

DMHMRSAS System Transformation:

- Allocation of New Funds
- Access to Children's Mental Health Services
- MH/Criminal Justice Cross-Cutting Issues

Senate Finance Committee
October 29, 2008

James Reinhard, M.D.
Commissioner, DMHMRSAS

System Transformation

System Transformation:

- Moves away from institutional-based care to community-based care.
- Requires ongoing evaluation to improve our existing system of services and supports. Self-evaluation is occurring with specific focus on better serving children and their families, individuals with intellectual disabilities, and geriatric populations.
- Succeeds when we collaborate. Public Safety and HHR partnership improves capacity to address cross-cutting MH and SA issues.

General Assembly commitment and funding support allows DMHMRSAS to build a more responsive system of services and supports.

Allocation of Funding for Mental Health Law Reform

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Virginia's Current MH Services Need

- Over **308,000** Virginia adults (6% of the population) have had a serious mental illness at any time during the past year (DMHMRSAS estimate from national prevalence data).
- In FY07, **state facilities served 5,814 individuals** for MH services (unduplicated).
- Individuals served by **CSBs in MH services** (unduplicated):
 - **2007 – 126,632**
 - **2006 – 118,732**
 - **2005 – 115,173**
 - **2004 – 109,175**
 - **2003 – 109,025**

2008 MH Reforms

- Changing criteria for emergency custody, temporary detention, and commitment from “imminent danger” to “substantial likelihood that in the near future he will:
 - a) cause serious physical harm to himself or another person, as evidenced by recent behavior causing, attempting, or threatening such harm, or
 - b) suffer serious harm due to substantial deterioration of his capacity to protect himself from such harm or provide for his basic human needs”.
- Allowing an emergency custody order to be extended from four to six hours.

2008 MH Reforms

- Clarifying responsibilities of CSBs and independent examiners throughout the civil commitment process, including mandatory outpatient treatment.
- Requiring CSB staff to attend commitment hearings.
- Requiring independent examiners and treating physicians of TDO patients to be available during hearings.
- Authorizing information disclosure among providers to deliver, coordinate or monitor treatment, and between providers and courts to monitor service delivery and treatment compliance.

MH Reform Implementation Activities

- Extensive coordination among stakeholders to synchronize implementation activity.
- Consistent guidance presented at DMHMRSAS and court trainings for common application of new laws.
- Nearly 400 participants in DMHMRSAS' first training on Code change implementation.
- Developed issue-specific “guidance memos”, an array of new forms, Webinar trainings, and a Web page as support and information resources.
- Civil commitment trainings will be expanded regionally to reach more people.

Civil Commitment Reform Allocation

The biennium budget included **\$28.3M** in Item 316.KK to offset the fiscal impact of civil commitment reforms, including:

- emergency services;
- crisis stabilization services; and
- case management, and inpatient and outpatient services for individuals who are in need of emergency mental health services

To determine the funding allocation, DMHMRSAS:

- Sought input from CSB executive directors.
- Consulted with stakeholders, including:
 - VACSB
 - VA Hospital & Healthcare Assn
 - Office of the Exec. Secretary
of the Supreme Court
 - DMAS
 - VA Sheriff's Assn
 - Medical Society of VA
- Established a reporting mechanism to track these funds during FY09-FY10.

FY09 – FY10 Allocation Overview

FY 2009	\$10.3M
Partial-year funds allocated to the 40 CSBs	\$9.9M
Partial-year implementation of Southside VA Crisis Residential Stabilization program	\$250,000
Funds set aside for unanticipated costs related to Code changes documented during implementation	\$141,713
FY 2010	\$18,006,164
Full-year funds for allocations to the 40 CSBs	\$12.1M
Additional targeted services based on FY09 implementation evaluation	\$4,873,639
Full-year funding of Southside VA Residential Crisis Stabilization program	\$750,000
Funds set aside for unanticipated costs related to Code changes documented during implementation	\$250,000

FY09 – FY10 Allocation Methodology

Population size was used because:

- Population has a reasonable relationship to increased workload in implementing reforms.
- Using a straight per capita allocation would not give small CSBs sufficient funds to implement reforms.
- CSBs first grouped into 4 categories of population size (small, medium-small, medium-large and large) to ensure a base level of adequate resources for all CSBs (CSB leadership approved this methodology).
- Additional funds were added to FF/FC CSB's existing allocation as a large CSB based on its exceptionally large population size.

FY09 – FY10 Allocation Methodology

FY 2009 and FY 2010 Individual CSB Allocations

CSB Population Group	FY2009	FY 2010
Small (0 - 84,579)	\$162,430	\$198,895
Medium-Small (84,580 - 169,158)	\$216,575	\$265,194
Medium-Large (169,159 - 253,737)	\$270,718	\$331,492
Large (253,738+)	\$324,862	\$397,862
Fairfax-Falls Church	\$433,149	\$530,387
Total for all 40 CSBs	\$9,908,286	\$12,132,525

FY09 – FY10 Allocation Methodology

CSBs must use their allocations to achieve the following broad goals:

1. Address Code changes (Ch. 8 of Title 37.2) related to the civil involuntary commitment process, such as attendance at commitment hearings and initiation of treatment during TDO period.
2. Address Emergency Services and Case Management Services Performance Expectations and Goals in Exhibit B of the FY09 performance contract.
3. Increase mandatory outpatient treatment capacity.

- CSBs submitted proposed uses of individual allocations for DMHMRSAS approval.
- Disbursements of the allocations are being included in CSBs' semi-monthly payments.
- Each CSB must also submit a quarterly status report on its implementation of the approved proposals.

FY09 Approved CSB Proposals

Service	FTEs	Consumers	State \$	Total Cost*
Emergency Services	91	22,292	\$5.6M	\$6.62M
Outpatient Services	32	5,084	\$2.6M	\$3.98M
Case Management	31	3,061	\$1.7M	\$1.81M
Total	154	30,437	\$9.9M	\$12.41M

Goals and Expectations

- Our goal is fair and consistent application of new laws.
- Some new laws may increase involuntary treatment while others may decrease it – stakeholders helped balance public safety and civil liberties.
- Statutory changes are only part of reforming our complex public mental health system.
- The Governor and General Assembly recognized this by passing and signing comprehensive reform legislation and appropriating a downpayment on additional funds needed to implement the reform.
- True reform will be brought by investing in community mental health services that engage more people in person-centered, recovery-oriented, voluntary interventions.

DMHMRSAS

Commonwealth of Virginia Department of
**Mental Health, Mental Retardation
and Substance Abuse Services**

Access to Children's Mental Health Services

Scope of the Problem

- Access to children's behavioral health services is improved, but still inadequate.
- The Inspector General reported in Sept. 2008:
“Families seeking services for children and adolescents with mental health service needs face enormous differences in service availability depending on where they live. Whether measured by expenditures, staffing, or percentage of child population served, the availability of mental health services for children and adolescents offered by CSBs varies widely among communities.”
- Over the past 16 years, most major funding initiatives have been targeted and restricted by appropriation language, reducing our flexibility to use those dollars for children's services.

Services Provided to Children

- Virginia's population of children is approximately 1.8 million.
- The estimated number of children who have a serious emotional disturbance ranges from 47,179 to 103,794.
- About 98 percent of public mental health services to children are provided in the community.

Treatment Services for Children

- **CSA** - \$383M in state GF; 45 percent is spent on residential treatment.
- **DJJ** – Provides behavioral health services to children in the criminal justice system.
- **Private sector** provides community and residential services for children.

In FY 2007*:

- CSBs served 41,353 children
- Total cost - \$62,483,037
- Cost per child - \$1,510.97

* Performance contract data

Services Provided to Children

- The following services are available to children through CSBs:

Emergency Services; prescreening for inpatient care	Crisis Stabilization
Home Based Therapy/Intensive In-Home Services	Mental Health Psychiatrist Services
Residential Services (short-term crisis only)	Office Based Substance Abuse Treatment
Mental Health Case Management	Office Based Mental Health Therapy
Substance Abuse Case Management	CSA Evaluations
School Based Day Treatment	Mental Retardation Case Management
Intensive Care Coordination	

- Pointing to the tremendous diversity of service capacity across the state, the IG's review of CSBs showed:
 - **12** CSBs have **4 to 6** of these services
 - **22** CSBs have **7 to 9** of these services
 - **6** CSBs have **10 to 12** of these services

State facilities play a limited role in the overall children's service system, but do provide short-term services for children in two state facilities:

Commonwealth Center for Children and Adolescents

- 48 beds
- FY08 average daily census – 33
- Average length of stay – 21.2 days

Southwestern Virginia Mental Health Institute

- 16 beds
- FY08 average daily census – 9
- Average length of stay – 16.4 days

Census Variation

2008 Census	CCCA	SWVMHI
January 10	37	10
April 17	45	10
July 17	27	3
October 16	37	13

Private Children's Beds

Facility	Location	# Beds
Inova Mt. Vernon	Alexandria	3 (emergency only)
Inova Fairfax	Fairfax	6
Peninsula Behavioral Health Center	Hampton	10
Carilion/Roanoke Memorial	Roanoke	12
Centra Health – VA Baptist	Lynchburg	14
Bon Secours Maryview	Portsmouth	16
Mary Washington Hospital Psychiatric Unit	Fredericksburg	18
Tucker's Pavilion (CJW)	Richmond	18
HHC Poplar Springs Hospital	Petersburg	23
VA Beach Psychiatric Center	Virginia Beach	24
Lewis Gale Center for Behavioral Health	Salem	24
VCU Virginia Treatment Center for Children	Richmond	26
VA Psychiatric Center/Dominion Hospital	Falls Church	20
TOTAL		224

Mental Health – Criminal Justice Cross-Cutting Issues

Asking the Questions

- **Do Virginia jails house a large number of persons with mental illness?**
 - Survey data show that Virginia's jails house more persons with mental illness per day than do all state hospitals; MH treatment has become a major operational component of jails.
 - 2005 and 2007 Virginia Local & Regional Jails MH Surveys
 - Joint effort of Compensation Board and DMHMRSAS
 - Requested by Senate Finance Subcommittees
- **What types of MH Treatment do Virginia jails provide?**
 - Have the jails really replaced psychiatric hospitals as the main treatment site for those with criminal justice involvement?

Jail Inmates with Mental Illness

- 5240 total inmates with mental disorder in all the jails on Oct. 16, 2007.
- 18.5% of total population; (compare with 2005 results showing 16%).
 - 877 – Schizophrenia
 - 1693 – Bipolar or Major Depression
 - 962 – Dysthymia (less severe, chronic form of depression)
 - 1200 – Other mental illness
- 1,766 Total Jail Inmates treated with antipsychotic medications on Oct. 16, 2007.

Comparison: State Hospital “Landscape”

- MH Hospital Census: 1,450.
- 200 total jail inmates hospitalized on survey date; limited capacity/waiting lists.
- Estimate of average per diem cost for jail inmate with mental illness: \$100.
- As of June 30, 2008, the average daily cost for state MH facilities was \$595.81.

- **Average Daily Census** for forensic patients has grown by 18% since FY 2001.
- **Forensic patients** comprise 35% of all adult psychiatric beds.
- **6 Categories of Forensic clientele:**
 - Evaluations
 - Emergency MH Treatment
 - Restoration to Competency to Stand Trial
 - Unrestorably Incompetent to Stand Trial
 - DOC Parolees with mental illness committed on release from DOC
 - Insanity Acquittees (NGRI)

Discharged Forensic Patients FY 2001-2008

- **Evaluations: 24 days**
- **Emergency Treatment: 32 days**
- **Competency Restoration: 93 days**
- **URIST defendants, DOC Parolees: 352 days**
- **NGRI acquittees (1993-2005): 1,610 days**

Challenges

- The demand for secure beds is always greater than the supply, especially when community alternatives are not available
- Increase in hospitalized NGRI acquttees decreases short-term beds
- 57% increase in total jail census in past 10 years
- Referral decisions for state MH beds is made by the criminal justice system as opposed to civil commitments to MH beds which are made by CSB “gatekeepers” and civil courts.

- State hospital admissions were reduced by expanding the DMHMRSAS community-based forensic evaluation program.
- 2003 change in NGRI law for Misdemeanant NGRIs (Limit of 1 year as NGRI).
- Outpatient Competency Restoration program holds promise (60 defendants restored in community in FY08).
- HPR-IV Jail Services Team: Provides MH care in 3 Jails; reduces need for hospitalization (Program responds to CSH referrals).

- **Commonwealth Consortium for MH/CJ Transformation**
- **Executive Order 62, January 2008**
- **Joint Effort of HHR and Public Safety:**
 - Executive branch coordination of state, regional, local MH/CJ initiatives.
- **Dual Purpose:**
 - Preventing unnecessary involvement of persons with mental illness in the Virginia criminal justice system.
 - Promoting public safety by improving access to needed mental health treatment for persons with mental illness for whom arrest and incarceration cannot be prevented.

Commonwealth Consortium: Goals

- Enhance collaboration by identifying and supporting effective programs, practices, and training across secretariats, agencies, systems, regions and localities.
- Transformation Planning
 - Diversion programs, jail treatment and re-entry
- Criminal Justice/Mental Health Training Academy
 - “Academy without walls”
 - Stakeholder and provider education, cross training and outreach

Commonwealth Consortium: Transforming Options

- Reduce role of jails as hospital substitutes for some inmates:
 - Post-booking diversion from jail
 - Reentry Planning; equate release from jail for Persons with Mental Illness to discharge from state psychiatric hospital
 - Establish closer ties for planning and service delivery among state hospitals, jails and CSBs
 - Promote continuity of care through in-jail treatment and “wraparound” services access on discharge
 - Create meaningful, specialized housing options in all communities

Commonwealth Consortium: Progress

- **Governor's Conference, May 2008**
 - Trained "Teams" of MH & CJ experts in intercept approach
 - Began local community collaboration for change
- **GAINS Center Cross-Systems Mapping, August 2008**
 - "Training of Trainers" 24 MH/CJ leaders
 - CSB/DMHMRSAS and local Community Corrections Directors from 7 regions of the state
 - 2-day intensive training for guiding local stakeholders groups in Diversion/Reentry planning, needs assessment for their communities
 - Implementation of mappings in beginning in selected localities
- **Progressively increasing involvement across MH/CJ agency boundaries:**
 - Joint DMHMRSAS/CSB/DOC training and programmatic activities increasing
 - DMHMRSAS/DCJS Collaboration with CIT, training of Jail Officers, etc.
 - Shared "ownership" of DOC Reentry initiative goals by DMHMRSAS/CSBs

Progress Update

- State Coordinator for Criminal Justice and Mental Health Initiatives in Place
 - *A National GAINS Center Best Practice: The Boundary Spanner*
 - Knowledgeable in mental health, criminal justice and related systems
 - Comfortable working in multiple systems
 - Credible among disparate stakeholders
 - Effective in facilitation, negotiation and consensus building

Progress Update (Cont'd)

- Developed through collaborative efforts of HHR and Public Safety Secretaries
 - Provide leadership, staffing and outreach for Consortium
 - Provide centralized locus for communication among local, regional and state stakeholders involved in CJ/MH activities
 - Develop agendas, strategies and processes for Consortium leadership meetings and events

Commonwealth Consortium: Progress

- **2008 Virginia General Assembly Funding:**
 - \$3.8M in total Jail Diversion/Reentry funding
 - \$300,000 for Crisis Intervention Team training
- **DMHMRSAS Funding Plans:**
 - Continued funding of 7 existing jail diversion programs
 - Accepting program proposals from 13 localities, based on current level of targeted programs
 - Will select 6-10 proposals, based on defined criteria
 - December 1, 2008 implementation

Jail Diversion Funding Allocation Process

- 13 CSBs solicited to develop funding proposals
 - Alexandria
 - Arlington
 - Chesterfield
 - Fairfax-Falls Church
 - Hampton-Newport News
 - Henrico Area
 - Middle Peninsula-Northern Neck
 - New River Valley
 - Norfolk
 - Portsmouth
 - Rappahannock Area
 - Region 10
 - Virginia Beach

Jail Diversion Funding Allocation Process

- Considered three major goals in allocating funds for crisis intervention training and jail diversion programs:
 - Reaching out to a broad array of criminal justice/mental health stakeholders
 - Creating a foundation for success
 - Identifying, supporting, and expanding upon excellence in initiatives already underway

Jail Diversion Funding Allocation Process

- 80 percent of the funds (\$2.16M) will be allocated based on:
 - Initial analysis of existing communities, programs, and practices already providing CJ/MH services
 - ID and review initiatives by CSB service area using 10 key threshold factors
 - Invite top tier to submit proposals using a structured application process that includes specific deliverables and outcomes
 - Fund best 6–10 programs

Jail Diversion Funding Allocation Process

- 20 percent of the available funds allocated to support broad based initiatives that will benefit all stakeholders:
 - Support Commonwealth Consortium goals
 - Provide Cross Systems Mapping
 - Develop comprehensive evaluation and data collection process
 - Expand opportunities for cross program development and information exchange