

2009 Legislative and Budget Priorities

The National Association of State Mental Health Program Directors reports that Virginia ranks 9th in the country on spending for institutional care, but *only 39th on spending for community-based mental health services*. Virginia took a step forward in the 2008 legislative session with a “down payment” in funding for community-based mental health services. This session, there is more to be done to ensure that Virginia fulfills its promise to Virginia’s citizens by continuing to implement a full array of community-based services. In the face of challenging economic times and budget cuts, we must ensure that funding for mental health care remains a priority and that the gains from 2008 are not undone.

Quick Virginia Facts

- National prevalence data indicate that about **298,000** adult Virginians have a serious mental illness at any time during a given year. National prevalence rates also suggest that about **102,000** children and adolescents in Virginia have a serious emotional disturbance, and 65,000 of them are extremely impaired.ⁱ
- Average Community Services Board (CSB) Wait Time for Adult Outpatient Services for non-emergency Clinician Appointment: **30.22 days**ⁱⁱ
- Average CSB Wait Time for Child/Adolescent Outpatient Services for non-emergency Clinician Appointment: **37.42 days**ⁱⁱⁱ
- Number of Adults with Serious Mental Illness on CSB Waiting Lists for Mental Health Services: **4,029**^{iv}
- Number of Children and Adolescents With or At Risk of Serious Emotional Disturbance on CSB Waiting List for Mental Health Services: **1,680**^v

- **Implement advance directive legislation** to authorize and empower individuals to make instructional health-care decisions pertaining to non-end-of-life care issues, such as mental health treatment.
- **Implement the portability of auxiliary grants for housing, a cost-neutral housing proposal**^{vi} that will enable eligible individuals with mental illness to live in the least restrictive and most integrated setting available. For people with serious mental illness, lack of appropriate housing is a significant barrier to living successfully in the community—leaving too many in inappropriate or substandard housing or on the street.
- **Expand crisis stabilization** capacity to ensure that all 40 Community Services Boards are able to provide a safe, therapeutic program to support and stabilize adults experiencing acute psychiatric crisis. Goals of crisis stabilization include serving as an alternative to psychiatric hospitalization; providing step-down transition from inpatient care; and diverting persons from jail. Services can include 24-hour supervision; psychiatric assessment, treatment planning and referral; medication evaluation, education, and management; individual and group counseling; and discharge planning. Some population centers in Virginia do not have access to these services.
- **Increase access to local hospital beds, medications for indigent persons, and housing arrangements for community stability** through Local Inpatient Purchase of Beds (LIPOS) for the prevention of serious crises and incidents. Using private hospital beds can help leverage Medicaid funding for community services boards while keeping individuals closer to their homes, families, and peer supports.
- **Expand jail diversion programs to ensure that people with serious mental illness receive treatment**, not jail time. Fully fund Virginia’s jail diversion programs using the Sequential Intercept Model, which provides diversion strategies at every point of intersection between a person with mental illness/co-occurring disorders and a law enforcement officer. Expand Crisis Intervention Training (CIT) programs to help law enforcement respond safely and quickly to people with serious mental illness in crisis--avoiding injuries, consumer deaths, jail time, and community tragedy. CIT training reduces officer stigma and prejudice towards people with mental illness.^{vii} After the introduction of CIT in Memphis, officer injuries sustained during responses to “mental disturbance” calls dropped 80%.^{viii} After the introduction of CIT in Albuquerque, the number of crisis intervention calls requiring SWAT team involvement declined by 58%.^{ix}
- **Support recommendations of the Task Force on Children’s and Adolescent Mental Health from the Commission on Mental Health Law Reform**, including improving access to in-home and community-based mental health services, supporting improvements to the Comprehensive Services Act, and supporting school-based mental health services.

ⁱ JLARC Report on Availability and Cost of Licensed Psychiatric Services in Virginia; July 2007

ⁱⁱ Office of the Inspector General For Mental Health, Mental Retardation & Substance Abuse Services; Survey of CSB Outpatient Service Capacity and Commitment Hearing Attendance; September 2007

ⁱⁱⁱ Ibid.

^{iv} Commonwealth of Virginia Community Mental Health Services Block Grant Application; Department of Mental Health, Mental Retardation & Substance Abuse Services' August 2009

^v Ibid.

^{vi} Office of The Secretary of Health and Human Resources; Auxiliary Grant Portability, A Report on the Feasibility of Restructuring Auxiliary Grants for Certain CSB Case Management Consumers; 2007

^{vii} Compton, M., Esterberg, M., McGee, R., Kotwicki, R., & Oliva, J. (2006). "Crisis intervention team training: changes in knowledge, attitudes, and stigma related to schizophrenia." *Psychiatric Services*, 57, 1199-1202.

^{viii} Dupont, R., Cochran, S., & Bush, A. (1999) "Reducing criminalization among individuals with mental illness." Presented at the US Department of Justice and Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA) Conference on Forensics and Mental Illness, Washington, DC, July 1999.

^{ix} Bower, D., & Pettit, G. (2001). The Albuquerque Police Department's Crisis Intervention Team: A Report Card. *FBI Law Enforcement Bulletin*.