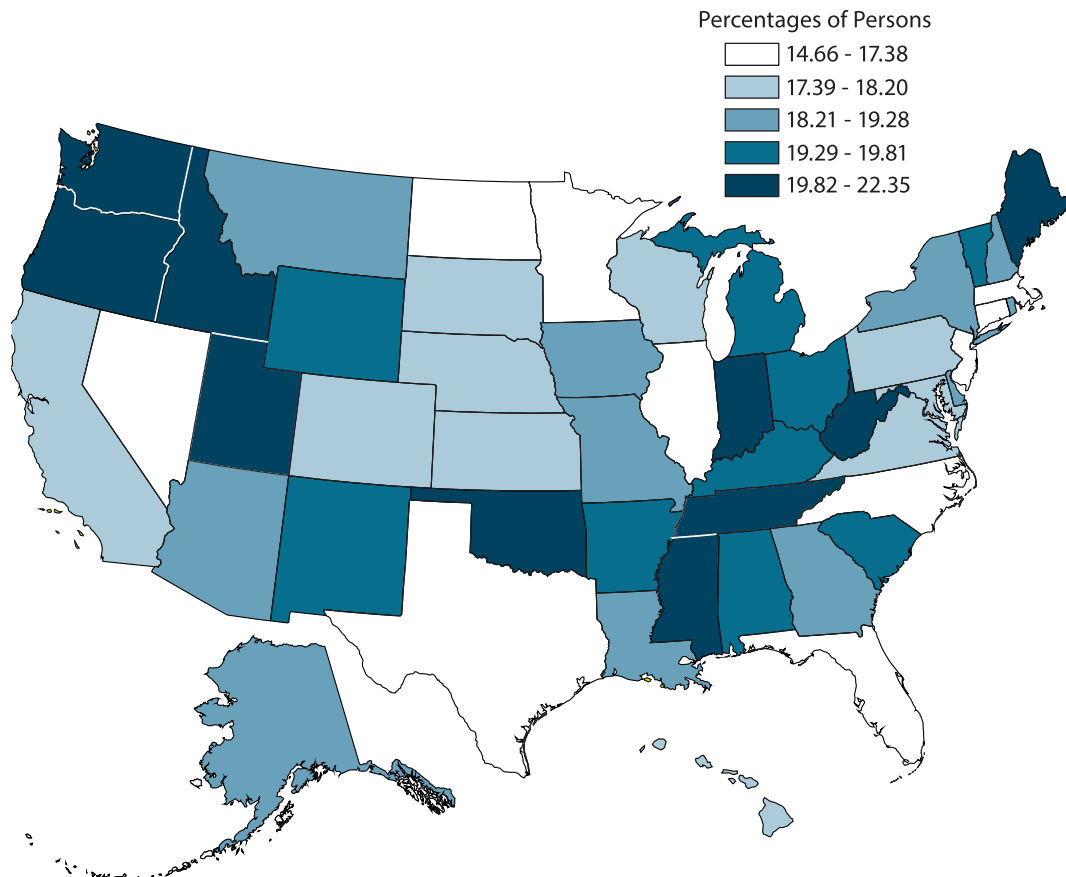
According to the federal Substance Abuse and Mental Health Systems Administration (SAMHSA), 17.5 percent of Virginia residents aged 18 and older had any mental illness in the past year during the 2011-2012 survey period. The state percentage was only slightly below the national average of 18.19 percent (**Figure 1**).

Children, of course, experience mental health problems too. National prevalence rates suggest that in Virginia there are between 85,000 and 104,000 children and adolescents (ages 9-17) who have a serious emotional disturbance. Between 47,000 and 66,000 of these children and adolescents are extremely impaired.³

Despite increased awareness of mental illness and the availability of better treatment, stigma of mental illness exists and has a significant impact on the lives of people dealing with the condition.⁴ People with mental illness face real and perceived threats about being discriminated against. Health



Figure 1: Any Mental Illness in the Past Year Among Persons Aged 18 or Older, Annual Averages Based on 2011 and 2012 Surveys



“The media perpetuates age-old myths and stereotypes about mentally ill people.”

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, “National Surveys on Drug Use and Health (NSDUHs), 2011 (revised October 2013) and 2012.” <http://www.samhsa.gov/data/2k14/NSDUH170/sr170-mental-illness-state-estimates-2014.htm>

insurance companies still do not provide ample and equitable coverage for mental health treatment. The media perpetuates age-old myths and stereotypes about mentally ill people. Hollywood blockbusters portray mentally ill people as deranged and violent murderers. Even our popular culture uses words such as “crazy” and “schizophrenic” to describe political scenarios, people or events.

Treatment for mental illness includes counseling and therapy, medication, support groups, education about the illness, inpatient hospital-based treatment, and wrap-around services such as mobile outreach teams and intensive case management. With effective treatment, along with supportive interpersonal relationships, access to transportation, adequate housing, adequate diet and sleep, and meaningful paid or volunteer activities, mental illness recovery is possible.

Despite the effectiveness of treatments for mental illness and significant advances in effective medications and evidence-based treatments, not everyone who has a mental illness receives treatment, and not everyone who is treated receives quality care. Many population centers are still

lacking basic mental health services such as crisis response and inpatient acute care. There are costs to untreated mental illness including exacerbated symptoms, high rates of emergency room visits, homelessness, incarceration, suicide, lost work-days, and family distress. Consider the following:

- Nationwide, approximately 26 percent of homeless adults staying in shelters have serious mental illness.⁵
- Nationally, depression is responsible for up to 70 percent of psychiatric hospitalizations and about 40 percent of suicides.⁶
- In 2010 suicide ranked 11th for cause of death among Virginia residents and was the third leading cause among 10 to 24 year-olds.⁷ In 2011 1,067 Virginians died by suicide.⁸
- In Virginia, 23.7 percent of all inmates in local and regional jails, or 6,322 people, have a mental illness. For fiscal year (FY) 2012 the total cost of mental health treatment in Virginia’s jails was estimated at \$13.3 million.⁹

With 1 in 4 adults over the age of 18 experiencing a diagnosable mental disorder in a given

year, it is important to examine these and other topics related to mental illness.¹⁰ What are the challenges and shortcomings of our mental health system? What are the trends and opportunities? And what does the future look like for mental health care in Virginia?

This article will provide an overview of major events in the history of mental health care in Virginia; explore contemporary issues impacting mental health care, and make recommendations for the future of mental health care in Virginia. It will be divided into four sections: (1) a description of Virginia's mental health system; (2) an overview of major federal mental health policies; (3) the impact of mental health policy developments in Virginia since the 1990s, including an analysis of the mental health legislation adopted in the 2014 session of the General Assembly; and (4) recommendations for the future.

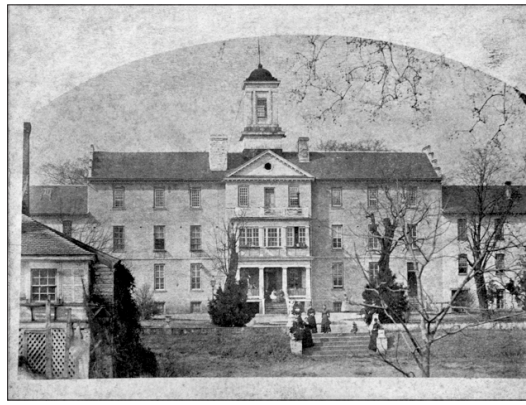
Virginia's Mental Health System

Virginia's involvement with mental health treatment dates back to 1773 when Eastern State Hospital in Williamsburg was founded. The hospital was the first public facility in the United States for people with mental illness.¹¹ At that time it was thought that people with mental disorders were incurable and beyond salvation so most were institutionalized, some indefinitely.

Western Lunatic Asylum, now known as Western State Hospital, was founded in 1825 by the Virginia General Assembly as the second state-run mental institution.¹² Situated in Staunton, the Western State Hospital includes a cemetery on its old grounds for an estimated 2,900 people who died while residing at the hospital.¹³ Virginia's Southwestern Virginia Mental Health Institute, located in Marion, has buried more than 1,200 people in its cemetery, all of whom were patients at the hospital.¹⁴

For decades, hospital-based care was the standard mode of treatment for mental illness. There was little else available in the way of proven, effective mental health care and the advent of psychiatric medications didn't impact the mental health system until the mid-twentieth century. Families had few resources available to them, stigma and discrimination of people with mental illness was commonplace, and doctors routinely recommended long-term, often indefinite, hospitalizations in state-run mental hospitals in the absence of other more effective forms of treatment.

Beginning in the 1960s, the federal government played an increasingly significant role in the payment and delivery of mental health services and in shaping state systems. The Kennedy Administration enacted the Community Mental Health



The original building of Eastern Lunatic Asylum in Williamsburg, now known as Eastern State Hospital. Photo courtesy of The Colonial Williamsburg Foundation.

Act of 1963. This act promoted community-based services and paved the way for federal funding for the creation of community mental health services. The act's passage spurred the nationwide development of mental health centers that provided outpatient services such as therapy appointments, psychiatric services, and case management. In Virginia and elsewhere in the nation patients were discharged from state mental institutions to live in the community, resulting in a large decrease in the institutional population (**Figure 2**).

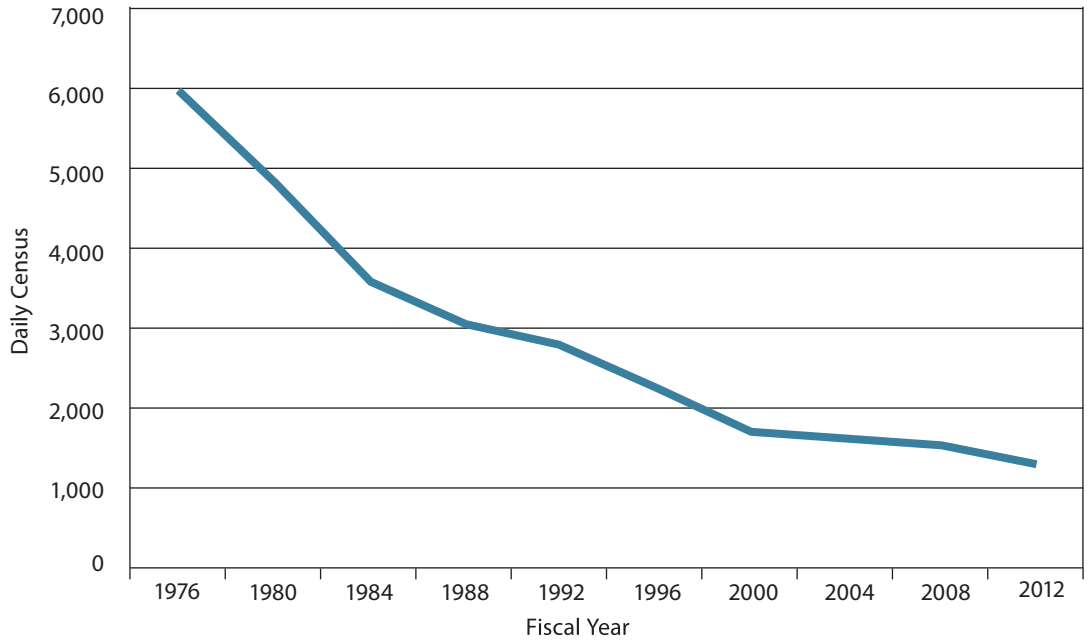
The advent of new psychotropic medications was another critical factor and much-needed innovation in the push to community-based living. These new medications—often referred to as “atypical” or “second generation” medications—were much more effective than their previous first generation medications and had fewer side effects. The generic names of second-generation medications include clozapine, olanzapine, quetiapine, risperidone, paliperidone, aripipazole, and ziprasidone. The older medications—chlorpromazine (brand name Thorazine) and haloperidol (brand name Haldol)—often caused terrible and permanent side effects such as Tardive Dyskinesia (uncontrollable twitching) as well as disabling drowsiness and listlessness.

In 1968 enabling legislation was passed in Virginia that established community services boards, or CSBs, which are Virginia's system for delivering services to poor or disabled citizens in need of mental health and other services. The first two boards were established in Arlington and Prince William counties.

As shown in **Figure 3**, Virginia currently operates 40 community services boards. The boards are publicly funded agencies established in the *Virginia Code* to provide mental health, substance abuse, and intellectual disability services to Virginians with Medicaid or those who are uninsured. Intellectual disability refers to

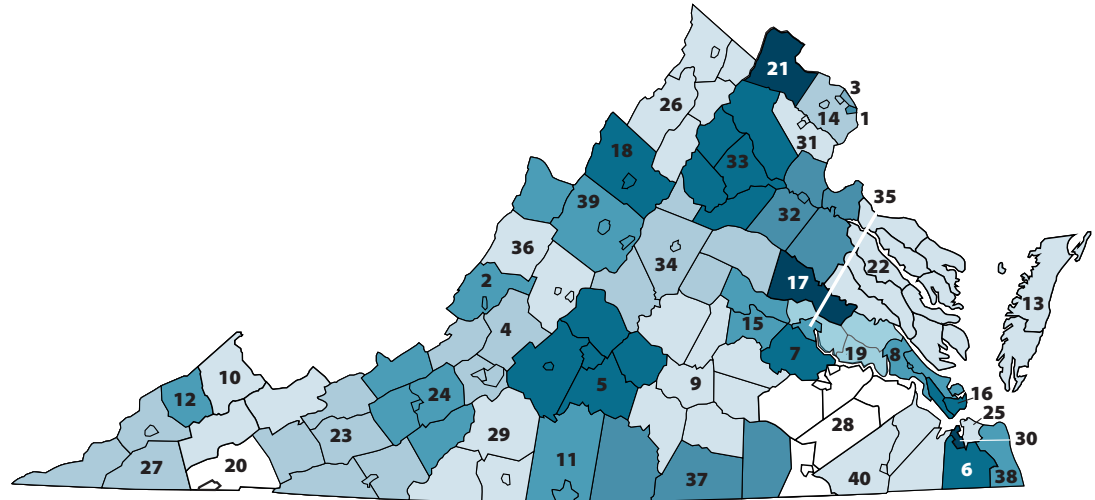
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Figure 2: Virginia State Mental Hospital Average Daily Census, FY 1976 to FY 2012



Source: James Stewart, III, DBHDS Commissioner, "Virginia's Publicly-Funded Behavioral Health and Developmental Services System and BHDS Budget Update," HHR Subcommittee, Senate Finance Committee August 27, 2012," p. 5. http://sfc.virginia.gov/pdf/health/2012/Interim/082712_Stewart.pdf

Figure 3: Location of Virginia Community Services Boards



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

Source: Virginia Department of Behavioral, Health and Development Services, "Community Services Board (CSB) Address List," (April 25, 2014).

disorders such as Down Syndrome, autism, and other developmental disorders that are characterized by below normal IQ. The clinical term is “mental retardation,” but the term used in social and advocacy fields is “intellectual disability.” It is distinct and separate from mental illness. The issues and differences are too great for the scope of this article.

By law, Virginia’s community services boards are mandated in the *Code* to provide emergency services and “...subject to the availability of funds appropriated for them, case management services.”¹⁵ Emergency services include crisis intervention and stabilization, preadmission screening for hospitalization, hospital discharge planning, short-term counseling, and referral assistance.¹⁶ Case management includes assistance with locating, developing, or obtaining needed services and resources; needs assessments and planning services; coordination of services with service providers, monitoring service delivery, and identification of and outreach to individuals and families in need of services

Beyond the core services of emergency services and case management, additional services may be provided by the community services boards including: outpatient services (individual and group therapy and psychiatric consultations); medication management and hospital discharge planning; case management (linkages and referrals to complementary, supportive services); day support; residential services; prevention services; and paraprofessional peer-based services (peer support groups).

The Virginia Department of Behavioral Health and Developmental Services (DBHDS) contracts on an annual basis with each community

services board. The resulting “performance contracts” delineate the responsibilities of each community services board, specify conditions to receive state-controlled funds, identify groups of individuals to be served, and include reporting requirements, among other things. In addition to contracting with community services boards to deliver services, the department operates nine state psychiatric hospitals (**Table 1**).

Virginia’s public mental health system also relies on private providers, including for-profit companies and non-profit organizations, to provide services. The Virginia Department of Behavioral Health and Developmental Services is responsible for licensing all private (and public) mental health service providers who want to operate in the state. There are roughly 600 private providers in Virginia who offer services such as intensive in-home services, therapeutic day treatment, and supportive housing.¹⁷

Money flows to the public mental health service system in the following forms: state general fund dollars appropriated by the General Assembly, federal grants, reimbursements from Medicaid and Medicare, local governments, and, to a lesser extent, private insurance and fee-for-services.

Major Federal Mental Health Policies

Federal policies and legal decisions have helped shape the way Virginia’s mental health system operates and exists today. In addition to the Community Mental Health Act of 1963, covered in a previous section of this article, Medicaid (1965), the Americans with Disabilities Act (1990), and The Mental Health Parity and Addiction Equity Act (MHPAEA) (2008) were formative policies that influenced Virginia’s mental health care

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Table 1: Virginia’s State Psychiatric Hospitals, September 2013

Hospital	Location	Population Served	Bed Capacity
Catawba Hospital	Catawba Town in Roanoke County	Adults, age 18+	102
Central State Hospital	Petersburg City	Primarily inmates being transferred from jails awaiting competency restoration in order to stand trial for a crime	179
Commonwealth Center for Children and Adolescents	Staunton City	Children and adolescents under the age of 18	30
Eastern State Hospital	Williamsburg City	Adults, age 18+	254
Northern Virginia Mental Health Institute	Falls Church City	Adults, age 18+	120
Piedmont Geriatric Hospital	Burkeville Town in Nottoway County	Adults 65+	105
Southern Virginia Mental Health Institute	Danville City	Adults, age 18+	65
Southwestern Virginia Mental Health Institute	Marion Town in Smyth County	Adults, age 18+	155
Western State Hospital	Staunton City	Adults, age 18+	202
Total			1,212

Source: Virginia’s Publicly-Funded Behavioral Health and Developmental Services System Orientation Session for Secretary William A. Hazel, Jr., M.D. (March 31, 2010). <http://www.dbhds.virginia.gov/documents/100331Orientation.pdf>

“The landmark Olmstead Supreme Court decision, although not a federal policy, was a decisive legal case that impacted mental health care delivery nationwide and in Virginia, too.”

system. The landmark *Olmstead* Supreme Court decision, although not a federal policy, was a decisive legal case that impacted mental health care delivery nationwide and in Virginia, too. The decision determined that people with disabilities have a right to be treated in the least restrictive setting.

Medicaid and the Financing and Delivery of Mental Health Services

Medicaid plays an important role in the financing and delivery of mental health services. It's the primary source of funding for treatment and support services for both children and adults living with severe mental illness. Nationally, Medicaid pays for more than half of the public mental health services administered by states.¹⁸ Financing for Medicaid is shared jointly by state governments and the federal government; the cost share is referred to as the match rate. The match rate is based on a state's per capita income, so poorer states receive a higher match rate. Since Virginia has a relatively high per capita income, its match rate is 50/50, meaning the federal government pays 50 percent and Virginia pays 50 percent.

The significance of Medicaid to mental health care is that it provides a relatively generous benefits package for mental health services as compared to private sector insurance. Private sector mental health benefits tend to cover only inpatient psychiatric care, partial day hospitalization, outpatient therapy, and psychiatric medications. On the other hand, although specific services vary from state to state depending on the defined state Medicaid benefits, Medicaid generally covers specialized mental health services that are geared towards treating adults with severe mental illness and children/adolescents with serious emotional disorders. In Virginia the Department of Medical Assistance Services defines such services as shown in **Exhibit 1**.

An important aspect of Medicaid is the Institute of Mental Disease (IMD) exclusion policy. This policy has its roots in the 1960s when Medicaid was being developed. When the federal government enacted the federal-state cost-sharing structure of Medicaid, it didn't want to create a situation whereby new federal Medicaid monies would supplant existing state and local mental health spending. Since states and localities had traditionally been responsible for funding treatment in psychiatric institutions, Medicaid required exclusion for the treatment of mental illnesses in an "institute of mental disease." Such an institute is an inpatient facility of more than 16 beds whose patient roster is more than 51 percent people with severe mental illness. Exemptions for children (categorized as not yet 22) and the elderly (categorized as over 64) were added, but the exclusion for adults between the ages of 22 and 64 was upheld by the Supreme Court.¹⁹ Then in the early 1980s, a 16-bed exemption was enacted by Congress as a response to the court's decision. Allowing a 16-bed exemption re-affirmed the federal government's opposition to financing the practice of "warehousing" in state psychiatric hospitals.

In essence, the IMD exclusion prohibits Medicaid reimbursement for individuals who are receiving treatment in an IMD if they are between the ages of 22 and 64. The mental health community has long believed that this exclusion amounts to discrimination because it singles out a type of illness that is not eligible for reimbursement in a particular treatment facility by a federal entitlement program. Not only is the facility prohibited from reimbursement under the IMD exclusion, but also the individual patient's Medicaid is terminated while a patient in an IMD. So in order to receive treatment for medical disorders related to his mental illness, he must be discharged from

Exhibit 1: Medicaid Coverage of Mental Health Services in Virginia

Intensive Community Treatment/Assertive Community Treatment (ICT/ACT). Sometimes referred to as a "hospital without walls," this service program delivers an array of mental health services for adults with serious mental illness who need intensive levels of support and service in their natural environment to permit or enhance functioning in the community. The services are delivered through a multi-disciplinary team of mental health professionals. It is available either directly or on call 24 hours per day, seven days per week, and 365 days per year.

Intensive In-Home Services for Children and Adolescents. Services for children/adolescents under age

21 are intensive, time-limited interventions provided to a child who is at risk of being moved into an out-of-home placement or who is being transitioned to home from out-of-home placement. Services provide crisis treatment; individual and family counseling; and communication skills (e.g., counseling to assist the child and his parents to understand and practice appropriate problem-solving, anger management, and interpersonal interaction, etc.); case management activities and coordination with other required services; and 24-hour emergency response **Therapeutic Day Treatment for children and adolescents.** Services are a combination of

Exhibit 1: Medicaid Coverage of Mental Health Services in Virginia (continued)

psychotherapeutic interventions combined with medication education and mental health treatment offered in programs of two or more hours per day with groups of children and adolescents

Psychosocial Rehabilitation. Psychosocial rehabilitation services are programs of two or more consecutive hours per day provided to groups of adults in a non-residential setting

Mental Health Case Management. A service to assist individuals, eligible under the State Plan who reside in a community setting in gaining access to needed medical, social, educational, and other services

Mental Health Skills-building. Training and support services to enable individuals with significant psychiatric functional limitations to achieve and maintain community stability and independence in the most appropriate, least restrictive environment.

Crisis Intervention. Crisis intervention services are mental health care, available 24 hours a day, seven days per week, to provide assistance to individuals experiencing acute mental health dysfunction requiring immediate clinical attention.

Crisis Stabilization. Crisis stabilization services are direct mental health care to non-hospitalized individuals (of all ages) experiencing an acute crisis of a psychiatric nature that may jeopardize their current community living situation. The goals are to avert hospitalization or re-hospitalization; provide normative environments with a high assurance of safety and security for crisis intervention; stabilize individuals in psychiatric crisis; and mobilize the resources of the community support system, family members, and others for ongoing maintenance, rehabilitation, and recovery.

Day Treatment/Partial Hospitalization. The services are delivered when the individual is at risk of psychiatric hospitalization or is transitioning from a psychiatric hospitalization to the community. Day Treatment/Partial Hospitalization services are programs of two or more consecutive hours per day, which may be scheduled multiple times per week and provided to groups of individuals in a non-residential setting.

Source: Virginia Department of Medical Assistance Services, *Virginia DMAS Medicaid Provider Manual*. <https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual>

the IMD, have his Medicaid eligibility reinstated, be treated in a medical/surgical center, and then be readmitted to the IMD for mental health care.

Legislation has been introduced at the federal level for years to repeal the IMD exclusion, but thus far it has not been successful. Under the Affordable Care Act, funding was included for demonstration projects to determine the impact of lifting the IMD exclusion. Under the demonstration project, federal matching funds will be provided to reimburse private hospitals for inpatient psychiatric care for Medicaid recipients aged 22 to 64 who are experiencing a psychiatric emergency.²⁰ The demonstration project has not concluded yet and results are not available, but advocates and providers are eagerly waiting the outcomes. Virginia was not one of the demonstration sites.

The Americans with Disabilities Act

The Americans with Disabilities Act (ADA), approved by the United States Congress in 1990, was groundbreaking legislation that provided the legal framework for persons with disabilities, including those with mental illnesses, to make claims of discrimination. The legislation was a hard fought victory for individuals with disabilities and the disability community at large who faced unnecessary burdens accessing aspects

of everyday life that non-disabled persons enjoy routinely. The goal of the ADA focused on “the elimination of discrimination in employment; public services; and accommodations such as housing, transportation, recreation, voting, health, communication, and access to services.”²¹ It made discrimination based on disability illegal in the areas of employment, services rendered by state and local governments, places of public accommodation, transportation and telecommunication services.²² It also articulated enforceable standards to address discrimination.

The Americans with Disabilities Act opened up all facets of society to people with disabilities: it required public buildings to meet a certain level of accessibility; required new construction of places of public accommodation to be accessible; and even required certain private establishments such as restaurants and stores, to be accessible. In addition to requiring accommodations for physical disabilities, the ADA had a significant impact on people with mental illnesses in two ways. First, it required access and availability of services, prohibiting discrimination against the mentally ill for public accommodations such as day care centers, homeless shelters and food banks. Second, the ADA helped pave the way for people with mental illnesses to gain employment by requiring private and nonprofit businesses to make reasonable

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accommodations for the person's disability, and by prohibiting discriminatory processes such as screening methods that would screen someone out for having a psychiatric disability or segregating an employee in a way that would adversely impact his status or opportunities in the work place.

The Olmstead Supreme Court Decision

In the early 1990s, Lois Curtis and Elaine Curtis were voluntarily hospitalized for the treatment and care of mental illness and developmental disabilities. After obtaining treatment and becoming stabilized, they were deemed ready for discharge by their treating physicians yet remained indefinitely hospitalized for several years. Restricted from being discharged from the hospital, the women filed suit for release under ADA. The Supreme Court heard the case and in 1999 ruled "...unjustified segregation of persons with disabilities constitutes discrimination in violation of Title II of the Americans with Disabilities Act."²³ Title II of the act covers "public entities," which includes state-funded psychiatric hospitals. In essence, *Tommy Olmstead, Commissioner, Georgia Department of Human Resources, et al. v. L. C.* found that persons with disabilities had a right to receive services in the least restrictive environment if services are appropriate, the person does not oppose community-based treatment, and the services can be reasonably accommodated.

The Mental Health Parity and Addiction Equity Act (MHPAEA)

Until the mid-1990s health insurance companies had the right to provide unequal (i.e., lesser) coverage and benefits for mental health services than for medical/surgical services. This disparity was partly remedied with the passage of the Mental Health Parity Act of 1996 (MHPA). The MHPA prohibited annual or lifetime dollar limits for mental health that were less favorable than medical/surgical benefits. For consumers and advocates, however, the MHPA didn't go far enough because discrepancies in co-pays, service limitations, and other insurance benefits were still unequal between mental health and medical/surgical health. This meant that families could pay thousands of dollars in out-of-pocket costs for psychiatric hospital care and other mental health benefits. The advocacy community continued to push on this insurance discrimination issue and after decades of intensive advocacy the more comprehensive Mental Health Parity and Addiction Equity Act (MHPAEA) was passed in 2008. MHPAEA preserved the original provisions of MHPA and added new protections, including extending equal coverage provisions to substance

use disorders, and ensuring that health plan features like co-pays, deductibles, and visit limits are no more restrictive for mental health/substance use disorders than they are for medical/surgical benefits.²⁴

On November 8, 2013, the Obama Administration issued the long-awaited final regulations, which implement the MHPAEA Act. The regulations, which took effect January 1, 2014, are expected to impact 62 million lives nationally.²⁵ The regulations perform the following: (1) ensure that parity applies to intermediate levels of care received in residential treatment or intensive outpatient settings; (2) clarify the scope of the transparency required by health plans, including the disclosure rights of plan participants, to ensure compliance with the law; (3) clarify that parity applies to all plan standards, including geographic limits, facility-type limits and network adequacy; and (4) eliminate the provision that allowed insurance companies to make an exception to parity requirements for certain benefits based on "clinically appropriate standards of care," which clinical experts advised were not necessary and which were confusing and open to potential abuse.²⁶

The Recovery Movement

In the 1980s and 1990s, a new movement within the mental health community was beginning to form. This grassroots movement—known as "recovery"—borrowed its philosophy heavily from the substance abuse field, which acknowledged that people with drug and alcohol addictions can and do recover from lifelong, gripping addiction disorders. In communities throughout the nation, former patients were speaking out to tell their stories of experiencing mental illness, receiving treatment, and through a combination of effective therapeutic treatment and supportive family and friend networks, going on to live fully recovered lives of "mental wellness," maintained similarly through a combination of therapeutic treatment and a support network.

The Americans with Disabilities Act and *Olmstead* ruling helped spur the growth of the recovery movement. It was embraced by mental health advocacy organizations, seeped into the service delivery system, and spread throughout the country. Supporters of the philosophy developed and promoted innovative ideas such as peer-based support services—support groups and services delivered not by licensed social workers and psychiatrists, but by persons who had experienced mental illness and had become stabilized through treatment and were living successfully in the community, called "peer specialists." Virginia community services boards began employing peer

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specialists to provide the personal experience and personal touch alongside licensed professionals. States began to amend their Medicaid plans to include reimbursement for peer specialist services, lending credibility and clout to the peer specialist and recovery treatment philosophy. Educational programs evolved to include peer education programs such as the National Alliance on Mental Illness' "Peer-to-Peer," a ten-week peer-based program that focuses on crisis prevention, mindfulness, and advance directives, and "Wellness, Recovery, Action Planning" (WRAP), a nationally-renowned program that uses peer support to advance wellness and prevent mental health crises.

In its final report in 2003, *Achieving the Promise: Transforming Mental Health Care in America*, the President's New Freedom Commission on Mental Health defined recovery as follows:

...the process in which people are able to live, work, and learn, and participate fully in their communities. For some individuals recovery is the ability to live a fulfilling and productive life despite a disability. For others, recovery implies the reduction or complete remission of symptoms. Science has shown that having hope plays an integral role in an individual's recovery.²⁷

In 2006 the Substance Abuse and Mental Health Services Administration (SAMHSA), the

federal mental health policy and funding agency, announced a consensus statement on recovery, created by a group of experts from around the country, including former mental health patients. In addition, SAMHSA also announced a number of fundamental components to recovery. The ten fundamental components of mental health recovery include the principles shown in **Exhibit 2**.

Impact of Mental Health Policy Developments in Virginia, 1990s to the Present

In the 1990s the United States Department of Justice (DOJ) began investigating Virginia's state-run mental hospitals for providing inadequate patient care that, in some instances, led to patient deaths. Gloria Huntley, a patient at Central State Hospital in Petersburg, Virginia, died in 1996 at the age of 31 after spending more than 300 hours in physical restraint—including two stretches of more than 100 hours in restraints.²⁸ Her death, and others, spurred a national outcry for reform by mental health and human rights advocates. In 1997 and 1998, lawsuits were settled for Eastern State Hospital, Central State Hospital, Northern Virginia Mental Health Institute and Western State Hospital. DOJ compelled Virginia to improve treatment, increase staffing levels, decrease the number of patients in facilities,

"In the 1990s the United States Department of Justice...began investigating Virginia's state run mental hospitals for providing inadequate patient care that, in some instances, led to patient deaths."

Exhibit 2: Fundamental Components of Mental Recovery Principles

Self-Direction. Consumers determine their own path of recovery with their autonomy, independence, and control of resources.

Individualized and Person-Centered. There are multiple pathways to recovery based on an individual's unique strengths as well as his or her needs, preferences, experiences, and cultural background.

Empowerment. Consumers have the authority to participate in all decisions that will affect their lives, and they are educated and supported in this process.

Holistic. Recovery encompasses an individual's whole life, including mind, body, spirit, and community. Recovery embraces all aspects of life, including housing, social networks, employment, education, mental health and health care treatment, and family supports.

Non-Linear. Recovery is not a step-by step process but one based on continual growth, occasional setbacks, and learning from experience.

Strengths-Based. Recovery focuses on valuing and building on the multiple capacities, resiliencies, talents, coping abilities, and inherent worth of individuals. The process of recovery moves forward through interaction with others in supportive, trust-based relationships.

Peer Support. Mutual support plays an invaluable role in recovery. Consumers encourage and engage others in recovery and provide each other with a sense of belonging.

Respect. Eliminating discrimination and stigma are crucial in achieving recovery. Self-acceptance and regaining belief in oneself are particularly vital.

Responsibility. Consumers have a personal responsibility for their own self-care and journeys of recovery. Consumers identify coping strategies and healing processes to promote their own wellness.

Hope. Hope is the catalyst of the recovery process and provides the essential and motivating message of a positive future. Peers, families, friends, providers, and others can help foster hope.

“The challenge with achieving the goals of downsizing and reinvestment was that the closure of state hospital beds and the growth in capacity of community-based services did not keep pace with one another.”

discharge eligible patients to the community, and develop individual treatment plans.²⁹

Subsequent state hospital downsizing had a significant impact on the mental health care system in Virginia. In 1996 Virginia had 2,222 state hospital beds. A mere 8 years later, 634 beds had been cut from the state hospital system. Eastern State Hospital alone reduced its bed capacity for non-geriatric adults from 247 to 145 beds in a three-year period.³⁰ James City County, where Eastern State now is located, was so dismayed by the downsizing and subsequent impact that the Board of Supervisors issued a proclamation officially opposing the “inadequately-planned downsizing.”³¹

For a state that relied so heavily for so many years on state hospitals to provide mental health care, downsizing without adequate planning and resources was a significant jolt to the system. The private sector attempted to take up some of the slack by building free-standing facilities or adding psychiatric beds to general hospitals, but this was not terribly successful due to low reimbursement rates for psychiatric beds, pushback from communities not eager to accept a “mental hospital” in its neighborhood, and a generally lukewarm response to invest in inpatient psychiatric care.

Nonetheless, the shift to community-based care began to sweep the nation, and the *Olmstead* decision of 1999 reinforced the idea of serving people with mental illness in the least restrictive setting. This meant that Virginia was well in line with the evolving mental health care environment. Downsizing of state-run hospital beds led to Virginia’s reinvestment initiative: a push to reinvest funds from closed hospital beds into the development of community-based services and a concerted effort to fund community services in general. In 2003, under the Warner Administration, the legislature approved the Governor’s Community Reinvestment Initiative which redirected over \$10 million to programs such as crisis intervention, discharge assistance planning, assertive community treatment programs, jail mental health services, and funding known as local inpatient purchase of services (LIPOS) to purchase bed space at private hospitals.³² Two years later, the legislature approved \$3.8 million in new funding to support crisis stabilization programs—short-term residential facilities that serve as an intermediary to an actual hospital—and allocated an additional \$2 million for LIPOS funding. These funding initiatives were regarded as much-needed advances in developing a truly community-based system of care and were especially needed in light of continued downsizing of hospital beds. In northern Virginia, 24 percent of

the region’s private psychiatric bed capacity vanished in 2005 due primarily to the closure of psychiatric wards at four hospitals. A lack of state run beds at nearby hospitals, and an inadequate supply of crisis intervention and crisis stabilization services to provide intermediary services that serve to deflect a hospital admissions meant that people ended up being transported far away from family, friends and familiar areas to other hospitals in distant regions such as Staunton, Williamsburg, or even Danville.

The challenge with achieving the goals of downsizing and reinvestment was that the closure of state hospital beds and the growth in capacity of community-based services did not keep pace with one another. The community system, including private hospitals, struggled to develop the kind of services needed to care for seriously mentally ill people the way the state hospitals had been able to. Budget cuts exacerbated the problem. In 2002, Virginia cut community mental health system funding by 10 percent, weakening an already fragile safety net, and an additional 15 percent was cut from “nondirect care” funding of state mental hospitals—yet even nondirect care funding cuts have an impact on the safety net as a whole and, furthermore, send a message that the mental health system is not a priority and can simply somehow manage to absorb budget cuts.

One impact of a shrinking hospital system and inadequate community-based supports is an increase in the number of people with mental illness in Virginia’s jails. Since 2005 the Virginia Compensation Board has conducted an annual jail survey to find out the number of inmates in Virginia’s local and regional jails with a mental illness. In 2005, 16 percent of inmates had a mental illness.³³ The share increased to 18.5 percent in 2007 and to 23.7 percent in 2012.^{34 35} Survey methods have improved over time, which may be part of the reason why the percentage has increased, but it is uniformly agreed that, increasingly, adults with mental illness in Virginia who cannot access mental health services often wind up in jail. State and local dollars are now being invested in mental health treatment in jails: the annual statewide cost of providing mental health services in jails in fiscal year 2012 was \$13.3 million, with \$3.7 million spent on psychotropic medications; localities picked up about 60 percent of the cost of mental health treatment in jails and state general fund dollars paid for about 10 percent.

Post-Virginia Tech “Down Payment”

The Virginia Tech tragedy of April 16, 2007, when 32 people were killed and 17 were wounded by a mentally ill student who then took his own

life, revealed numerous policy, procedural and access to services problems in Virginia's mental health system. The problems included insufficient outpatient capacity (i.e., therapy services, counseling, emergency services), waiting periods for services that ranged from 12.93 days to 113.69 days, outdated mental health laws, and gaps in procedures for community services boards regarding the involuntary commitment process.³⁶ The 2008 Virginia General Assembly acted swiftly to add new money to the historically underfunded system with \$42 million added to the community services board system to expand emergency services, case management and outpatient services. This new funding was considered a "down payment," meaning it was a small deposit to help secure a more adequate mental health system.

In addition to increased funding approved by the legislature in the 2008 session, modifications to Virginia's mental health laws were also enacted, notably, changing the civil commitment criteria from a threshold of "imminent danger" to "substantial likelihood," lengthening the emergency custody order period from four to six hours, and clarifying Virginia's procedures for mandatory outpatient treatment. Prior to these changes, Virginia's civil commitment criteria—the criteria by which a person could be held against her will for a mental health evaluation—was at a fairly high threshold as compared to the rest of the country. Virginia required that a person be in imminent danger of harm to self or others, but many states had already loosened their involuntary commitment standards to require a less strict burden of proof than "imminent danger." The "imminent danger" threshold was long considered to be vague and subject to different interpretations. It was also widely considered to be too strict—that a person should not have to be in imminent danger in order to receive treatment. But Virginia's history of protecting personal rights of liberty along with inertia and lack of consensus about where to move the dial on this issue kept Virginia's threshold at "imminent danger."

In 2007, the Virginia Tech Review Panel, appointed by Governor Kaine to review the mental health system and mental health laws, recommended that Virginia's criteria for commitment be revised with language requiring "substantial likelihood" or "significant risk" that the person will cause serious injury to himself or others "in the near future."³⁷ Consequently, after vigorous debate during the 2008 legislative session by lawmakers, advocates, service providers and citizens, Virginia's law was changed to the "substantial likelihood" threshold. The state's involuntary commitment criteria to receive inpatient treatment

now require that a person be substantially likely to "suffer serious harm due to substantial deterioration of his capacity to protect himself from harm or to provide for his basic human needs as evidenced by current circumstances."

Procedures for mandatory outpatient commitment were also modified. Mandatory outpatient commitment is a form of court-ordered treatment that is served in the community rather than in a hospital. Three main changes were made in 2008 to mandatory outpatient treatment: (1) streamlining and clarifying the procedures for ordering, delivering and monitoring mandatory outpatient treatment orders,³⁸ (2) requiring the attendance of a community services board's representative either in person or by teleconference at all commitment hearings; and (3) enacting changes to allow "significantly more evidentiary information to be considered by magistrates, judges, and special justices when making decisions about court-ordered treatment."

Budget Cuts FY 2009 to FY 2012

As previously noted, in the session immediately following the Virginia Tech tragedy, the legislature approved \$42 million in new funding for mental health services (emergency services, case management, and outpatient services). But then the recession hit, and beginning in 2009 much of the funding was reduced due to budget cuts. Between fiscal years 2009-2012, Virginia cut \$37.7 million in funding from its mental health budget, representing 8.9 percent change between fiscal years 2009 and 2012, and the 11th deepest cut in the nation.³⁹

Funding Increases 2012-2013

During the McDonnell Administration, as the state's fiscal situation improved, the legislature approved slight increases in funding for mental health services, which are shown in **Table 2**.

These funding increases were viewed as small victories by mental health advocates. Despite the initiatives, several priorities were *not* addressed including crisis intervention training for law enforcement personnel, crisis stabilization services, intensive outreach teams [formally known as Programs of Assertive Community Treatment teams (PACT)], and outpatient counseling.

An Overview of Mental Health Funding, 2005 to 2014

Funding for mental health services has been on a roller coaster as summarized in **Table 3**. Fiscal years 2005 and 2006 saw increases in funding for mental health services (approximately \$23 million and \$11 million respectively). Fiscal years 2007

"[Prior to new legislation in 2008]... Virginia's civil commitment criteria—the criteria by which a person could be held against her will for a mental health evaluation—was at a fairly high threshold as compared to the rest of the country."

“...it has been challenging for the mental health system to reliably sustain services in an environment of financial uncertainty.”

Table 2: Virginia Mental Health Budget Increases, 2012 to 2013

Fiscal Year	Program	Amount
2012	Children’s psychiatry and crisis response services	3.2
2012	Development of therapeutic assessment “drop off” centers	0.6
2012	Amount to keep 13 inpatient beds at the Northern Virginia Mental Health Institute operating through FY 2013	0.6
2013	Further development of therapeutic assessment “drop off” centers	0.9
2013	Suicide prevention funding	0.5
2013	Implement Mental Health First Aid Training	0.6
2013	Expand children’s mental health crisis services	1.9
2013	Funding for Discharge Assistance Planning	1.5

and 2008 saw increases in funding for community mental health services but reductions in funding for state hospitals. Then starting in 2009, there were significant reductions. As mentioned earlier, between fiscal years 2009–2012, Virginia cut its mental health budget by \$37.7 million. The take-away message is that it has been challenging for the mental health system to reliably sustain services in an environment of financial uncertainty. The impact is felt by those needing services: longer waiting periods or the elimination of services altogether.

2014 General Assembly Session Developments

The 2014 General Assembly adjourned on Saturday, March 8, 2014. This year’s session proved to be a busy time, as the need to address gaps in Virginia’s mental health system was a primary focus and at the forefront the legislative agenda in response to the tragedy that befell state Senator Creigh Deeds’ family in late 2013. Legislators considered a range of proposals intended to

reform and strengthen the current system not only through policy changes but also by including additional mental health funding in Virginia’s FY 2014–2016 biennial budget.

Emergency Custody Order (ECO) and Temporary Detention Order (TDO). Proposals to extend the ECO timeframe ranged from a 2-hour extension to one 24-hour block. Proposals for the TDO extension involved requiring a 24-hour minimum for TDOs and a 72-hour maximum for TDOs (Virginia’s current TDO is 48 hours, with no minimum requirement). Several bills were passed. HB 487 provides one eight hour block for the total ECO period. This bill also requires an individual to be provided with information about the ECO and TDO processes.

SB 260, an “omnibus” mental health bill, includes several major concepts. It increases the ECO period to eight hours and removes provisions to get further extensions from a magistrate. Additionally, if the adult/minor is being detained in a state facility, an employee or designee of the

Table 3: Virginia Mental Health Funding, 2005 to 2014 (Millions of Dollars)

	Fiscal Year									
	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Community Services Boards										
New funding	8.60	10.05	13.83	3.47	16.40	7.50	0.40	3.90	2.10	5.15
Reductions	0.00	0.00	0.00	0.00	-12.40	-16.70	3.80 ^a	0.00	0.00	0.00
Net change	8.60	10.05	13.83	3.47	4.00	-9.20	4.20	3.90	2.10	5.15
State hospitals										
New funding	14.80	0.98	0.14	1.30	0.00	0.00	2.00	0.00	0.60	0.70
Reductions	0.00	0.00	-1.60	-7.10	-3.10	-13.10	-2.00	-5.30	0.00	0.00
Net change	14.80	0.98	-1.46	-5.80	-3.10	-13.10	0.00	-5.30	0.60	0.70
Total net change	23.40	11.03	12.37	-2.33	0.90	-22.30	4.20	-1.40	2.70	5.85

^a Supplanted \$4.5 million general fund support in FY 2010 with one-time nongeneral fund balances to support community mental health provided by CSBs--general fund support restored in FY 2011.

Source: John Pezzoli, Acting Commissioner, DBHDS, “Proposed Budget for Virginia’s Behavioral Health and Developmental Services System, Health and Human Resources Subcommittee, House Appropriations Committee” (January 14, 2014)

http://hac.virginia.gov/subcommittee/health_human_resources/files/01-14-14/DBHDS%20-%20Proposed%20Budget%2014-14.pdf

CSB may continue looking for an additional four hours for an alternative facility to provide appropriate care. This four-hour period is not in addition to the ECO, but it runs concurrently with the TDO; the provision expires on June 30, 2018 unless re-enacted prior to that. Any person being detained under a TDO must be given a written summary of ECO and TDO procedures and protections. SB 260 requires the Virginia Department of Behavioral Health and Developmental Services to create a bed registry to include real-time updates from public and private facilities to aid emergency clinicians in finding an appropriate bed in a timely manner. It extends the TDO period from 48-hour maximum to a 72-hour maximum, and it mandates that a state facility is required to serve as the facility of last resort, meaning that if a bed in a private hospital has not been identified for a TDO within the 8-hour ECO period, the individual will be transported to a state facility. The bed registry became effective immediately upon the bill's passage and the ECO and TDO extensions become effective on July 1, 2014.

State as Bed of Last Resort. The legislature also grappled with the problem of inadequate capacity at state psychiatric facilities. State hospitals have been downsized over the years and there has been a shift in policy and process towards using inpatient services at private hospitals. The problem is that sometimes private hospitals won't admit a person so the state hospital needs to serve as the safety net. Yet it's not always possible for a person to be admitted to a state hospital due to its lack of capacity and other reasons. In fact, in 2011 the Inspector General for DBHDS reported on the practice of "streeting." The term refers to a person being released from temporary detention because there is no psychiatric facility willing to admit the person.⁴⁰ Between April 1, 2010 and March 31, 2011, approximately 200 individuals who met the criteria for TDO were released from custody and "streeted" because no inpatient care could be found. Legislation was introduced in the 2014 session to remedy this problem by requiring state hospitals to serve as the bed of last resort. SB 260 and HB 293 provide that a state facility is the facility of last resort if a bed is not identified within the designated ECO timeframe.

Acute Psychiatric Bed Registry. An issue that surfaced following the Deeds tragedy was the need for an online bed registry for psychiatric beds. There was widespread agreement among advocates, providers and others that a bed registry is an important tool for enabling emergency clinicians to quickly identify available beds in Virginia. DBHDS reported that a bed registry was already under development but that budget cuts delayed

the project start date.⁴¹ Nevertheless legislation was introduced during the 2014 session requiring the creation of a bed registry. HB 1232 and SB 260 require DBHDS to develop and implement an acute psychiatric bed registry with "real-time" updates for public and private facilities.

Mental Health System Study. A resolution introduced by Senator Deeds, SJ 47, requires a joint subcommittee to study mental health services. The joint subcommittee will (1) review and coordinate with the work of the Governor's Task Force on Improving Mental Health Services and Crisis Response; (2) review Virginia laws governing the provision of mental health services, including involuntary commitment of persons in need of mental health care; (3) assess the systems of publicly-funded mental health services, including emergency, forensic and long-term mental health care, and the services provided by local and regional jails and juvenile detention facilities; (4) identify gaps in services and the types of facilities and services that will be needed in the twenty-first century; (5) examine and incorporate the objectives of House Joint Resolution 240 (1996) and House Joint Resolution 225 (1998) into its study;⁴² (6) review and consider a report to be prepared by the Behavioral Health Services Study Commission,⁴³ and (7) recommend statutory or regulatory changes needed to improve access to services, the quality of services, and outcomes for individuals in need of services.

Other Actions. In addition to the aforementioned legislation, the General Assembly focused on proposals to increase funding for mental health services including money for Programs of Assertive Community Treatment teams (PACT), children's crisis services, discharge assistance planning, therapeutic assessment "drop off" centers, inpatient capacity at state hospitals, and permanent supportive housing. At the time this article was written in mid-May 2014, the legislature's final decision about how to allocate additional general fund dollars for mental health services was unknown due to pending budget negotiations between the House and the Senate.

Also unresolved is the issue of expanding health care coverage to uninsured adults. Under the Affordable Care Act (ACA), one mechanism of covering uninsured adults was for all states to expand Medicaid coverage to eligible adults up to 133 percent of the federal poverty level. The Supreme Court's ruling in July 2012 held that states have the right to determine whether to expand Medicaid; expansion could not be required under the Affordable Care Act. This began a long and complex dialogue among state lawmakers and citizens about the merits of Medicaid

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expansion to eligible adults in Virginia. During the 2014 session, the Virginia Senate put forth a proposal called Marketplace Virginia—this plan would enable eligible adults who currently are ineligible for Medicaid and the health insurance exchanges to qualify for health insurance coverage. The impact of the proposed plan on adults with mental illness, as well as the mental health system, would be extraordinary. An estimated 77,000 uninsured Virginians have a mental illness, with 40,000 of them having a serious mental illness such as schizophrenia or bipolar disorder.⁴⁴ Instead of seeking care, many uninsured Virginians with mental health disorders go without the care they need because the cost of co-pays and fees is too high, or even due to the fear of mounting medical bills. Having health insurance coverage enables people to get access to necessary services and supports, medications, and ongoing care, which help to prevent them from entering a crisis situation. Hospitalizations and emergency treatment options can be traumatizing to the individual and are costly to Virginia’s taxpayers. Ongoing treatment reduces the risk of crises and lessens the burden on the hospital and criminal justice systems. The proposed Marketplace Virginia plan would infuse an estimated \$1.2 billion for much-needed new community mental health services for Virginia’s mental health system between FY 2015 and FY 2022.⁴⁵ It would also infuse \$426 million in the same years for traditional psychiatric services such as outpatient appointments, prescriptions and inpatient hospitalization.

Because of a lack of compromise on whether to extend health insurance coverage to the uninsured, the legislature adjourned without a budget. As of this writing, the budget has not been adopted and the ACA issue, which is of major importance for the mental health advocates, has not been resolved.

Recommendations for the Future

Squeezing down budgetary costs has been the most abiding and continuing theme for Virginia’s public mental health system since its inception. Uncovered scandals, investigations by the U.S. Department of Justice, and the disaster on Virginia Tech’s campus in 2007 as well as the tragedy experienced by Senator Deeds’ family have helped spur change but sustained progress is still needed. Efforts in the past decade have brought funding for critical innovations such as new medications, Programs of Assertive Community Treatment, housing support services, and crisis stabilization. These initiatives have brought incremental and important change but have not fully addressed the infrastructure or capacity needs of Virginia’s community based

system of care, which must be addressed in order for meaningful change to take place.

There are a number of actions that leaders in state government can take to improve Virginia’s mental health system. In general, the state needs to shift its focus from a crisis-driven, institution-heavy system to one that utilizes early intervention services and supports long-term recovery. Virginia still relies too heavily on inpatient hospitals to provide long-term mental health services. A robust array of services bolstered by adequate funding and an adequate work force can help address mental health crises before they escalate.

One of the most important actions Virginia can do is to ensure that there is a uniform level of services in the public mental health system. In fact, recommendations from legislative studies and commissions conducted from 1949 through 2000 have come up with virtually the same conclusions—there is a consistent need to increase the availability of community services to prevent crises, to diagnose and treat mental illness, and to make sure that people are treated in the least restrictive setting possible.⁴⁶ Services need to include a broad array of clinical care and supportive services to promote stabilization from crisis, rehabilitation, and long-term recovery and independence. There shouldn’t be a variance in what exists in different parts of the state as there is now.

For a start, the commonwealth needs to increase crisis response services such as 24-hour mobile crisis teams, psychiatry services, and crisis stabilization units. Crisis response services are important because they provide an immediate point of contact between a person experiencing a mental health crisis and mental health professionals. Such professionals, who are trained in handling crises, are able to use a number of strategies to address and resolve a crisis. They may reach out in-person to the affected individual, provide on-site care and treatment at a local mental health center, or furnish a short-term residential facility where the person can go. These short-term crisis stabilization units provide treatment and care for people who are not acute enough to go to the hospital, yet need a structured, intensive environment to help lessen and resolve a mental health crisis. As of 2013 publicly-funded crisis stabilization units served 19 of the 40 community services board catchment areas in varying degrees of operation. Some operate 24 hours a day, 7 days a week while most operate less than that. Additional funding and capacity is needed to ensure that all population centers in Virginia have access to crisis stabilization services as opposed to the patchwork that exists now.

The commonwealth needs to fund additional Programs of Assertive Community Treatment teams. Many localities in Virginia are underserved with this vital service. At a minimum, each community services board would have funding and staffing for at least one PACT team, with densely populated areas having more based on population and need.

Virginia should also amend the Medicaid state plan to include reimbursement for peer support specialists. Peer support specialists, covered in an earlier section, are people with mental illness experience employed in paraprofessional roles in mental health service settings such as outpatient clinics and inpatient hospitals. Peer support specialists have achieved a degree of recovery and are in a position to guide and help others. They use their personal experiences combined with training and supervision to augment the professional work of a trained mental health clinician. Empirical evidence shows that peer support has value. First generation studies showed that it was feasible to hire people in recovery to serve as mental health staff. Second generation studies showed that peer staff could generate at least equivalent outcomes to non-peer staff in similar roles and that peers could engage people into care and reduce hospital readmissions.⁴⁷ Third generation studies are investigating whether or not there are unique contributions that peer supporters can make to mental health care. Thus far, hope and activation for involvement in treatment and self-care have been identified as contributions peers make. More than 30 states now reimburse for peer specialist services through Medicaid; Virginia is not one of them. This should change.

A well-trained and ample workforce is one of the keys to a high-quality mental health care system. Yet the country as a whole is experiencing a shortage of qualified mental health personnel and Virginia is no exception. The federal Health Professional Shortage Area (HPSA) designation identifies an area or population as having a shortage of dental, mental, and primary health care providers.⁴⁸ A HPSA designation is based on three criteria, established by federal regulation: (1) The area must be rational for delivery of health services. (2) A specified population-to-provider ratio representing shortage must be exceeded within the area as evidenced by more than 3,500 persons per physician (or 3,000 persons per physician if the area has “high needs”). (3) Health care resources in surrounding areas must be unavailable because of distance, overutilization or access barriers.

As of July 2013 Virginia had 47 mental health care health professional shortage area designations.⁴⁹ The primary factor used to determine

a HPSA designation is the number of health professionals relative to the population with consideration of high need. Based on the federal guideline of 1 psychiatrist per 30,000 people, 32 psychiatrists are needed to remove Virginia’s health professional shortage area designation.

Beyond psychiatrists, many other types of mental health professionals are needed to ensure an adequate mental health workforce. In fact, nearly 90 percent of mental health services administered in Virginia are done so by licensed clinical social workers, licensed professional counselors, and nurse practitioners specializing in psychiatric mental health.⁵⁰ Data gathered between August and November 2012 by the Virginia Healthcare Foundation survey of 37 out of 40 of Virginia’s community services board showed that there were 64 open mental health profession positions in Virginia’s CSBs, most for full-time staff.⁵¹ These included positions for licensed clinical social workers (LCSWs) (20), licensed professional counselors (LPCs) (17), psychiatrists (14), psychiatric-mental health nurse practitioners (PMHNPs) (7), clinical psychologists (4), and psychiatric mental health nurses (2). But while all licensed mental health professionals are challenging to recruit and hire, board certified psychiatrists and child psychiatrists are the most difficult.

Virginia could do four things to ensure an adequate supply of qualified mental health personnel: (1) Establish education subsidies, loan forgiveness programs, and other incentives for students pursuing careers in mental health. (2) Promote and provide training on the key skills necessary for working with people who have serious mental illnesses. (3) Provide on-going education for mental health service professionals and paraprofessionals. (4) Develop competitive salary and benefit structures for employees working in mental health services.

Virginia needs to shift its housing policy to a permanent supportive housing philosophy instead of one focused on shelters, group homes, transitional homes, residential facilities, and assisted living facilities. Permanent supportive housing is an evidenced-based model that needs to be expanded and financed by the state as part of the mental health safety net, and Virginia needs to make auxiliary grants portable. Auxiliary grants are entitlements received by people who receive Social Security Supplemental Security Income (SSI). Auxiliary grants that are funded by state and local governments. Currently, recipients of auxiliary grants are only able to use this dedicated housing stipend at assisted living facilities or adult foster care homes. Yet these housing settings are not the preferred choice by many adults with mental

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“Virginia should continue the decriminalization of persons with mental illness. The presence of persons with mental illness in the criminal justice system is one of the great problems of our day.”

illness who desire a more independent setting, nor are they evidence-based programs. Further, many areas of Virginia do not even have assisted living facilities or adult foster care homes that accept auxiliary grants as a form of payment.

Virginia should change the funding structure of its civil commitment process. Currently, for patients who do not have insurance, the state will pay for initial hospital-based care but only if the person is involuntarily committed. This needs to change. If a person is in need of inpatient care, she should receive it regardless of whether she admits herself voluntarily or is admitted per judicial order. Changing the way this is structured could remove some of the financial incentives that influence decisions about how to provide care for people.

The inherent complexity of mental illness needs to be addressed through family and community educational efforts utilizing programs like NAMI’s Family-to-Family and Mental Health First Aid. Family-to-Family educates family members about the illness of a loved one and how to work effectively with that family member and providers, how to best provide support to the individual, and how to be an advocate for the family member.⁵² Mental Health First Aid is a program similar to regular first aid for cardiopulmonary resuscitation (CPR). It trains everyday citizens on how to recognize signs and symptoms of mental illness and substance abuse. More widespread uses of these and other educational programs helps to normalize mental illness, reduce stigma, and provide tools to families and communities who interact with people with mental illness every day.

Virginia should continue the decriminalization of persons with mental illness. The presence of persons with mental illness in the criminal justice system is one of the great problems of our day. Society has become increasingly concerned about the number of persons with mental illness in jails and prisons, as well as the treatment provided. Virginia needs to expand the programs and services that help to divert people with mental illness from jails. Steps include funding additional crisis intervention teams (specialized training for law enforcement officers and other first responders who are often called to the scene to manage people in psychiatric distress) and ensuring that all regions have access to 24-hour crisis assessment centers. Such centers enable law enforcement officers to work hand-in-hand with mental health professionals to route people to the appropriate treatment hospital instead of to jail. Additional recommendations include preventing arrest and incarceration of persons with serious mental illness by providing adequate housing and community services; implementing mental health

specialty dockets (dedicated courts for mental health cases); improving jail mental health services; ensuring timely mental health hospital admission for inmates needing inpatient treatment; and addressing shortages in crisis services and access to psychiatric hospital beds.

High quality leadership, transparency and accountability are extremely important for an overall effective mental health system. Virginia’s mental health system should be transparent to those it serves and the public at large. Being able to measure and report on the success of services is critical to transparency and accountability. While a number of valuable reports about mental health services are available to the public on state websites, improvements should be made that so that actual service outcomes are captured and understood. The information could help guide system improvements. Additionally, a sustained effort by leaders in the highest levels of government is required to attain transparency and accountability.

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Mira E. Signer has been the Executive Director of the National Alliance on Mental Illness of Virginia since 2007. Along with public policy, grassroots advocacy, program development, and nonprofit expertise, Mira brings her personal experiences, challenges, and lessons learned from friends and loved ones who have dealt with mental illness, which is part of her motivation to reduce stigma and improve Virginia’s mental health system. A native of Arlington, Virginia, she received a B.A. in anthropology from James Madison University and a Masters in Social Work with a concentration in administration, planning and policy practice from Virginia Commonwealth University. She currently serves on numerous task forces and committees related to improving mental health in Virginia.

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