BHC Behavioral Health Commission

Executive Summary

2025

Report Document #108

Commonwealth of Virginia
2026

Behavioral Health Commission

Membership
Senator R. Creigh Deeds, Chair
Delegate Patrick A. Hope, Vice Chair

Senator Lashrecse D. Aird
Delegate Ellen H. Campbell
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Senator Tara A. Durant
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Senator Russet W. Perry
Delegate Vivian E. Watts
Delegate Rodney T. Willett

Staff
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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.

The Honorable Glenn Younkin
Governor of Virginia
Patrick Henry Building, 3rd Floor
1111 East Broad Street
Richmond, Virginia 23219

Members of the Virginia General Assembly
Virginia General Assembly Building
201 N 9th St
Richmond, Virginia 23219

Dear Governor Younkin and Members of the General Assembly:

Please find enclosed the executive summary of the activities conducted by the Behavioral Health Commission in 2025. This report fulfills the requirements of § 30-407 of the Code of Virginia.

Respectfully submitted,

R. Creigh Deeds, Chair

2025 BHC Executive Summary

The General Assembly established the Behavioral Health Commission (BHC) in 2021 through the Code of Virginia, Title 30, Chapter 63. The BHC is charged with encouraging the adoption of policies and making recommendations that provide Virginians with enhanced access to a full continuum of high-quality and efficient behavioral health services. The Commission also provides ongoing oversight of behavioral health services and the behavioral health service system by monitoring and evaluating established programs, services, delivery and payment structures, and the implementation of new services and initiatives in the state.

The BHC conducted the following activities in 2025 to accomplish its mission.

Annual workplan

The BHC adopts an annual workplan that lays out the work that will be undertaken by staff and identifies how that work relates to the strategic goals identified by the Commission. The annual workplan is the mechanism used to operationalize the Commission's multi-year strategic framework (discussed further on p. 8). A summary of the work directed to BHC staff in 2025 is shown below, and a full copy of the workplan is available here. The activities conducted and reports published to address the 2025 workplan items are summarized in subsequent sections of this document.

Initiatives	Complexity	Completion	Source
Tracking current efforts			
▪ Crisis services implementation	H	October	Budget, SB 574
▪ Marcus Alert System implementation	H	September	BHC directed
Monitoring program implementation and performance			
▪ STEP-VA	M	October	BHC directed
Conducting research			
▪ Crisis services & civil commitment	H	October	Budget, SB 574
▪ Marcus Alert System effectiveness	H	September	BHC directed
▪ Local match of state CSB funding	L	November	BHC directed
Building and maintaining knowledge			
▪ BHC meetings at service locations	M	2025	BHC directed
▪ Behavioral health/criminal justice coalition	L	2025	Stakeholders
▪ State Child Fatality Review Team	L	2025	Stakeholders
Facilitating legislative and budget actions			
▪ BHC legislative agenda	H	December	BHC directed

Staff reports

During 2025, the BHC staff completed and briefed two studies, one monitoring report, and one targeted study that included several policy options and recommendations. BHC members voted during the November meeting on the options and recommendations they wish to support as a Commission during the 2026 legislative session.

Implementation and effectiveness of the Marcus Alert System

The Marcus-David Peters Act was passed during the 2020 Special Session with the goals of improving responses to behavioral health crises and diverting individuals in crisis from law enforcement when possible. The legislation created two new systems and their requirements: (1) the Marcus Alert system, and (2) a comprehensive crisis system. The two systems were intended to work in tandem to serve individuals experiencing a behavioral health crisis. While the state's comprehensive crisis system would provide access to behavioral health services for individuals calling 988 (the state's mental health crisis line), the Marcus Alert system would address primarily how to respond to behavioral health calls placed to 911 and how to transfer calls between 988 and 911. State agencies and stakeholders stated that "ultimately, the goal is a system where a call to 988, 911, or other crisis lines all connect the individual or family in crisis to an all-payer crisis services continuum in which the response does not differ based on the access point used (i.e., 'no wrong number')."

The study found that:

- One-third of Virginia localities have implemented Marcus Alert, and the rest can likely implement by the statutory deadline of July 1, 2028 with support from the legislature and state agencies.
- Each Community Service Board (CSB) receives the same funding amount to implement Marcus Alert, whereas the distribution of funds should reflect the varied needs of CSBs and local agencies.
- The majority of behavioral health calls to 911 still receive a law enforcement response, but the rate of behavioral health responses is increasing. Higher urgency calls, in particular, often do not receive a behavioral health response.
- The response capacity of community care teams available to dispatch by 911 is insufficient.
- A better process is needed for ongoing evaluation of Marcus Alert's effectiveness.

The following policy options and recommendations were identified to address key issues:

- Option 1 - The General Assembly may wish to consider amending the budget language related to Marcus Alert implementation to:
    - remove the fixed $600,000 allocation per CSB;
    - grant the Department of Behavioral Health and Developmental Services (DBHDS) discretion to distribute available Marcus Alert funds based on the needs of each community; and

  - stipulate that funding must be provided to public safety answering points (PSAPs) for necessary system updates, training, and related expenses.

- Option 2 - The General Assembly may wish to consider amending § 15.2-1726 to include co-response teams with jurisdiction in multiple localities as an acceptable reciprocal agreement between law enforcement agencies.
- Option 3 - The General Assembly may wish to consider funding and directing DBHDS to establish a pilot program available to localities that have implemented Marcus Alert. These pilots would expand the availability of behavioral health-only teams that can be dispatched from 911 call centers.
- Option 4 – The General Assembly may wish to consider funding one additional FTE for a Co-response Coordinator at the Department of Criminal Justice Services (DCJS).
- Option 5 - The General Assembly may wish to consider amending § 9.1-193 to transfer responsibility for initiating profile deletion within the database from PSAPs to individuals when individuals use a third-party platform not accessible to the PSAP.
- Option 6 - The General Assembly may wish to consider amending §37.2-311.1 to specify that DBHDS and DCJS have authority to update the "written plan for the development of a Marcus Alert system," provided that stakeholders are afforded an opportunity to provide input before updates are finalized.
- Recommendation 1 - DBHDS should amend the Marcus Alert Local Plan Guide to strongly encourage CSBs to hire a local Marcus Alert coordinator with implementation funds if they do not already employ staff in this role.
- Recommendation 2 – The General Assembly may wish to consider amending § 9.1-193 (H) to change the Code reference from "clause (iv) of subdivision B 2 of § 37.2-311.1", to "clause (vi) of subdivision B 2 of § 37.2-311.1".
- Recommendation 3 –DBHDS and DCJS should complete "train the trainer" sessions for the Advanced Marcus Alert training no later than December 31, 2025. DBHDS and DCJS should ensure that Advanced Marcus Alert training is made available to staff at CSBs, PSAPs, and law enforcement agencies no later than April 1, 2026.
- Recommendation 4 – The General Assembly may wish to consider including funding in the 2026 Appropriation Act for the remaining thirteen CSBs that have not yet begun their Marcus Alert planning process.
- Recommendation 5 – DBHDS should update the Marcus Alert Local Plan Guide to include a section on plans for the database and for advertising it in the community.
- Recommendation 6 – The General Assembly may wish to amend §37.2-311.1 to specify that DBHDS is the agency responsible for convening the Marcus Alert Evaluation Task Force and require that the Task Force be convened at least quarterly to design and implement an evaluation process as described in the state plan for Marcus Alert. To provide adequate staffing for this project, the General Assembly may wish to consider including in the Appropriation Act funding and one position for a Marcus Alert Evaluation Analyst at DBHDS.

- Recommendation 7 – DBHDS should revise data collection procedures to allow PSAPs to submit Marcus Alert data through computer-aided dispatch (CAD) system reports, and to minimize the administrative burden on PSAP staff.

Aligning crisis services

In recent years Virginia has invested heavily in adopting and building out the three essential components of the Crisis Now model, which includes 988 and the regional crisis call centers; regional mobile crisis response; and crisis facilities, including Crisis Receiving Centers and Crisis Stabilization Units. Despite large investments in these components, Virginia continues to rely heavily on emergency departments and psychiatric facilities, which are outside of the crisis system, for individuals who are involved in the civil commitment process. Pursuant to SB 574 (2024), BHC staff identified barriers to maximizing access to crisis services for individuals who are involved in, or at imminent risk of becoming involved in, the civil commitment process.

The study found that:

- Virginia's current crisis system is not designed to serve (1) most high-acuity crises that could result in an Emergency Custody Order (ECO), and (2) involuntary patients. The state will not realize the full potential of a crisis system until these populations receive appropriate crisis services.
- Most involuntary patients are generally unable to benefit from crisis services because of barriers in the state's current crisis system, not in the civil commitment process;
- Regional mobile crisis teams cannot be dispatched from 911 call centers, but doing so for higher-acuity crises could help divert individuals from the civil commitment process;
- Only one crisis facility in Virginia can be considered to follow the "no-barrier" approach, but this model could help avoid or shorten civil commitment, offer an alternative to psychiatric hospitalization, and reduce the burden of civil commitment on law enforcement.

The following policy options and recommendations were identified to address key issues:

- Option 1 – The General Assembly may wish to fund a pilot program that would enable regional mobile crisis teams to be dispatched to Level 3 calls from 911 call centers. The pilot should define public safety risks and dispatch protocols. Results of the pilot program could be used to refine Marcus Alert triage protocols statewide.
- Option 2 – The General Assembly may wish to direct the Secretary of Health and Human Resources to investigate what regulatory, billing, or training changes would be required to enable regional mobile crisis dispatch based on third-party referrals and provide a report of its findings and recommendations to the BHC by December 1, 2026.
- Option 3 – The General Assembly may wish to direct DBHDS to identify strategies to incentivize crisis facilities in Virginia to adopt a "no-barrier" approach for individuals under an ECO or Temporary Detention Order (TDO). DBHDS should also assess the

changes and resources that would be needed to implement this model. Findings and recommendations should be reported to the BHC by December 1, 2026.

- Recommendation 1 – DBHDS should modify its training for CSB preadmission screening clinicians to include a module developed with the Office of the Attorney General of Virginia. This module should emphasize true liability exposure and legal guidance and the training should be conducted as soon as practicable after a clinician is hired.
- Recommendation 2 – DBHDS should collaborate with DCJS to identify strategies for law enforcement to better utilize the direct line to regional hubs for dispatching regional mobile crisis teams.
- Recommendation 3 – DBHDS should develop a comprehensive plan for rapid drop-off capabilities at crisis facilities that align with national best practice models. The plan should define the future role of Crisis Intervention Team Assessment Centers (CITACs), determine necessary facility integrations, estimate required funding, and establish a clear timeframe for achieving full statewide implementation of these services.

Monitoring STEP-VA

STEP-VA requires every CSB across Virginia to establish a core set of behavioral health services, ensuring that certain essential services can be accessed statewide regardless of geographic location. STEP-VA was created to address two primary goals: (1) expanding access to behavioral health services across Virginia, and (2) improving the quality of those services.

The following policy options and recommendations were identified to address key issues:

- Option 1 – The General Assembly may wish to consider directing the Secretary of Health and Human Resources to convene a taskforce to develop a proposed strategic vision for STEP-VA that incorporates stakeholder, legislative, and public input.
- Option 2 – The General Assembly may wish to consider amending §37.2-500 of the Code of Virginia to codify the strategic vision of STEP-VA during the 2028 session.
- Option 3 – The General Assembly may wish to consider directing DBHDS, in conjunction with the Department of Medical Assistance Services (DMAS), to assist a representative sample of CSBs with conducting an analysis of their Medicaid revenue and creating action plans to maximize Medicaid billing and revenue.
- Option 4 – The General Assembly may wish to consider directing DMAS to:
    - identify the steps necessary for Virginia to transition to a prospective payment system (PPS) as required to fully adopt the Certified Community Behavioral Health Clinic (CCBHC) model, and
    - estimate any fiscal impact to the state and to CSBs, and
    - report findings to the House Appropriations Committee, the Senate Finance and Appropriations Committee, and the BHC by December 1, 2026.

- Option 5 – The General Assembly may wish to consider including $2 million in the 2024-2026 Appropriation Act to conduct statewide and CSB-level comprehensive needs assessments.
- Recommendation 1 – The General Assembly may wish to consider appropriating STEP-VA funding as one amount rather than setting out appropriations for each STEP, beginning with the 2026-2028 Appropriations Act.
- Recommendation 2 – DBHDS should make necessary changes to the CSB performance contract to eliminate STEP-specific distribution of funds.

Local match for CSB funding

Currently, statute directs the state to contribute no more than 90 percent of the total amount of state and local matching funds received by CSBs—that is, local matching funds must account for at least 10% of total funding. Between 11 and 15 CSBs have fallen short of the 10 percent local match requirement each year since FY22, with shortfalls concentrated in rural and fiscally stressed areas. In FY25, 11 CSBs received less than the required 10 percent local match, reaching a peak of 15 in FY24. These CSBs are predominantly located in rural areas of the state. Fiscal stress and population density are the strongest predictors of local contributions. The current matching requirement does not account for several factors that affect localities' ability to contribute. In particular, the 10 percent match applies uniformly across all localities regardless of variations in fiscal capacity or population density. The current formula also penalizes regional hubs, which must match regional funds that flow into their CSB even though those are designed to support an entire region, and does not account for the fact that localities finalize their budget before knowing how much their CSB will receive from the state. This targeted study did not include staff options or recommendations; however, members recommended one option after hearing the presentation.

- The General Assembly may wish to consider including language in the 2026-2028 Appropriation Act directing DBHDS to examine alternatives to the current 10% local match requirement for CSBs and to report back to the BHC with recommendations by November 1, 2026.

Legislative options and recommendations

BHC members voted to support the recommendations and options listed below and to sponsor corresponding legislation and budget amendments in the 2026 legislative session. All policy options/recommendations listed below can be found in the 2026 BHC legislative packet.

Staff monitoring

STEP-VA

- Recommendation 1 unanimously approved.
- Options 1, 3- 5 were unanimously approved.

Staff studies

Implementation and effectiveness of the Marcus Alert system

- Recommendations 2, 4 and 6 were unanimously approved.
- Options 1- 6 were unanimously approved.

Crisis services and civil commitment

- Options 1 – 3 were unanimously approved.

Local match of CSB funding

- Option 1 (member recommendation) was unanimously approved.

Other

Autism Commission

- Make the Autism Advisory Council a permanent commission and fund Commission staff and operations

Incentives for mental health professionals to participate in Medicaid

- Direct DMAS to examine incentives for behavioral health professionals to increase Medicaid participation and serve more serious mental illness (SMI)

BHC impact as of 2025

The Behavioral Health Commission measures its performance using the proportion of recommendations supported by the Commission that is implemented, subset between the implementation of (1) options and recommendations generated by BHC staff and (2) recommendations provided by other research entities. The following information captures the outcome of BHC recommendations between the 2023 and 2025 legislative sessions. More information can be found on the BHC website.

59%	18	$65M
recommendations implemented via legislative action	bills enacted to improve the behavioral health system	additional funding to support behavioral health services & staff

BHC recommendations implemented	2025	2023-2025 Cumulative
Recommendations adopted by BHC	11	66
Recommendations implemented through BHC action	4	39
% of BHC recommendations implemented	36%	59%
Recommendations implemented through BHC legislation		
# Introduced through legislation	3	23
# Implemented through legislation	2	18
% of legislative recommendations implemented	67%	78%
Implemented through BHC budget amendments		
# Introduced through budget	8	43
# Implemented through budget	2	21
% of budget recommendations implemented	*25%*	*49%*

Commission meetings

The Behavioral Health Commission met six times, and the Executive Committee met once in 2025 on the dates listed below. Two BHC meetings were held in facilities that provide behavioral health services and each included a tour for members and BHC staff. In addition to BHC staff presentations, numerous stakeholders were asked to brief members throughout the year.

All staff and stakeholder presentations, as well as meeting minutes and full videos of the meetings can be found on the BHC website.

- June 3 – St. Joseph's Villa
- July 8 – Western State Hospital
- September 9
- October 7
- November 12
- November 13 (Executive Committee meeting)
- December 2

Strategic framework

In 2023, Commission members adopted a strategic framework to help guide the work of the BHC over the next five years (2027). A complete version of the BHC's strategic framework is available here.

Vision, mission, and purpose

BHC members have formalized the vision, mission, and purpose of the Behavioral Health Commission in accordance with statute.

Vision

Virginia has a full continuum of high-quality, effective, and efficient behavioral health services accessible to all persons in the Commonwealth.

Mission

To improve behavioral health services and the behavioral health system in Virginia by encouraging the adoption of policies that increase and ensure access to a full continuum of high-quality, effective, and efficient behavioral health services for all Virginians, when and where they are needed.

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.

Strategic goals

The BHC identified and prioritized key strategic goals to help realize the Commission's vision and fulfill its mission. These strategic goals are also used to select and prioritize the work undertaken by BHC staff.

Strategic Goal	Description
1. **Complete continuum of care**	Individuals can receive the most appropriate services for their needs because an adequate supply of services is available along the entire continuum of behavioral health care and prevention.
2. **Timely access to services statewide**	Individuals can receive the services they need when and where they need them.
3. **Cost-efficient care for everyone**	Sufficient funding is available for the state and providers to build and operate services and patients can afford the services they need.

4. Effective and efficient services	Behavioral health services are high-quality and effective, and provided efficiently.
5. Lower inappropriate criminal justice involvement	Individuals with behavioral health disorders are not unnecessarily involved in the criminal justice system, and those who are involved with the criminal justice system receive appropriate treatment that also mitigates recidivism.

BHC roles

To realize the Commission's vision and mission, Commission members adopted five specific roles to most effectively contribute toward improving Virginia's behavioral health system.

Role	Description
1. Map current initiatives and track progress	Mapping the scope and content of current efforts to improve the behavioral health system in order to understand the interactions between and potential implications for the behavioral health system to identify proposals that warrant legislative support and areas for further study and investigation.
2. Monitor implementation of funded initiatives	Monitoring implementation and performance of initiatives that have been funded by the General Assembly to identify implementation challenges and unintended consequences and to ensure that funded initiatives yield expected results.
3. Conduct research to improve understanding of the behavioral health system and its components	Conducting research to address issues identified through mapping and monitoring and other issues identified by the Commission and to fill gaps in knowledge and improve understanding of the behavioral health system and its component parts.
4. Build and maintain institutional knowledge	Building and maintaining institutional knowledge through mapping, monitoring, and research, educating new legislators and others regarding the behavioral health system and issues affecting the behavioral health system, and maintaining institutional knowledge about past initiatives and efforts.
5. Facilitate legislative and budgetary action to implement recommendations	Using all information obtained through research and monitoring to develop an impactful, actionable legislative agenda that BHC members sponsor in the General Assembly.


BHC
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