University of Virginia
SCHOOL of LAW

State and Local Government Policy Clinic
Andrew Block, Director

MEMORANDUM

To:	**The Behavioral Health Commission**
From:	**Thomas Driscoll, Carson White, and Andy Block**
Re:	**Virginia's Crisis Response System: Current Policy Proposals and Goals and the Potential Role of the Behavioral Health Commission**
Date:	**July 13, 2023**

INTRODUCTION

The Executive Director of the Behavioral Health Commission (BHC) requested the State and Local Government Policy Clinic to research and report back on three questions regarding Virginia's Crisis Response System:[1]

1. What are national best practices when it comes to an effective, statewide, crisis response system, and in particular, what are national best practices when it comes to call centers, mobile crisis teams, and crisis stabilization programs?
2. Where does Virginia stand when compared to national best practices?
3. How close would the budget amendments proposed by the Governor, the House, and the Senate, or the final budget if passed, get Virginia to national standards?

In this report, we set out to answer those questions. We will conclude by offering some suggestions for the unique role that the BHC might play when it comes to crisis response based on the answers to those questions. Our suggestions are made while keeping in mind that under any of the budget scenarios Virginia will still need to do more work in terms of funding, execution, and oversight, both for the structural aspects of crisis response like response teams and crisis receiving centers (CRCs), as well as the operational aspects including staffing and data collection.

We should note at the outset that we recognize that an effective crisis response system also requires full staffing, effective training, and a continuum of front-end services to help people avoid crisis entirely. For purposes of this project, however, we have not examined those topics.

[1] Here, we have confined our analysis of Virginia's crisis response system to the three infrastructural elements for a health system which have been defined by SAMHSA and CrisisNow as essential to creating a continuum of care that follows national best practices: regional call centers, mobile crisis response teams, and crisis stabilization programs along with a brief overview of sustainable funding practices.

RESEARCH METHODS

In preparation for writing this report, we surveyed best practices by reading reports from national entities such as the Substance Abuse and Mental Health Services Administration (SAMHSA) and CrisisNow as well as studying successful policies adopted by certain states including Arizona, Georgia, and Utah. We also analyzed Governor Youngkin's proposed budget and the amendments adopted by the House of Delegates as well as the Senate. Finally, we read relevant materials including the Department of Behavioral Health and Developmental Services (DBHDS)'s North Star Strategic Plan and the Department of Medical Assistance Services (DMAS)'s Project BRAVO (Behavioral Health Reform for Access, Value, and Outcomes).

In addition to this literature review, we met with several experts including staff from the Senate Finance and House Appropriations Committees, Curt Gleeson with DBHDS, and Lisa Jobe-Shields with DMAS. We also spoke with state leaders in Arizona, Georgia, and Utah this past spring to identify common threads across peer states with successful crisis response models.[2]

EXECUTIVE SUMMARY

Over the past decade, Virginia's behavioral health system, like those in many states, has become increasingly strained. Between FY 2012 and FY 2021, there was a 68% increase in state psychiatric hospital admissions, resulting in many facilities operating at or near capacity with waitlists. One of the biggest factors contributing to this trend was an increase in temporary detention orders (TDOs).[3] In 2022, Virginia's system reached a breaking point as staffing levels reached critical levels, prompting state officials to temporarily restrict new admissions at five facilities. This emergency decision, in addition to a series of high-profile incidents including the deaths of Marcus-David Peters in 2018 and Irvo Otieno in 2023, has sparked a heightened level of scrutiny into Virginia's behavioral health system.

On December 14, 2022, Governor Glenn Youngkin unveiled the "Right Help, Right Now" plan aimed at improving the state's existing crisis infrastructure as well as expanding several key services. Since this time, the House of Delegates and Senate have both passed a series of budget amendments modifying, and often expanding upon, the Governor's original proposal.

With these three policy options now on the table, this report aims to: 1): Define national best practices for an effective, statewide crisis response system, 2): Discuss where Virginia currently stands with respect to these standards, and 3): Assess the extent to which these policy options will help Virginia reach these standards. Ultimately, while this report does not recommend one policy option over the rest, it does provide the BHC with three key suggestions: 1): Work with the administration, DBHDS, DMAS, and staff from both Senate and House appropriations committees to establish financial and operational goals for a fully funded and effective crisis response system, 2): Establish financial and operational benchmarks and require DBHDS and DMAS to submit regular performance reports, and 3): Utilize financial and operational goals to inform and guide future funding decisions. These suggestions

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[2] *See* Clare Hachten, Michael Ferguson, and Andy Block, Crisis Response Systems in Arizona, Utah, and Georgia, Appendix 1 at 19.

[3] CSB Behavioral Health Services, Joint Legislative Audit and Review Commission Report 571, iv (Dec. 2022)

underscore the unique and important role the commission will play over the coming years monitoring the expansion and enhancement of Virginia's behavioral health system.

NATIONAL BEST PRACTICES

The two major sources of information on national best practices in crisis care are SAMHSA and CrisisNow. They have both published extensive, publicly available resources as well as models for state leadership and advocates to use in their individual reform efforts. These models are estimates and, because each state has unique pieces of behavioral health infrastructure already in place, the application of these best practices must be tailored to specific states. Many of the labels and definitions SAMSHA and CrisisNow provide are purposefully vague to account for this variation. Arizona, Utah, and Georgia all utilize the recommendations provided by these entities and have been successful in transforming their behavioral health systems to achieve better outcomes for their residents.

- *National Best Practices Infrastructure*

SAMHSA published its National Guidelines for Behavioral Health Crisis Care in 2020.[4] This is the primary federal resource identifying best practices for crisis care, although each state system will necessarily look different because of variations in health infrastructure and administrative differences.

Closely related to SAMHSA is CrisisNow, a coalition of public health organizations providing resources to help states reach nationally recognized best practices for their crisis care systems. CrisisNow is led by the National Association of State Mental Health Program Directors (NASMHPD), the National Action Alliance for Suicide Prevention, the National Suicide Prevention Lifeline, the National Council for Mental Wellbeing, and RI International. SAMHSA and CrisisNow both note that, in order to align with best practices, a behavioral health crisis program must implement three infrastructural elements to form a "no-wrong-door" continuum of care to most effectively address behavioral crises. Essentially, best practices provide that emergency call centers, community-based response frameworks, and emergency facilities for substance abuse and mental health crisis care be independently operated from those structures traditionally used for physical healthcare (i.e., 911, ambulance and fire services, and emergency departments).[5]

The three crisis response system components should be enacted along with a set of six core principles which include:

- Addressing Recovery Needs
- Significant Role for Peers
- Trauma-Informed Care
- Zero Suicide/Suicide Safer Care
- Safety/Security for Staff and People in Crisis

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[4]SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMIN., NATIONAL GUIDELINES FOR BEHAVIORAL HEALTH CRISIS CARE: BEST PRACTICE TOOLKIT (2020), https://www.samhsa.gov/sites/default/files/national-guidelines-forbehavioral-health-crisis-care-02242020.pdf.

[5] PAUL GLADYS, DAVID COVINGTON, AND DR. BRIAN HEPBURN, SUSTAINABLE FUNDING FOR MENTAL HEALTH CRISIS SERVICES (2022). https://crisisnow.com/wp-content/uploads/2022/01/Sustainable-Funding-Crisis-Coding-Billing-2022.pdf.

- Crisis Response Partnerships with Law Enforcement, Dispatch, and Emergency Medical Services (EMS)

Additionally, SAMHSA is currently focusing on furthering racial and identity-based equity in behavioral health systems.[6] Arizona, Georgia, and Utah have achieved national recognition for their crisis response systems and markedly improved outcomes, seemingly by adapting these elements to their state-specific healthcare systems. These improvements include significant reductions in law enforcement hours, incarceration rates, and hospitalizations related to behavioral health crises.[7]

  - *Regional Call Centers*

The first element of no-wrong-door infrastructure is regional or statewide coordinated crisis call centers. These should be connected with the 988 national suicide crisis line for best results.[8] Call centers can be evaluated for efficacy based on responsiveness as well as the percentage of callers who either have their crisis resolved over the phone or are otherwise provided with external care.[9] To comply with SAMHSA's guidelines, crisis call centers must operate 24/7, have clinicians on staff, answer every call, be able to assess suicide risk, coordinate with mobile crisis teams in the region, and connect individuals to facilities via warm handoffs.[10] Arizona and Utah both rely on private contractors to facilitate their call center services, while Georgia uses the public Georgia Crisis and Access Line (GCAL) to provide emergency call center services.[11]

  - *Mobile Crisis Response Teams*

Second, SAMHSA and CrisisNow recommend that states employ mobile crisis teams (MCTs) that are accessible throughout the state. These teams should be available 24/7 and be able to reach individuals within a designated region who are experiencing a crisis in less than ninety minutes.[12] SAMHSA recommends these teams be comprised of at least 2 providers, one of whom should be a licensed clinician.[13] MCTs can be evaluated for efficacy based on the number of people in crisis they can serve and

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[6] SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMIN., NATIONAL GUIDELINES FOR BEHAVIORAL HEALTH CRISIS CARE: BEST PRACTICE TOOLKIT (2020).

[7] CrisisNow, The Arizona Model of Crisis Receiving Centers (June 19, 2021), https://talk.crisisnow.com/wpcontent/uploads/2021/06/19-The-Arizona-Model-of-Crisis-Receiving-Centers.pdf.

[8] Implementation of the 988 Hotline: A Framework for State and Local Systems Planning, Virginia Department of Behavioral Health and Disability Services, https://dbhds.virginia.gov/assets/doc/hr/Health-Equity/mdpa/implementation-of-the-988-hotline-a-framework-for-state-and-local-systems-planning-(1).pdf.

[9] SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMIN., NATIONAL GUIDELINES FOR BEHAVIORAL HEALTH CRISIS CARE: BEST PRACTICE TOOLKIT (2020).

[10] Clare Hachten, Michael Ferguson, and Andy Block, Crisis Response Systems in Arizona, Utah, and Georgia.

[11] Tom Betlach & David Covington, Crisis Now: Transforming Services is Within Our Reach https://www.nasmhpd.org/sites/default/files/Tom%20Betlach_Sunday.pdf; BEHAVIORAL HEALTH CRISIS RESPONSE COMM., SB155: INITIAL 988 MENTAL HEALTH ASSISTANCE REPORT 7-9 (2021); Judy Fitzgerald, Commissioner, Georgia Behavioral Health System Overview (Dec. 16, 2019), https://www.house.ga.gov/Documents/CommitteeDocuments/2019/Behavioral_Health_Reform/Behavioral_Health_Reform_Commission_12.16.19_FINAL.pdf.

[12] SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMIN., NATIONAL GUIDELINES FOR BEHAVIORAL HEALTH CRISIS CARE: BEST PRACTICE TOOLKIT (2020).

[13] Zoom Interview with Curt Gleeson, Assistant Commissioner of Crisis Services, Virginia Department of Behavioral Health and Disability Services (July 10, 2023).

the percentage of crisis responses resolved in the community, outside of crisis care facilities. Arizona uses private providers for its mobile response, and has determined requirements for timing and specific services to be provided statewide.[14] Utah requires that its privately-operated teams include one mental health therapist and one certified crisis worker, preferably a peer with behavioral health or substance use experience.[15] Georgia, similarly to its call centers, uses the GCAL integrated statewide system to provide mobile crisis services, and certified peer specialists are present in every element of its continuum of care.[16]

- *Crisis Receiving and Stabilization Programs*

Finally, the third attribute required to bring a state behavioral health crisis system in line with national best practices is 23-hour crisis receiving and stabilization programs. These programs should be required to accommodate every patient seeking care. Crisis Receiving Centers (CRCs) must provide in-person medical assessment and stabilization, be able to address both mental health and substance abuse issues, ensure a quick drop-off time for law enforcement, and screen for suicide and violence risk.[17] This is a more general term that can refer to different facilities depending on the state or region in question. Crisis Stabilization Units (CSUs) are time-limited facilities (usually up to 23 hours) that allow for observation services and de-escalation of behavioral health crises, often removing the need for someone experiencing a crisis to be admitted into a hospital or other urgent care setting. The opportunity for short-term treatment, typically with access to medication management, counseling, and other resources, has been shown to reduce the use of state mental health hospitals and create better outcomes for practitioners and patients. Removing law enforcement from the crisis care continuum earlier in the process is also desirable from a health outcome and budgetary perspective.[18] These programs are evaluated for success by SAMHSA based on referral statistics, length of stay, readmission rates, and improvement in future ability to avoid or address a behavioral health crisis, among other factors. Successful peer states vary widely in the number of administrative methods they use for short-term CSUs, but all share an adherence to SAMHSA and CrisisNow descriptions of these facilities.

- *Sustainable Funding*

A sustainable funding model is also critical to achieving a successful state behavioral health crisis system. The importance of this element is highlighted in national best practices resources. For example, CrisisNow provides resources about how funding streams can be used most effectively in behavioral health crisis systems. Despite Arizona, Utah, and Georgia having different funding models and levels of reliance on federal resources, specifically Medicaid funding, their crisis response systems have achieved

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[14] Tom Betlach & David Covington, Crisis Now: Transforming Services is Within Our Reach https://www.nasmhpd.org/sites/default/files/Tom%20Betlach_Sunday.pdf.

[15] *See* Laura Summers et al., Utah's Mental Health System 8-9 (Aug. 2019) (providing a detailed breakdown of Utah's funding), https://le.utah.gov/interim/2019/pdf/00003401.pdf; Clare Hachten, Michael Ferguson and Andy Block, Crisis Response Systems in Arizona, Utah, and Georgia.

[16] Judy Fitzgerald, Commissioner, Georgia Behavioral Health System Overview (Dec. 16, 2019), https://www.house.ga.gov/Documents/CommitteeDocuments/2019/Behavioral_Health_Reform/Behavioral_Health_Reform_Commission_12.16.19_FINAL.pdf.

[17] Clare Hachten, Michael Ferguson and Andy Block, Crisis Response Systems in Arizona, Utah, and Georgia.

[18] Balfour ME & Zeller SL, Community-Based Crisis Services, Specialized Crisis Facilities, and Partnerships With Law Enforcement, 21 Focus (Am. Psychiatric Publ'g), Jan. 2023, at 18.

national recognition.[19] Arizona, Georgia, and Utah use braided funding, which involves "lacing together funds from multiple sources to support a common goal or idea such that each individual funding source maintains its specific program identity and can be tracked independently from planning through evaluation."[20] These leading states also commonly contract with private providers to facilitate their crisis response services which can simplify funding challenges in some cases.

CrisisNow has published a sustainable funding guide that includes a discussion of standardized health coding and reimbursement strategies. They emphasize how funding and budgeting structures can influence health parity, which is a priority for behavioral health system reform efforts.[21] Additionally, CrisisNow describes how standardizing the Medicaid billing code system for crisis services can improve outcomes by making accurate data about the utilization of behavioral health systems available and allowing entities to analyze what may be working well and where certain systems may be struggling. Medicaid coding refers to the practice of different health systems using standardized codes to claim Medicaid reimbursement for the same services. Nationally determined coding systems would influence health systems to provide more consistent services throughout a state, which aligns with SAMHSA's best practices guidelines.[22]

VIRGINIA'S BEHAVIORAL HEALTH CRISIS RESPONSE SYSTEM

Virginia's policy makers, appropriators, and practitioners have devoted considerable time and effort and enacted extensive programming in recent years to bring the state into closer alignment with national best practices for crisis care.

These policy efforts include Deeds Commission and the subsequent creation of the Behavioral Health Commission, Governor Youngkin's "Right Help, Right Now" plan, Virginia DMAS's Project BRAVO, the implementation of the Marcus-David Peter's Act, and the DBHDS North Star Strategic Plan.

Thanks to this focus, Virginia has improved and strengthened crisis response services across the state. These transformation efforts began in response to a Department of Justice settlement agreement requiring statewide crisis services for individuals with developmental disabilities.[23] Similar suits catalyzed reform efforts in states such as Georgia with premier crisis response frameworks.[24] Federal 988 implementation efforts have been impactful as well. The state is using the CrisisNow model as a

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[19] ROBERT SHAW, FINANCING MENTAL HEALTH CRISIS SERVICES (Aug. 2020), https://www.nasmhpd.org/sites/default/files/2020paper7.pdf.
[20] Braided and Blended Funding, National Association of City and County Health Officials, https://www.naccho.org/uploads/downloadable-resources/Programs/Public-Health-Infrastructure/Innovation-Snapshot-5.pdf.
[21] PAUL GLADYS, DAVID COVINGTON, AND DR. BRIAN HEPBURN, SUSTAINABLE FUNDING FOR MENTAL HEALTH CRISIS SERVICES (2022).
[22] *Id*.
[23] DOJ Settlement Agreement, Department of Behavioral Health and Disability Services, https://dbhds.virginia.gov/doj-settlement-agreement/.
[24] Press Release, U.S. Department of Justice, Justice Department Obtains Comprehensive Agreement Regarding the State of Georgia's Mental Health and Developmental Disability System (October 19, 2010), https://www.justice.gov/opa/pr/justice-department-obtains-comprehensive-agreement-regarding-state-georgia-s-mental-health.

benchmark for its crisis response system reform efforts, while adapting its general recommendations to the specific challenges, structure, and history of the Virginia health system.[25]

Despite these efforts and the undeniable progress that has been made, more work remains to be done. For example, according to CrisisNow, and not counting current budget proposals, Virginia will need to spend approximately $300 million more per year ($790 million total) to operate a continuum of crisis care that comports with SAMHSA and CrisisNow's models.[26] These costs include bringing Virginia up to a minimum of 64 mobile crisis response teams, 468 crisis receiving chairs, 398 short-term crisis beds, and 1,134 acute psychiatric inpatient beds.

The Joint Legislative Audit and Review Commission (JLARC) is another influential entity that has provided important data on where Virginia's crisis system stands today. Notably, its December 2022 report outlines challenges and reform recommendations for the state.[27]

- *Regional Call Centers*

According to DBHDS, Virginia is doing well compared to many states in terms of its crisis call center infrastructure.[28] DBHDS facilitates call centers 5 health service regions.[29] Two private service providers hold the five contracts to operate the call centers – PRS CrisisLink holds four, while Frontier Health, based in Tennessee, holds the fifth. The state has integrated these centers with the 988 national suicide and behavioral crisis call line, which will likely increase their efficacy, especially once marketing and education efforts begin. Federal funds are available to help states implement call centers and integrate them with the 988 national hotline.

- *Mobile Crisis Response Teams*

The state currently has 36 operational mobile crisis teams that can respond to crises within their service area within one hour.[30] According to the state's own estimates, Virginia requires 70 such teams to achieve full state coverage. State funding for these teams under our current administrative model flows from DBHDS through local CSBs. Ideally, the plans currently in progress will provide adequate mobile crisis services to bring Virginia in line with successful peer states and national best practices. Even with the necessary funding, however, it will be important to monitor local staffing, implementation, and training.

- *Crisis Receiving Centers, Crisis Stabilization Units, and Comprehensive Psychiatric Emergency Programs*

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[25] Zoom Interview with staff from Virginia House Appropriations Committee (June 15, 2023).
[26] CrisisNow, Crisis Resource Need Calculator, https://calculator.crisisnow.com/#/datainsights?chart=SC&geo=State&lob=All&location_key=VA&metric1=bh_high_needs&tab=Map.
[27] CSB Behavioral Health Services, Joint Legislative Audit and Review Commission Report 571, iv (Dec. 2022).
[28] Zoom Interview with Curt Gleeson, Assistant Commissioner of Crisis Services, Virginia Department of Behavioral Health and Disability Services (July 10, 2023).
[29] *Id.*
[30] Right Help, Right Now: Transforming Behavioral Healthcare for Virginians, https://www.hhr.virginia.gov/media/governorvirginiagov/secretary-of-health-and-human-resources/pdf/behavioral-health/Right-Help-Right-Now_01-11-23.pdf.

Virginia has 252 short-term (under 23-hour) crisis beds making up its CSUs. CrisisNow estimates that Virginia should have 398 short-term crisis beds to adequately meet demand within the state. Only three crisis stabilization units with twenty-five beds total are equipped to serve youth.[31] The state also has 186 crisis receiving center slots, while the CrisisNow model suggests that Virginia should maintain 468 of these slots.[32] The state is in the process of planning for and standing up more robust crisis receiving centers as part of its existing continuum of care infrastructure.[33] In addition to CSUs, the state has seen some success with comprehensive psychiatric emergency programs (CPEPs) often implemented in private hospitals as an alternative to a traditional emergency room, with security procedures and other qualities that allow for the disengagement of law enforcement, immediate medication management and counseling services, and integration with community services.[34] Therefore CPEPs may serve an equivalent role to detached outpatient crisis receiving centers. A notable example is the Carilion CPEP, which has been quite successful and may be able to serve as a model or training resource for other CPEPs that are being rolled out in the near future.[35]

D. Virginia Medicaid Initiatives in Crisis Services

Virginia has made real progress towards integrating Medicaid into the crisis response system. Specifically, DMAS implemented four new Medicaid services for crisis care during Phase 1 of Project BRAVO. The approach to crisis services within Medicaid is to integrate with the broader statewide infrastructure being built through other reforms (DOJ Settlement agreement, STEP-VA, Marcus Alert, 988), to be part of Virginia's plan for a payer-agnostic, evidence-based approach to crisis care state-wide.[36] The four new Medicaid services for crisis care include: Mobile Crisis, Community Stabilization, 23-hour Observation Services, and Residential Crisis Stabilization Per Diem.[37] DMAS is also running a behavioral health dashboard which, while challenged by implementation problems and complications during the COVID-19 pandemic, shows high utilization of Medicaid reimbursements for crisis response in Virginia.[38]

POLICY PROPOSALS

On December 14, 2022, Governor Glenn Youngkin unveiled the "Right Help, Right Now" plan aimed at improving Virginia's existing crisis infrastructure as well as expanding several key services. Since this time, the House of Delegates and Senate have passed a series of budget amendments modifying, and

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[31] JOINT LEGISLATIVE AUDIT AND REV. COMM'N, REPORT 571 iv (Dec. 2022).
[32] Right Help, Right Now: Transforming Behavioral Healthcare for Virginians, https://www.hhr.virginia.gov/media/governorvirginiagov/secretary-of-health-and-human-resources/pdf/behavioral-health/Right-Help-Right-Now_01-11-23.pdf; CrisisNow, Crisis Resource Need Calculator, https://calculator.crisisnow.com/#/datainsights?chart=SC&geo=State&lob=All&location_key=VA&metric1=bh_high_needs&tab=Map.
[33] Zoom Interview with Curt Gleeson, *supra* note 28.
[34] *Id.*
[35] *Id*.
[36] Zoom Interview with Lisa Jobe-Shields, Behavioral Health Division Director, Virginia Department of Medical Assistance Services (June 30, 2023).
[37] Behavioral Health Service Utilization and Expenditures, Virginia Department of Medical Assistance Services, https://www.dmas.virginia.gov/data/behavioral-health/behavioral-health-service-utilization-and-expenditures/.
[38] Zoom Interview with Lisa Jobe-Shields, *supra* note 36.

often expanding upon, the Governor's original proposal. At the time of this report, the General Assembly has not yet reached an agreement on the final budget for FY 2024.

This section breaks down the three policy options currently on the table, concentrating on the following items: Mobile Crisis Teams (MCTs), Crisis Receiving Centers (CRCs), Crisis Stabilization Units (CSUs), Comprehensive Psychiatric Emergency Programs (CPEPs), support for law enforcement, school-based programs and services, residential housing, Medicaid improvements, and certain miscellaneous initiatives.

A. *Governor Youngkin's "Right Help, Right Now" plan*

Governor Youngkin's proposal focuses on pre-crisis prevention services and is centered around six strategic goals: [39]

1. Provide same-day care for individuals experiencing behavioral health crises.
2. Reduce the burden on law enforcement to monitor and care for patients.
3. Expand the behavioral health system's capacity to treat patients.
4. Provide targeted support for substance abuse disorder.
5. Improve recruitment, compensation, and retention for those working in the behavioral health system, especially in underserved communities.
6. Ease administrative burdens and improve the overall quality of care.

To meet these goals, the Governor has requested more than $230 million in new funding for behavioral health in a revised biennial budget for 2022-2024.[40] This includes:

Item	Amount and Description
Mobile Crisis Teams (MCTs)	$20 million to fund at least 30 new MCTs, ensuring statewide coverage for 988 hotline calls (i.e., every Virginian can be reached within an hour's drive by an MCT) by the end of FY 2024. In 2022, the state had 36 MCTs and needed an additional 34 MCTs to meet its statewide coverage goal. This amendment also provides funding to improve staffing, training, and infrastructure for existing MCTs.
Crisis Receiving Centers (CRCs)	$12 million in FY 2024 and $9 million in FY 2025 to build six new adult CRCs. $10 million in FY 2024 and $7.5 million in FY 2025 to build five new youth CRCs.

[39] Glenn Youngkin, *Right Help, Right Now: Transforming Behavioral Health Care for Virginians* (Commonwealth of Virginia, 2022).
[40] *Id.* at 34.

	New CRCs will be built across the state in priority areas to ensure that facilities are evenly distributed (i.e., one CRC for every 250,000 residents and all Virginians live within an hour's drive of a site).
Crisis Stabilization Units (CSUs)	$12 million in FY 2024 and $7.5 million in FY 2025 to build three new CSUs. $9 million in FY 2024 and $6 million in FY 2025 to build two new youth CSUs. $11.5 million in FY 2024 and $11.5 million in FY 2025 to enhance 16 existing CSUs. New CSUs will be built across the state in priority areas to ensure that facilities are evenly distributed (i.e., one CSU for every 250,000 residents and all Virginians live within an hour's drive of a site).
Comprehensive Psychiatric Emergency Programs (CPEPs)	$20 million to build three new CPEPs. These hospital-based programs are secure facilities specifically designed to treat patients suffering experiencing behavioral health crises and are an alternative to emergency departments. At the time of this report, Virginia has three CPEPs that are currently operating or under construction — Carilion Clinic in Roanoke, Centra Virginia Baptist Hospital in Lynchburg, and Chesapeake Regional Hospital in Chesapeake.
Support for Law Enforcement	$4.1 million to support the creation of a new mental health transportation pilot program. $1 million to compensate off-duty officers for monitoring and transporting patients under emergency custody orders (ECOs) and temporary detention orders (TDOs). $4 million to create a series of dedicated law enforcement positions for executing EDOs and TDOs.
School-based Programs and Services	$15 million to expand the current elementary, middle, and high school-based

	mental health program to new communities. $9 million to expand tele-behavioral health services in public schools as well as on college campuses.
Supervised Residential Care	$8 million to create 100 new placements for patients with extraordinary barriers to discharge.
Permanent Supportive Housing (PSH)	No proposed changes from the 2022-24 Biennium Budget.
Medicaid Improvements	$41.6 million to provide a 5% increase in provider reimbursement rates for personal care, respite, and companion services. $15.1 million to support the creation of 500 new development disability waiver slots for priority one patients (i.e., those who are anticipated as needing waiver services in less than a year). $4.3 million to cover administrative costs for managed care organization re-procurement. $500,000 to fund improvements to the waiver administration system.
Increased Compensation/Benefits for Mental Health Providers	$9 million to increase compensation for staff in state psychiatric hospitals. $5 million to expand student loan repayments for psychiatric nurses and nurse practitioners. $3 million to expand student loan repayments for child and adolescent psychiatric providers. $1 million to create new psychiatric residency slots.
Miscellaneous	$8 million to fund a public awareness campaign about the dangers of fentanyl use as well as expand access to Naloxone. $7 million to designate a portion of the opioid settlement fund for fentanyl.

	$3 million to enhance a crisis therapeutic home in Region 5.

If the "Right Help, Right Now" plan is adopted in its entirety, the Commonwealth will spend more than $660 million in FY 2024 on behavioral health services. Governor Youngkin has called this a "down payment on successfully transforming the behavioral health system in Virginia." [41]

At the time of this report, the only ongoing operating costs mentioned in the Governor's plan are for CRCs and CSUs. The breakdown of costs for these items in FY 2024 and FY 2025 is provided in the table below:

Site Type	**Budget Request New Sites/Site Enhancement**	**FY 2024 Unit Cost**	**FY 2025 Unit Cost**	**FY 2024**	**FY 2025**
Adult CRCs (*New*)	6	$2,000,000	$1,500,000	$12,000,000	$9,000,000
Youth CRCs (*New*)	5	$2,000,000	$1,500,000	$10,000,000	$7,500,000
Adult CSUs (*New*)	3	$4,000,000	$2,500,000	$12,000,000	$7,500,000
Youth CSUs (*New*)	2	$4,500,000	$3,000,000	$9,000,000	$6,000,000
Adult CSUs (*Enhancements*)	16	$718,750	$718,750	$11,500,000	$11,500,000
Total Site Costs				$54,500,000	$41,500,000

B. Amendments adopted by the House of Delegates

The House of Delegates has passed the following amendments on top of the amount originally requested by Governor Youngkin:

Item	**Amount and Description**
Mobile Crisis Teams (MCTs)	No changes from the Governor's plan.
Crisis Receiving Centers (CRCs)	No changes from the Governor's plan.
Crisis Stabilization Units (CSUs)	An additional $25 million to create more adult CSUs. This amendment also directs DBHDS to place the new facilities in "priority areas" across the state which include Harrisonburg, Hanover County,

[41] *Id.*

	Prince William County, as well as the Northern Neck and Middle Peninsula.[42]
Comprehensive Psychiatric Emergency Programs (CPEPs)	An additional $6 million to support the ongoing construction of a CPEP at Chesapeake Regional Hospital.[43] An additional $250,000 to provide Carillion's CPEP with technical assistance.[44]
Support for Law Enforcement	No changes from the Governor's plan.
School-based Programs and Services	No changes from the Governor's plan.
Supervised Residential Housing	No changes from the Governor's plan.
Permanent Supportive Housing (PSH)	No changes from the Governor's plan.
Medicaid Improvements	No changes from the Governor's plan.
Increased Compensation/Benefits for Mental Health Providers	$36.5 million to increase compensation for CSB staff. CSBs will have discretion as to how they allocate this additional funding. If distributed evenly, this amendment will provide a 5% pay raise for all CSB employees, including those who are supported using local funds and Medicaid.[45]
Miscellaneous	An additional $8.4 million to support children's behavioral health services, increasing total new spending on this item in FY 2024: $16.8 million. Virginia has not increased its contribution to children's behavioral health services since FY 2017.[46]

Additionally, the House of Delegates has passed language-only amendments requiring DBHDS to provide the General Assembly with an annual report on CSB performance as well as use non-general funds to contract with local law enforcement to transport patients under TDOs.[47] [48] The House has not passed any amendments to reduce the amount requested by the Governor.

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[42] Va. Gen. Assembly, *Budget Amendments – HB 1400 (Floor Approved) Item 312 #1h* (2023), https://budget.lis.virginia.gov/amendment/2023/1/HB1400/Introduced/FA/312/1h/

[43] Va. Gen. Assembly, *Budget Amendments – HB 1400 (Floor Approved) Item 312 #4h* (2023), https://budget.lis.virginia.gov/amendment/2023/1/HB1400/Introduced/FA/312/4h/

[44] Va. Gen. Assembly, *Budget Amendments – HB 1400 (Floor Approved) Item 311 #6h* (2023), https://budget.lis.virginia.gov/amendment/2023/1/HB1400/Introduced/FA/311/6h/

[45] Va. Gen. Assembly, *Budget Amendments – HB 1400 (Floor Approved) Item 313 #1h* (2023), https://budget.lis.virginia.gov/amendment/2023/1/HB1400/Introduced/FA/313/1h/

[46] Va. Gen. Assembly, *Budget Amendments – HB 1400 (Floor Approved) Item 313 #3h (2023)*, https://budget.lis.virginia.gov/amendment/2023/1/HB1400/Introduced/FA/313/3h/

[47] Va. Gen. Assembly, *Budget Amendments – HB 1400 (Floor Approved) Item 311 #3h (2023)*, https://budget.lis.virginia.gov/amendment/2023/1/HB1400/Introduced/FA/311/3h/

[48] Va. Gen. Assembly, *Budget Amendments – HB 1400 (Floor Approved) Item 312 #5h (2023)*, https://budget.lis.virginia.gov/amendment/2023/1/HB1400/Introduced/FA/312/5h/

The proposed new spending for adult CSUs relies on the same estimated initial and operating costs in the Governor's plan. The cost of these additional adult CSUs in FY 2024 and FY 2025 is provided in the table below:

Site Type	**Budget Request New Sites/Site Enhancement**	**FY 2024 Unit Cost**	**FY 2025 Unit Cost**	**FY 2024**	**FY 2025**
Adult CSUs (*New*)	~~3~~ 8	$4,000,000	$2,500,000	~~$12,000,000~~ $37,000,000	~~$7,500,000~~ $20,000,000

C. Amendments adopted by the Senate

The Senate has passed the following amendments on the next page in addition to the amount originally requested by Governor Youngkin:

Item	**Amount and Description**
Mobile Crisis Teams (MCTs)	No changes from the Governor's plan.
Crisis Receiving Centers (CRCs)	An additional $30 million to create new CRCs and CSUs as well as enhance existing sites, increasing total new spending on these two items in FY 2024 to $84.5 million.[49] [50]
Crisis Stabilization Units (CSUs)	An additional $30 million to create new CRCs and CSUs as well as enhance existing sites, increasing total new spending on these two items in FY 2024 to $84.5 million.[51] [52]
Comprehensive Psychiatric Emergency Programs (CPEPs)	No changes from the Governor's plan.
Support for Law Enforcement	A proposal to transfer $4.1 million in the Governor's plan to create a mental health transportation pilot program from the Compensation Board to DBHDS.[53]
School-based Programs and Services	No changes from the Governor's plan.

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[49] Va. Gen. Assembly, *Budget Amendments – SB 800 (Floor Approved) Item 312 #1s* (2023), https://budget.lis.virginia.gov/amendment/2023/1/SB800/Introduced/FA/312/1s/.

[50] At the time of this report, no specific details have been released about the number of new and enhanced CRCs this amendment will fund.

[51] Va. Gen. Assembly, *Budget Amendments – SB 800 (Floor Approved) Item 312 #1s* (2023), https://budget.lis.virginia.gov/amendment/2023/1/SB800/Introduced/FA/312/1s/

[52] At the time of this report, no specific details have been released about the number of new and enhanced CSUs this amendment will fund.

[53] Va. Gen. Assembly, *Budget Amendments – SB 800 (Floor Approved) Item 311 #5s* (2023), https://budget.lis.virginia.gov/amendment/2023/1/SB800/Introduced/FA/311/5s/

Supervised Residential Housing	No changes from the Governor's plan.
Permanent Supportive Housing (PSH)	$50 million to provide up to 3,000 patients with serious mental health issues stable housing.[54]
Medicaid Improvements	An additional $57.4 million in FY 2024 to provide a 10% increase in the reimbursement rate for the following community-based mental health services: intensive in-home treatment, mental health skill building, psychosocial rehabilitation, therapeutic day treatment, outpatient psychotherapy, and peer recovery support services.[55] $450,000 to fund a DMAS study establishing a methodology for an annual adjustment for inflation of community-based behavioral health services rates as well as redetermining the therapeutic day treatment rate and structure.[56]
Increased Compensation/Benefits for Mental Health Providers	$50 million to increase compensation for CSB staff. [57] [58]
Miscellaneous	$650,000 to fund the creation of a new online portal that CSBs can use to share patient information and documents with inpatient psychiatric facilities.[59] $1 million to fund youth cannabis prevention programs.[60] An additional $8.4 million to support children's behavioral health services, increasing total new spending on this item

[54] Va. Gen. Assembly, *Budget Amendments – SB 800 (Floor Approved) Item 313 #1s* (2023), https://budget.lis.virginia.gov/amendment/2023/1/SB800/Introduced/FA/313/1s/
[55] Va. Gen. Assembly, *Budget Amendments – SB 800 (Floor Approved) Item 304 #4s* (2023), https://budget.lis.virginia.gov/amendment/2023/1/SB800/Introduced/FA/304/4s/
[56] Va. Gen. Assembly, *Budget Amendments – SB 800 (Floor Approved) Item 308 #5s* (2023), https://budget.lis.virginia.gov/amendment/2023/1/SB800/Introduced/FA/308/5s/
[57] Va. Gen. Assembly, *Budget Amendments – SB 800 (Floor Approved) Item 313 #5s* (2023), https://budget.lis.virginia.gov/amendment/2023/1/SB800/Introduced/FA/313/5s/
[58] At the time of this report, no specific details have been released about the level of discretion CSBs will have in allocating these funds as well as the impact this amendment will have on staff compensation.
[59] Va. Gen. Assembly, *Budget Amendments – SB 800 (Floor Approved) Item 311 #2s* (2023), https://budget.lis.virginia.gov/amendment/2023/1/SB800/Introduced/FA/311/2s/
[60] Va. Gen. Assembly, *Budget Amendments – SB 800 (Floor Approved) Item 313 #2s* (2023), https://budget.lis.virginia.gov/amendment/2023/1/SB800/Introduced/FA/313/2s/

	for FY 2024 to $16.8 million. This amendment is identical to one passed by the House of Delegates.[61] An additional $8.7 million for CSBs to offset inflationary costs from providing the first three steps of STEP-VA (i.e., same-day access, primary care screening, and outpatient services) An additional $7.9 million to expand the Virginia Mental Health Access Program (VMAP) to infants and toddlers. In addition to hiring new early childhood specialists, this amendment will also fund training for primary care providers.[62]

Additionally, the Senate passed language-only amendments that would require DBHDS to provide a report to BHC reviewing performance contracts with CSBs, develop a plan to restore bed capacity in the state hospital system, and partner with DMAS to review the extent to which CSBs are billing for Medicaid-eligible services.[63] [64] [65] The Senate also passed an amendment to scale back $500,000 in new spending. This would eliminate three of the five new positions proposed by Governor Youngkin to oversee the new system.[66]

D. Comparison of New Funding for Key Components in FY 2024

Item	Governor's Plan	House Amendments	Senate Amendments
Mobile Crisis Teams (MCTs)	$20 million (70 MCTs which will provide statewide coverage)	$20 million (No change from Governor's plan)	$20 million (No change from Governor's plan)

[61] Va. Gen. Assembly, *Budget Amendments – SB 800 (Floor Approved) Item 313 #3s* (2023), https://budget.lis.virginia.gov/amendment/2023/1/SB800/Introduced/FA/313/3s/
[62] Va. Gen. Assembly, *Budget Amendments – SB 800 (Floor Approved) Item 312 #2s* (2023), https://budget.lis.virginia.gov/amendment/2023/1/SB800/Introduced/FA/312/2s/
[63] Va. Gen. Assembly, *Budget Amendments – SB 800 (Floor Approved) Item 311 #13s* (2023), https://budget.lis.virginia.gov/amendment/2023/1/SB800/Introduced/FA/311/13s/
[64] Va. Gen. Assembly, *Budget Amendments – SB 800 (Floor Approved) Item 311 #19s* (2023), https://budget.lis.virginia.gov/amendment/2023/1/SB800/Introduced/FA/311/19s/
[65] Va. Gen. Assembly, *Budget Amendments – SB 800 (Floor Approved) Item 311 #17s* (2023), https://budget.lis.virginia.gov/amendment/2023/1/SB800/Introduced/FA/311/17s/
[66] Va. Gen. Assembly, *Budget Amendments – SB 800 (Floor Approved) Item 311 #10s* (2023), https://budget.lis.virginia.gov/amendment/2023/1/SB800/Introduced/FA/311/10s/

Crisis Receiving Centers (CRCs) Crisis Stabilization Units (CSUs)	Total: $54.5 million CRCs: $22 million (6 new adult CRCs and 5 new youth CRCs) CSUs: $32.5 million (3 new adult CSUs, 2 new youth CSUs, and 16 adult CSU enhancements)	Total: $79.5 million CRCs: $22 million (No change from Governor's plan) CSUs: $57.5 million (8 new adult CSUs, 2 new youth CSUs, and 16 adult CSU enhancements)	Total: $84.5 million (At the time of this report, we had not obtained specific details about the number of new and enhanced CRCs as well as CSUs this amendment will fund)
Increased Compensation for CSB Staff	$0	$36.5 million (CSBs will have discretion in allocating these increased funds for employee compensation. If evenly distributed, this amendment will fund a 5% pay increase for all CSB staff)	$50 million (At the time of this report, we had not obtained specific details about the level of discretion CSBs will have in allocating these funds as well as the impact this amendment will have on staff compensation)

RECOMMENDATIONS

Fortunately, under any budget scenario, Virginia will make real progress towards building out a comprehensive, effective, statewide crisis response system. However, providing this additional funding, as explained above, will still leave work to do in terms of both future funding and implementation. This work will likely take more than one additional budget cycle and extend beyond the current administration. In our view, therefore, the Behavioral Health Commission has a potentially critical role to play in ensuring that this work continues until "completion." **To fulfill this vital role, we suggest that the BHC consider the following:**

1. **Work with the administration, DBHDS, DMAS, and staff from both Senate and House appropriations committees to establish financial and operational goals for a fully funded and effective crisis response system;**

2. **Establish financial and operational benchmarks and require DBHDS and DMAS to submit regular performance reports; and**

3. **Utilize financial and operational goals to inform and guide future funding decisions.**

CONCLUSION

Relative to best practices, Virginia's crisis response system is moving in the right direction but will need continuous investment and attention from state leadership to achieve better crisis outcomes. Many of the new services the state needs to establish, and existing services the state needs to expand, will require significant operational costs – initial investments will not be enough to bring the state up to the level of a truly effective, statewide, crisis response system. Given that funding priorities, staffing, and operational focus can vary from administration to administration, it will be vitally important for the Behavioral Health Commission to play a strong and consistent role in overseeing the implementation of current reform efforts, and exercising leadership in the General Assembly when it comes to fully funding a robust and effective crisis response system.

APPENDIX 1

SCHOOL of LAW

State and Local Government Policy Clinic
Andrew Block, Director

MEMORANDUM

To: **Nathalie Molliet-Ribet**
From: **Michael Ferguson, Clare Hachten, and Andy Block**
Re: **Crisis Response Systems in Arizona, Utah, and Georgia**
Date: **April 11, 2023**

INTRODUCTION

This memo provides an overview of the mental health crisis systems in Arizona, Utah, and Georgia. Each state has an integrated crisis system consisting of a central call center, mobile crisis teams, and various forms of crisis receiving centers. After providing an overview of the crisis system in each state, we go on to discuss commonalities between the three systems as well as provide recommendations on how Virginia could go about implementing them.

In preparing this memo, we looked at resources provided by the Arizona Health Care Cost Containment System (AHCCCS), CrisisNow, the Substance Abuse and Mental Health Services Administration (SAMHSA), the Georgia Department of Behavioral Health and Developmental Disabilities, the Utah Department of Health and Human Services, and the Utah Behavioral Health Commission. We also spoke with Tom Betlach, the director of the AHCCCS during much of Arizona's implementation of the CrisisNow model; CJ Loiselle, the current grant director for crisis care at AHCCCS; Paloma Kwiedacz and Anne Ngamsombat, crisis system coordinators for AHCCCS; and Nichole Cunha, a crisis administrator at the Utah Department of Health and Human Services. While we are familiar with Virginia's crisis system from our work throughout the year with Senator Deeds, we did not take a close look at which elements of the CrisisNow model Virginia has already implemented or is in the process of implementing.

EXECUTIVE SUMMARY

While Arizona, Utah, and Georgia have structured their behavioral health crisis systems in different ways, there are commonalities between the states. Each state's system reflects the core elements of the CrisisNow model, adopted by the National Association of State Mental Health Program Directors as the standard for crisis care. Each state has call centers that are integrated with the national 988 hotline as well as mobile crisis teams

and crisis receiving centers. Mobile crisis teams are available statewide and are able to get people the help they need quickly, no matter where they are. Furthermore, each state has invested in crisis receiving centers that are capable of caring for people for at least twenty-three hours. These centers accept everyone and ensure quick drop-off times for law-enforcement. Another key driver of the success in Arizona, Utah, and Georgia is that each state bills Medicaid for as many services as possible so that it is able to maximize the impact of the rest of its funding.

Most individuals who experience a mental health crisis in Virginia wind up in emergency rooms. Not only is a hectic, crowded emergency room unsuitable to stabilize an individual in crisis, but it is also expensive. Furthermore, law enforcement officers spend hours, even days, maintaining custody of individuals in emergency rooms when they could be fulfilling other obligations. Effective call centers, when integrated with statewide mobile crisis teams, can often stabilize individuals without the need to transport them to an emergency room or crisis receiving center (CRCs). Furthermore, crisis receiving centers are tailored towards the needs of individuals in crisis and can often treat individuals in less than twenty-four hours and return them to their community. Investing in a full continuum of care – call centers, mobile crisis teams, and crisis receiving centers – will result in better care for Virginians, reduced hospitalizations, cost-savings for the state, as well as a reduction in the burden on law enforcement.

SUMMARY OF PROBLEM IN VIRGINIA

Virginia's mental health system is struggling to meet increased demand for mental health services with its current slate of resources. In 2022, Community Services Boards (CSBs) served twenty percent more people with a serious mental illness than a decade ago.[1] Funding for CSBs has not kept pace with increased demand, and the resultant system relies heavily on hospital emergency departments to treat people in mental health crisis.[2] Furthermore, state hospitals have struggled to meet increased demand for beds amidst serious staffing shortages.[3]

Many of the issues in Virginia stem from the lack of a comprehensive system of mental health care with a full continuum of services. While Virginia has some Residential Crisis Stabilization Units (RCSUs) and 23-hour CRCs, these facilities do not meet statewide demand for their services. Due to this lack of capacity, and statutory constraints, Virginia's CRCs do not accept individuals under emergency custody. As a result, most individuals under ECOs and temporary detention orders (TDOs) are sent to hospital emergency departments instead. Many individuals who wind up in emergency departments do not improve during the time they spend there and are therefore taken to state psychiatric hospitals. However, many of these people don't need to be in hospitals; they need to be treated and stabilized at a CRC and/or RCSU (depending on the length of stay) and

[1] CSB Behavioral Health Services, Joint Legislative Audit and Review Commission Report 571, iv (Dec. 2022)

[2] Sarah Vogelsong, *Youngkin Proposes $230 Million Behavioral Health* Overhaul, VIRGINIA MERCURY (Dec. 14, 2022, 6:06 PM), https://www.virginiamercury.com/2022/12/14/youngkin-proposes-230-million-behavioral-health-overhaul/.

[3] JOINT LEGISLATIVE AUDIT AND REV. COMM'N, REPORT 571 iv (Dec. 2022).

returned to the community.[4] A comprehensive system of mental health care services would better enable Virginia to treat individuals in their communities without having to admit them to emergency departments or state psychiatric hospitals.

ARIZONA

In 1981, the Arizona Center of Law in the Public Interest filed a class-action lawsuit on behalf of a class of chronically mentally ill individuals in Maricopa County, alleging that the Arizona Department of Health Services did not provide a comprehensive community mental health system as required by statute.[5] In 2014, the state reached an agreement which ended the litigation and established guidelines for the provision of mental health services going forward.[6] Among other things, the agreement required that Maricopa County develop a mobile outreach capacity with in-home respite supports, crisis stabilization units with twenty-four hour crisis and respite beds, urgent care centers, and acute inpatient services.[7] The following sections detail the main features of the system Arizona implemented in the years following the end of this litigation. The system initially began in Maricopa County and, after success there, Arizona expanded it throughout the state.

The Work is Contracted Out

Arizona has three Regional Behavioral Health Authorities (RBHAs) serving six Geographical Service Areas (GSAs) throughout the state. Each RBHA contracts with a service provider that is responsible for providing all crisis services for a given region.[8] The state requires that each contractor provide specified services within their respective region, including crisis phone services, mobile crisis services, and stabilization services.[9] The state also has requirements specific to each component of the crisis response system.

The call centers in each region must have a single, toll-free number that is publicized throughout the region. The contractor must answer calls in three rings or less, provide follow-up calls within 72 hours, and provide an on-call nurse.[10] Each region's mobile crisis teams must be able to travel to a person within 90 minutes of the crisis call, assess the person, and provide appropriate intervention. The mobile crisis teams also must be able to transport individuals to other facilities when needed.[11] Finally, CRCs must operate 24 hours, 7 days a week,

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[4] Jackie DeFusco, *New Report Reveals Gaps in Virginia's Mental Health System as Both Parties Pledge to Make it a Priority*, ABC 8NEWS (DEC, 13, 2022, 7:06 PM), https://www.wric.com/news/virginia-news/new-report-reveals-gaps-in-virginias-mental-health-system-as-both-parties-pledge-to-make-it-a-priority/.

[5] *Arnold v. Arizona Dep't of Health Servs*., 160 Ariz. 593 (1989).

[6] Ariz. Health Care Cost Containment System, *Arnold v. Sarn,* (Revised Oct. 2022), https://www.azahcccs.gov/AHCCCS/HealthcareAdvocacy/arnoldvsarn.html

[7] Joint Stipulation on Exit Criteria and Disengagement, *Arnold v. Arizona Dep't of Health Servs.*, 160 Ariz. 598 (1989) (No. C-432355), https://azahcccs.gov/AHCCCS/Downloads/ArnoldVSarn/arnold-v-sarn-joint-stipulation-on-exit-criteria.pdf

[8] Tom Betlach & David Covington, Crisis Now: Transforming Services is Within Our Reach https://www.nasmhpd.org/sites/default/files/Tom%20Betlach_Sunday.pdf

[9] *Id*.

[10] *Id*.

[11] *Id*.

and provide 23-hour crisis stabilization observation. They must accept everyone and ensure quick drop-off times for law enforcement. This means that law enforcement officers are relieved of custody within minutes upon arrival at a CRC, freeing them up for other obligations. Additionally, stabilization centers must provide short-term (72-hour) stabilization services and communicate daily on bed availability.[12]

Braided Funding Model

Arizona uses a braided funding model to fund its crisis system: federal, state, and county dollars are supplemented with federal grants and distributed to the RHBAs. In 2020, Arizona, through the RBHAs, spent $158.5 million on crisis services, only 16 percent of which was spent serving non-Medicaid members. Thus, the expansion of Medicaid has been crucial to the success of the system. The Arizona Health Care Cost Containment System (AHCCCS) can draw on federal funding for crisis services offered to Medicaid beneficiaries and match the state's contribution. Arizona also maximizes parity by billing commercial insurance for as many crisis services as possible.[13]

Reduction in Law Enforcement Hours

In 2020, there were 30,500 police drop-offs at stabilization centers in Arizona, resulting in a reduction of police time equivalent to 33 full-time police officers, and a reduction of 63-years' worth of emergency department boarding.[14]

Reduction in Hospitalizations and Incarceration

Furthermore, 24/7 CRCs can provide necessary care to patients immediately, oftentimes returning them to the community without the need for hospitalization. The CRC in Tucson estimates that between sixty and seventy percent of the patients it treats are able to return to their communities without hospitalization.[15] Additionally, since the stabilization center's inception, the percentage of inmates with a severe mental illness at the county jail has decreased by half.[16]

UTAH

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[12] *Id*.
[13] ROBERT SHAW, FINANCING MENTAL HEALTH CRISIS SERVICES (Aug. 2020), https://www.nasmhpd.org/sites/default/files/2020paper7.pdf
[14] CrisisNow, The Arizona Model of Crisis Receiving Center (June 19, 2021), https://talk.crisisnow.com/wp-content/uploads/2021/06/19-The-Arizona-Model-of-Crisis-Receiving-Centers.pdf
[15] COMM. ON PSYCHIATRY & CMTY. FOR THE GROUP FOR THE ADVANCEMENT OF PSYCHIATRY, ROADMAP TO THE IDEAL CRISIS SYSTEM 106 (Mar. 2021).
[16] *Id*.

In recent years, Utah's legislature has been working to establish a comprehensive crisis system. In 2017 and 2018, SB 37 and HB41 (respectively) established a statewide crisis line,[17] and HB 370 established five mobile crisis outreach teams (MCOTs) throughout the state.18 In 2020, HB 32 provided for both the establishment of at least one crisis receiving center and expansion of MCOTs.19 In 2021, SB 155 established a permanent, restricted account in the state budget dedicated to crisis care, and tasked the Behavioral Health Crisis Response Commission (BHCRC) with studying the crisis system and making recommendations which continue to guide the state.20 And, most recently, SB 179 appropriated funds to build at least one receiving center in rural areas.21

Crisis Line

The legislature has expanded Utah's crisis system rapidly, although there is still work to be done. Generally, following from the SB155 report's recommendations, Utah has been attempting to meet standards set by the Substance Abuse and Mental Health Services Administration (SAMHSA).22 Today, the statewide crisis line has integrated with the national 988 line and is well supported.23 Key standards are that calls are answered within five rings, call abandonment is less than five percent of total calls, and ninety percent of in-state calls to 988 are answered by in-state operators.24 Currently, 86% of calls are successfully stabilized over the phone, with only 6% to 8% requiring the dispatch of a MCOT.25

Mobile Crisis Outreach Teams

Working alongside the crisis line, Utah operates fifteen 24/7 MCOTs across the state.26 These are currently evenly distributed across urban and rural areas.27 These teams require the combination of a Mental Health Therapist and another Certified Crisis worker - preferably a person with lived experience with mental health or substance use concerns.28 The goal, however, is to expand this number to twenty-six over the coming years,

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[17] Statewide Crisis Line, 2017 Utah Laws Ch. 23 (S.B. 37); Mental Health Crisis Line Amendments, 2018 Utah Laws Ch. 407 (H.B. 41).
18 Suicide Prevention and Medical Examiner Provisions, 2018 Utah Laws Ch. 414 (H.B. 370).
19 Crisis Services Amendments, 2020 Utah Laws Ch. 303 (H.B. 32).
20 988 Mental Health Crisis Assistance, 2021 Utah Laws Ch. 76 (S.B. 155); *see also* BEHAVIORAL HEALTH CRISIS RESPONSE COMM., SB155: INITIAL 988 MENTAL HEALTH ASSISTANCE REPORT (2021).
21 Criminal Justice Amendments, 2022 Utah Laws Ch. 187 (S.B. 179).
22 SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMIN., NATIONAL GUIDELINES FOR BEHAVIORAL HEALTH CRISIS CARE: BEST PRACTICE TOOLKIT (2020), https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf
23 BEHAVIORAL HEALTH CRISIS RESPONSE COMM., SB155: INITIAL 988 MENTAL HEALTH ASSISTANCE REPORT 7 (2021); Sofia Jeremias, *How a 20-Minute Phone Call is Saving Lives in Utah* (Dec. 5, 2022, 8:00 AM), https://www.sltrib.com/news/2022/12/05/how-20-minute-phone-call-is/
24 BEHAVIORAL HEALTH CRISIS RESPONSE COMM., SB155: INITIAL 988 MENTAL HEALTH ASSISTANCE REPORT 7-9 (2021) (Crisis line professionals may be: Peer Professionals, persons with lived experience related to mental illness or substance use; mid-level case managers; Social Service Worker (SSW); or other qualified mental health professional who holds a Crisis Worker Certification).
25 *Id.*
26 *Id.* at 11.
27 *Id.*
28 *Id.*

which is estimated to potentially save tens of millions in savings on inpatient psychiatric beds.29 While not all patients who utilize MCOTs would otherwise go to a receiving center or hospital, sixty-nine percent of MCOT patients remain at home and eleven percent remain in place.30 This shows the importance of MCOTs to both serving patient needs and reducing overcrowding at healthcare facilities.

Crisis Receiving Centers

Utah currently has three crisis receiving centers and is working on opening three more.31 Like Arizona, Utah's receiving centers are required to be open 24/7, to take all patients, and to care for them for up to twenty-three hours.32 They are also required to execute drop-offs as quickly as possible – the median drop-off time for law enforcement so far this year is less than five minutes.33 The receiving centers have been successful at both stabilizing people and diverting them from the criminal justice system: seventy-nine percent of individuals went home after receiving treatment at a receiving center and only fifteen percent had involvement with law enforcement.34 Furthermore, only four percent of patients had to be hospitalized, with the remainder going primarily to residential care for mental health or substance abuse.35 Currently, these residential beds are mostly unconnected to the state's crisis system; however, the state plans to substantially expand their subacute facilities in the coming years.[36]

The Work is Contracted Out

As in Arizona, Utah contracts with Local Mental Health/Substance Abuse Authorities (LMHAs), who contract with service providers to deliver crisis care services.37 Of the six operating and planned crisis receiving centers, four are being operated by LMHAs, while the remaining two are run by private organizations. For example, Salt Lake County relies on Optum Health to run its receiving center.38 Mobile crisis teams are similarly run by LMHAs. Medicaid recipients also receive a limited number of services through contracted Accountable Care Organizations.39 Finally, Utah's Crisis Line Call Center is operated by Huntsman Mental Health Institute.40

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29 *Id.*
30 Utah Dept. of Health & Human Services, Substance Use and Mental Health Data Portal, https://sumh.utah.gov/data-reports/data-portal-home.
31 UTAH BEHAVIORAL HEALTHCARE COMM., RECEIVING CENTERS FACT SHEET (Sept. 2022), https://le.utah.gov/interim/2022/pdf/00003490.pdf
32 BEHAVIORAL HEALTH CRISIS RESPONSE COMM., *supra* note 24 at 12.
33 Utah Dept. of Health & Human Services, *supra* note 30.
34 *Id.* The figure of individuals who returned home after treatment includes individuals who went to live with family or to a homeless shelter. Of the individuals who were involved with law enforcement, less than seven percent actually faced charges.
35 *Id.*
[36] BEHAVIORAL HEALTH CRISIS RESPONSE COMM., *supra* note 24 at 7.
37 *See* Laura Summers et al., Utah's Mental Health System 8-9 (Aug. 2019) (providing a detailed breakdown of Utah's funding), https://le.utah.gov/interim/2019/pdf/00003401.pdf
38 Optum, Salt Lake County Case Study, https://www.optum.com/content/dam/optum3/optum/en/resources/white-papers/8782_GOV_SLCCountyJailDiversion_Final_HR.pdf
39 Summers, *supra* note 36.
40 BEHAVIORAL HEALTH CRISIS RESPONSE COMM, *supra* note 24.

Funding

Utah utilizes several sources to fund its crisis system. As previously mentioned, Utah's legislature has provided substantial amounts to get the system up and running.41 Additionally, like Arizona, Utah employs federal block grant funding and relies heavily on both Medicaid and commercial insurance. 42 Utah employs a risk corridor funding model, where insurers have agreed to take on the full costs of care should those costs meet the expected levels. However, as costs diverge from what is expected, the government steps in to fill the gaps.43

GEORGIA

Much like Arizona, Georgia did not build its behavioral crisis system overnight. The United States Department of Justice (DoJ) sued Georgia for violating the Americans with Disabilities Act (ADA) and the 1999 Supreme Court decision in *Olmstead v. L.C.*44 The DOJ alleged that people with serious and persistent mental illness were stuck in an institutional setting because Georgia's community system was not robust enough.45 Georgia entered into a settlement agreement with the DOJ in 2010, which required it to make mental health mobile crisis teams available in every county and to build clinically staffed crisis services centers.46 The following sections detail the main features of the system, many of which were implemented in the years following the settlement agreement.

Georgia Crisis and Access Line

The Georgia Crisis and Access Line (GCAL) is a statewide call center that operates 24/7, connecting callers with licensed clinicians and trained professionals.47 Additionally, it has a mobile application and texting support.48 GCAL deploys mobile crisis response and manages entry into crisis services.49 GCAL has a referral board with an electronic database that provides a real-time picture of the availability of state-funded crisis beds, which includes CSU beds, state psychiatric hospital beds, state detox inpatient beds, and contracted beds in private psychiatric hospitals.50 GCAL and contracted providers can easily access information on who

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41 *Id.*
42 Utah Dept. of Health & Human Services, *supra* note 30.
43 *See* Galen Benshoof, Risk Corridors: What They Are and What They Do (Jan. 23, 2014), https://theincidentaleconomist.com/wordpress/risk-corridors/ for a further explanation of risk corridors in the context of the ACA.
44 Stephanie Hepburn, Georgia's Crisis System Transformation and Lessons Learned in Anticipation of 988 (Mar. 23, 2021), https://talk.crisisnow.com/georgias-crisis-system-transformation-and-lessons-learned-in-anticipation-of-988/
45 *Id.*
46 *Id.*
47 Judy Fitzgerald, Commissioner, Georgia Behavioral Health System Overview (Dec. 16, 2019), https://www.house.ga.gov/Documents/CommitteeDocuments/2019/Behavioral_Health_Reform/Behavioral_Health_Reform_Commission_12.16.19_FINAL.pdf
48 *Id.*
49 *Id.*
50 *Id.*

is waiting for a bed, how long they have been waiting, and how many beds are available.51 It also facilitates referral to services and/or placement in a treatment facility.

Mobile Crisis Response Service

Georgia's Mobile Crisis Response Service (MCRS) provides community-based, face-to-face, rapid responses to individuals in crisis.52 It is available 24/7 via GCAL and serves the entire state. MCRS offers crisis assessment, intervention, and referral services and includes post-crisis follow-up to ensure linkage with recommended services.53

Crisis Centers

Georgia has five Behavioral Health Crisis Centers (BHCC) throughout the state, which provide 24/7 walk-in services, as well as temporary observation (generally for no more than 24 hours), psychiatric crisis assessment, intervention, and counseling.54 BHCCs also include a Crisis Stabilization Unit, which provides short-term behavioral health crisis stabilization (the average length of stay is approximately six days).55 Georgia also has eighteen Crisis Stabilization Units (CSU) throughout the state, which serve as a residential alternative to inpatient hospitalization and provide community-based, medically monitored, short-term psychiatric stabilization and detoxification.56

Peer Support Services

Certified Peer Specialists (CPSs) are trained individuals who work from the perspective of their lived experience to provide support to individuals and families receiving mental health and/or substance use services.57 CPSs are present in all aspects of Georgia's crisis system, including GCAL, BHCCs, and CSUs.

COMMON THREADS ACROSS STATES

The behavioral health crisis systems in Arizona, Utah, and Georgia all align with the SAMHSA best practices.58 The three components underlying these practices are 24/7 call centers and mobile crisis teams, as

51 *Id*.
52 *Id*.
53 *Id*.
54 *Id*.
55 Georgia Dept. of Behavioral Health and Developmental Disabilities, The Crisis System of Georgia, https://dbhdd.georgia.gov/be-dbhdd/crisis-system-georgia
56 Fitzgerald, *supra* note 46.
57 Georgia Dept. of Behavioral Health and Developmental Disabilities, *supra* note 54.
58 Substance Abuse and Mental Health Services Admin., *supra* note 22.

well as 23-hour crisis receiving center that accept all individuals seeking care.59 SAMHSA's baseline expectations for each of these elements are as follows:

- Crisis call centers must operate 24/7, have clinicians on staff, answer every call, be able to assess suicide risk, coordinate with mobile crisis teams in the region, and connect individuals to facilities via warm handoffs.

- Mobile crisis teams must include a licensed clinician, be available to respond 24/7 to any individual in their designated region, and connect the individual to facilities as needed.

- Crisis receiving centers must be open and staffed with a qualified team 24/7, accept all individuals seeking care, provide medical assessment and stabilization, be able to address both mental health and substance abuse issues, ensure a quick drop-off time for law enforcement, and screen for suicide and violence risk.

In addition to the above features, there are similarities in how each state funds its system. Each state sources funding from multiple sources at the federal, state, and local level. Medicaid expansion has been crucial to the success of the crisis systems in both Arizona and Utah, while Georgia has yet to expand Medicaid.

IMPLEMENTATION IN VIRGINIA

After considering common threads across Arizona, Utah, and Georgia, we recommend the following as potential areas of improvement for Virginia:

1. Ensure that Virginia's local crisis hotlines are fully integrated with the national 988 line and mobile crisis teams in the region.

When seeking to reduce both overcrowding and negative outcomes in crisis care, the benefits of an easily accessible crisis line cannot be ignored. An effective crisis call center can help stabilize individuals without any inpatient treatment. If stabilization rates reach those of Utah (86%)60, total admittances to inpatient facilities can be significantly reduced. Furthermore, crisis lines are essential to enabling mobile crisis teams to divert individuals from hospitals and to stabilize them as quickly as possible.

2. Ensure that CSBs are consistently billing Medicaid

The expansion of Medicaid has been critical to the success of the behavioral health crisis systems in both Arizona and Utah. Both states worked to align their statutory and administrative schemes to ensure that

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59 *Id*.
60 Behavioral Health Crisis Response Comm., *supra* note 24.

providers can bill Medicaid for as many mental health crisis services as possible. While Georgia has not expanded Medicaid, the state uses Medicaid administrative funds to support its call center, GCAL.

In the past decade, however, Virginia's CSBs have not consistently billed Medicaid for their services. While the proportion of CSB consumers covered by Medicaid has increased over the past decade, Medicaid funding for CSB behavioral health services has decreased fifteen percent over this same period.61 Medicaid reimbursements account for about twenty percent of all CSB funding, but CSBs are not receiving as much Medicaid funding as they could be.62 Some CSBs cite the complexity of billing procedures and requirements for reimbursements, which is in part due to the increased complexity of the claiming and billing process associated with integrating behavioral health services into Medicaid managed care contracts (MCOs).63 Streamlining the process by which CSBs bill Medicaid for services could result in increased reimbursement rates which would help ensure that non-Medicaid state general funds and local funds are used more efficiently.

In addition to maximizing funding from Medicaid, Virginia should explore ways to work with private insurers to support crisis services as essential insurance services.

3. Commit to funding a statewide continuum of RCSUs, 23-hour CRCs, and mobile crisis outreach teams

Virginia's experience over the last decade has proven that too many individuals in mental health crisis do not get better in hospital emergency departments. Hospitals have served an outsized role in Virginia's mental health crisis system, resulting in increased burdens on emergency departments and law enforcement, as well as worse outcomes for patients. While Virginia does currently have some RCSUs and 23-hour CRCs, many areas of the state do not have these facilities and thus default to transporting individuals in crisis to hospital emergency departments. Furthermore, because of the short ECO period, these facilities do not take people in emergency custody; thus, the presence of a CRC in a community in Virginia does not result in reducing the transportation of such individuals to the emergency department. By investing in creating more of these facilities throughout the state, Virginia can provide necessary care to individuals within their own communities and obviate the need to take them to hectic emergency rooms. The experiences of Arizona, Utah, and Georgia show that many individuals, when taken to RCSUs or similar facilities, are able to be stabilized and returned to the community. Thus, by investing in these facilities, it is likely that fewer Virginians will need inpatient treatment in state psychiatric hospitals.

Furthermore, properly funding a network for mobile crisis teams across the State will enable callers to the 988-crisis line to receive the care they need. Effective mobile crisis teams can divert patients from hospitals and stabilization centers. In Utah, eighty percent of individuals treated by a mobile crisis team are able to remain at home, suggesting that Virginia can divert a significant portion of individuals from inpatient care by properly utilizing mobile crisis teams.64

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61 Joint Legislative Audit and Rev. Comm'n., *supra* note 3 at vi.
62 *Id*.
63 *Id*.
64 Utah Dept. of Health & Human Services, *supra* note 30.

While developing the state's crisis continuum will require substantial funding, Virginia is likely to save a lot of money as it stops relying on emergency departments and inpatient treatment. CrisisNow provides a detailed and modifiable calculator for states.65 This calculator estimates a $790 million annual cost to Virginia should the CrisisNow model be adopted, compared to a $1.7 billion counterfactual where Emergency Departments and In-patient care make up the crisis system entirely. While these numbers are estimates, they show that Virginia is likely to save money in the long-run by investing in RCSUs and other stabilization centers.

4. Consider using private providers to both deliver and coordinate regional services.

As discussed above, Arizona and Utah make use of contracted services with private entities to both deliver direct services and to coordinate regional crisis response. The Virginia Department of Juvenile Justice has employed a similar model – using private entities to coordinate regional service continuums – to serve court-involved youth. Virginia should explore the benefits, and drawbacks, of employing a similar model when standing up regional crisis response systems. To be clear, this is not to say that CSBs would stop performing their same essential functions. It is just to say that if Virginia moved to larger service regions it might be helpful to have service coordination that could include multiple CSB's.

5. Extend the ECO period.

While the General Assembly has tried to do this several times unsuccessfully, this is in part because Virginia does not have sufficient infrastructure to treat people under an ECO outside of a hospital emergency room. Investing in RCSUs and 23-hour CRCs may make stakeholders more amenable to extending the ECO period, as there will be places throughout the state that can stabilize individuals under an ECO and enable them to return home without being subjected to involuntary hospitalization. Thus, while it will be harder to model Virginia's system after any of these states without extending the ECO period, this should not dissuade Virginia from investing in a comprehensive system of mental health crisis care.

CONCLUSION

While the crisis systems of Arizona, Utah, and Georgia differ in some ways, they have three things in common: a comprehensive call center that is reachable 24/7, mobile crisis teams capable of reaching people statewide, and some kind of crisis receiving center that is capable of accommodating all patients for an extended period of time. Call centers and mobile crisis teams are often able to stabilize people without any need for inpatient care, saving the state money and sparing the individual the trauma of being transported somewhere else. Crisis receiving centers provide individuals with the appropriate care and can stabilize them

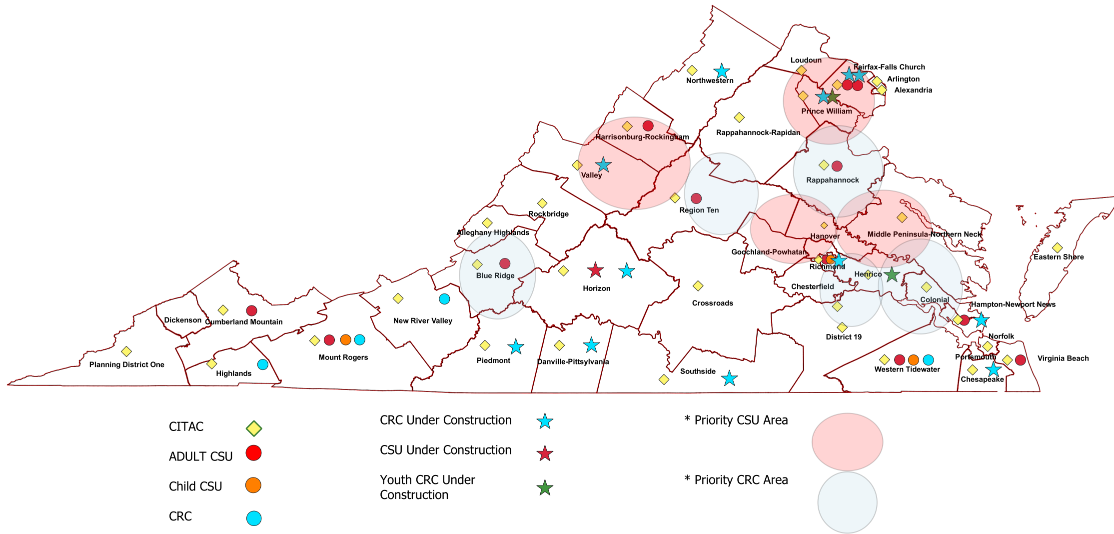
65 CrisisNow, Crisis Resource Need Calculator, https://calculator.crisisnow.com/#/data-insights?chart=SC&geo=State&lob=All&location_key=VA&metric1=bh_high_needs&tab=Map

without the need for involuntary commitment, freeing up space in psychiatric hospitals and saving the state money in the long-run. Furthermore, when crisis receiving centers are equipped to quickly take custody of individuals from law enforcement, this saves law enforcement officers time and allows them to focus on other obligations. By investing in integrated call centers, statewide mobile crisis teams, and crisis receiving centers, Virginia can deliver better care to individuals in crisis, reduce burdens on psychiatric hospitals and law enforcement officers, as well as minimize overall costs.

APPENDIX 2

Figure 1 (courtesy of the House Appropriations Committee):

Existing and Planned Crisis Sites, including Priority Areas



*Priority Areas identified as accessible within one hour of a facility, population coverage of 250,000, TDO rates outside of 1 Standard Deviation and evaluation of readiness and assets.
01.2023