BHC Behavioral Health Commission

Summary of proposed study

Utilization and effectiveness of MOT/AOT

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

Source of study request: BHC Executive Committee request and staff recommendation

Estimated workload: High

Background: Mandatory outpatient treatment (MOT) is a court-supervised program used as a less-restrictive alternative to involuntary admission to a psychiatric facility or as a step-down service following inpatient treatment. Individuals who can be ordered to MOT must meet the same standard as they would 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 has the ability to adhere to the mandatory treatment plan. A relatively low number of individuals appear to receive MOT in Virginia: in FY19, less than 1 percent of commitment hearings resulted in MOT, while nearly 60% were involuntarily committed, 20% were voluntarily hospitalized, and the remainder of cases (19%) were dismissed. In FY23, 235 people received CSB services through MOT orders. 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 that is closer to home, 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. The study 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.

BHC Behavioral Health Commission

Summary of proposed study

Efficiency of the competency restoration process

Strategic goals addressed: Lower criminal justice involvement

Source of study request: BHC Executive Committee request and staff recommendation

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. A quarter of patients who received inpatient competency restoration services in FY19 were readmitted within three years of discharge. 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.

BHC Behavioral Health Commission

Program monitoring schedule

As of October 2026

Program / initiative	Budget			Review cycle		
	FY23-24 ($M)	FY25-26 ($M)	Change (%)	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	552.1	865.9	57%	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	175.0	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

Program / initiative	Budget			Review cycle		
	FY23-24 ($M)	FY25-26 ($M)	Change (%)	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	2027	**2027**
8. Census reduction pilot projects Funding to provide community-based services to individuals clinically ready for discharge and to purchase acute inpatient or community-based services as an alternative to state hospital admissions	55.4	27.0	-51%	Periodic	2027	**2027**
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; includes only Project BRAVO services, does not include new or legacy Behavioral Health Redesign services