BHC Behavioral Health Commission

Workplan

2026

Commonwealth of Virginia

Behavioral Health Commission

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Purpose

The Commission is established in the legislative branch of state government for the purpose of studying and making recommendations for the improvement of behavioral health services and the behavioral health service system in the Commonwealth to encourage the adoption of policies to increase the quality and availability of and ensure access to the full continuum of high-quality, effective, and efficient behavioral health services for all persons in the Commonwealth. In carrying out its purpose, the Commission shall provide ongoing oversight of behavioral health services and the behavioral health service system in the Commonwealth, including monitoring and evaluation of established programs, services, and delivery and payment structures and implementation of new services and initiatives in the Commonwealth and development of recommendations for improving such programs, services, structures, and implementation.

2026 BHC Workplan

The Behavioral Health Commission (BHC) uses a structured yet flexible process to plan staff work each year. This process takes into consideration the size and experience level of current staff; the complexity of the work being proposed; the amount of time available to complete the work; the degree of flexibility afforded by the entity proposing the work; the time sensitivity of the work; and the type of research needed. The BHC's workplan also places higher priority on those initiatives that are expected to help the Commission progress most significantly toward its goals while also playing the roles it has adopted in its strategic framework.

The 2026 workplan presented in this document was approved by the Commission during its December 2, 2025, meeting. Because no new work was directed to the BHC during the 2026 legislative session, the workplan presented in December is now considered final.

Summary of work undertaken by the Commission in 2026

Studies and other work can be referred to the Behavioral Health Commission in several ways, but they must be approved by the full Commission before they are assigned to staff. The Commission can direct staff to work on initiatives that support the goals set forth in its strategic framework. The BHC can also receive work from joint resolutions or legislation passed by the General Assembly, language in the Appropriation Act, letters from Committee chairs, requests from BHC members, and staff recommendations.

The initiatives included in the 2026 workplan are organized into four categories that correspond to the roles that the BHC adopted in its strategic framework: (1) tracking new initiatives; (2) monitoring program implementation and performance; (3) conducting research; (4) building and maintaining knowledge; and (5) facilitating legislative and budget action. The table on the following page summarizes the work that will be undertaken in each category in 2026.

Description of initiatives to be completed in 2026

Each item on the annual workplan is assigned to a BHC staff member, who is responsible for developing a research plan laying out how the work will be conducted and completed by its due date. Research plans are reviewed by the Executive Director, who provides continuous guidance, feedback, and quality control throughout the course of each assignment to ensure that final products are objective, substantiated, comprehensive, and on point.

2026 BHC workplan initiatives	Time required	Expected completion	Source
Tracking current efforts			
Improvements in the behavioral health system	L/M	Ongoing	BHC directed
Monitoring program implementation and performance			
1. Project BRAVO / Behavioral Health Redesign	M	Fall 2026	BHC directed
2. Discharge Assistance Program (DAP)	M	Winter 2026	BHC directed
Conducting research			
1. **Behavioral health services in Virginia jails** Identify behavioral health services and needs in Virginia jails, determine how consistent jail practices are with proposed minimum standards, and identify opportunities to improve access to treatment for jail inmates with SMI and SUD.	H	Fall 2026	BHC directed
2. **Availability and effectiveness of substance use supports and services (SUSS) in Virginia schools** Identify the types of SUSS offered in each division, the extent to which they are accessible by the student population, and options to better meet student needs.	H	Fall 2026	BHC directed
3. **Efficiency of the competency restoration process** Provide options and recommendations for improving the effectiveness and efficiency of the competency restoration process.	H	2027	BHC directed
4. **Utilization of Mandatory Outpatient Treatment (MOT)/ Assisted Outpatient Treatment (AOT)** Determine if higher MOT utilization or AOT could help serve more individuals in less-restrictive environments and reduce TDO admissions, thereby alleviating the state's bed crisis.	H	2027	BHC directed
Building and maintaining knowledge			
1. BHC meetings at service locations	M	Summer 2026	BHC directed
2. Participation in workgroups related to competency restoration and involuntary medications in jails	M	Summer 2026	Stakeholders
Facilitating legislative and budget actions			
BHC legislative agenda	H	Winter 2026	BHC directed

The studies and activities in the 2026 workplan are summarized below. Legislation and other source documents associated with studies and monitoring efforts are included in the appendix.

Tracking current efforts

Source: BHC directed
Staff lead: Nathalie Molliet-Ribet
Scheduled completion: ongoing

Tracking new and planned initiatives and analyzing their scope and content can provide valuable insight into their interactions and potential impacts on the behavioral health system. This understanding will enable the Commission to identify proposals that warrant legislative support and areas that require further study and investigation.

Monitoring program implementation and performance

Source: BHC directed
Staff lead: Abigail Cornwell
Scheduled completion: 2026

Monitoring the implementation and performance of mature initiatives that have received state funding can help identify implementation challenges and design flaws, drive accountability, and ensure that expected results are met. By conducting ongoing monitoring of key programs and initiatives, the BHC can help provide the resources needed to help address implementation challenges and determine when state funding should no longer be invested. The following programs have been identified as top priorities for monitoring during 2026:

- **Project BRAVO/Behavioral Health Redesign.** Project BRAVO aims to integrate evidence-based behavioral health services into Virginia's Medicaid program. In FY25, more than $421M was spent on Project BRAVO services. If effective, the implementation of Project BRAVO could improve access to a broader continuum of services, reduce emergency department visits, and provide alternatives to inpatient psychiatric hospitalization. BHC staff will assess how the availability, utilization, and outcomes of Project BRAVO services have changed since the initiative began. The future direction of Virginia's Behavioral Health Redesign initiative, which is the next phase of Project BRAVO, will also be examined. The cost of services that will be redesigned in this next phase amounted to more than $355M in FY25.
- **Discharge assistance planning (DAP)**. DAP provides support for individuals in state hospitals who are clinically ready for discharge but who face barriers to community placement. The General Assembly appropriated $35.5 million in general funds for the program for FY25. An effective DAP program can help reduce extraordinary barriers to discharge, promote recovery in the least restrictive

settings, and improve the availability of inpatient psychiatric beds. BHC staff will assess how DAP is being implemented across the state and evaluate its effectiveness in increasing discharge rates and improving long-term outcomes for individuals receiving these services.

Conducting research

The following studies were approved by the Commission for completion in 2026 and 2027.

Behavioral health services in Virginia jails

Source: BHC directed
Staff lead: Claire Mairead
Scheduled completion: October 2026

The rate of mental illness in jails has increased by over 50 percent in the last decade—from 14.0% of inmates in 2014 to 21.1% in 2024. Many jails lack adequate resources or capacity to provide appropriate behavioral health treatment, which can destabilize the jail environment, create safety concerns, and lead to increased use of jail temporary detention orders (TDOs) and competency restoration services. In an attempt to establish a floor for the availability and quality of behavioral health services in Virginia jails, the 2019 General Assembly directed the Board of Local and Regional Jails to establish standards for behavioral health services in local correctional facilities and to develop procedures for enforcing them. The Board convened a workgroup, which proposed 15 minimum standards for behavioral health in jails. Although the Board voted unanimously to adopt 14 of the 15 recommended standards in 2020, revised standards have not been submitted for the regulatory process.

BHC staff will conduct an environmental scan of behavioral health services, treatment, and practices in Virginia jails; determine to what extent those are consistent with the minimum standards adopted by the Board in 2020; examine barriers to meeting the proposed minimum standards; and provide options and recommendations for achieving minimum standards of behavioral health treatment in jails.

Availability & effectiveness of substance use services and supports (SUSS) in Virginia public schools

Source: BHC directed
Staff lead: John Barfield
Scheduled completion: November 2026

Virginia's state and administrative codes require public schools to offer drug and substance-related education, as well as health education that includes instruction on mental health and the connection between mental health and substance use disorders (SUDs). Local school divisions retain significant authority over how to fulfill these

requirements, which services to offer, and whether to develop their own programs. Because of the flexibility enjoyed by localities in Virginia, divisions are not required to report on their SUD offerings to the state and there is little information available centrally about the types of SUSS offered in each division and the extent to which they are accessible to the student population. It is also unknown whether school divisions have collected data on the efficacy of their programs, and to what extent they are evidence-based or follow the principles of effective SUSS programs.

BHC staff will identify the types of SUSS used in Virginia's public schools; assess the availability of SUSS and estimate to what extent they meet the needs of students; determine the barriers preventing divisions from fully addressing those needs; and develop recommendations for addressing such barriers.

Efficiency of the competency restoration process

Source: BHC directed
Staff lead: Claire Mairead
Scheduled completion: 2027

Individuals who are found incompetent to stand trial and ordered to be restored to competency typically receive restoration services in a state psychiatric hospital, even though statute gives preference to outpatient restoration. Competency restoration cases have been a primary driver of the growing forensic population in state hospitals over the last decade. Because forensic patients can only be admitted to state hospitals, the increase in this population has crowded out patients under a civil commitment order and contributed to wait lists for admission to state facilities. About 30 percent of restoration cases involve patients charged strictly with misdemeanor offenses, which has brought into question whether the extensive resources used to restore them to competency in state facilities are disproportionate for low-level charges. Other states have adopted various strategies to reduce the impact of competency restoration cases on their state facilities, including limiting the duration of competency restoration and not pursuing restoration for certain nonviolent offenses.

BHC staff will review utilization of inpatient and outpatient competency restoration services, analyze the impact of current restoration court orders and treatment settings on the state behavioral health system, and identify other states' approaches to judicial discretion and automatic dismissal for certain charges, as well as initiatives used to reduce re-admissions when appropriate. Using the results of these analyses, staff will provide options and recommendations for maximizing efficiency in cases involving an incompetent defendant.

Utilization and effectiveness of MOT/AOT

Source: BHC directed
Staff lead: John Barfield
Scheduled completion: 2027

Mandatory outpatient treatment (MOT) is a court-supervised program used as a less-restrictive alternative to involuntary commitment for individuals who meet the standard for involuntary admission to a state facility, or as a step-down service following an inpatient stay. Relatively few individuals appear to receive MOT in Virginia: in FY19, less than 1 percent of commitment hearings resulted in MOT, while the rest resulted in involuntarily commitment, voluntary hospitalization, or dismissal. Stakeholders have indicated that MOT is seldom used due to a lack of effective enforcement mechanisms, and the perception that some CSBs do not provide the level or quality of services available at state facilities. Increasing MOT utilization in Virginia could result in more people being placed in a less-restrictive environment and could also help alleviate the state's bed crisis by reducing the number of people under a civil commitment order who are served in an inpatient setting. Effective MOT services could also reduce the occurrence of re-commitment and re-hospitalization for individuals who have a history of repeatedly cycling through the civil commitment process. Other states have implemented various forms of MOT, sometimes called "assisted outpatient treatment" (AOT). Many states with AOT have adopted "substantial deterioration" standards, which are much broader than civil commitment criteria and allow AOT to be used in more situations.

BHC staff will examine MOT utilization in Virginia and identify the factors that limit its use, explore MOT / AOT models and accountability mechanisms in other states, and compare their benefits and challenges with Virginia's current model. The study will also identify strategies to maximize the utilization and effectiveness of mandatory outpatient treatment.

Facilitating legislative and budget actions

To facilitate action on Commission priorities, staff work with BHC members to develop a legislative and budget proposal that acts upon a range of options and recommendations that originate from BHC staff research or from research conducted by other legislative study commissions (e.g., JLARC). A policy option or recommendation cannot be adopted and included in the proposal if a majority of the Senate members or a majority of the House members appointed to the Commission (i) vote against the recommendation and (ii) vote for the recommendation to fail notwithstanding the majority vote of the Commission.

Once a list of recommendations has been finalized in November, BHC staff request bills to be prefiled and work with staff from the Division of Legislative Services, Senate Finance and Appropriations Committee, and House Appropriations Committee to draft language that operationalizes Commission recommendations. Each recommendation is introduced by a BHC member as a bill or budget amendment, as appropriate. The outcome of each bill and budget amendment is tracked and reported by staff on the BHC website.

2026 Commission meeting schedule

Meetings of the Behavioral Health Commission will take place on the following dates in 2026. The schedule of staff presentations is subject to change.

Date	Planned staff presentations
June	– Impact of BHC recommendations – Overview of key budget and legislative actions impacting the behavioral health system and services – Site visit
July	– Site visit
August	*No meeting*
September	– Staff report on monitoring Project BRAVO/ Behavioral Health Redesign
October	– Staff presentation on behavioral health services in Virginia jails
November	– Staff presentation on substance use supports and services in Virginia public schools – Discussion and vote on 2026 options and recommendations
December	– Review of 2027 legislative packet – Discussion of 2027 workplan priorities

Other organizational products

Executive summary

Every year, the Chair of the Behavioral Health Commission is required to submit to the General Assembly and to the Governor an executive summary of the work completed by the Commission during the calendar year. The executive summary is prepared by staff, using materials presented to BHC members during the course of the year. The document also conveys the recommendations adopted by the Commission. Once approved by the Chair of the Commission, the summary is submitted no later than the first day of the next regular session of the General Assembly.

Presentations to other entities

BHC staff are invited by other legislative bodies and outside organizations to present on study findings or about the BHC every year. A list of presentations made each year is available in that year's Executive Summary report.

Appendix

Monitoring cycle for program implementation and performance

As of December 2025 Program / initiative	Budget FY23-24 ($M)	 FY25-26 ($M)	 Change (%)	Review cycle Frequency	 First time	 Most recent
1. STEP-VA Funds CSBs to provide the same core offering of nine services to enhance access and consistency, and promotes quality through metrics and oversight.	237.9	266.2	12%	Biennial	2023	2025
2. Project BRAVO / Behavioral Health Redesign* Expands array of behavioral health services available to Medicaid members and improves quality and cost effectiveness through enhanced service design.	538.4	n/a	n/a	Biennial	2023	2026
3. Permanent Supportive Housing (PSH) Provides housing with tenancy and other supportive services needed to help individuals with a serious mental illness remain stably housed independently.	113.4	175	54%	Periodic	2024	2024
4. Crisis system build out Continues implementation of Crisis Now model in Virginia.	98.0	148.6	52%	Periodic	2024	2025
5. Dropoff centers / CITACs Provides an alternative location for law enforcement officers (LEOs) to take individuals who need behavioral health assessment and care. LEOs can transfer custody to other officers assigned to CITACs and return to patrol quickly.	24.6	24.6	0%	Periodic	2025	2025
6. Marcus Alert Coordinates 911 and 988 call centers and establishes specialized law enforcement response when responding to a behavioral health crisis.	13.5	29.0	115%	Periodic	2025	2025

As of December 2025 Program / initiative	Budget FY23-24 ($M)	 FY25-26 ($M)	 Change (%)	Review cycle Frequency	 First time	 Most recent
7. Discharge Assistance Planning (DAP) Assists individuals who face barriers to. discharge from state hospitals with transitioning to community.	71.0	71.0	0%	Periodic	2026	2026
8. Census reduction pilot projects Funding to provide community-based services to individuals clinically ready for discharge and to purchase acute impatient or community-based services as an alternative to state hospital admissions.	55.4	27.0	-51%	Periodic	--	
9. Housing for the seriously mentally ill Funds supervised residential care, with priority for individuals on state hospitals' EBL.	4.0	16.0	300%	Periodic	--	
10. Alternative transportation and custody (incl. SCOPS) Funds alternatives to law enforcement transportation and custody of individuals under a TDO awaiting a hospital bed.	18.2	33.1	82%	As needed	--	
11. Virginia Mental Health Access Program (VMAP) Trains primary care providers to screen for, manage, and treat pediatric mental health conditions.	17.7	29.6	67%	As needed	--	
12. Discharge transportation program Provides transportation to individuals from state psychiatric facilities to their homes upon discharge when admissions resulted from a TDO.	2.3	2.3	0%	As needed	--	

* Project BRAVO actual expenditures are presented in lieu of a budget because there is no line-item budget exists for specific Medicaid services

Summaries of proposed studies

Behavioral health services in Virginia jails

Strategic goals addressed: Complete continuum of care, effective and efficient services

Estimated workload: High

Background: The rate of mental illness in jails has increased by over 50 percent in the last decade—from 14.0% of inmates in 2014 to 21.1% in 2024, according to data from the State Compensation Board. This presents new challenges for jails, which may lack the resources or capacity to provide adequate levels of treatment for inmates, some of whom are in acute crisis. Untreated mental illness can destabilize the jail environment and create safety concerns for jail personnel and inmates alike. Mentally ill inmates who do not receive treatment may ultimately be placed under a jail TDO and hospitalized in a state facility, and they may need competency restoration services if they decompensate to a point where they are incompetent to stand trial. The rising forensic population in state hospitals has contributed to the bed crisis in state facilities, and a waitlist now exists for forensic patients in need of acute mental health treatment even though their admission is prioritized under state law. The prioritization of forensic patients under a jail TDO has also increased wait times for civil patients seeking a bed.

Proposed scope

- Conduct environmental scan of behavioral health services, treatment, and practices that are available, versus those needed, in Virginia jails
- Determine the extent to which the services, policies, and practices in Virginia jails are consistent with the proposed minimum standards
- Examine barriers to (i) providing appropriate services and treatment to inmates with serious mental illness/substance use disorders (SUDs)and (ii) meeting minimum standards of care
- Provide options and recommendations for addressing barriers to the treatment of all inmates with serious mental illness and SUDs, including funding necessary to achieve baseline standards of behavioral health treatment in jails

Recent work / work in progress

- HB 1942 (Bell) was passed during the 2019 General Assembly session, requiring the Board of Local and Regional Jails to establish minimum standards for behavioral health services in local correctional facilities and procedures for enforcing such minimum standards, with the advice of and guidance from DBHDS and the State Inspector General. HB 1942 also required the Chairman of the Board of Corrections to convene a work group to determine the cost of implementing the minimum standards. The work group produced a report in 2019 that laid out 15 recommended minimum standards for behavioral health in jails and estimated a fiscal impact. Although the Board voted unanimously to adopt 14 of the 15 recommended standards in 2020, revised standards have not been submitted for the regulatory process.
- The State Compensation Board publishes an annual report that includes data on mental illness among inmates and mental health treatment, using self-reports by the jails.

Availability and effectiveness of programs for substance use disorders (SUDs) in Virginia schools

Strategic goals addressed: Complete continuum of care

Estimated workload: Medium/High

Background: Virginia's state and administrative codes require public schools to offer drug and substance-related education, as well as physical and health education that includes instruction on mental health and the connection between mental health and substance use disorders (SUDs). However, local school divisions retain significant authority over how to fulfill these requirements, which services to offer, and whether to develop their own programs. Because of the flexibility enjoyed by localities in Virginia, divisions are not required to report about their SUD offerings to the state, such that little is known about the types of SUD programs and services offered in each division and the extent to which they are accessible by the student population. It is also unknown whether school districts have collected data on the efficacy of their programs, and to what extent they are evidence based or follow the principles of effective SUD programs.

Proposed scope

- Assess the availability of SUSS and measure to what extent they meet the needs of students
- Identify what strategies divisions and schools have used to better meet the needs of students
- Identify the barriers divisions and schools face to more fully meeting students' needs, and how they could be addressed
- Examine partnerships between schools and community providers and referral processes for connecting students to treatment
- Evaluate the risks and negative student outcomes associated with ineffective referral systems or failed community treatment linkages

Recent work / work in progress

- The Virginia Department of Education conducted a survey in 2025 that details the availability of school-based mental health and substance use services across the Commonwealth. The report includes data that can help evaluate the availability of school-based services and better understand how school facilitate access to community providers. Although the report provides insights into some aspects of substance use services and supports (SUSS), the report lacks specificity on the availability of specific types of services and supports and on the types of community partnerships or referral mechanism for SUSS.
- The Virginia Department of Criminal Justice Services conducted an evaluation of the effectiveness of the Drug Abuse Resistance Education (D.A.R.E.) program in 2017. The report found that the evidence for the effectiveness of the program was mixed at best, and included a review of other programs that have been found to be effective in reducing substance abuse based on scientific, evidence-based studies.

Efficiency of the competency restoration process

Strategic goals addressed: Lower criminal justice involvement

Estimated workload: High

Background: When an individual is found incompetent to stand trial and is ordered to be restored to competency, restoration usually happens in a state psychiatric hospital. Although statute directs the court to consider outpatient services first, 75 percent of individuals received competency restoration services in an inpatient setting in FY22, based on a 2022 BHC study. At that time, inpatient restoration took 14 weeks and cost nearly $110,000 per patient, on average. Competency restoration cases have been a primary driver of the growing forensic population in state hospitals over the last decade. Because forensic patients can only be admitted to state hospitals, the increase in this population has crowded out patients under a civil commitment order and contributed to wait lists for admission in state facilities.

Competency restoration services are intended to enable individuals to participate in their trial, not to treat the underlying behavioral health conditions that may have prompted their incompetence, and readmissions are common. About 30 percent of these cases involve patients charged with misdemeanor-only offenses, which has brought into question whether the extensive resources used to restore them to competency in state facilities are disproportionate for low-level charges. Other states have adopted various strategies to reduce the impact of competency restoration cases on their state facilities, including limiting the duration of competency restoration and not pursuing restoration for certain offenses.

Proposed scope

- Review utilization of inpatient and outpatient competency restoration services, and the factors associated with referrals to each setting
- Analyze impact of current restoration court orders and treatment settings on the state behavioral health system, including the capacity of state hospitals, access to services for other patients, and cost efficiency
- Identify other states' approaches to judicial discretion and automatic dismissal for certain charges, as well as initiatives used to reduce re-admissions when appropriate
- Provide options and recommendations for improving the effectiveness and efficiency of the competency restoration process

Recent work / work in progress

- The BHC studied the impact of SB 198 (2022) and competency restoration for defendants charged with misdemeanors.
- In 2020, Daniel Murrie (ILPPP), Brett Gardner (ILPPP), and Angela Torres (DBHDS) published “The Impact of Misdemeanor Arrests on Forensic Mental Health Services: A State-Wide Review of Virginia Competence to Stand Trial Evaluations” in Psychology, Public Policy, and Law. Their analysis focused on the prevalence of misdemeanor competency restorations and their fiscal impact on the state.

Utilization and effectiveness of MOT/AOT

Strategic goals addressed: Complete continuum of care; effective and efficient services

Estimated workload: High

Background: Mandatory outpatient treatment (MOT) is a court-supervised program used as a less-restrictive alternative to involuntary commitment, or as a step-down service following inpatient treatment. Individuals ordered to MOT must meet the standard for involuntary admission—that by clear and convincing evidence, they have a mental illness, and that as a result of this illness there is a substantial likelihood that they will in the near future cause serious physical harm to themselves or others, or suffer serious harm due to their inability to care for themselves. MOT can be ordered by a judge or special justice when CSB outpatient services are deemed appropriate, and the individual can adhere to the mandatory treatment plan. Relatively few individuals appear to receive MOT in Virginia: in FY19, less than 1 percent of commitment hearings resulted in MOT, with the rest involuntarily committed, voluntarily hospitalized, or dismissed. Stakeholders have indicated that MOT is seldom used due to a lack of effective enforcement mechanisms, and the perception that some CSBs do not provide the level and quality of services available at state facilities.

Other states have implemented various forms of MOT, sometimes called "assisted outpatient treatment" (AOT). Many have adopted broader "substantial deterioration" standards that allow AOT to be used in more situations. Under this standard, individuals with a mental illness may be ordered to treatment if they do not meet civil commitment standards, but their condition is likely to deteriorate and result in serious harm in the absence of services. Increasing MOT utilization in Virginia could put more people in a less-restrictive environment and could also help alleviate the state's bed crisis by reducing the number of people under a civil commitment order who are served in an inpatient setting. Effective MOT services could also reduce the occurrence of re-commitment and re-hospitalization for individuals who have a history of repeatedly cycling through the civil commitment process.

Proposed scope

- Examine MOT utilization in Virginia and identify the factors that limit its use
- Explore MOT / AOT models and accountability mechanisms in other states, and compare their benefits and challenges with Virginia's current model
- Identify the steps needed to implement alternative models that would be viable in Virginia
- Identify strategies to maximize utilization and effectiveness

Recent work / work in progress:

- The Institute for Law, Psychiatry, and Public Policy (ILPPP) conducted an exploratory study of MOT orders in Virginia from 2012-2018 and found that MOT was appropriately used for individuals at highest risk of repeated hospitalizations. However, there were significant data limitations due to lack of access to private hospital records, which account for most psychiatric admissions in Virginia.


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