Summary of proposed study

Behavioral health services in Virginia jails

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

Source of study request: Commission request

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
- Review and update proposed baseline standards for behavioral health treatment in jails
- Examine barriers to (i) providing appropriate services and treatment to inmates with serious mental illness and (ii) meeting baseline standards of care
- Provide options and recommendations for addressing barriers to the treatment of all inmates with serious mental illness, 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 Corrections (now 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. It is unclear whether the Board of Corrections has taken any steps to begin the regulatory process to establish the minimum standards.
- 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.

Summary of proposed study

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

Strategic goals addressed: Complete continuum of care

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

Estimated workload: Medium/High

Background: In 2025, Virginia had the 28th highest percentage of youth (ages 12-17) with a SUD (8.7 percent, or 57,000 young Virginians) in the country. Forty-four public schools reported activating their crisis management plan due to a drug overdose in the 2023-2024 school year. Virginia's state and administrative codes[1] 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, 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

- Identify the types and availability of SUD programs in Virginia public schools and determine to what extent existing programs follow best practices
- Compare Virginia's approach to school-based SUD prevention with other states'
- Examine barriers to expanding access to evidence-based SUD prevention programs
- Assess program efficacy based on existing data, if available
- Provide options and recommendations to enhance the availability and effectiveness of school-based SUD programs

Recent work / work in progress

- The Virginia Department of Education published a 2021 report after the legalization of recreational marijuana for adults in Virginia, which included a statewide plan to inform state policy and budgeting and to help school divisions provide education for students to make healthy, informed decisions about cannabis and other drugs.
- 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.

[1] Relevant code sections include §22.1-206 through §22.1-206.02, and §22.1-207; the relevant administrative code section is 8VAC 20-310-10.

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.

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.

Program monitoring schedule

As of December 2025

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	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	175.0	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 Program (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 inpatient 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