DBHDS
Virginia Department of Behavioral Health and Developmental Services

AGENDA PACKET

AS ADOPTED

State Board of Behavioral Health and Developmental Services

Wednesday, July 15, 2026

DBHDS Central Office, 13th Floor
Jefferson Building, 1220 Bank Street, Richmond, VA 23219

Meetings are in person with a physical quorum present; however, electronic meeting access is available.

8:30 a.m. — **POLICY AND EVALUATION COMMITTEE MEETING**
Medium Conference Room, 13th Floor South

Membership: McDonald, Graser, Schroder, Coster, (Vacancy)

Electronic Meeting Access:	
Microsoft Teams	Click here to join Committee Meeting
Meeting ID:	218 687 493 397 324
Passcode:	zA3Zp6ZR
Audio only	
Dial in by phone:	434-230-0065
Phone Conference ID:	780 888 809#

Agenda, pages **19-29**

8:30 a.m. — **PLANNING AND BUDGET COMMITTEE MEETING**
Large Executive Board Room, 13th Floor South

Membership: Andis, Chung, Vadella, (Vacancy)

Electronic Meeting Access:	
Microsoft Teams	Click here to join Committee Meeting
Meeting ID:	222 831 169 776 747
Passcode:	JS6nr3wy
Audio only	
Dial in by phone:	434-230-0065
Phone Conference ID:	630 541 716#

Agenda, pages **30-33**

9:30 a.m. — **REGULAR QUARTERLY BOARD MEETING**
Large Executive Board Room, 13th Floor South

Electronic Meeting Access:	
Microsoft Teams	Click here to join Full Board Meeting
Meeting ID:	222 831 169 776 747
Passcode:	JS6nr3wy
Audio only	
Dial in by phone:	434-230-0065
Phone Conference ID:	630 541 716#

Agenda, pages **2-3**

AGENDA PACKET AS ADOPTED

State Board of Behavioral Health and Developmental Services

WEDNESDAY, JULY 15, 2026

Regular Quarterly Board Meeting

9:30 a.m.

DBHDS Central Office, 13th Floor South Large Executive Board Room
Jefferson Building, 1220 Bank Street, Richmond, VA 23219

ELECTRONIC MEETING ACCESS	
Microsoft Teams	Click here to join
Meeting ID:	222 831 169 776 747
Passcode:	JS6nr3wy
Audio only	
Dial in by phone:	434-230-0065
Phone Conference ID:	630 541 716#

Meeting is in person with a physical quorum present; however, electronic meeting access is available.

1.	**CALL TO ORDER**		
	A. Determination of Quorum **B.** Welcome and Introductions **C.** Adoption of Agenda **D.** Approval of Draft Minutes	Action Item	Pages **4-18**
2.	**OFFICER ELECTIONS**		
	A. Presentation of Slate of Candidates **B.** Nominations from the Floor **C.** Election of Chair and Vice Chair **D.** Passing of the Gavel	Action Item	
3.	**PUBLIC COMMENT**		
	Public comment on agenda items will be accepted in person or virtually using the electronic meeting access option. Comment will not be accepted on regulatory actions or rulemaking petitions for which the public comment period has closed. Each commenter, whether in-person or virtual, will be limited to three minutes. **Pre-registration is requested but not required.** Persons wishing to comment are asked to email mary.broz-vaughan@dbhds.virginia.gov by 5:00 p.m., on Tuesday, July 14, 2026.		
4.	**STANDING COMMITTEE REPORTS**		

5.	**UNFINISHED BUSINESS**		
	Consideration of revisions recommended by the Policy and Evaluation Committee in April.	Action Item	Pages **34-46**
6.	**COMMISSIONER'S REPORT**		
7.	**REGULATORY AFFAIRS REPORT**		
	A. Standard Action to Integrate Central Registry into MOUD Treatment Provider Licensing Regulations	Action Item	Pages **47-51**
	B. Updated Emergency/NOIRA Actions to Align Licensing Regulations with Most Recent DMAS Revisions to Redesigned Medicaid Services	Action Item	Pages **52-134**
	i. Summary of Major Changes		Page **53**
	ii. Community Psychiatric Support & Treatment (CPST)		Pages **54-81**
	iii. Coordinated Specialty Care (CSC)		Pages **82-108**
	iv. Recovery and Empowerment Center (REC)		Pages **109-134**
	C. Regulatory Activity Status Report	Information	Pages **135-136**
8.	**NEW BUSINESS**		
	A. Annual Meeting Schedule Adoption	Action Item	Page **137**
	B. State Human Rights Committee Appointments	Action Item	Pages **138-141**
9.	**VACSB QUARTERLY UPDATE**		
10.	**DBHDS PRESENTATION:** SCHOOL-BASED MENTAL HEALTH PROGRAMS		
11.	**LUNCH BREAK**		
12.	**DBHDS PRESENTATION:** 2026-2028 BIENNIAL STATE BUDGET		
13.	**ANNOUNCEMENTS**		
14.	**ADJOURNMENT**		

NEXT MEETING: WEDNESDAY, SEPTEMBER 23, 2026

The agenda and packet as adopted by the Board was made available to the public at the meeting in accordance with the Virginia Freedom of Information Act (§ 2.2-3700 et seq. of the Code of Virginia).

DRAFT MINUTES

State Board of Behavioral Health and Developmental Services

REGULAR QUARTERLY BOARD MEETING

Wednesday, April 22, 2026

Northern Virginia Mental Health Institute (NVMHI)
3302 Gallows Road, Falls Church, VA 22042

The meeting was held in person with a physical quorum present and with electronic or phone connection available.

MEMBERS PRESENT	R. Blake Andis Sandy Chung, MD Caroline Coster, MD Rebecca Graser Jane McDonald Nina Schroder Tony Vadella	**MEMBERS ABSENT**	None
DBHDS STAFF present for all or part of the meeting	Mary Broz-Vaughan, Regulatory Affairs Director/State Board Liaison Madelyn Lent, Public Policy Manager Meghan McGuire, Deputy Commissioner, Policy and Public Affairs Susan Puglisi, Regulatory Research Specialist Alyssa Ward, Chief Deputy Commissioner Daryl Washington, Commissioner		
INVITED GUESTS present for all or part of the meeting	Katherine Beach, NVMHI Chief Clinical Officer Ronald Cress, NVMHI Chief Operating Officer Lauren Cunningham, DBHDS Communications Director Jennifer Faison, VACSB Executive Director Cassie Grillon, DBHDS Marketing & Communications Manager Mason Kaufmann, DBHDS Digital Production Specialist Josie Mace, DBHDS Legislative Affairs Director Nathan Miles, DBHDS Chief Financial Officer Bowen Monroe-Mihailoff, DBHDS Public Affairs Manager Candace Roney, DBHDS Addiction, Recovery & Wellness Supports Director Rick Wallace, NVMHI Interim CEO and Chief Nurse Officer		
OTHER ATTENDEES	Mark Blackwell; LeVar Bowers; Tom Jackson, Virginia Recovery Advocacy Project; Cara Kaufman, DARS; Kristine Konen; Crystal Lipford, DBHDS Quality & Risk Management Director; Katherine Means, DBHDS Assistant Commissioner for Quality Management and Strategic Outcomes; Dev Nair, DBHDS Assistant Commissioner for Provider Management; Chaye Neal-Jones, DBHDS Enterprise Management Services Director; Kimora Porter, DBHDS Quality Assurance & Healthcare Compliance Director.		

CALL TO ORDER	Chair Blake Andis called the meeting to order at 9:35 a.m.
Determination of Quorum	Sheriff Andis reported that a quorum was present with no board members participating remotely.
Introductions	Sheriff Andis announced the resignations of board members Cindy Lamb and Debbie Marrs, noting that Virginians interested in applying to fill vacancies may do so via the Secretary of the Commonwealth's website. Sheriff Andis welcomed Commissioner Washington and Dr. Ward and asked for introductions.
Adoption of Agenda	A motion was made by Ms. McDonald and seconded by Dr. Chung to adopt the agenda. The motion carried unanimously.
Approval of Minutes	Sheriff Andis advised the board of one technical amendment to the December 10, 2025, meeting minutes. Mr. Vadella moved to approve the minutes en bloc as amended. Dr. Chung seconded the motion, which carried unanimously.
Public Comment	Sheriff Andis opened the floor for public comment. Kristine Konen addressed the board regarding recovery services and offered written comment for the record. Mark Blackwell addressed the board regarding recovery services and offered written comment for the record. Tom Jackson addressed the board regarding recovery services and offered written comment for the record. Sheriff Andis closed public comment.
Standing Committee Reports	Ms. McGuire reported that the Planning and Budget Committee reviewed the statutory background and historical context for the bylaws provision on liaison assignments. Staff will draft revisions to provide clarity and flexibility for the committee to consider at its next meeting. Ms. Lent reported that the Policy and Evaluation Committee reviewed draft revisions and field review comments for Policy 6005 (FIN) 94-2 – Retention of Unspent State Funds by Community Services Boards, as well as Policy 3000 (CO) 74-10 – Appointments of Department Employees to Community Services Boards. After discussion, Committee members voted to recommend both policies to the full board as revised.

Unfinished Business	At the December meeting, the Policy and Evaluation Committee voted to recommend amendments to Policy 2011 (ADM) 88-3 – Naming of Buildings, Rooms, and Other Areas at State Facilities. Sheriff Andis directed members to the revisions in the agenda packet. On a motion by Dr. Chung, properly seconded by Ms. McDonald, the board unanimously approved the revisions to Policy 2011 as presented.
Regulatory Business	Sheriff Andis asked Ms. Puglisi to review the agenda item authorizing a revised Emergency/Notice of Intended Regulatory Action (NOIRA) action. Ms. Puglisi explained that the board, at its December meeting, voted to develop emergency regulations to ensure consistency with the newly funded Medicaid services for Coordinated Specialty Care (CSC) based on the draft DMAS policy published at that time. However, on March 26, 2026, DMAS announced changes to its CSC policy. As a result, to remain aligned with DBHDS licensing regulations, this revised Emergency/NOIRA action conforms to those changes because consistency is important for licensed providers as well as for individuals receiving services and their families. **MOTION:** Dr. Chung moved to adopt revised emergency regulations amending 12VAC35-105 to align with Medicaid behavioral health services redesign for Coordinated Specialty Care, as presented, and to issue a NOIRA for permanent replacement regulations. Ms. Schroder seconded, and the motion carried unanimously.
Facility Tour	Sheriff Andis recessed the meeting while the board toured the facility. He announced the meeting would reconvene at approximately 10:45 a.m.
The Board recessed at 10:00 a.m. to reconvene at 10:45 a.m.	
The Board reconvened at 11:00 a.m.	
Facility Overview	NVMHI executive leadership team members presented on the facility's history, services, successes, and challenges. Presentation available from board office upon request.
Commissioner's Report	Commissioner Washington provided updates on the crisis system transformation, hospital census/waitlist dashboard, and community continuum of care. Presentation available from board office upon request.
Lunch Recess	Sheriff Andis recessed the meeting for lunch.
The Board recessed at 12:00 p.m. to reconvene at 12:15 p.m.	
The Board reconvened at 12:15 p.m.	

Reordering of Agenda	Sheriff Andis requested unanimous consent to take business out of order to accommodate presenters' schedules. Without objection, board members agreed to reorder the agenda.
Certified Recovery Residences Update	Dr. Roney reviewed the legal framework governing recovery residences in preparation for future regulatory actions directed by 2026 legislation. Presentation available from board office upon request.
Post-Session Legislative and Budget Update	Ms. Mace summarized significant DBHDS legislation from the 2026 General Assembly Session. Mr. Miles noted the legislature continues to negotiate work on the budget. Presentation available from board office upon request.
Communications Update	Ms. Cunningham reviewed DBHDS internal and external communications activities and impact. Presentation available from board office upon request.
VACSB Update	Ms. Faison updated the board on Virginia Association of Community Services Boards (VACSB) budget and policy priorities.
New Business	Sheriff Andis called for any new business. Mr. Vadella and Ms. Schroder requested discussion regarding the public comment received about recovery services. Commissioner Washington explained that the change represents an internal restructuring intended to streamline operations and more fully integrate the perspective of recovery services throughout the organization. He expressed support for the change and noted that DBHDS is in the process of identifying appropriate metrics to evaluate whether the restructuring achieves its intended outcomes. Ms. McGuire clarified that certain information presented by commenters was inaccurate, specifically noting there has been no overall reduction in funding allocated to recovery activities. She stated that staff are actively working to distribute these funds more equitably among recovery organizations across Virginia. Ms. McGuire also acknowledged concerns raised during public comment regarding communication and indicated that, following the conclusion of the General Assembly session, DBHDS is initiating workgroups to address provider concerns and broader system-level issues. Dr. Ward added that the formation of workgroups is intended not only to improve internal communication among staff but also to ensure that relevant information is shared appropriately with external stakeholders.

Commending Resolutions	Continuing with new business, Sheriff Andis directed members to draft copies of commending resolutions for the two board members whose recent resignations he referenced at the beginning of the meeting. On a motion by Mr. Vadella, properly seconded by Dr. Chung, the board unanimously adopted the commending resolutions honoring the service of former board members Cindy Lamb and Debbie Marrs.
Announcements	Ms. Broz-Vaughan reminded board members of the quarterly budget report. The handout was for informational purposes only and did not require any action.
ADJOURNMENT	Sheriff Andis adjourned the meeting at 1:35 p.m.
The State Board adjourned at 1:35 p.m.	

NEXT MEETING SCHEDULED FOR WEDNESDAY, JULY 15, 2026

PUBLIC COMMENT

Received electronically Monday, April 20, 2026 4:24 PM

Good morning, members of the Board.

I am a person with a chronic, progressive, and fatal disease. My disease of substance addiction and mental health issues. I spent almost 40 years in the incessant, relentless cycle of addiction. Today my disease is in remission due to a rigorous, persistent, and intentional holistic recovery process. This process does more than keep my disease at bay; it affords me a life of purpose and meaning. Fundamental to my recovery—and the recovery of thousands of Virginians—is the act of helping others navigate their own path to wellness.

I am requesting that you direct DBHDS Leadership to:

- Reestablish the Office of Recovery Services, and
- Establish a formal communications channel to facilitate ongoing dialogue between the DBHDS Senior Leadership, Virginians in recovery, and the peer recovery workforce.

Having served in the DBHDS Office of Recovery Services (ORS), I have experienced the unique value of collaborating with professionals who view every challenge through a recovery lens. We share a camaraderie born of lived experience that allows us to serve our constituents with unmatched authenticity.

In 2010, DBHDS established a visionary roadmap that moved Virginia from a facility-bound system to a community-focused model. It established the ORS to ensure that the "Voice of Recovery" was not a footnote, but the foundation of our strategic planning. Virginia became a national innovator by refusing to classify individuals by their diagnosis, choosing instead a holistic strength-based foundation.

This approach is backed by rigorous data. Evidence from the American Hospital Association and SAMHSA shows that recovery-oriented systems utilizing peer specialists lead to a 43% reduction in inpatient services and a 56% decrease in readmission rates. The Return on Investment is undeniable: studies show a return of over $2.25 for every dollar invested in peer recovery services.

Despite this, we are currently witnessing a catastrophic reversal of progress. The recent decision to close the Office of Recovery Services and reallocate staff into diagnosis-based silos was made unilaterally. In my 20 years in the Virginia recovery landscape, I have never seen such a consequential decision made without stakeholder involvement. Our fundamental value of "Nothing About Us Without Us" was intentionally ignored, and the major outcry in opposition was ignored.

The adverse effects are already visible:

• Decimated Resources: Discretionary funding has been eliminated, and Recovery Community Organizations - the backbone of our safety net—have seen their budgets slashed and threatening their mere existence.

• Systemic Confusion: Our constituents no longer know who to contact. The centralized "home" for recovery has vanished-hidden within clinical diagnosis-based bureaucracy.

• A Culture of Fear: There is no longer a forum to voice concerns. Peers and organizations are now fearful of repercussions if their needs do not align with administration silos.

By splitting recovery staff into "diagnosis" offices, you signal that the person is their disease, not their potential.

Recovery is not a sub-category of a diagnosis; it is the evidence-based solution to our state's mental health crisis. I urge this Board and the incoming administration to honor the data and our history of innovation. Restore the Office of Recovery Services to as the voice of recovery on a senior leadership capacity.

Furthermore, I request that a formal communications channel be established to facilitate ongoing dialogue between the DBHDS Senior Leadership, Virginians in recovery, and the peer recovery workforce. It is essential that those on the front lines of this crisis have a structured and transparent way to provide input and receive updates on policies that directly impact their lives and livelihoods.

Thank you for your time.

Mark Blackwell

PUBLIC COMMENT

Received electronically Tuesday, April 21, 2026 4:20 PM

Public comment to the DBHDS Board

Submitted by Kristine Konen, MBA, PRS

April 2026

Good morning members of the Board,

In 2014, while being treated for a mental health emergency, my voice was taken away by the attending clinical staff treating me. Long story short, I consider myself lucky I'm still alive.

There are so many nuances to mental health, substance use and problem gambling treatment, all cannot be named. No matter how many years of clinical experience in the arena, peer supports and the recovery voice – along with their understanding allies - contribute a significant factor in how a human should be treated.

I am reaching out today to connect in relation to re-establishing the Recovery voice at DBHDS.

In early 2026, a group of advocates gathered data, including both a survey of peers (n=47) and a separate March consensus workshop with 16 leaders. The survey results are rather alarming; 75.1% of peers surveyed do not currently know which DBHDS office to contact to get their questions answered. There are over 1,800 peers certified in Virginia with limited guidance on where to turn to find answers. If answers are found, it takes a significant amount of time because they are buried six layers deep.

As a result of the March 2026 consensus workshop, the top priorities identified were:

1. Establishing a sustainable relationship with DBHDS leadership.
2. Communication - with Recovery having a permanent home at the Department.

In relation to communication, a workgroup was promised last year during the DBHDS leadership presentation SAARA hosted in the month of May. It has taken 10 months to establish there will be a workgroup starting in Spring 2026.

To say the 2025 re-alignment of the Office of Recovery Services was detrimental to the treatment of peers seeking services for mental health, substance use and problem gambling disorders is an understatement. The re-alignment not only shifted services to a clinical model, when peer support is intended to be non-clinical, it also shifted the funding sources many community organizations relied on for serving as bridges in their local communities.

Breaking down the infrastructure built during the last 10 years was done without input from anyone in the peer community. No peers, no allies, nothing. The voice of recovery was suppressed. It is disheartening at best that this was the path chosen. I am reaching out with the hope the new administration will seriously consider re-establishing an elevated Recovery voice within DBHDS.

Thank you for your time.

PUBLIC COMMENT

Received electronically Tuesday, April 21, 2026 4:22 PM

tom.jackson@varecoveryadvocacy.org
434-249-0851

Mr. Chairman and Members of the Board:

My name is Tom Jackson. I am a Registered Peer Recovery Specialist, a PRS instructor, a founding member of the DSBHDS Peer Ethics Committee, and a person with lived and living experience in recovery since May 13, 1991.

I am also the Co-Lead Organizer of the Virginia Recovery Advocacy Project on whose behalf I am speaking, and also the 2026 Co-Chair of the Recovery Professionals and Community Partners Roundtable, and I retired from Western State last fall after 22 years in public and community co-occurring mental health and substance use services.

While we do need a "No Wrong Door" policy as contained in Right Help, Right Now, we also need a "One Stop Shop" for peer workforce and recovery issues. As the Roundtable survey results others have presented or will present, since the Office of Recovery Services was disbanded, over 72% of respondents found it "challenging or a lot more challenging" to find where to get responses from the Department, and about 50% of them found it took much longer than expected and/or the first response they received was incorrect.

When Department leadership disbanded ORS, they did it in the dark, with no feedback requested from the recovery community beforehand, no acknowledgement of the almost four hundred emails, letters and petition signatures we sent, and no input from the people actually doing the work. Bluntly, that inconsiderate and shortsighted process shows exactly how much the leadership at the time valued our voices.

To fix that, we need to restore ORS to what it originally was: a successful, nation-leading, direct, two-way communications pipeline to the Commissioner, not one or two levels down in a clinical-oriented bureaucracy that still doesn't often treat us as equals.

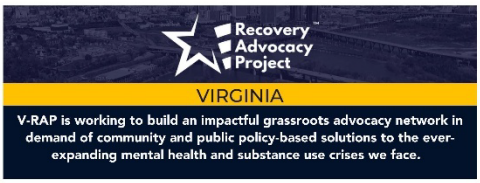
With regard to funding cuts, as an example, the Virginia Certification Board last month posted a one-sentence notice on their web page that they are no longer in the business of certifying continuing education credits for us, with no explanation, and no guidance to alternative sources. Again, that kind of one-sided treatment never happened when ORS was in place.

Please restore ORS to what it originally was, a permanent direct report to the Commissioner, and from there we can do what the disbanding was alleged to accomplish – making sure the voices of recovery are heard throughout the Department.

Thank you.

Thomas A. Jackson
Co-Lead Organizer

652 W Frederick St
Staunton VA 24401



NEW BUSINESS

COMMONWEALTH of VIRGINIA

STATE BOARD OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES

Cindy Lamb

At its regular meeting on Wednesday, April 22, 2025, the State Board of Behavioral Health and Developmental Services unanimously adopted the following resolution:

WHEREAS, Cindy Lamb was appointed by Governor Glenn Youngkin to the State Board of Behavioral Health and Developmental Services in 2023; and

WHEREAS, Cindy Lamb served as a family member of an individual who is receiving or who has received services; and

WHEREAS, during her tenure, Cindy Lamb did faithfully endeavor to protect the rights and safety of individuals and their families, and to strengthen Virginia's system of community mental health, developmental, and substance use disorder services; and

WHEREAS, Cindy Lamb's advocacy, integrity, and commitment earned her the respect and admiration of the members of the Board, its staff, and all others associated with its activities; now, therefore, be it

RESOLVED, That the State Board of Behavioral Health and Developmental Services does hereby express its affection and gratitude to Cindy Lamb, for her contributions to this body; and be it

RESOLVED FURTHER, That this Resolution be made a part of the official minutes of the Board, and that a framed copy thereof be presented to Cindy Lamb, so that all may know of the high regard in which she is held.

COMMONWEALTH of VIRGINIA

STATE BOARD OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES

Debbie Marrs

At its regular meeting on Wednesday, April 22, 2025, the State Board of Behavioral Health and Developmental Services unanimously adopted the following resolution:

WHEREAS, Debbie Marrs was appointed by Governor Glenn Youngkin to the State Board of Behavioral Health and Developmental Services in 2025; and

WHEREAS, Debbie Marrs served as a family member of an individual who is receiving or who has received services; and

WHEREAS, during her tenure, Debbie Marrs did faithfully endeavor to protect the rights and safety of individuals and their families, and to strengthen Virginia's system of community mental health, developmental, and substance use disorder services; and

WHEREAS, Debbie Marrs's advocacy, integrity, and commitment earned her the respect and admiration of the members of the Board, its staff, and all others associated with its activities; now, therefore, be it

RESOLVED, That the State Board of Behavioral Health and Developmental Services does hereby express its affection and gratitude to Debbie Marrs, for her contributions to this body; and be it

RESOLVED FURTHER, That this Resolution be made a part of the official minutes of the Board, and that a framed copy thereof be presented to Debbie Marrs, so that all may know of the high regard in which she is held.

DRAFT MINUTES

State Board of Behavioral Health and Developmental Services

PLANNING AND BUDGET COMMITTEE

Wednesday, April 22, 2026

Northern Virginia Mental Health Institute (NVMHI)
3302 Gallows Road, Falls Church, VA 22042

The meeting was held in person with a physical quorum present and with electronic or phone connection available.

MEMBERS PRESENT	R. Blake Andis Sandy Chung, MD Tony Vadella
MEMBERS ABSENT	None
STAFF PRESENT	Mary Broz-Vaughan, Regulatory Affairs Director/State Board Liaison Meghan McGuire, Deputy Commissioner, Policy and Public Affairs Susan Puglisi, Regulatory Research Specialist

CALL TO ORDER	Blake Andis called the meeting to order at 8:50 a.m.
Determination of Quorum	Sheriff Andis reported that a quorum was present with no members participating remotely.
Adoption of Agenda	A motion was made by Dr. Chung and seconded by Mr. Vadella to adopt the agenda. The motion carried unanimously.
Review Meeting Plan for 2026-28 Biennium	Ms. Broz-Vaughan reviewed the meeting plan adopted by the board in July 2025, including the standing agenda items to be covered for the remainder of the year. In planning for future presentations, committee members directed staff to focus on the board's priority areas of workforce and system capacity, community-based services, substance use disorder treatment, the crisis continuum, and school-based programs.
Review of Board Bylaws Article VIII	Ms. McGuire provided historical context and statutory background for the board's bylaws provision on liaison assignments. After discussion, committee members requested staff draft revisions to the bylaws and accompanying guidelines to provide clarity and flexibility.
Announcements	Ms. Broz-Vaughan directed committee members to the quarterly budget report. The handout was for informational purposes only and did not require any action.
ADJOURNMENT	Sheriff Andis adjourned the meeting at 9:15 a.m.

STATE BOARD OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES

Policy and Evaluation Committee
DRAFT MINUTES
APRIL 22, 2026
NORTHERN VIRGINIA MENTAL HEALTH INSTITUTE
3302 GALLOWS ROAD, FALLS CHURCH, VA 22042

This meeting will be held in person with a physical quorum present, with electronic or phone connection available.

Members Present: Jane McDonald (Committee Chair), Rebecca Graser, Nina Schroder, Caroline Coster, M.D.

DBHDS Staff Present: Madelyn Lent, Public Policy Manager
Nathan Miles, Chief Financial Officer (virtual)
Chaye Neal-Jones, Director, Office of Enterprise Management Services (virtual)
Benjamin Marks, Director of Facility Data Analytics and Evaluation (virtual)
Crystal Lipford, Director of Quality and Risk Management, Division of Facility Services (virtual)
Kimora Porter, Director of Quality Assurance and Healthcare Compliance (virtual)

I. Call to Order

II. Welcome and Introductions (5 min)

Jane McDonald called the meeting to order at 8:55 am.

III. Adoption of Agenda, April 22, 2026

Rebecca Graser moved to adopt the agenda. Nina Schroder seconded. The agenda was adopted unanimously.

IV. Adoption of Minutes, December 10, 2025

Nina Schroder moved to adopt the minutes. Dr. Caroline Coster seconded. The minutes were adopted unanimously.

V. Review Policy Plan for FY2025 - FY2030 (5 min)

Madelyn Lent presented the policy plan and the committee briefly reviewed.

VI. Presentation of Background Reviews (15 min)

The committee received background information on Policy 1030 (SYS) 90-3 Consistent Collection and Utilization of Data in State Facilities and Community Services Boards to start the periodic review cycle for this policy. Benjamin Marks, Director of Facility Data Analytics and Evaluation, provided a conceptual overview of agency recommended technical revisions which will be presented in detail at the next meeting.

The committee postponed review of Policy 1040 (SYS) 06-3 Involvement and Participation of Individuals Receiving Services and Family Members. The background review will be provided with the presentation of draft revisions at the July committee meeting.

VII. Presentation of draft revisions for recommendation to the full board (25 min)

The committee reviewed draft revisions recommended by the Department for Policy 3000 (CO) 74-10 Appointments of Department Employees to Community Services Boards and field review comments received from Community Services Boards at the December meeting. Rebecca Graser motioned to recommend the revisions to the full board and Nina Schroder seconded. The motion passed unanimously.

The committee reviewed draft revisions recommended by the Department for Policy 6005 (FIN) 94-2 Retention of Unspent State Funds by Community Services Boards. The committee reviewed comments received from Community Services Boards (CSBs) on the revisions presented by the Department at the December committee meeting. The committee reviewed updated revisions included in the April committee meeting materials packet. Nathan Miles, DBHDS Chief Financial Officer responded to members' questions. Members requested a technical edit to consistently use the term "balances of unspent state general funds" throughout the document. Members noted the revisions would clarify that the performance contract process would be the vehicle for negotiating and establishing requirements for unspent general fund balances within the general parameters established by the policy. Revisions would also establish explicit requirements for the Department to communicate with CSBs prior to taking actions related to unspent general fund balances. Nina Schroder motioned to recommend the revisions to the full board and Rebecca Graser seconded. The motion passed unanimously.

VIII. Next Quarterly Meeting: July 15, 2026.

IX. Adjournment

Jane McDonald adjourned the meeting at 9:27 am.

All current policies of the State Board are here: https://dbhds.virginia.gov/about-dbhds/Boards-Councils/state-board-of-BHDS/bhds-policies/.

DRAFT MINUTES

State Board of Behavioral Health and Developmental Services

DINNER MEETING

Tuesday, September 21, 2026

Alta Strada – Mosaic
2911 District Avenue, Fairfax, VA 22031

MEMBERS PRESENT	R. Blake Andis Caroline Coster, MD Rebecca Graser Nina Schroder Tony Vadella
MEMBERS ABSENT	Sandy Chung, MD Jane McDonald
STAFF PRESENT	Mary Broz-Vaughan, Regulatory Affairs Director / State Board Liaison Madelyn Lent, Public Policy Manager Meghan McGuire, Deputy Commissioner, Policy and Public Affairs Chaye Neal-Jones, Director of Enterprise Management Services Susan Puglisi, Regulatory Research Specialist Candace Roney, PhD, Director of Addiction, Recovery, and Wellness Supports Alyssa Ward, PhD, Chief Deputy Commissioner Daryl Washington, Commissioner

CALL TO ORDER	Blake Andis called the dinner meeting to order at 6:10 p.m. Sheriff Andis explained the purpose of the informal gathering was to receive information about community programs and services, noting the members would not discuss or transact public business.
ADJOURNMENT	The meeting adjourned at 8:00 p.m.

STATE BOARD OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES

Policy and Evaluation Committee
DRAFT AGENDA
JULY 15, 2026
DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES CENTRAL OFFICE
1220 BANK STREET RICHMOND, VA 23219
This meeting will be held in person with a physical quorum present, with electronic or phone connection available.

I. Call to Order

II. Welcome and Introductions (5 min)

III. Adoption of Agenda, July 15, 2026

IV. Adoption of Minutes, April 22, 2026

V. Review Policy Plan for FY2025 - FY2030 (5 min)

VI. Introduce Draft Revisions

The committee received background information on Policy 1030 (SYS) 90-3 Consistent Collection and Utilization of Data in State Facilities and Community Services Boards to start the periodic review cycle for this policy at the April meeting. Department staff will present recommended technical revisions to the policy.

The committee postponed review of Policy 1040 (SYS) 06-3 Involvement and Participation of Individuals Receiving Services and Family Members. Department staff will provide a background review and recommended revisions to the policy. The background review for this policy was originally scheduled for the April meeting. The committee postponed this agenda item to the next meeting for the background review to be provided with the presentation of draft revisions.

VII. Next Quarterly Meeting: September 23, 2026.

VIII. Adjournment

All current policies of the State Board are here: https://dbhds.virginia.gov/about-dbhds/Boards-Councils/state-board-of-BHDS/bhds-policies/.

	Revised 11/30/93 Revised 09/07/05 Revised 4/09/13 *Revised ??/??/????*
POLICY MANUAL **State Board of Behavioral Health and Developmental Services** **Department of Behavioral Health and Developmental Services**	
	POLICY 1030 (SYS) 90-3 Consistent Collection and Use of Data About Individuals and Services
Authority	Board Minutes Dated: June 27, 1990 Effective Date: June 27, 1990 Approved by Board Chairman s/Greer D. Wilson, Ed.D.
References	§ 37.2-500, § 37.2-504, §37.2-508, § 37.2-601, § 37.2-605, and § 37.2-608 of the Code of Virginia (1950), as amended STATE BOARD POLICY 1021 (SYS) 87-9 Core Services Taxonomy STATE BOARD POLICY 1034 (SYS) 05-1 Partnership Agreement STATE BOARD POLICY 4018 (CSB) 86-9 Community Services Board ~~Performance Contracts~~ Current Community Services Performance Contract *Community Services Board Interface Requirements & Design Document* ~~Current Community Consumer Submission (CCS) Extract Specifications~~ ~~Current State Facility Director Performance Agreements~~ ~~Current Core Services Taxonomy~~ ~~Current Department of Mental Health, Mental Retardation and Substance Abuse Services Information Technology Strategic Plan~~ Current version of AVATAR (State Facility *Administrative and Billing* Information System) *Millennium Electronic Health Record (State Facility Clinical Information System)*
Supersedes	STATE BOARD POLICY 1037 (SYS) 05-4 Individual Consumer Information and the Community Consumer Submission
Background	The Department recognizes that development of efficient and compatible information systems, identification and implementation of data reporting requirements that are cost-effective and consistent, and use of the data that these systems produce are integral to the effective, efficient, and accountable provision and management of services to individuals receiving services, hereafter referred to as individuals, and the responsible stewardship of financial and human resources. Beginning in the early 1980s, the Department, in collaboration with the Virginia

	Association of Community Services Boards (VACSB) Data Task Force and representatives from state facilities, initiated efforts to standardize data collection for community services boards and behavioral health authorities, hereafter referred to as CSBs, and state hospitals and training centers, hereafter referred to as state facilities. By 1985, this collaboration produced the original core services taxonomy, the first individualized client data elements (ICDE) that listed minimum data elements to be collected by CSBs, and the community services performance contract, all of which established routine reporting requirements and a minimum data set for CSBs or state facilities. In 1993, the VACSB established the Administration Committee, which included department staff, to review and update data collection and reporting documents. The committee developed the Reporting Requirements for CSBs Manual that included the core services taxonomy, ICDE, and reporting requirements. Until Fiscal Year (FY) 2004, the Department collected and used only aggregate, summary data about individuals receiving services from CSBs, except for some data about individuals receiving substance abuse services. As state and federal reporting requirements became more extensive and complex, the Department and CSBs identified a need respond in a more efficient, less burdensome manner. The Department and VACSB Data Management Committee (DMC) developed the community consumer submission (CCS) in 2002 and 2003 to meet this need and replace the ICDE. The Department issued the original CCS specifications for implementation in FY 2004. CCS requirements were incorporated into the FY 2004 and FY 2005 community services performance contracts. The CCS enables CSBs and the Department to meet federal and other reporting requirements more efficiently and effectively, respond more easily to ad hoc data requests, maintain fewer stand-alone software applications and reports, and reduce administrative workloads. The CCS extracts data from CSB information systems, replacing additional data entry in separate applications; this eliminates repetitive entry of the same information in different automated or manual reports and ensures greater data accuracy, consistency, and reliability. CCS application software transmits extracted individual and services data to the Department. The Department analyzes this data and uses it to satisfy state and federal reporting requirements, respond to requests for information, and monitor and analyze service operations. The Department and DMC developed a second version, CCS 2, in 2004 and 2005 to address additional data and reporting requirements and a third version, CCS 3, in 2009 to include additional data elements and implement a new paradigm for collecting and reporting data. Data elements are defined in the current CCS 3 Extract Specifications, and services for which information is collected through the CCS are defined in the taxonomy. The CCS is an excellent example of the partnership and collaboration that exists between the Department and CSBs. Sections 37.2-500, 37.2-508, 37.2-601, and 37.2-608 of the Code authorize the Department to fund community mental health, developmental, and substance abuse services through performance contracts with each CSB. Sections 37.2-504 and 37.2-605 require CSBs to release data and information about individuals receiving services to the Department, as long as it implements procedures to protect

	the confidentiality of that data and information. Sections 37.2-508 and 37.2-608 require CSBs to provide data and information about individuals receiving services to the Department in order to receive state-controlled funds. STATE BOARD POLICY 1021 defines the core of mental health, developmental, and substance ~~abuse~~ *use* services to be provided by CSBs and states that the current core services taxonomy shall be used to classify, describe, and measure the services delivered by all CSBs and state facilities. STATE BOARD POLICY 1034 ~~continues the collaborative approach that produced the core services taxonomy, performance contract, and ICDE~~. This policy recognizes and supports the evolution in the relationship between CSBs and the Department and its state facilities to a more collegial partnership and establishes the Central Office, State Facility, and CSB Partnership Agreement as the ongoing basis for this relationship. The agreement states that, where possible, joint work groups, representing CSBs, the Central Office, and state facilities, shall review all surveys, measures, or other requirements for relevance, cost benefit, validity, efficiency, and consistency with this statement prior to implementation and on an ongoing basis as requirements change. STATE BOARD POLICY 4018 establishes the community services performance contract as the primary funding and accountability mechanism between the Department and CSBs. The Department has funded community services through these contracts since 1985. ~~All of the services in the community services performance contract and the associated contract reports are defined in the current core services taxonomy and reported through the CCS.~~ ~~The Department maintains an Information Technology Strategic Plan, as required by the Virginia Information Technologies Agency. This plan identifies the Department's current strategic information technology initiatives and projects.~~ AVATAR is the information system that collects *billing, admission, discharge* data and information and produces reports about individuals and services in state facilities and bills responsible parties for those services. *The CCS 3 application used by Virginia's CSBs was sunset after years of service due to its outdated infrastructure and inability to meet modern data demands. It is replaced by a new, state-of-the-art Enterprise Data Warehouse (EDW) application, marking a monumental shift in how Virginia CSBs manage and interact with behavioral health and developmental disability data. This transformative project completed in 2025, has modernized the data interface, improving efficiency, accessibility, and scalability for the 40 CSBs across Virginia.* *Key benefits of the new EDW include enhanced real-time analytics, enabling faster and more informed decision-making; reduction in administrative processing time due to streamlined workflows; and robust data security measures that safeguard sensitive health information while meeting stringent regulatory requirements. Cloud-native architecture ensures scalability to accommodate future growth and*

	technological advancements, positioning Virginia's behavioral health system for long-term success. *In 2021, DBHDS was the first state agency in the Commonwealth of Virginia to procure and implement an enterprise Electronic Health Record (EHR)– Cerner's Millenium EHR. This system has assisted in systematically collecting clinical data required for reporting and decision-making across the 12 state facilities.* *The predecessor to Millennium, Soarian, was provided by Siemens who was then acquired by Cerner. Cerner worked to migrate Soarian clients to their primary Millennium EHR solution. DBHDS was part of that effort. As part of that conversion, the EHR was expanded to include all 12 facilities. In June of 2022, Oracle acquired Cerner and now Cerner is formally known as Oracle Health.* *The Virginia Waiver Management System (WaMS) is the data management system that manages the Medicaid Developmental Disability waivers; houses a record of the Individualized Service Plan (ISP); is the entry point to request Service Authorization for DD waiver services; and acts as a conduit for communication between providers, support coordinators, and DBHDS.* *The Virginia Crisis Connect (VCC) Platform is a comprehensive online platform utilized by public and private providers to facilitate the delivery of crisis services across Virginia and collect data related to these services. The VCC includes: a crisis call center, a mobile crisis response dispatch center, a data entry interface for specific crisis services including the REACH program, a crisis facility bed registry, an inter-provider referral interface, and a follow-up interface.* The community services performance contract requires the Department and representatives of CSBs to work together to ensure that data and reporting requirements are consistent with each other, ~~and with~~ the current ~~core services taxonomy, CCS~~ information systems, and applicable federal requirements. The Department and CSBs accomplish this through their membership on and participation in the VACSB DMC.
Purpose	To articulate policy for the collection and use of data and information about services and individuals receiving services by the Department, CSBs, and state facilities ~~and to establish the CCS as the mechanism to collect, report, and utilize data and information about individuals receiving services from CSBs.~~
Policy	It is the policy of the Board that the Department, state facilities, and CSBs shall collect and report data and information that are consistent to the greatest extent possible about individuals and the services they receive. The Department, state facilities, and CSBs shall use this data and information to monitor and evaluate the effectiveness and efficiency of state facility and community services; to identify, monitor, and report individual outcome and provider performance measures; and to make decisions about the development and operation of state facility and community

	services. The Department, in collaboration with state facilities and CSBs, shall establish consistent data collection and data reporting requirements for CSBs and state facilities. Further, it is the policy of the Board that, in all circumstances, the Department, state facilities, and CSBs shall identify collaboratively the minimum data needed to satisfy a specific requirement or accomplish a particular task or responsibility, in order to limit the imposition of additional workload burdens on direct service and administrative support staff. Nothing in this policy should be construed to limit the abilities of the Department, state facilities, or CSBs to obtain or utilize any data or information necessary to carry out their legal responsibilities, duties, or authorities. It is also the policy of the Board that all current and future requirements for individual and service data and information shall be consistent, to the greatest extent possible, with each other and with the ~~current core services taxonomy, CCS, and AVATAR and other state facility~~ *information systems utilized by CSBs and state facilities*. Consistent data is critical for quality assurance activities, accountability, and meaningful and reliable individual outcome and provider performance data. All current and future requirements for individual and service data and information shall be identified and addressed collaboratively by the Department, state facilities, and CSBs in accordance with the partnership agreement established in STATE BOARD POLICY 1034. ~~The core services taxonomy and CCS~~ *Information systems* shall be developed and revised collaboratively by the Department, state facilities, and CSBs in accordance with that partnership agreement. Further, it is the policy of the Board that data and information about individuals receiving services from CSBs and the services they receive shall be collected through the ~~CCS~~ *Enterprise Data Warehouse (EDW)* to the greatest extent practicable. The Department and CSBs shall use the ~~CCS~~ *EDW* whenever possible to collect and report all required data and information and avoid the development and implementation of separate, stand-alone data collection and information system applications. It is also the policy of the Board that the Department shall identify points of responsibility within the Department's Central Office for: ■ the design of automated information systems, ■ the collection of state facility and community services data, ■ the coordination of responses to requests for individual, service, financial, and human resource data from state facilities and CSBs, and ■ the accuracy and reliability of automated CSB and state facility data. Further, it is the policy of the Board that the Department shall establish, to the greatest extent possible within available resources, automated information systems and other mechanisms to: ■ Assist CSBs and state facilities to reduce the paper work required to maintain clinical records and to collect and report individual and service data; ■ Track the movement of individuals among state facilities, between state facilities and CSBs, and among CSBs; ■ Measure provider performance and individual outcomes to assess the effectiveness of services;

	■ Support the development of an integrated system of quality improvement for state facility and CSB services; ■ Address federally-mandated individual, service, and manpower reporting requirements; and ■ Establish a data collection mechanism in which the Department, each state facility, and each CSB has access to the financial, individual, service, and human resources data that they mutually agree is critical to the management and operation of Virginia's public mental health, developmental, and substance abuse services system. It is also the policy of the Board that the Department, in conjunction with CSBs and state facilities, shall develop procedures that ensure the confidentiality of shared data and information about individuals. Documentation of those procedures shall be made available upon request. The Department, state facilities, and CSBs shall comply with the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations, Confidentiality of Alcohol and Substance Abuse Records (42 C.F.R. Part 2), and other applicable current or future federal or state statutes or regulations regarding confidentiality of information about individuals in their collection, transmission, disclosure, retention, and use of all individual or service data and information. Further, it is the policy of the Board that the Department shall make guidance available, ~~to guidance~~ to *the* CSBs and state facilities about the procurement of automated data processing hardware and software and technical assistance and funding to support ongoing training of information technology and data management staff at state facilities and CSBs. It is also the policy of the Board that each CSB and state facility shall develop policies and plans for ensuring the confidentiality, timeliness, quality, validity, and reliability of its automated data and information. Further, it is the policy of the Board that the Department shall provide for formal liaison with the Virginia Association of Community Services Boards to ensure the VACSB's involvement in issues pertaining to: ■ data collection and reporting activities of the Department, CSBs, and state facilities; ■ the development of uniform definitions and conventions used in data collection, reporting, and analysis activities; and ■ the review of procedures to ensure that they comply with the Health Insurance Portability and Accountability Act and other statutory or regulatory confidentiality requirements. Finally, it is the policy of the Board that the Commissioner shall ensure that compliance with this policy is reflected in annual community services performance contracts ~~and state facility director performance agreements~~.

POLICY MANUAL

State Board of Behavioral Health and Developmental Services
Department of Behavioral Health and Developmental Services

POLICY 1040 (SYS) 06-3 Involvement and Participation of Individuals Receiving Services and Family Members

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Authority

Board Minutes Dated: April 7, 2006
Effective Date: April 7, 2006
Approved by Board Chairman: /s/ Victoria Huber Cochran

References

§ 37.2-100, § 37.2-200, § 37.2-204, § 37.2-316, § 37.2-501, § 37.2-504, § 37.2-602, and § 37.2-605 of the Code of Virginia (1950), as amended
STATE BOARD POLICY 1034 (SYS) 05-1 Partnership Agreement
STATE BOARD POLICY 1036 (SYS) 05-3 Vision Statement

Background

Section 37.2-100 of the Code of Virginia defines an individual receiving services , hereafter referred to as an individual, as a current direct recipient of public or private mental health, developmental, or substance abuse treatment, rehabilitation, or habilitation services, and it defines a family member as an immediate family member of an individual receiving services or the principal caregiver of that individual. A principal caregiver is a person who acts in the place of an immediate family member, including other relatives and foster care providers, but does not have a proprietary interest in the care of the individual receiving services.

Section 37.2-200 states that one member of the Board shall be an individual who is receiving or who has received services, one member shall be a family member of an individual who is receiving or who has received services, and one member shall be an individual who is receiving or who has received services or a family member of such an individual. Section 37.2-204 states that one-third of the appointments made to state or local human rights committees shall be individuals who are receiving or who have received services or family members of such an individual, with at least two individuals who are receiving or who have received public or private mental health, developmental, or substance abuse treatment or habilitation services within five years of their initial appointments on each committee. Section 37.2-316 states that any state and community consensus and planning team considering any restructuring of the system of mental health services involving an existing state hospital shall include individuals receiving services and family members of individuals receiving services.

Background *(continued)*

Sections 37.2-501 and 37.2-602 state that one-third of the appointments to community services boards and behavioral health authorities, hereafter referred to as CSBs, shall be individuals who are receiving or who have received services or family members of individuals who are receiving or who have received services, at least one of whom shall be an individual receiving services. Compliance with these statutory requirements is the responsibility of the cities and counties that established the CSBs, rather than of the CSBs themselves. CSBs report the numbers of board members who are individuals who are receiving or who have received services or family members of individuals who are receiving or who have received services in their annual community services performance contracts with the Department. Since these requirements were enacted in 1998, the percent of CSB board member appointments who are individuals or family members has increased from 24 percent in FY 1998 to 49 percent in FY 2013. Sections 37.2-504 and 37.2-605 state that CSBs shall take all necessary and appropriate actions to maximize the involvement and participation of individuals receiving services and family members of individuals receiving services in policy formulation and services planning, delivery, and evaluation.

STATE BOARD POLICY 1034 establishes the Central Office, State Facility, and Community Services Board Partnership Agreement and lists core values that shall be included in the agreement. One of those values states that participation of the individual and, when one is appointed or designated, the individual's authorized representative in treatment planning and service evaluation is necessary and valuable and has a positive effect on service quality and outcomes.

STATE BOARD POLICY 1036 articulates a vision statement to guide the development and operations of the public mental health, developmental, and substance ~~abuse~~ *use* services system. The vision promotes self-determination, empowerment, recovery, resilience, health, and the highest possible level of participation by individuals receiving services in all aspects of community life, including work, school, family, and other meaningful relationships. This vision also includes the principles of inclusion, participation, and partnership. This policy requires the Department, state facilities, and CSBs to incorporate this vision in their policies, procedures, and daily operations.

Purpose

To articulate the importance of individual and family member involvement and participation in Virginia's public mental health, developmental, and substance ~~abuse~~ *use* services system and identify ways in which the Department, state hospitals and training centers, hereafter referred to as state facilities, and CSBs can support the involvement and participation of individuals and family members as partners in the design, operation, and evaluation of the public services system.

Policy

It is the policy of the Board that individuals and family members shall be invited, encouraged, and supported to participate and be involved in the development, operation, and evaluation of Virginia's public mental health, developmental, and substance ~~abuse~~ *use* services system to the greatest extent possible at local, regional, and state levels through the following activities:

- analyzing, formulating, and ~~implementing policies~~ *evaluating policy implementation*;
- planning services and designing programs;
- providing ~~direct~~ *peer support* services;
- advocating for resources ~~and~~ to fulfill~~ing~~ unmet needs for services;
- monitoring and evaluating services, providers, and the services system; and
- providing accountability and engaging in quality improvement activities.

It also is the policy of the Board that the Department, state facilities, and CSBs shall support individual and family member involvement and participation in these activities through:

- seeking the participation of significant numbers of individuals and family members on committees, work groups, task forces, and other planning or deliberative bodies;
- involving individuals and family members from the initial stages of planning and implementing service system initiatives, including determining local, regional, or statewide needs and identifying innovative approaches, developing plans and budgets, and providing services to address those needs;
- providing opportunities for individuals and family members to learn about system issues in which they will be involved;
- funding, providing, or supporting to the greatest extent practicable training that will enable individuals and family members to develop the skills, such as assertiveness, leadership, teamwork, communication, and advocacy, and the knowledge, such as planning, budgeting, evaluation, parliamentary procedure, and legislation, for them to participate effectively;
- assisting with ~~travel, child care, or lodging expenses~~ funding to the greatest extent possible when this would enable individuals or family members to participate;
- ~~employing individuals in suitable positions in their organizations, including, where feasible and to the extent practicable, positions that provide oversight, guidance, and monitoring; and~~ *ensuring adherence to equal opportunity employment requirements and supporting consideration for relevant lived experience in hiring throughout the organization*
- recruiting, training, and supporting individuals and family members to serve as board members and advocating their appointment with appointing authorities.

Policy
(continued)

Further, it is the policy of the Board that CSBs shall work closely with the boards of supervisors or city councils and county administrators or city managers of their local governments to help them meet or exceed the membership requirements in § 37.2-501 or § 37.2-602 of the Code of Virginia. The Department shall monitor the composition of each CSB board of directors through its performance contracts with CSBs and inform a CSB if its composition is not in compliance with these statutory requirements. The Department shall assist CSBs in working with their local governments, including helping to identify sources for appointments of individuals and family members who are knowledgeable about the services system and have public participation skills.

It also is the policy of the Board that the Department, state facilities, and CSBs shall encourage, support, fund, assist, monitor, and evaluate *the integration of peer support* services *throughout the continuum of care* ~~and supports run or provided by individuals~~ to the greatest extent practicable *across services and settings*. These services ~~and supports~~ may operate independently of, in partnership with, or by an agreement or contract with the Department, CSBs, or state facilities. ~~Individuals must be involved substantively in the design, leadership, administration, and day-to-day operation of these services and supports. Examples of these services and supports include community education; crisis prevention, intervention, and respite; drop-in centers; employment services or employment readiness support; outreach to individuals; housing; peer case management; peer companion or mentoring services; peer counseling; recovery and wellness education; recreation and arts; support groups; and technical assistance to develop services delivered by individuals.~~

Further, it is the policy of the Board that the Department, state facilities, and CSBs shall include a provision in their contracts with private and other public service providers to require compliance with the provisions of this policy that are applicable to their operations.

Finally, it is the policy of the Board that the Department, state facilities, and CSBs shall monitor and seek feedback from individuals and family members about their efforts to invite, encourage, and support the involvement and participation of individuals and family members in their operations and periodically report the results of this feedback to the Board.

State Board of Behavioral Health and Developmental Services

Planning and Budget Committee

DRAFT AGENDA

WEDNESDAY, JULY 15, 2026

DBHDS Central Office 13th Floor South Large Executive Board Room
Jefferson Building, 1220 Bank Street, Richmond, VA 23219

Meeting is in person with a physical quorum present; however, electronic meeting access is available.

I.	**CALL TO ORDER**
	A. Determination of Quorum B. Welcome and Introductions C. Adoption of Agenda D. Approval of Draft Minutes (April 22, 2026)
II.	**DRAFT REVISIONS RE: LIAISON ASSIGNMENTS**
	The committee reviewed Board Member Liaison Assignments at the April meeting. DBHDS staff will present recommended revisions to provide clarity and increased flexibility.
III.	**NEW BUSINESS**
IV.	**ANNOUNCEMENTS**
V.	**ADJOURNMENT**

ARTICLE VIII. ~~Liaison Assignments~~ Board Engagement and Liaison Activities

~~Pursuant to~~ Consistent with its responsibilities under § 37.2-203 of the Code of Virginia, the Board shall ensure that DBHDS initiates programs to educate Virginians about and elicit public support for the activities of the Department, state facilities, community services boards, and behavioral health authorities ~~are initiated by the Department~~. The Board fulfills this role through a combination of Department-led public education efforts, Board visibility and accessibility, and engagement by Board members with stakeholders and communities, which may include the following activities.

Section 1. DBHDS Staff Updates. The Board shall receive periodic updates from DBHDS regarding public education and outreach efforts and may provide feedback as appropriate. These updates may include information on statewide initiatives, communications strategies, and stakeholder perspectives. DBHDS may also share relevant materials to support Board awareness of system activities.

~~The Board seeks to further the integration and coordination of services to individuals receiving services and to support, encourage, and build close working partnerships among community services boards and behavioral health authorities, state facilities, and the Department. The Board also seeks to enhance its knowledge and understanding of the wide diversity of community and state facility services across the Commonwealth and to develop and maintain connections with entities in the public behavioral health and developmental services system.~~

~~The Chair, in consultation with Department staff, may develop a list for each Board member of agencies and organizations with which the Board wishes to liaise, including state facilities, the Virginia Association of Community Services Boards, community services boards and behavioral health authorities, and the State Human Rights Committee.~~

~~The Chair shall appoint members of the Board to serve as liaisons with these agencies and organizations, recognizing the time constraints of members and that each member may fulfill Board member liaison responsibilities in different ways.~~

Section 2. Liaison Engagement. To enhance its understanding of the system and inform its oversight role, the Board may facilitate opportunities for members to engage with state facilities, CSBs, and other stakeholders across the Commonwealth.

2.1. The Chair, in consultation with DBHDS staff, may identify geographic or programmatic areas for Board member engagement and may invite members to serve in a liaison capacity on a voluntary basis.

2.2. Liaison engagement is flexible and informal. It may include introductory or periodic outreach to assigned state facilities or CSBs; attending meetings or events when feasible; participating in phone or virtual check-ins with leadership of assigned state facilities or CSBs; and other opportunities to learn about services and system operations.

Section 3. Community Engagement. Board members, by virtue of their role, may be approached by individuals, families, and community members seeking information or assistance related to the behavioral health system. Members may, as appropriate, help connect individuals to available resources or Department staff and share general information about the system, while recognizing that they do not serve in an operational or case management role.

~~Board member liaisons shall report successes, issues, and concerns to the Board at its regular meetings and to appropriate Department staff. Board member liaisons shall confer or meet regularly with groups to which they are assigned and report to the full Board as necessary.~~

Section 4. Sharing Information with the Board. Board members are encouraged to share observations, themes, and insights from their engagement activities with the full Board and with DBHDS staff, as appropriate. The Chair may make time available periodically for voluntary updates and discussions on Board meeting agendas.

Section 5. Board Visibility and Accessibility. To promote awareness and support under Virginia Code § 37.2-203, the Board shall provide opportunities for public comment at its meetings in accordance with applicable policies and procedures and may take additional steps to encourage public participation. The Board may enhance its visibility through holding regular Board meetings in locations across the Commonwealth when feasible.

State Board of Behavioral Health and Developmental Services

Guidelines for Board Member Liaison Engagement

Purpose

Liaison engagement is a light-touch, high-value way for Board members to strengthen their understanding of services, challenges, and innovations across the Commonwealth. These activities inform the Board's policy, planning, and oversight responsibilities under § 37.2-203.

Assignment of Liaisons

The Board determines liaison assignments, typically organized by geographic region or programmatic area. Assignments are voluntary and flexible and may be revisited periodically. Once assignments are made, the Commissioner will send a brief introductory letter to assigned state facilities and CSBs, identifying the Board member liaison and the purpose of the role.

Getting Started

DBHDS will provide contact information for executive leadership (e.g., CSB Executive Directors, Facility Directors). Board members are encouraged to initiate an introductory outreach, such as a brief email. Engagement can be as simple as: introducing yourself as the Board liaison, expressing interest in learning about services and priorities, or identifying a convenient way to stay in touch (periodic call, occasional visit, etc.).

What "Informal Engagement" Means

Liaison engagement is informational, not operational. Board members do not direct, evaluate, or intervene in local operations. Board members should refer operational or constituent concerns to DBHDS staff as appropriate. Appropriate activities may include:

- Listening to high-level updates on services, capacity, workforce, and community needs
- Attending meetings, site visits, or events when feasible
- Learning about emerging challenges, innovations, and partnerships
- Observing how statewide initiatives are experienced locally

Community and Stakeholder Contact

Board members may be approached by individuals, families, or community stakeholders. In these situations, members should not attempt to resolve individual service issues or serve as a substitute for local provider or agency processes. Board members may share general information about the system, and/or help connect individuals to appropriate public resources or DBHDS staff.

Sharing Information with the Board

Board members are encouraged to share themes, observations, and insights, not individual anecdotes at Board meetings when the Chair includes a brief agenda item for voluntary liaison updates. Examples of helpful feedback include access challenges or service gaps, workforce or funding pressures, or promising practices or innovations.

Time Commitment and Expectations

There is no minimum required level of engagement. Members are encouraged to participate at a level that fits their schedule and interests. Even occasional engagement can provide meaningful insight to inform Board discussions.

UNFINISHED BUSINESS

Consideration of revisions recommended unanimously by Policy and Evaluation Committee

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Included in Agenda Packet:

- Committee-recommended revisions to *Policy 3000 (CO) 74-10 Appointments of Department Employees to Community Services Boards*

- Committee-recommended revisions to *Policy 6005 (FIN) 94-2 Retention of Unspent State Funds by Community Services Boards*
    - Also for reference: April field review and CSB-proposed revisions

Renewed: 05/87
Renewed: 03/22/89
Renewed: 09/25/91
Updated: 10/29/03
Updated: 12/06/11
Updated: ??/??/????

POLICY MANUAL

State Board of Behavioral Health and Developmental Services
Department of Behavioral Health and Developmental Services

POLICY 3000 (CO) 74-10 Appointments of Department Employees to Community Services Boards

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Authority

Board Minutes Dated: September 25, 1974
Effective Date: September 25, 1974
Approved by Board Chairman: s/Richard M. Gillis.

References

§ 37.2-203, § 37.2-304, § 37.2-500, § 37.2-501 § 37.2-601, and § 37.2-602 of the Code of Virginia (1950)

Background

Originally, the Board received a number of inquiries about the appointment of an employee of the Department to a community services board. Also, concerns were raised regarding possible perceptions of conflicts of interest if Department employees served on CSBs. In response to these concerns, the Board adopted this policy.

Section 37.2-203 of the Code of Virginia authorizes the Board to adopt policies governing the operation of state hospitals, training centers, and community services boards and behavioral health authorities. Section 37.2-304 authorizes the Commissioner to supervise and manage the Department and its state facilities. Sections 37.2-500 and 37.2-601 authorize the establishment of community services boards and behavioral health authorities, hereafter referred to as CSBs. Finally, § 37.2-501 and § 37.2-602 govern the appointment of CSB board members by the governing bodies of the cities and counties that established the CSBs. Those two Code sections do not address appointments of Department employees to CSBs. Consequently, because appointments to CSBs are made by local governments rather than CSBs, those appointments are not under the purview of the Board's policy authority. However, the Board may adopt policy that directs the Department to ensure that its employees do not accept appointments as CSB board members.

Purpose

To prohibit Department employees from accepting appointments as CSB board members.

Policy	It is the policy of the Board that the Department, in order to avoid any appearance of impropriety or conflict of interest, shall ensure that members of its ~~classified employees~~ *workforce* shall not accept appointments as CSB board members. *For the purposes of this policy, the term workforce references all classified and wage employees as well as any contractor or subcontractor who has received compensation under a paid contract with DBHDS within the preceding twelve (12) months.*

Updated: 07/26/2011
Updated: 07/17/2019
Updated: ??/??/????

POLICY MANUAL

State Board of Behavioral Health and Developmental Services
Department of Behavioral Health and Developmental Services

POLICY 6005(FIN)94-2 Retention of Unspent State Funds by Community Services Boards

Authority

Board Minutes Dated: July 27, 1994
Effective Date: July 1, 1994
Approved by Board Chairman: James G. Lumpkin

References

Realizing the Vision: Barriers to an Integrated System, Department of Mental Health, Mental Retardation and Substance Abuse Services, January 27, 1993
State Board Policy 4018 (CSB) 86-9 Community Services Performance Contracts
Community Services Performance Contract
§§ 37.2-508, ~~and §~~ 37.2-509, 37.2-608 and 37.2-611 of the Code of Virginia (1950)

Supercedes

STATE BOARD POLICY 3002 (CO) 86-16 System-wide Staff Training

Background

Before FY 1995, the Department applied year-end balances of unspent state funds at community services boards and the behavioral health authority, hereafter referred to as CSBs, to the next year's state fund allocations for CSBs so that the state appropriation and balances equaled state awards. If state balances reported in the fall were below the estimates projected in the previous spring's budget deliberations, a deficit could occur. This happened in FY 1993, and a deficit was averted only by a transfer of funds to the CSB appropriation.

Realizing the Vision: Barriers to an Integrated System, the Visions Task Force report, recommended preserving any unbudgeted and unspent revenues within the system. The Visions Financial Resources Committee proposed amending § 37.1-199(a) of the Code of Virginia so that CSBs could retain unspent revenues to expand and enhance services. The State Board supported this amendment, but it was not introduced, based on a determination that it could be implemented administratively.

Subsequently, the Virginia Association of Community Services Boards and the Department developed a proposal, the basis for this policy, that prevented future deficits, instituted a budget process in which CSB awards equaled the state appropriation, and implemented the Visions recommendation.

The Code of Virginia §§37.2-508 and 37.2-608 outlines the performance contract as the identified contracting mechanism the Department shall use to develop and

initiate negotiation of community services requirements, oversight and monitoring of all state-controlled funds awarded to the community services boards.

State Board POLICY 4018 (CSB) 86-9 Community Services Performance Contracts recognizes the community services performance contract as the primary accountability mechanism between the Department and individual CSBs. The performance contract governs unspent balances with detail and enforceability while incorporating substantive protections to both prevent future deficits and limit accrual of funds to support effective and efficient allocations of resources.

Purpose

To ~~establish~~ *define* the ability of CSBs to retain balances of unspent state general funds *through the performance contract process*.

Policy

It is the policy of the Board that:

- *requirements for unspent fund balances for state general funds must be defined in the performance contract and changes must be negotiated through the Department's performance contract process in collaboration with the CSBs. The performance contract may:*
    - ~~the Department shall~~ allow CSBs to retain balances of unspent state general funds after the end of the fiscal year in which the Department granted those funds;
    - *define the maximum acceptable amount of each unspent state fund balance that a CSB may accumulate and define the maximum total accumulation of state funds.*
    - *define the process for unspent balances to be expended in accordance with spending plans to be established between the Department and CSB.*
- the Department ~~shall~~ *may* allocate the funds in the CSB state appropriation ~~without~~ applying estimated year-end balances of unspent state general funds to the next year's CSB awards of state general funds *as permitted under §§ 37.2-509 and 37.2-611 after consultation with the CSB to ensure mutual awareness and understanding of the impact to the budget of the CSB;*
- ~~based on~~ *Pursuant to* the General Assembly Appropriations Act prohibition against using state funds to supplant the funds provided by local governments for existing services, there should be no reduction of local matching funds as a result of a CSB's retention of any balances of unspent state general funds; and
- *i*~~I~~f a CSB ~~delivers less than the levels of services in its final approved Community Services Performance Contract, established pursuant to §§ 37.2-~~

~~508 of the Code of Virginia and State Board Policy 4018, while~~ generat~~esing~~ significant balances of unspent state general funds*, and is not able to develop a viable spending plan in collaboration with the Department,* it may have to return ~~some~~ *a portion or all* of its balances to the Department or its state fund allocations in the next fiscal year may be reduced. *The Department shall consult with the CSB prior to taking action to ensure mutual awareness and understanding of the impact of the proposed action to the budget of the CSB.*

~~It is also the policy of Board that the Department shall apply procedures, which are authorized by § 37.2-509 of the Code of Virginia and are consistent with those in the Community Services Performance Contract, to retrieve unspent state general funds from or reduce future state general fund allocations to a CSB that delivers less than the levels of services in its final approved Performance Contract while generating significant balances of unspent state general funds.~~

Finally, it is the policy of the Board that the Community Services Performance Contract shall contain principles and procedures for the more effective and consistent utilization of unexpended state general fund balances from previous fiscal years by CSBs.

State Board of Behavioral Health and Developmental Services
Policy Development and Evaluation Committee
April 22, 2026
COMMENTS ON ONE POLICIES: ONE WINDOW (OCTOBER 31 - NOVEMBER 24)

Policy:	DBHDS Recommended Revisions to Policy 6005 (CO) 74-10 Appointments of Department Employees to Community Services Boards
Window:	**January 8 – March 13**

Date Rcv'd	Contact	Comment
01/14/2026	Michael Goodrich Assistant Director-Administration Prince William	Any funds retained by a CSB should be percentage based, not dollar based. DBHDS should be permitted to keep an administrative fee no larger than the federal indirect cost percentage to administer the year over year carryover. However, the CSB should be able to carry over the funds to provide services to its catchment area.
02/25/2026	Kyle Vaught ES Director Crossroads	Would this policy include the state retroactively reclaiming unspent funds previously awarded?
03/03/2026	Brandie Williams Deputy Executive Director Rappahannock Area CSB	Thank you for inviting comment on the proposed updates to Policy 6005 related to the treatment of unexpended state general funds by Community Services Boards (CSBs). To support the Department's consideration of stakeholder input, the Virginia Association of Community Services Boards (VACSB) has submitted a redlined draft identifying recommended edits and clarifications. The policy as currently written properly affirms that CSBs are allowed to carry forward unspent state general fund balances and that those funds should not be routinely or automatically used to reduce subsequent allocations. As revisions move forward, I recommend incorporating the additional refinements outlined in the VACSB redline so the policy more fully aligns with existing statutory authority and present-day operating practices. First, the revised policy should more clearly identify the Community Services Boards collaboration and input when setting expectations regarding unencumbered state general fund balances, including guidance on reserve levels and spending plan requirements. The policy should outline a collaboration framework which strengthens shared understanding, promotes transparency, and reinforces mutual accountability. Second, the policy should explicitly call for engagement with any affected CSB before projected year-end balances are applied toward future funding, funds are recaptured, or subsequent state allocations are adjusted. When sizable balances are identified, a collaborative process to establish an appropriate and workable spending plan supports financial stability and upholds the cooperative relationship between the Department and CSBs. Thank you

		again for the opportunity to provide input on these proposed changes.
03/11/2026	Kevin Mullins Executive Director Dickenson County Behavioral Health	Comment Regarding Proposed Changes to Policy 6005 (FIN) 94-2 – Retention of Unspent State Funds Thank you for the opportunity to provide comment regarding potential modifications to Policy 6005 (FIN) 94-2 and the proposal to limit retained balances by reducing future warrant payments until those balances reach an "acceptable" level. As the Executive Director of one of the smallest Community Services Boards in the Commonwealth, I would like to emphasize the importance of maintaining reasonable operating reserves to ensure the continuity of essential behavioral health services. For many CSBs—particularly smaller and rural boards—retained state funds function as necessary working capital rather than idle balances. These reserves allow organizations to manage fluctuations in revenue, respond to service demands, and maintain continuity of care during periods of delayed or interrupted funding. Because CSBs operate critical safety-net services, including crisis response and behavioral health treatment, maintaining financial stability is essential to ensuring that services remain available without interruption. A policy that automatically reduces warrant payments until retained balances are reduced could unintentionally create cash-flow challenges. This concern is particularly relevant for smaller CSBs that operate with limited financial flexibility and fewer alternative funding sources. Reasonable reserves allow CSBs to meet payroll obligations, maintain service capacity, and continue operations during periods when state payments or other funding streams may be delayed. If changes to the policy are being considered, it would be helpful for the Commonwealth to clearly define what constitutes an "acceptable" reserve balance. Establishing objective guidelines—such as a percentage of operating expenses or a reasonable number of months of operating reserves—would promote fiscal accountability while still allowing CSBs to responsibly manage their finances. Additionally, consideration should be given to differences in size and financial capacity among CSBs. Smaller boards may require proportionally greater reserves to maintain operational stability, and a uniform standard could disproportionately affect rural or smaller service areas. The original intent of Policy 6005 recognized the importance of allowing CSBs to retain unspent funds in order to responsibly manage service delivery across fiscal years. Preserving that flexibility, while establishing reasonable guardrails for reserve levels, would maintain both fiscal accountability and the stability necessary to deliver critical behavioral health services across the Commonwealth. Thank you for the opportunity to provide input on this important matter.
03/11/2026	Ivy Sager Executive Director Hanover CSB	Please refer to the redlined document from VACSB reflecting suggested changes and clarifications to this proposed policy. Hanover CSB supports the edits reflected in the redlined version. Those revisions appropriately clarify the retention of unencumbered funds by CSBs and reinforce the Performance Contract as the primary mechanism for defining requirements related to unencumbered state general fund balances, including reserve parameters and spending plan

		expectations. Thank you for the opportunity to provide input.
03/12/2026	Kim Shaw Executive Director Rockbridge	Consideration of waivers for the 25% carry-over allowance for restricted funds, IF DBHDS with unnecessary internal (not state or federal guidelines) are the reason for the delay in spending.
03/12/2026	Connie Barnes Financial Officer VA Beach CSB- Department of Health Services	CSBs utilize carryover funding as a necessary stabilizer against economic volatility and escalating operational requirements. These reserves are essential for addressing unpredictable shifts in the economic landscape, particularly regarding the recruitment and retention of high-quality personnel. Furthermore, as the costs for client-facing essentials—such as housing and utilities—continue to rise, the ability to retain unspent balances remains vital. While our preference is to maintain the current carryover model, we strongly advocate for an increase in the allowable percentage to ensure long-term fiscal sustainability.
03/13/2026	Anna Jones Quality Assurance Manager Henrico Area Mental Health and Developmental Services	Henrico Area Mental Health and Developmental Services appreciates the opportunity to comment on the proposed revisions to Policy 6005 regarding retention of unspent state general funds by Community Services Boards. For reference, a VACSB redlined document reflecting suggested clarifications has been shared with DBHDS to assist in its review of submitted comments. The current policy appropriately establishes that CSBs may retain balances of unspent state general funds and that those balances should not automatically be applied to reduce future allocations. As the Board considers revisions, we encourage additional clarifications as outlined in the VACSB redline document to better reflect current statutory authority and operational practice. First, the policy should clearly reinforce the Community Services Performance Contract as the primary mechanism for defining requirements related to unencumbered state general fund balances, including reserve parameters and spending plan expectations. Anchoring these requirements in the performance contract supports collaboration, accountability, and transparency. Second, the policy should clearly emphasize consultation with the impacted CSB before applying estimated year-end balances to future allocations, retrieving funds, or reducing future state allocations. Providing an opportunity to collaboratively develop a viable spending plan when significant balances exist promotes fiscal stability and reinforces the partnership between the Department and CSBs. Finally, the policy should continue to reflect the General Assembly's prohibition against supplanting local matching funds with retained state balances. Continued clarity on this point is important to preserve the integrity of the state-local funding structure. Thank you for the opportunity to provide input.
03/13/2026	Terrelle Stewart Executive Director	I appreciate the opportunity to comment on the proposed revisions to Policy 6005 regarding retention of unspent state general funds by Community Services Boards. For reference, a

	Greater Reach Community Services Board (formerly known as District 19 Community Services Board)	VACSB redlined document reflecting suggested clarifications has been shared with DBHDS to assist in its review of submitted comments. The current policy appropriately establishes that CSBs may retain balances of unspent state general funds and that those balances should not automatically be applied to reduce future allocations. As the Board considers revisions, I encourage additional clarifications as outlined in the VACSB redline document to better reflect current statutory authority and operational practice. First, the policy should clearly reinforce the Community Services Performance Contract as the primary mechanism for defining requirements related to unencumbered state general fund balances, including reserve parameters and spending plan expectations. Anchoring these requirements in the performance contract supports collaboration, accountability, and transparency. Second, the policy should clearly emphasize consultation with the impacted CSB before applying estimated year-end balances to future allocations, retrieving funds, or reducing future state allocations. Providing an opportunity to collaboratively develop a viable spending plan when significant balances exist promotes fiscal stability and reinforces the partnership between the Department and CSBs. Significant federal Medicaid eligibility changes will be effective next year. The changes add a work requirement for certain individuals currently receiving Medicaid. Many individuals receiving CSB services are Medicaid recipients and will likely be subject to the new work requirements. Some of these individuals may not understand or be able to comply with the new requirements. As a result, individuals will lose Medicaid eligibility and CSBs will no longer receive Medicaid reimbursement for critical services. CSBs must continue to provide essential services to individuals who lose Medicaid eligibility; the result will be a funding gap for critical services provided by CSBs. The DBHDS proposal to cap unspent funds is a dramatic departure from the current budgeting process. A change of this magnitude must allow for careful evaluation of the impact of any unspent funding on the Virginia Community Services Board system as a whole and on each CSB. A reasonable approach would be to continue the current budgeting process, allow unspent funding to be carried forward into 2028and concurrently assess the impact of the Medicaid work requirement on current and future Medicaid funding and reimbursements for individuals receiving services through CSBs. Finally, the policy should continue to reflect the General Assembly's prohibition against supplanting local matching funds with retained state balances. Continued clarity on this point is important to preserve the integrity of the state-local funding structure. Thank you for the opportunity to provide input.

State Board of Behavioral Health and Developmental Services
Department of Behavioral Health and Developmental Services

POLICY 6005(FIN)94-2 Retention of Unspent State Funds by Community Services Boards

Authority

Board Minutes Dated: July 27, 1994
Effective Date: July 1, 1994
Approved by Board Chairman: James G. Lumpkin

References

Realizing the Vision: Barriers to an Integrated System, Department of Mental Health, Mental Retardation and Substance Abuse Services, January 27, 1993
State Board Policy 4018 (CSB) 86-9 Community Services Performance Contracts
Community Services Performance Contract
§§ 37.2-508, ~~and §~~ 37.2-509, 37.2-608 and 37.2-611 of the Code of Virginia (1950)

~~Supercedes~~**Supersedes** STATE BOARD POLICY 3002 (CO) 86-16 System-wide Staff Training

Background

Before FY 1995, the Department applied year-end balances of unspent state funds at community services boards and the behavioral health authority, hereafter referred to as CSBs, to the next year's state fund allocations for CSBs so that the state appropriation and balances equaled state awards. If state balances reported in the fall were below the estimates projected in the previous spring's budget deliberations, a deficit could occur. This happened in FY 1993, and a deficit was averted only by a transfer of funds to the CSB appropriation.

Realizing the Vision: Barriers to an Integrated System, the Visions Task Force report, recommended preserving any unbudgeted and unspent revenues within the system. ~~The Visions Financial Resources Committee proposed amending § 37.1-199(a) of the Code of Virginia so that CSBs could retain unspent revenues to expand and enhance services. The State Board supported this amendment, but it was not introduced, based on a determination that it could be implemented administratively.~~

Subsequently, the Virginia Association of Community Services Boards and the Department developed a proposal, the basis for this policy, that prevented future deficits, instituted a budget process in which CSB awards equaled the state appropriation, and implemented the Visions recommendation.

Since that time, there have been many system and administrative impacts that now require a shift in this policy. Remaining at the core is the shared vision outlined in the Partnership Agreement that there is "a common desire for the public system of care to excel in the delivery and seamless continuity of services to individuals receiving services and their families."

The Code of Virginia §§37.2-508 and 37.2-608 outlines the performance contract as the identified contracting mechanism the Department shall use to develop and

Commented [IS1]: Consider changing this word to "unencumbered" consistent with other changes in document

Commented [IS2]: This information should not be removed. It provides historical/background context. The proposed policy change doesn't change this history. Added language that indicates why there is a shift now but keeps the historical context.

initiate negotiation of community services requirements, oversight and monitoring of all state-controlled funds awarded to the community services boards. This is an annual collaborative process that ensures both parties have input on this important document that drives and operationalizes the shared vision.

State Board POLICY 4018 (CSB) 86-9 Community Services Performance Contracts recognizes the community services performance contract as the primary accountability mechanism between the Department and individual CSBs.

The performance contract ~~governs unspent~~ provides a framework to address unencumbered balances with detail and enforceability while incorporating substantive protections to both prevent future deficits and limit accrual of funds to support effective and efficient allocations of resources.

Purpose

To ~~establish~~ ~~*define*~~ *provide the framework for* ~~the ability of~~ CSBs to retain balances of ~~unspent~~ unencumbered state general funds~~.~~ ~~*through the performance contract process.*~~

Policy

It is the policy of the Board that:

- *requirements for ~~unspent~~ unencumbered fund balances for state general funds must be defined in the performance contract and changes must be negotiated between the Department and the CSBs as part of the annual review process. ~~through the Department's performance contract process in collaboration with the CSBs~~. The performance contract may:*
    - ~~the Department shall~~ allow CSBs to retain balances of ~~unspent~~ unencumbered state general funds after the end of the fiscal year in which the Department granted those funds *in a reserve fund*;
    - *define the maximum acceptable amount of each ~~unspent~~unencumbered state fund balance that a CSB may accumulate in reserve funds and define the maximum total accumulation of state funds in reserve;*
    - *allow flexibility in spending from the reserve fund with an agreed upon spending plan between the Department and CSB.~~-~~*
- the Department ~~shall~~ *may* allocate the funds in the CSB state appropriation ~~without~~ applying estimated year-end balances of ~~unspent~~ unencumbered state general funds to the next year's CSB awards of state general funds *as permitted under §§ 37.2- 509 and 37.2-611 but may only do so after consulting with the CSB in order to not negatively impact that CSBs budget and/or cash flow*;
- ~~based on~~ ~~*P*~~*pursuant to* the General Assembly Appropriations Act prohibition against using state funds to supplant the funds provided by local governments for existing services, there should be no reduction of local matching funds as a

result of a CSB's retention of any balances of ~~unspent~~ unencumbered state general funds; and

- ~~*I*~~If a CSB ~~delivers less than the levels of services in its final approved Community Services Performance Contract, established pursuant to §§ 37.2-508 and 37.2-608 of the Code of Virginia and State Board Policy 4018, while~~ generates~~ing~~ significant balances of ~~unspent~~ unencumbered state general funds, and is not able to develop a viable spending plan in collaboration with the Department, it may have to return ~~some~~ *a portion or all* of its balances to the Department or its state fund allocations in the next fiscal year may be reduced. No action will be taken without direct consultation with the impacted CSB.

Commented [IS3]: This should be removed as the "levels of service" language no longer applies in the same way with the new data systems and dashboard.

~~It is also the policy of Board that the Department shall apply procedures, which are authorized by § 37.2-509 of the Code of Virginia and are consistent with those in the Community Services Performance Contract, to retrieve unspent state general funds from or reduce future state general fund allocations to a CSB that delivers less than the levels of services in its final approved Performance Contract while generating significant balances of unspent state general funds.~~

Finally, it is the policy of the Board that the Community Services Performance Contract shall contain principles and procedures for the more effective and consistent utilization of ~~unexpended~~ unencumbered state general fund balances from previous fiscal years by CSBs.

DBHDS
Virginia Department of Behavioral Health and Developmental Services

REGULATORY AFFAIRS

Standard Action to Integrate Central Registry into Medication for Opioid Use Disorder (MOUD) Treatment Provider Licensing Regulations

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Included in Agenda Packet:

- DRAFT Agency Background Document (Form TH-01)

Background:
DBHDS Licensing Regulations currently require medication for opioid use disorder (MOUD) treatment providers to call, fax, or email other providers within a 50-mile radius to determine if an individual is dually enrolled (12VAC35-105-1000). This best practice makes Virginians safer on two fronts by preventing dual enrollment. First, dual enrollment allows individuals to duplicate doses from multiple MOUD providers, which can increase the risk of overdose. Secondly, dual enrollment may be utilized to divert medication to illicit markets.

Since 2025, DBHDS has worked with providers and Lighthouse Software Systems to stand up a central registry in the Commonwealth. Seventeen states use Lighthouse central registry (https://www.lhss.net/central-registry) to protect against dual enrollment; however, participation by MOUD providers in Virginia is currently voluntary.

Justification:
The Office of Addiction, Recovery, and Wellness Supports requested an amendment to the Licensing Regulations to mandate participation by MOUD treatment providers in a central registry to expedite the admission process and ensure enrollment verification is accurate.

A central registry system expedites the admission process by ensuring MOUD providers do not need to call, fax, or email nearby providers to verify against dual enrollment. Instead, a single verification inquiry can be made immediately. The central registry also verifies an individual's medication and dose which can facilitate access to treatment throughout the Commonwealth during emergencies.

Any additional costs would be offset by the reduction in administrative burden and duplication efforts. The central registry also simplifies accurate data reporting in accordance with state and federal requirements. Finally, the central registry can be an effective tool for communicating with MOUD providers.

Action Needed:
Authorize a Notice of Intended Regulatory Action (NOIRA) to amend the Licensing Regulations to mandate participation by medication for opioid use disorder (MOUD) treatment service providers in a central registry.

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Notice of Intended Regulatory Action (NOIRA)
Agency Background Document

Agency name	Department of Behavioral Health and Developmental Services
Virginia Administrative Code (VAC) Chapter citation(s)	12VAC35-105
VAC Chapter title(s)	Regulations for Licensing Providers by the Department of Behavioral Health and Developmental Services
Action title	MOUD Central Registry
Date this document prepared	June 2, 2026

This information is required for executive branch review and the Virginia Registrar of Regulations, pursuant to the Virginia Administrative Process Act (APA), Executive Order 19 (2022) (EO 19), any instructions or procedures issued by the Office of Regulatory Management (ORM) or the Department of Planning and Budget (DPB) pursuant to EO 19, the Regulations for Filing and Publishing Agency Regulations (1 VAC 7-10), and the *Form and Style Requirements for the Virginia Register of Regulations and Virginia Administrative Code*.

Brief Summary

Provide a brief summary (preferably no more than 2 or 3 paragraphs) of the subject matter, intent, and goals of this regulatory change (i.e., new regulation, amendments to an existing regulation, or repeal of an existing regulation).

The Virginia Department of Behavioral Health and Developmental Services (DBHDS) intends to require medication for opioid use disorder (MOUD) treatment services to participate in a central registry system. The purpose of the central registry system will be to: expedite the admission process by verification of medication and dose; prevent an individual from simultaneously enrolling in more than one MOUD treatment service; facilitate disaster response; allow access to treatment during emergencies throughout the Commonwealth; and ensure accurate data reporting and dispensing of medication in accordance with state and federal laws and regulations. Therefore, mandatory participation in the central registry system will help protect the health, safety, and welfare of Virginians.

Acronyms and Definitions

Define all acronyms or technical definitions used in this form.

DBHDS – Department of Behavioral Health and Developmental Services
Licensing Regulations – Rules and Regulations for Licensing Providers by the DBHDS (12VAC35-105)
State Board – State Board of Behavioral Health and Developmental Services

Mandate and Impetus

Identify the mandate for this regulatory change and any other impetus that specifically prompted its initiation, (e.g., new or modified mandate, petition for rulemaking, periodic review, or board decision). For purposes of executive branch review, "mandate" has the same meaning as defined in the ORM procedures, "a directive from the General Assembly, the federal government, or a court that requires that a regulation be promulgated, amended, or repealed in whole or part."

No specific mandate is tied to this action. Its impetus derives from changes in best practices within the service and the desire of the Commonwealth to protect the health, welfare, and safety of Virginians.

Legal Basis

Identify (1) the promulgating agency, and (2) the state and/or federal legal authority for the regulatory change, including the most relevant citations to the Code of Virginia and Acts of Assembly chapter number(s), if applicable. Your citation must include a specific provision, if any, authorizing the promulgating agency to regulate this specific subject or program, as well as a reference to the agency's overall regulatory authority.

Section 37.2-203 of the Code of Virginia authorizes the State Board to adopt regulations that may be necessary to carry out the provisions of Title 37.2 and other laws of the Commonwealth administered by the Commissioner and DBHDS.

Section 37.2-404 of the Code of Virginia authorizes the Commissioner, subject to regulations adopted by the State Board, to license providers.

At its meeting on July 15, 2026, the State Board voted to authorize staff to initiate this regulatory action.

Purpose

Describe the specific reasons why the agency has determined that this regulation is essential to protect the health, safety, or welfare of citizens. In addition, explain any potential issues that may need to be addressed as the regulation is developed.

The central registry system will expedite the admission process to MOUD treatment services. Currently, regulations require MOUD providers to call, fax, or email providers within a 50-mile radius to determine if an individual is dually enrolled. Instead, with a central registry a single inquiry can be made to prevent an individual from simultaneously enrolling in two or more MOUD treatment services. The central registry also expedites verification of medication and dose, which can facilitate access to treatment throughout the

Commonwealth during emergencies. The central registry also simplifies accurate data reporting and dispensing of medication in accordance with state and federal laws and regulations.

The purpose of a central registry is to provide the Commonwealth with a tool to ensure that dual enrollment verification is accurate, help provide care during emergencies, and communicate with MOUD treatment services. Therefore, mandatory participation in the central registry system will help protect the health, welfare, and safety of Virginians.

Substance

Briefly identify and explain the new substantive provisions that are being considered, the substantive changes to existing sections that are being considered, or both.

This action will make changes to two sections:

12VAC35-105-645. Initial contacts, screening and admission. Adds a subsection which requires MOUD treatment services to collect data, specifically the number of individuals who are not admitted due to their refusal to consent to a central registry inquiry. The MOUD treatment service provider will be required to report this nonidentifying information to the department monthly.

12VAC35-105-1000. Preventing duplication of medication services. Deletes the current requirements and instead directs MOUD treatment service providers to: participate in a central registry; have three staff members who have access to the central registry; obtain written consent from individuals prior to initiating a central registry inquiry; initiate a central registry inquiry prior to admission; verify the individual is not dually enrolled; report all required data; and treat data as confidential in accordance with the law.

Alternatives to Regulation

Describe any viable alternatives to the regulatory change that were considered, and the rationale used by the agency to select the least burdensome or intrusive alternative that meets the essential purpose of the regulatory change. Also, include discussion of less intrusive or less costly alternatives for small businesses, as defined in § 2.2-4007.1 of the Code of Virginia, of achieving the purpose of the regulatory change.

There are no viable alternatives; without a regulatory mandate, participation by MOUD treatment service providers will remain optional and the central registry will not be as effective.

Periodic Review and Small Business Impact Review Announcement

This NOIRA is not being used to announce a periodic review or a small business impact review.

Public Participation

Indicate how the public should contact the agency to submit comments on this regulation, and whether a public hearing will be held, by completing the text below. In addition, as required by § 2.2-4007.02 of the

Code of Virginia, describe any other means that will be used to identify and notify interested parties and seek their input, such as regulatory advisory panels or general notices.

The Department of Behavioral Health and Developmental Services is providing an opportunity for comments on this regulatory proposal, including (i) the costs and benefits of the regulatory proposal, (ii) any alternative approaches, and (iii) the potential impacts of the regulation.

Anyone wishing to submit written comments for the public comment file may do so through the Public Comment Forums feature of the Virginia Regulatory Town Hall web site at: https://townhall.virginia.gov. Comments may also be submitted by mail or email to Susan Puglisi, P.O. Box 1797, Richmond, VA 23218-1797, susan.puglisi@dbhds.virginia.gov. In order to be considered, comments must be received by 11:59 pm on the last day of the public comment period.

A public hearing will not be held following the publication of the proposed stage of this regulatory action.

DBHDS
Virginia Department of Behavioral Health and Developmental Services

REGULATORY BUSINESS

UPDATED Emergency/NOIRA Actions
Align Licensing Regulations with most recent DMAS revisions to Redesigned Medicaid Services

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Included in Agenda Packet:

- Summary of Major Changes
- Three (3) DRAFT Agency Background Documents (Form TH-05)
- Three (3) DRAFT Amendments to DBHDS Licensing Regulations (12VAC35-105)

Background:
Virginia's behavioral health system is undergoing a multi-phased, interagency process of transformation to enhance the service delivery system. The General Assembly directed DBHDS to align its Licensing Regulations with the modifications being made to Medicaid and initially established a July 1, 2026, implementation date for Behavioral Health Redesign.

As a result, in late 2025, the board voted to initiate the emergency regulatory process to ensure consistency with the three new Medicaid service categories based on draft DMAS policies issued at that time.

Justification:
In the intervening months since the board initiated its emergency regulatory actions, DMAS announced changes to its draft policy manuals, some of which create inconsistencies or may generate confusion. Additionally, the General Assembly extended the Behavioral Health Redesign implementation deadline by one year, to July 1, 2027.

Although Medicaid policies for the three new service categories are not yet finalized, emergency regulations must be in place to begin licensing providers under the new redesigned services. DBHDS licensure is a prerequisite for DMAS enrollment and credentialing by Medicaid managed care organizations (MCOs).

Staff Recommendation:
Withdraw the board's previously authorized emergency actions for Behavioral Health Redesign (CPST, CSC, and REC) and replace with revised regulatory packages, developed in collaboration with DMAS, to conform to planned amendments to Medicaid policy manuals.

Action Needed:
Authorize three revised Emergency/NOIRA actions as presented to align DBHDS Licensing Regulations with redesigned Medicaid services for:

- Community Psychiatric Support and Treatment (CPST);
- Coordinated Specialty Care (CSC), and
- Recovery and Empowerment Center (REC).

Standard actions to establish permanent regulations will follow the emergency actions.

Summary of Major Changes

CPST

- Reduces experience requirement for LMHP (from two years to one year)
- Adds QMHP-Trainees as eligible treatment team members
- Increases maximum group therapy ratios to 1:8 for children and adolescents (from 1:6) and to 1:12 for adults (from 1:10)
- Eases restriction on in-office programming from no more than one hour a week per individual to a maximum of 50% of service delivery hours a week per individual

CSC

- Removes three-year duration-of-treatment restriction (relies instead on standard discharge criteria)
- Clarifies crisis support services requirements

REC

- Removes clinical director as a minimum position requirement
- Allows assessment to be completed up to 12 months before admission (increased from 30 days)
- Amends discharge criteria to reflect voluntary nature of Clubhouse services
- Clarifies crisis support services requirements

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Emergency Regulation and Notice of Intended Regulatory Action (NOIRA) Agency Background Document

Agency name	Department of Behavioral Health and Developmental Services (DBHDS)
Virginia Administrative Code (VAC) Chapter citation(s)	12VAC35-105
VAC Chapter title(s)	Rules and Regulations for Licensing Providers by the Department of Behavioral Health and Developmental Services (12VAC35-105)
Action title	2026 Community Psychiatric Support and Treatment (CPST) alignment with Medicaid behavioral health services redesign
Date this document prepared	July 14, 2026

This information is required for executive branch review and the Virginia Registrar of Regulations, pursuant to the Virginia Administrative Process Act (APA), Executive Order 19 (2022) (EO 19), any instructions or procedures issued by the Office of Regulatory Management (ORM) or the Department of Planning and Budget (DPB) pursuant to EO 19, the Regulations for Filing and Publishing Agency Regulations (1 VAC 7-10), and the *Form and Style Requirements for the Virginia Register of Regulations and Virginia Administrative Code*.

Brief Summary

Provide a brief summary (preferably no more than 2 or 3 paragraphs) of the subject matter, intent, and goals of this regulatory change (i.e., new regulation, amendments to an existing regulation, or repeal of an existing regulation). Alert the reader to all substantive matters or changes. If applicable, generally describe the existing regulation.

In 2025, the General Assembly directed the Department of Behavioral Health and Developmental Services (DBHDS) through the budget bill to utilize emergency authority to align licensing regulations with the modifications being made to Medicaid behavioral health services by July 1, 2026. During the 2026 Special Session I, the 2026-2028 Appropriation Act extended the implementation deadline for behavioral health redesign by one year and reauthorized the directive for emergency regulations (Item 297).

To comply with the legislative mandates, the State Board of Behavioral Health and Developmental Services must adopt three separate emergency actions that conform DBHDS Licensing Regulations with changes to be made by the Department of Medical Assistance Services (DMAS) replacing legacy

services with Community Psychiatric Support and Treatment (CPST); Coordinated Specialty Care (CSC); and Mental Health Clubhouse Services (Clubhouse).

This regulatory action will establish the newly licensed service of CPST.

Acronyms and Definitions

Define all acronyms used in this form, and any technical terms that are not also defined in the "Definitions" section of the regulation.

Community Psychiatric Support and Treatment (CPST)
Department of Behavioral Health and Development Services (DBHDS)
Department of Medical Assistance Services (DMAS)
State Board of Behavioral Health and Developmental Services (State Board)

Mandate and Impetus (Necessity for Emergency)

Explain why this rulemaking is an emergency situation in accordance with § 2.2-4011 A and B of the Code of Virginia. In doing so, either:

a) *Indicate whether the Governor's Office has already approved the use of emergency regulatory authority for this regulatory change.*
b) *Provide specific citations to Virginia statutory law, the appropriation act, federal law, or federal regulation that require that a regulation be effective in 280 days or less from its enactment.*

As required by § 2.2-4011, also describe the nature of the emergency and of the necessity for this regulatory change. In addition, delineate any potential issues that may need to be addressed as part of this regulatory change.

Item 297 of the 2026-2028 Appropriation Act directs DBHDS to promulgate emergency regulations, in collaboration with DMAS, to "align licensing regulations with the modifications being made to Medicaid behavioral health services." A regulatory action to establish permanent regulations will follow this emergency action.

Legal Basis

Identify (1) the promulgating agency, and (2) the state and/or federal legal authority for the regulatory change, including the most relevant citations to the Code of Virginia or Acts and Assembly chapter number(s), if applicable. Your citation must include a specific provision, if any, authorizing the promulgating agency to regulate this specific subject or program, as well as a reference to the agency's overall regulatory authority.

DBHDS was directed by the General Assembly during the 2026 Special Session I to promulgate emergency regulations that align its provider licensing regulations with the modifications being made by DMAS to Medicaid behavioral health services. Item 297 of the 2026-2028 Appropriation Act mandates the changes within this regulatory action.

Section 37.2-203 of the Code of Virginia gives the State Board the authority to adopt regulations that may be necessary to carry out the provisions of Title 37.2 of the Code and other laws of the Commonwealth administered by the DBHDS commissioner. The State Board voted to adopt this regulatory action at its meeting on July 15, 2026.

Purpose

Describe the specific reasons why the agency has determined that this regulation is essential to protect the health, safety, or welfare of citizens. In addition, explain any potential issues that may need to be addressed as the regulation is developed.

The purpose of this action is to comply with the legislative mandate by aligning DBHDS licensing regulations with anticipated DMAS changes to Medicaid by establishing the new behavioral health service of CPST.

The goal of CPST is to assist individuals in achieving personal independence and success in their daily lives by: (1) helping individuals access necessary services and support systems within their communities; (2) fostering hope and resilience while addressing mental health challenges through person-centered care; and (3) assisting individuals in developing daily living skills and coping strategies to manage their mental health.

Substance

Briefly identify and explain the new substantive provisions, the substantive changes to existing sections, or both. A more detailed discussion is provided in the "Detail of Changes" section below.

The substantive provisions of this regulatory action include:

1) Definitions necessary for the integration of CPST into the Licensing Regulations;
2) Admission criteria for CPST;
3) Discharge criteria for CPST;
4) Minimum requirements for CPST treatment teams and staffing; and
5) Minimum CPST service delivery and location requirements.

Issues

Identify the issues associated with the regulatory change, including: 1) the primary advantages and disadvantages to the public, such as individual private citizens or businesses, of implementing the new or amended provisions; 2) the primary advantages and disadvantages to the agency or the Commonwealth; and 3) other pertinent matters of interest to the regulated community, government officials, and the public. If there are no disadvantages to the public or the Commonwealth, include a specific statement to that effect.

Virginia's behavioral health system is undergoing a multi-phased, interagency process of transformation to enhance the service delivery system. This requires coordination among agencies with responsibilities for licensing, funding, and oversight behavioral health services in the Commonwealth.

The primary advantages of this regulatory action include (1) improving access to a continuum of high-quality behavioral health services for Virginians; (2) ensuring CPST providers adhere to a base level of model fidelity; and (3) reducing administrative burden by aligning provider licensing regulations with Medicaid service expectations.

There are no known disadvantages to the public or the Commonwealth.

Alternatives to Regulation

Describe any viable alternatives to the regulatory change that were considered, and the rationale used by the agency to select the least burdensome or intrusive alternative that meets the essential purpose of the regulatory change. Also, include discussion of less intrusive or less costly alternatives for small businesses, as defined in § 2.2-4007.1 of the Code of Virginia, of achieving the purpose of the regulatory change.

There are no alternatives to the regulatory changes contained herein that could achieve the essential purpose of this action, which itself is mandated by the General Assembly.

The amendments are limited to those that are necessary to avoid conflict between DBHDS licensing regulations and planned DMAS modifications to Medicaid behavioral health services. Misalignment would be problematic for licensed providers of behavioral health services seeking DMAS enrollment, many of which are small businesses, as well as for individuals receiving services and their families.

Periodic Review and Small Business Impact Review Announcement

This NOIRA is not being used to announce a periodic review or a small business impact review.

Public Participation

Indicate how the public should contact the agency to submit comments on this regulation, and whether a public hearing will be held, by completing the text below. In addition, as required by § 2.2-4007.02 of the Code of Virginia describe any other means that will be used to identify and notify interested parties and seek their input, such as regulatory advisory panels or general notices.

The Department of Behavioral Health and Developmental Services is providing an opportunity for comments on this regulatory proposal, including but not limited to (i) the costs and benefits of the regulatory proposal, (ii) any alternative approaches, and (iii) the potential impacts of the regulation.

Anyone wishing to submit written comments for the public comment file may do so through the Public Comment Forums feature of the Virginia Regulatory Town Hall web site at: https://townhall.virginia.gov. Comments may also be submitted by mail or email to Susan Puglisi, 1220 Bank Street, Richmond Virginia, 23219, or susan.puglisi@dbhds.virginia.gov. In order to be considered, comments must be received by 11:59 pm on the last day of the public comment period.

A public hearing will not be held following the publication of the proposed stage of this regulatory action.

Detail of Changes

List all regulatory changes and the consequences of the changes. Explain the new requirements and what they mean rather than merely quoting the text of the regulation. For example, describe the intent of the language and the expected impact. Describe the difference between existing requirement(s) and/or agency practice(s) and what is being proposed in this regulatory change. Use all tables that apply, but delete inapplicable tables.

If an existing VAC Chapter(s) is being amended or repealed, use Table 1 to describe the changes between existing VAC Chapter(s) and the emergency regulation. If existing VAC Chapter(s) or sections are being repealed and replaced, ensure Table 1 clearly shows both the current number and the new number for each repealed section and the replacement section.

Table 1: Changes to Existing VAC Chapter(s)

Current chapter-section number	New chapter-section number, if applicable	Current requirements in VAC	Change, intent, rationale, and likely impact of new requirements
12VAC35-105-20. Definitions		Definitions for the Licensing Regulations.	Addition of the following terms: "Behavioral Health Technician" or "BHT" means a person who has completed, at a minimum, an associate degree and registered with the Board of Counseling to practice in accordance with the provisions of § 54.1-3518 of the Code of Virginia and regulations of the Board of Counseling and provides collaborative behavioral health services. "Community Psychiatric Support and Treatment" or "CPST" means a multi-component, team-based service for adults and youth that consists of assessment, crisis and functional supports, counseling, therapeutic interventions, and care coordination. CPST services concentrate on restoring functional skills of daily living, building natural supports, and achieving identified person-centered goals and objectives identified in the individual's ISP. CPST services focus on the individual's ability to succeed in the community by showing improvement in school, work, and family function as well as improving the individual's family or caregiver capacity to help the individual successfully function in the home and community. "Early serious mental illness" means the initial onset of a diagnosable mental, behavioral, or emotional disorder that significantly impacts an individual's functioning, potentially hindering their ability to achieve expected levels of interpersonal, academic or occupational success.

			"Licensed mental health professional-resident" or "LMHP-R" means the same as “resident” as defined in 18VAC115-20-10 for licensed professional counselors, 18VAC115-50-10 for licensed marriage and family therapists, or 18VAC115-60-10 for licensed substance abuse treatment practitioners. An LMHP-R shall be in continuous compliance with the regulatory requirements of the applicable counseling profession for supervised practice. "LMHP-resident in psychology" or "LMHP-RP" means an individual in a residency as that term is defined in 18VAC125-20-10 for clinical psychologists. An LMHP-RP shall be in continuous compliance with the regulatory requirements for supervised experience as found in 18VAC125-20-65. "LMHP-supervisee in social work," "LMHP-supervisee," or "LMHP-S" means the same as "supervisee" as defined in 18VAC140-20-10 for licensed clinical social workers. An LMHP-S shall be in continuous compliance with the regulatory requirements for supervised practice as found in 18VAC140-20-50. "Rehabilitation skills practice" means a subcomponent of restorative evidenced-based therapeutic interventions for individuals who need individualized, collaborative, hands-on training to build developmentally appropriate skills. "Restorative evidence-based therapeutic interventions" means evidence-based practices designed to decrease symptoms of the individual's mental health diagnosis, restore functional skills of daily living, build natural supports, and achieve identified person-centered goals and objectives as set forth in the ISP. Restorative evidence-based therapeutic interventions is focused on the individual’s ability to succeed in the community and to show improvement in school, work, and home functioning.

			"Serious emotional disturbance" or "SED" means an individual under the age of 18 having within the past year a diagnosable mental, behavioral, or emotional disorder resulting in functional impairment that substantially interferes with or limits the individual's role or functioning in family, school, or community activities. "Serious mental illness" or "SMI" means an individual over the age of 18 having within the past year a diagnosable mental, behavioral, or emotional disorder that substantially interferes with the individual's life and ability to function. Likely impact: Clearer regulations. Alignment with Medicaid service changes and current evidence-based practices and terminology to provide person-centered treatment.
12VAC35-105-30. Licenses.			Addition of the license types: Community psychiatric support and treatment for children and adolescents Community psychiatric support and treatment Likely impact: Clearer regulations. Alignment with Medicaid service changes and current evidence-based practices and terminology to provide person-centered treatment.
	12VAC35-105-1421. Admission Criteria.		Intent: Provide clear admission requirements within CPST programs. Impact: Robust, effective mental health treatment within the Commonwealth that is appropriately administered.
	12VAC35-105-1422. Discharge criteria.		Intent: Provide clear discharge requirements within CPST programs. Impact: Robust, effective mental health treatment within the Commonwealth that is appropriately administered.
	12VAC35-105-1423. Treatment team and staffing.		Intent: Update the requirements of providers of CPST services specifically related to personnel. Impact: Robust, effective mental health treatment within the Commonwealth.
	12VAC35-105-1424.		Intent: Provide clear service delivery requirements within CPST programs.

	Service delivery and location.		Impact: Robust, effective mental health treatment within the Commonwealth that is appropriately administered.
	12VAC35-105-1425. Location requirements.		Intent: Provide clear location requirements within CPST programs. Impact: Robust, effective mental health treatment within the Commonwealth that is appropriately administered.

Project 8445 - Emergency/NOIRA

Department of Behavioral Health And Developmental Services

Community Psychiatric Support and Treatment (CPST)

12VAC35-105-20. Definitions.

The following words and terms when used in this chapter shall have the following meanings unless the context clearly indicates otherwise:

"Abuse" means, as defined by § 37.2-100 of the Code of Virginia, any act or failure to act by an employee or other person responsible for the care of an individual in a facility or program operated, licensed, or funded by the department, excluding those operated by the Virginia Department of Corrections, that was performed or was failed to be performed knowingly, recklessly, or intentionally, and that caused or might have caused physical or psychological harm, injury, or death to an individual receiving care or treatment for mental illness, developmental disabilities, or substance abuse. Examples of abuse include acts such as:

1. Rape, sexual assault, or other criminal sexual behavior;
2. Assault or battery;
3. Use of language that demeans, threatens, intimidates, or humiliates the individual;
4. Misuse or misappropriation of the individual's assets, goods, or property;
5. Use of excessive force when placing an individual in physical or mechanical restraint;
6. Use of physical or mechanical restraints on an individual that is not in compliance with federal and state laws, regulations, and policies, professional accepted standards of practice, or the individual's individualized services plan; or
7. Use of more restrictive or intensive services or denial of services to punish an individual or that is not consistent with the individual's individualized services plan.

"Activities of daily living" or "ADLs" means personal care activities and includes bathing, dressing, transferring, toileting, grooming, hygiene, feeding, and eating. An individual's degree of independence in performing these activities is part of determining the appropriate level of care and services.

"Addiction" means a primary, chronic disease of brain reward, motivation, memory, and related circuitry. Addiction is defined as the inability to consistently abstain, impairment in behavioral control, persistence of cravings, diminished recognition of significant problems with one's behaviors and interpersonal relationships, and a dysfunctional emotional response. Like other chronic diseases, addiction often involves cycles of relapse and remission. Without treatment or engagement in recovery activities, addiction is progressive and can result in disability or premature death.

"Admission" means the process of acceptance into a service as defined by the provider's policies.

"Allied health professional" means a professional who is involved with the delivery of health or related services pertaining to the identification, evaluation, and prevention of diseases and disorders, such as a certified substance abuse counselor, certified substance abuse counseling assistant, peer recovery support specialist, certified nurse aide, or occupational therapist.

"ASAM" means the American Society of Addiction Medicine.

"Assertive community treatment service" or "ACT" means a self-contained interdisciplinary community-based team of medical, behavioral health, and rehabilitation professionals who use a

team approach to meet the needs of an individual with severe and persistent mental illness. ACT teams:

1. Provide person-centered services addressing the breadth of an individual's needs, helping the individual achieve his personal goals;

2. Serve as the primary provider of all the services that an individual receiving ACT services needs;

3. Maintain a high frequency and intensity of community-based contacts;

4. Maintain a very low individual-to-staff ratio;

5. Offer varying levels of care for all individuals receiving ACT services and appropriately adjust service levels according to each individual's needs over time;

6. Assist individuals in advancing toward personal goals with a focus on enhancing community integration and regaining valued roles, such as worker, family member, resident, spouse, tenant, or friend;

7. Carry out planned assertive engagement techniques, including rapport-building strategies, facilitating meeting basic needs, and motivational interviewing techniques;

8. Monitor the individual's mental status and provide needed supports in a manner consistent with the individual's level of need and functioning;

9. Deliver all services according to a recovery-based philosophy of care; and

10. Promote self-determination, respect for the individual receiving ACT as an individual in such individual's own right, and engage peers in promoting recovery and regaining meaningful roles and relationships in the community.

"Authorized representative" means a person permitted by law or 12VAC35-115 to authorize the disclosure of information or consent to treatment and services or participation in human research.

"Behavior intervention" means those principles and methods employed by a provider to help an individual receiving services to achieve a positive outcome and to address challenging behavior in a constructive and safe manner. Behavior intervention principles and methods shall be employed in accordance with the individualized services plan and written policies and procedures governing service expectations, treatment goals, safety, and security.

"Behavioral Health Technician" or "BHT" means a person who has completed, at a minimum, an associate degree and registered with the Board of Counseling to practice in accordance with the provisions of § 54.1-3518 of the Code of Virginia and regulations of the Board of Counseling and provides collaborative behavioral health services.

"Behavioral treatment plan," "functional plan," or "behavioral support plan" means any set of documented procedures that are an integral part of the individualized services plan and are developed on the basis of a systematic data collection, such as a functional assessment, for the purpose of assisting individuals to achieve the following:

1. Improved behavioral functioning and effectiveness;

2. Alleviation of symptoms of psychopathology; or

3. Reduction of challenging behaviors.

"Board" or "state board" means, as defined by § 37.2-100 of the Code of Virginia, the State Board of Behavioral Health and Developmental Services. The board has statutory responsibility for adopting regulations that may be necessary to carry out the provisions of Title 37.2 of the Code of Virginia and other laws of the Commonwealth administered by the commissioner or the department.

"Brain injury" means any injury to the brain that occurs after birth that is acquired through traumatic or nontraumatic insults. Nontraumatic insults may include anoxia, hypoxia, aneurysm, toxic exposure, encephalopathy, surgical interventions, tumor, and stroke. Brain injury does not include hereditary, congenital, or degenerative brain disorders or injuries induced by birth trauma.

"Care," "treatment," or "support" means the individually planned therapeutic interventions that conform to current acceptable professional practice and that are intended to improve or maintain functioning of an individual receiving services delivered by a provider.

"Case management service" or "support coordination service" means services that can include assistance to individuals and their family members in accessing needed services that are responsive to the individual's needs. Case management services include identifying potential users of the service; assessing needs and planning services; linking the individual to services and supports; assisting the individual directly to locate, develop, or obtain needed services and resources; coordinating services with other providers; enhancing community integration; making collateral contacts; monitoring service delivery; discharge planning; and advocating for individuals in response to their changing needs. "Case management service" does not include assistance in which the only function is maintaining service waiting lists or periodically contacting or tracking individuals to determine potential service needs.

"Clinical experience" means providing direct services to individuals with mental illness or the provision of direct geriatric services or special education services. Experience may include supervised internships, practicums, and field experience.

"Clinically managed high-intensity residential care" or "Level of care 3.5" means a substance use treatment program that offers 24-hour supportive treatment of individuals with significant psychological and social problems by credentialed addiction treatment professionals in an interdisciplinary treatment approach. A clinically managed high-intensity residential care program provides treatment to individuals who present with significant challenges, such as physical, sexual, or emotional trauma; past criminal or antisocial behaviors, with a risk of continued criminal behavior; an extensive history of treatment; inadequate anger management skills; extreme impulsivity; and antisocial value system.

"Clinically managed low-intensity residential care" or "Level of care 3.1" means providing an ongoing therapeutic environment for individuals requiring some structured support in which treatment is directed toward applying recovery skills; preventing relapse; improving emotional functioning; promoting personal responsibility; reintegrating the individual into work, education, and family environments; and strengthening and developing adaptive skills that may not have been achieved or have been diminished during the individual's active addiction. A clinically managed low-intensity residential care program also provides treatment for individuals suffering from chronic, long-term alcoholism or drug addiction and affords an extended period of time to establish sound recovery and a solid support system.

"Clinically managed population specific high-intensity residential services" or "Level of care 3.3" means a substance use treatment program that provides a structured recovery environment in combination with high-intensity clinical services provided in a manner to meet the functional limitations of individuals. The functional limitations of individuals who are placed within this level of care are primarily cognitive and can be either temporary or permanent.

"Collaborative behavioral health services" means the same as the term is defined in § 54.1-3500 of the Code of Virginia.

"Commissioner" means the Commissioner of the Department of Behavioral Health and Developmental Services.

"Community-based crisis stabilization" means services that are short term and designed to support an individual and the individual's natural support system following contact with an initial crisis response service or as a diversion to a higher level of care. Providers deliver community-

based crisis stabilization services in an individual's natural environment and provide referrals and linkage to other community-based services at the appropriate level of care. Interventions may include mobile crisis response, brief therapeutic and skill-building interventions, engagement of natural supports, interventions to integrate natural supports in the de-escalation and stabilization of the crisis, and coordination of follow-up services. Coordination of specialized services to address the needs of co-occurring developmental disabilities and substance use disorders are also available through this service. Services include advocacy and networking to provide linkages and referrals to appropriate community-based services and assist the individual and the individual's family or caregiver in accessing other benefits or assistance programs for which the individual may be eligible. Community-based crisis stabilization is a non-center, community-based service. The goal of community-based crisis stabilization services is to stabilize the individual within the community and support the individual or the individual's support system (i) as part of an initial mobile crisis response; (ii) during the period between an initial mobile crisis response and entry into an established follow-up service at the appropriate level of care; (iii) as a transitional step-down from a higher level of care if the next level of care service is identified but not immediately available for access; or (iv) as a diversion to a higher level of care.

"Community gero-psychiatric residential services" means 24-hour care provided to individuals with mental illness, behavioral problems, and concomitant health problems who are usually 65 years of age or older in a geriatric setting that is less intensive than a psychiatric hospital but more intensive than a nursing home or group home. Services include assessment and individualized services planning by an interdisciplinary services team, intense supervision, psychiatric care, behavioral treatment planning and behavior interventions, nursing, and other health-related services.

"Community Psychiatric Support and Treatment" or "CPST" means a multi-component, team-based service for adults and youth that consists of assessment, crisis and functional supports, counseling, therapeutic interventions, and care coordination. CPST services concentrate on restoring functional skills of daily living, building natural supports, and achieving identified person-centered goals and objectives identified in the individual’s ISP. CPST services focus on the individual’s ability to succeed in the community by showing improvement in school, work, and family function as well as improving the individual’s family or caregiver capacity to help the individual successfully function in the home and community.

"Complaint" means an allegation of a violation of this chapter or a provider's policies and procedures related to this chapter.

"Conveyance" means a motor vehicle that serves as the mobile component of a mobile MAT program.

"Co-occurring disorders" means the presence of more than one and often several of the following disorders that are identified independently of one another and are not simply a cluster of symptoms resulting from a single disorder: mental illness, a developmental disability, substance abuse (substance use disorders), or brain injury.

"Co-occurring services" means individually planned therapeutic treatment that addresses in an integrated concurrent manner the service needs of individuals who have co-occurring disorders.

"Corrective action plan" means the provider's pledged corrective action in response to cited areas of noncompliance documented by the regulatory authority.

"Correctional facility" means a facility operated under the management and control of the Virginia Department of Corrections.

"Credentialed addiction treatment professional" means a person who possesses one of the following credentials issued by the appropriate health regulatory board: (i) an addiction-credentialed physician or physician with experience or training in addiction medicine; (ii) a

licensed nurse practitioner or a licensed physician assistant with experience or training in addiction medicine; (iii) a licensed psychiatrist; (iv) a licensed clinical psychologist; (v) a licensed clinical social worker; (vi) a licensed professional counselor; (vii) a licensed nurse practitioner with experience or training in psychiatry or mental health; (viii) a licensed marriage and family therapist; (ix) a licensed substance abuse treatment practitioner; (x) a resident who is under the supervision of a licensed professional counselor (18VAC115-20-10), licensed marriage and family therapist (18VAC115-50-10), or licensed substance abuse treatment practitioner (18VAC115-60-10) and is registered with the Virginia Board of Counseling; (xi) a resident in psychology who is under supervision of a licensed clinical psychologist and is registered with the Virginia Board of Psychology (18VAC125-20-10); or (xii) a supervisee in social work who is under the supervision of a licensed clinical social worker and is registered with the Virginia Board of Social Work (18VAC140-20-10).

"Crisis" means a deteriorating or unstable situation often developing suddenly or rapidly that produces acute, heightened, emotional, mental, physical, medical, or behavioral distress.

"Crisis education and prevention plan" or "CEPP" means a department-approved, individualized, client-specific document that provides a concise, clear, and realistic set of supportive interventions to prevent or de-escalate a crisis and assist an individual who may be experiencing a behavioral loss of control. The goal of the CEPP is to identify problems that have arisen in the past or are emergent in order to map out strategies that offer tools for the natural support system to assist the individual in addressing and de-escalating problems in a healthy way and provide teaching skills that the individual can apply independently.

"Crisis planning team" means the team who is consulted to plan the individual's safety plan or crisis ISP. The crisis planning team consists, at a minimum, of the individual receiving services, the individual's legal guardian or authorized representative, and a member of the provider's crisis staff. The crisis planning team may include the individual's support coordinator, case manager, the individual's family, or other identified persons, as desired by the individual, such as the individual's family of choice.

"Crisis receiving center," "CRC," or "23-hour crisis stabilization" means a community-based, nonhospital facility providing short-term assessment, observation, and crisis stabilization services for up to 23 hours. This service is accessible 24 hours per day, seven days per week, 365 days per year, and is indicated when an individual requires a safe environment for initial assessment and intervention. This service includes a thorough assessment of an individual's behavioral health crisis, psychosocial needs, and supports in order to determine the least restrictive environment most appropriate for stabilization. Key service functions include rapid assessment, crisis intervention, de-escalation, short-term stabilization, and appropriate referrals for ongoing care. This distinct service may be co-located with other services such as crisis stabilization units.

"Crisis stabilization" means direct, intensive nonresidential or residential care and treatment to nonhospitalized individuals experiencing an acute crisis that may jeopardize their current community living situation. Crisis stabilization is intended to avert hospitalization or rehospitalization; provide normative environments with a high assurance of safety and security for crisis intervention; stabilize individuals in crisis; and mobilize the resources of the community support system, family members, and others for ongoing rehabilitation and recovery.

"Crisis stabilization unit," "CSU," or "residential crisis stabilization unit" is a community-based, short-term residential treatment unit. CSUs serve as primary alternatives to inpatient hospitalization for individuals who are in need of a safe, secure environment for assessment and crisis treatment. CSUs also serve as a step-down option from psychiatric inpatient hospitalization and function to stabilize and reintegrate individuals who meet medical necessity criteria back into their communities.

"Day support service" means structured programs of training, assistance, and specialized supervision in the acquisition, retention, or improvement of self-help, socialization, and adaptive skills for adults with a developmental disability provided to groups or individuals in nonresidential community-based settings. Day support services may provide opportunities for peer interaction and community integration and are designed to enhance the following: self-care and hygiene, eating, toileting, task learning, community resource utilization, environmental and behavioral skills, social skills, medication management, prevocational skills, and transportation skills. The term "day support service" does not include services in which the primary function is to provide employment-related services, general educational services, or general recreational services.

"Department" means the Virginia Department of Behavioral Health and Developmental Services.

"Developmental disability" means a severe, chronic disability of an individual that (i) is attributable to a mental or physical impairment or a combination of mental and physical impairments other than a sole diagnosis of mental illness; (ii) is manifested before the individual reaches 22 years of age; (iii) is likely to continue indefinitely; (iv) results in substantial functional limitations in three or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, or economic self-sufficiency; and (v) reflects the individual's need for a combination and sequence of special interdisciplinary or generic services, individualized supports, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated. An individual from birth to nine years of age, inclusive, who has a substantial developmental delay or specific congenital or acquired condition may be considered to have a developmental disability without meeting three or more of the criteria described in clauses (i) through (v) if the individual without services and supports has a high probability of meeting those criteria later in life.

"Developmental services" means planned, individualized, and person-centered services and supports provided to individuals with developmental disabilities for the purpose of enabling these individuals to increase their self-determination and independence, obtain employment, participate fully in all aspects of community life, advocate for themselves, and achieve their fullest potential to the greatest extent possible.

"Diagnostic and Statistical Manual of Mental Disorders" or "DSM" means the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition, DSM-5, of the American Psychiatric Association.

"Direct care position" means any position that includes responsibility for (i) treatment, case management, health, safety, development, or well-being of an individual receiving services or (ii) immediately supervising a person in a position with this responsibility.

"Discharge" means the process by which the individual's active involvement with a service is terminated by the provider, individual, or individual's authorized representative.

"Discharge plan" means the written plan that establishes the criteria for an individual's discharge from a service and identifies and coordinates delivery of any services needed after discharge.

"Dispense" means to deliver a drug to an ultimate user by or pursuant to the lawful order of a practitioner, including the prescribing and administering, packaging, labeling, or compounding necessary to prepare the substance for that delivery (§ 54.1-3400 et seq. of the Code of Virginia).

"Early serious mental illness" means the initial onset of a diagnosable mental, behavioral, or emotional disorder that significantly impacts an individual’s functioning, potentially hindering their ability to achieve expected levels of interpersonal, academic or occupational success.

"Emergency service" means unscheduled and sometimes scheduled crisis intervention, stabilization, and referral assistance provided over the telephone or face-to-face, if indicated,

available 24 hours a day and seven days per week. Emergency services also may include walk-ins, home visits, jail interventions, and preadmission screening activities associated with the judicial process.

"Group home or community residential service" means a congregate service providing 24-hour supervision in a community-based home having eight or fewer residents. Services include supervision, supports, counseling, and training in activities of daily living for individuals whose individualized services plan identifies the need for the specific types of services available in this setting.

"HCBS Waiver" means a Medicaid Home and Community Based Services Waiver.

"Home and noncenter based" means that a service is provided in the individual's home or other noncenter-based setting. This includes noncenter-based day support, supportive in-home, and intensive in-home services.

"Individual" or "individual receiving services" means a current direct recipient of public or private mental health, developmental, or substance abuse treatment, rehabilitation, or habilitation services and includes the terms "consumer," "patient," "resident," "recipient," or "client". When the term is used in this chapter, the requirement applies to every individual receiving licensed services from the provider.

"Individualized services plan" or "ISP" means a comprehensive and regularly updated written plan that describes the individual's needs, the measurable goals and objectives to address those needs, and strategies to reach the individual's goals. An ISP is person-centered, empowers the individual, and is designed to meet the needs and preferences of the individual. The ISP is developed through a partnership between the individual and the provider and includes an individual's treatment plan, habilitation plan, person-centered plan, or plan of care, which are all considered individualized service plans.

"Informed choice" means a decision made after considering options based on adequate and accurate information and knowledge. These options are developed through collaboration with the individual and the individual's authorized representative, as applicable, and the provider with the intent of empowering the individual and the individual's authorized representative to make decisions that will lead to positive service outcomes.

"Informed consent" means the voluntary written agreement of an individual or that individual's authorized representative to surgery, electroconvulsive treatment, use of psychotropic medications, or any other treatment or service that poses a risk of harm greater than that ordinarily encountered in daily life or for participation in human research. To be voluntary, informed consent must be given freely and without undue inducement; any element of force, fraud, deceit, or duress; or any form of constraint or coercion.

"Initial assessment" means an assessment conducted prior to or at admission to determine whether the individual meets the service's admission criteria; what the individual's immediate service, health, and safety needs are; and whether the provider has the capability and staffing to provide the needed services.

"Inpatient psychiatric service" means intensive 24-hour medical, nursing, and treatment services provided to individuals with mental illness or substance abuse (substance use disorders) in a hospital as defined in § 32.1-123 of the Code of Virginia or in a special unit of a hospital.

"Instrumental activities of daily living" or "IADLs" means meal preparation, housekeeping, laundry, and managing money. A person's degree of independence in performing these activities is part of determining appropriate level of care and services.

"Intellectual disability" means a disability originating before 18 years of age, characterized concurrently by (i) significant subaverage intellectual functioning as demonstrated by performance on a standardized measure of intellectual functioning administered in conformity with

accepted professional practice that is at least two standard deviations below the mean and (ii) significant limitations in adaptive behavior as expressed in conceptual, social, and practical adaptive skills.

"Intensity of service" means the number, type, and frequency of staff interventions and other services provided during treatment at a particular level of care.

"Intensive in-home service" means family preservation interventions for children and adolescents who have or are at risk of serious emotional disturbance, including individuals who also have a diagnosis of developmental disability. Intensive in-home service is usually time-limited and is provided typically in the residence of an individual who is at risk of being moved to out-of-home placement or who is being transitioned back home from an out-of-home placement. The service includes 24-hour per day emergency response; crisis treatment; individual and family counseling; life, parenting, and communication skills; and case management and coordination with other services.

"Intermediate care facility/individuals with intellectual disability" or "ICF/IID" means a facility or distinct part of a facility certified by the Virginia Department of Health as meeting the federal certification regulations for an intermediate care facility for individuals with intellectual disability and persons with related conditions and that addresses the total needs of the residents, which include physical, intellectual, social, emotional, and habilitation, providing active treatment as defined in 42 CFR 435.1010 and 42 CFR 483.440.

"Investigation" means a detailed inquiry or systematic examination of the operations of a provider or its services regarding an alleged violation of regulations or law. An investigation may be undertaken as a result of a complaint, an incident report, or other information that comes to the attention of the department.

"Licensed mental health professional" or "LMHP" means a physician, licensed clinical psychologist, licensed professional counselor, licensed clinical social worker, licensed substance abuse treatment practitioner, licensed marriage and family therapist, certified psychiatric clinical nurse specialist, licensed behavior analyst, or licensed psychiatric/mental health nurse practitioner.

"Licensed mental health professional-resident" or "LMHP-R" means the same as “resident” as defined in 18VAC115-20-10 for licensed professional counselors, 18VAC115-50-10 for licensed marriage and family therapists, or 18VAC115-60-10 for licensed substance abuse treatment practitioners. An LMHP-R shall be in continuous compliance with the regulatory requirements of the applicable counseling profession for supervised practice.

"LMHP-resident in psychology" or "LMHP-RP" means an individual in a residency as that term is defined in 18VAC125-20-10 for clinical psychologists. An LMHP-RP shall be in continuous compliance with the regulatory requirements for supervised experience as found in 18VAC125-20-65.

"LMHP-supervisee in social work," "LMHP-supervisee," or "LMHP-S" means the same as "supervisee" as defined in 18VAC140-20-10 for licensed clinical social workers. An LMHP-S shall be in continuous compliance with the regulatory requirements for supervised practice as found in 18VAC140-20-50.

"Location" means a place where services are or could be provided.

"Mandatory outpatient treatment order" means an order issued by a court pursuant to § 37.2-817 of the Code of Virginia.

"Medical detoxification" means a service provided in a hospital or other 24-hour care facility under the supervision of medical personnel using medication to systematically eliminate or reduce the presence of alcohol or other drugs in the individual's body.

"Medical evaluation" means the process of assessing an individual's health status that includes a medical history and a physical examination of an individual conducted by a licensed medical practitioner operating within the scope of his license.

"Medically managed intensive inpatient service" or "Level of care 4.0" means an organized service delivered in an inpatient setting, including an acute care general hospital, psychiatric unit in a general hospital, or a freestanding psychiatric hospital. This service is appropriate for individuals whose acute biomedical and emotional, behavioral, and cognitive problems are so severe that they require primary medical and nursing care. Services at this level of care are managed by a physician who is responsible for diagnosis, treatment, and treatment plan decisions in collaboration with the individual.

"Medically monitored intensive inpatient treatment" or "Level of care 3.7" means a substance use treatment program that provides 24-hour care in a facility under the supervision of medical personnel. The care provided includes directed evaluation, observation, medical monitoring, and addiction treatment in an inpatient setting. The care provided may include the use of medication to address the effects of substance use. This service is appropriate for an individual whose subacute biomedical, emotional, behavioral, or cognitive problems are so severe that they require inpatient treatment but who does not need the full resources of an acute care general hospital or a medically managed intensive inpatient treatment program.

"Medication" means prescribed or over-the-counter drugs or both.

"Medication administration" means the legally permitted direct application of medications, as enumerated by § 54.1-3408 of the Code of Virginia, by injection, inhalation, ingestion, or any other means to an individual receiving services by (i) persons legally permitted to administer medications or (ii) the individual at the direction and in the presence of persons legally permitted to administer medications.

"Medication-assisted opioid treatment" or "opioid treatment service" means an intervention of administering or dispensing of medications, such as methadone, buprenorphine, or naltrexone approved by the federal Food and Drug Administration for the purpose of treating opioid use disorder.

"Medication-assisted treatment" or "MAT" means the use of U.S. Food and Drug Administration approved medications in combination with counseling and behavioral therapies to provide treatment of substance use disorders. Medication-assisted treatment includes medications for opioid use disorder as well as medications for treatment of alcohol use disorder.

"Medication error" means an error in administering a medication to an individual and includes when any of the following occur: (i) the wrong medication is given to an individual, (ii) the wrong individual is given the medication, (iii) the wrong dosage is given to an individual, (iv) medication is given to an individual at the wrong time or not at all, or (v) the wrong method is used to give the medication to the individual.

"Medication storage" means any area where medications are maintained by the provider, including a locked cabinet, locked room, or locked box.

"Mental Health Community Support Service" or "MCHSS" means the provision of recovery-oriented services to individuals with long-term, severe mental illness. MHCSS includes skills training and assistance in accessing and effectively utilizing services and supports that are essential to meeting the needs identified in the individualized services plan and development of environmental supports necessary to sustain active community living as independently as possible. MHCSS may be provided in any setting in which the individual's needs can be addressed, skills training applied, and recovery experienced.

"Mental health intensive outpatient service" means a structured program of skilled treatment services focused on maintaining and improving functional abilities through a time-limited,

interdisciplinary approach to treatment. This service is provided over a period of time for individuals requiring more intensive services than an outpatient service can provide and may include individual, family, or group counseling or psychotherapy; skill development and psychoeducational activities; certified peer support services; medication management; and psychological assessment or testing.

"Mental health outpatient service" means treatment provided to individuals on an hourly schedule, on an individual, group, or family basis, and usually in a clinic or similar facility or in another location. Mental health outpatient services may include diagnosis and evaluation, screening and intake, counseling, psychotherapy, behavior management, psychological testing and assessment, laboratory, and other ancillary services, medical services, and medication services. Mental health outpatient service specifically includes:

1. Mental health services operated by a community services board or a behavioral health authority established pursuant to Chapter 5 (§ 37.2-500 et seq.) or Chapter 6 (§ 37.2-600 et seq.) of Title 37.2 of the Code of Virginia;

2. Mental health services contracted by a community services board or a behavioral health authority established pursuant to Chapter 5 (§ 37.2-500 et seq.) or Chapter 6 (§ 37.2-600 et seq.) of Title 37.2 of the Code of Virginia; or

3. Mental health services that are owned, operated, or controlled by a corporation organized pursuant to the provisions of either Chapter 9 (§ 13.1-601 et seq.) or Chapter 10 (§ 13.1-801 et seq.) of Title 13.1 of the Code of Virginia.

"Mental health partial hospitalization service" means time-limited active treatment interventions that are more intensive than outpatient services, designed to stabilize and ameliorate acute symptoms and serve as an alternative to inpatient hospitalization or to reduce the length of a hospital stay. Partial hospitalization is provided through a minimum of 20 hours per week of skilled treatment services focused on individuals who require intensive, highly coordinated, structured, and interdisciplinary ambulatory treatment within a stable environment that is of greater intensity than intensive outpatient, but of lesser intensity than inpatient.

"Mental illness" means, as defined by § 37.2-100 of the Code of Virginia, a disorder of thought, mood, emotion, perception, or orientation that significantly impairs judgment, behavior, capacity to recognize reality, or ability to address basic life necessities and requires care and treatment for the health, safety, or recovery of the individual or for the safety of others.

"Missing" means a circumstance in which an individual is not physically present when and where he should be and his absence cannot be accounted for or explained by his supervision needs or pattern of behavior.

"Mobile crisis response" means a type of community-based crisis stabilization service that is available 24 hours per day, seven days per week, 365 days per year to provide rapid response, assessment, and early intervention to individuals experiencing a behavioral health crisis. Services are deployed in real time to the location of the individual experiencing a behavioral health crisis. The purpose of this service is to (i) de-escalate the behavioral health crisis and prevent harm to the individual or others; (ii) assist in the prevention of the individual's acute exacerbation of symptoms; (iii) develop an immediate plan to maintain safety; and (iv) coordinate care and linking to appropriate treatment services to meet the needs of the individual.

"Mobile medication-assisted treatment program" or "mobile MAT program" means a MAT operating from a motor vehicle or conveyance that serves as a mobile component to a licensed MAT location registered with the U.S. Drug Enforcement Administration as required by 21 CFR 1301.11 et seq.

"Motivational enhancement" means a person-centered approach that is collaborative, employs strategies to strengthen motivation for change, increases engagement in substance use

services, resolves ambivalence about changing substance use behaviors, and supports individuals to set goals to change their substance use.

"Neglect" means, as defined by § 37.2-100 of the Code of Virginia, the failure by a person or a program or facility operated, licensed, or funded by the department, excluding those operated by the Department of Corrections, responsible for providing services to do so, including nourishment, treatment, care, goods, or services necessary to the health, safety, or welfare of an individual receiving care or treatment for mental illness, developmental disabilities, or substance abuse.

"Neurobehavioral services" means the assessment, evaluation, and treatment of cognitive, perceptual, behavioral, and other impairments caused by brain injury that affect an individual's ability to function successfully in the community.

"Office of Human Rights" means the Department of Behavioral Health and Developmental Services Office of Human Rights.

"Person-centered" means focusing on the needs and preferences of the individual; empowering and supporting the individual in defining the direction for his life; and promoting self-determination, community involvement, and recovery.

"Provider" means, as defined by § 37.2-403 of the Code of Virginia, any person, entity, or organization, excluding an agency of the federal government by whatever name or designation, that delivers (i) services to individuals with mental illness, developmental disabilities, or substance abuse (substance use disorders) or (ii) residential services for individuals with brain injury. The person, entity, or organization shall include a hospital as defined in § 32.1-123 of the Code of Virginia, community services board, behavioral health authority, private provider, and any other similar or related person, entity, or organization. It shall not include any individual practitioner who holds a license issued by a health regulatory board of the Department of Health Professions or who is exempt from licensing pursuant to §§ 54.1-2901, 54.1-3001, 54.1-3501, 54.1-3601, and 54.1-3701 of the Code of Virginia.

"Psychosocial rehabilitation service" means a program of two or more consecutive hours per day provided to groups of adults in a nonresidential setting. Individuals must demonstrate a clinical need for the service arising from a condition due to mental, behavioral, or emotional illness that results in significant functional impairments in major life activities. This service provides education to teach the individual about mental illness, substance abuse, and appropriate medication to avoid complication and relapse and opportunities to learn and use independent skills and to enhance social and interpersonal skills within a consistent program structure and environment. Psychosocial rehabilitation includes skills training, peer support, vocational rehabilitation, and community resource development oriented toward empowerment, recovery, and competency.

"Qualified developmental disability professional" or "QDDP" means a person who possesses at least one year of documented experience working directly with individuals who have a developmental disability and who possesses one of the following credentials: (i) a doctor of medicine or osteopathy licensed in Virginia, (ii) a registered nurse licensed in Virginia, (iii) a licensed occupational therapist, or (iv) completion of at least a bachelor's degree in a human services field, including sociology, social work, special education, rehabilitation counseling, or psychology.

"Qualified mental health professional" or "QMHP" means the same as the term is defined in § 54.1-3500 of the Code of Virginia.

"Qualified mental health professional-trainee" or "QMHP-T" means the same as the term is defined in § 54.1-3500 of the Code of Virginia.

"Qualified paraprofessional in mental health" or "QPPMH" means a person who meets at least one of the following criteria: (i) is registered with the United States Psychiatric Association (USPRA) as an Associate Psychiatric Rehabilitation Provider (APRP); (ii) has an associate degree in a related field (social work, psychology, psychiatric rehabilitation, sociology, counseling, vocational rehabilitation, human services counseling) and at least one year of experience providing direct services to individuals with a diagnosis of mental illness; (iii) is licensed as an occupational therapy assistant, and supervised by a licensed occupational therapist, with at least one year of experience providing direct services to individuals with a diagnosis of mental illness; or (iv) has a minimum of 90 hours classroom training and 12 weeks of experience under the direct personal supervision of a QMHP providing services to individuals with mental illness and at least one year of experience, including the 12 weeks of supervised experience.

"Quality improvement plan" means a detailed work plan developed by a provider that defines steps the provider will take to review the quality of services it provides and to manage initiatives to improve quality. A quality improvement plan consists of systematic and continuous actions that lead to measurable improvement in the services, supports, and health status of the individuals receiving services.

"Recovery" means a journey of healing and transformation enabling an individual with a mental illness to live a meaningful life in a community of his choice while striving to achieve his full potential. For individuals with substance abuse (substance use disorders), recovery is an incremental process leading to positive social change and a full return to biological, psychological, and social functioning. For individuals with a developmental disability, the concept of recovery does not apply in the sense that individuals with a developmental disability will need supports throughout their entire lives although these may change over time. With supports, individuals with a developmental disability are capable of living lives that are fulfilling and satisfying and that bring meaning to themselves and others they know.

"REACH crisis therapeutic home" or "REACH CTH" means a residential home with crisis stabilization REACH service for individuals with a developmental disability and who are experiencing a mental health or behavior crisis.

"REACH mobile crisis response" means a REACH service that provides mobile crisis response for individuals with a developmental disability and who are experiencing a mental health or behavior crisis.

"Referral" means the process of directing an applicant or an individual to a provider or service that is designed to provide the assistance needed.

"Regional education assessment crisis services habilitation" or "REACH" means the statewide crisis system of care that is designed to meet the crisis support needs of individuals who have a developmental disability and are experiencing mental health or behavior crisis events that put the individuals at risk for homelessness, incarceration, hospitalization, or danger to self or others.

"Rehabilitation skills practice" means a subcomponent of restorative evidenced-based therapeutic interventions for individuals who need individualized, collaborative, hands-on training to build developmentally appropriate skills.

"Residential" or "residential service" means providing 24-hour support in conjunction with care and treatment or a training program in a setting other than a hospital or training center. Residential services provide a range of living arrangements from highly structured and intensively supervised to relatively independent and requiring a modest amount of staff support and monitoring. Residential services include residential treatment, group homes, supervised living, community gero-psychiatric residential, ICF/IID, sponsored residential homes, medical and social detoxification, and neurobehavioral services.

"Residential crisis stabilization service" means (i) providing short-term, intensive treatment to nonhospitalized individuals who require multidisciplinary treatment in order to stabilize acute

psychiatric symptoms and prevent admission to a psychiatric inpatient unit; (ii) providing normative environments with a high assurance of safety and security for crisis intervention; and (iii) mobilizing the resources of the community support system, family members, and others for ongoing rehabilitation and recovery.

"Residential treatment service" means providing an intensive and highly structured clinically based mental health, substance abuse, or neurobehavioral service for co-occurring disorders in a residential setting other than an inpatient service.

"Restorative evidence-based therapeutic interventions" means evidence-based practices designed to decrease symptoms of the individual's mental health diagnosis, restore functional skills of daily living, build natural supports, and achieve identified person-centered goals and objectives as set forth in the ISP. Restorative evidence-based therapeutic interventions is focused on the individual's ability to succeed in the community and to show improvement in school, work, and home functioning.

"Respite care service" means providing for a short-term, time-limited period of care of an individual for the purpose of providing relief to the individual's family, guardian, or regular caregiver. Persons providing respite care are recruited, trained, and supervised by a licensed provider. These services may be provided in a variety of settings including residential, day support, in-home, or a sponsored residential home.

"Restraint" means the use of a mechanical device, medication, physical intervention, or hands-on hold to prevent an individual receiving services from moving his body to engage in a behavior that places him or others at imminent risk. There are three kinds of restraints:

1. Mechanical restraint means the use of a mechanical device that cannot be removed by the individual to restrict the individual's freedom of movement or functioning of a limb or portion of an individual's body when that behavior places him or others at imminent risk.

2. Pharmacological restraint means the use of a medication that is administered involuntarily for the emergency control of an individual's behavior when that individual's behavior places him or others at imminent risk and the administered medication is not a standard treatment for the individual's medical or psychiatric condition.

3. Physical restraint, also referred to as manual hold, means the use of a physical intervention or hands-on hold to prevent an individual from moving his body when that individual's behavior places him or others at imminent risk.

"Restraints for behavioral purposes" means using a physical hold, medication, or a mechanical device to control behavior or involuntarily restrict the freedom of movement of an individual in an instance when all of the following conditions are met: (i) there is an emergency; (ii) nonphysical interventions are not viable; and (iii) safety issues require an immediate response.

"Restraints for medical purposes" means using a physical hold, medication, or mechanical device to limit the mobility of an individual for medical, diagnostic, or surgical purposes, such as routine dental care or radiological procedures and related post-procedure care processes, when use of the restraint is not the accepted clinical practice for treating the individual's condition.

"Restraints for protective purposes" means using a mechanical device to compensate for a physical or cognitive deficit when the individual does not have the option to remove the device. The device may limit an individual's movement, for example, bed rails or a gerichair, and prevent possible harm to the individual or it may create a passive barrier, such as a helmet to protect the individual.

"Restriction" means anything that limits or prevents an individual from freely exercising his rights and privileges.

"Risk management" means an integrated system-wide program to ensure the safety of individuals, employees, visitors, and others through identification, mitigation, early detection, monitoring, evaluation, and control of risks.

"Root cause analysis" means a method of problem solving designed to identify the underlying causes of a problem. The focus of a root cause analysis is on systems, processes, and outcomes that require change to reduce the risk of harm.

"Screening" means the process or procedure for determining whether the individual meets the minimum criteria for initial assessment.

"Seclusion" means the involuntary placement of an individual alone in an area secured by a door that is locked or held shut by a staff person, by physically blocking the door, or by any other physical means so that the individual cannot leave the area.

"Serious emotional disturbance" or "SED" means an individual under the age of 18 having within the past year a diagnosable mental, behavioral, or emotional disorder resulting in functional impairment that substantially interferes with or limits the individual's role or functioning in family, school, or community activities.

"Serious mental illness" or "SMI" means an individual over the age of 18 having within the past year a diagnosable mental, behavioral, or emotional disorder that substantially interferes with the individual's life and ability to function.

"Serious incident" means any event or circumstance that causes or could cause harm to the health, safety, or well-being of an individual. The term "serious incident" includes death and serious injury.

"Level I serious incident" means a serious incident that occurs or originates during the provision of a service or on the premises of the provider and does not meet the definition of a Level II or Level III serious incident. Level I serious incidents do not result in significant harm to individuals but may include events that result in minor injuries that do not require medical attention or events that have the potential to cause serious injury, even when no injury occurs.

"Level II serious incident" means a serious incident that occurs or originates during the provision of a service or on the premises of the provider that results in a significant harm or threat to the health and safety of an individual that does not meet the definition of a Level III serious incident. "Level II serious incident" includes a significant harm or threat to the health or safety of others caused by an individual. Level II serious incidents include:

1. A serious injury;

2. An individual who is or was missing;

3. An emergency room visit;

4. An unplanned psychiatric or unplanned medical hospital admission of an individual receiving services other than licensed emergency services, except that a psychiatric admission in accordance with an individual's wellness plan shall not constitute an unplanned admission for the purposes of this chapter;

5. Choking incidents that require direct physical intervention by another person;

6. Ingestion of any hazardous material; or

7. A diagnosis of:

   a. A decubitus ulcer or an increase in severity of level of previously diagnosed decubitus ulcer;

   b. A bowel obstruction; or

   c. Aspiration pneumonia.

"Level III serious incident" means a serious incident, whether or not the incident occurs while in the provision of a service or on the provider's premises, that results in:

1. Any death of an individual;

2. A sexual assault of an individual; or

3. A suicide attempt by an individual admitted for services, other than licensed emergency services, that results in a hospital admission.

"Serious injury" means any injury resulting in bodily hurt, damage, harm, or loss that requires medical attention by a licensed physician, doctor of osteopathic medicine, physician assistant, or nurse practitioner.

"Service" means, as defined by § 37.2-403 of the Code of Virginia, (i) planned individualized interventions intended to reduce or ameliorate mental illness, developmental disabilities, or substance abuse (substance use disorders) through care, treatment, training, habilitation, or other supports that are delivered by a provider to individuals with mental illness, developmental disabilities, or substance abuse (substance use disorders). Services include outpatient services, intensive in-home services, medication-assisted opioid treatment services, inpatient psychiatric hospitalization, community gero-psychiatric residential services, assertive community treatment and other clinical services; day support, day treatment, partial hospitalization, psychosocial rehabilitation, and habilitation services; case management services; and supportive residential, special school, halfway house, in-home services, crisis stabilization, and other residential services; and (ii) planned individualized interventions intended to reduce or ameliorate the effects of brain injury through care, treatment, or other supports provided in residential services for persons with brain injury.

"Shall" means an obligation to act is imposed.

"Shall not" means an obligation not to act is imposed.

"Signed" or "signature" means a handwritten signature, an electronic signature, or a digital signature, as long as the signer showed clear intent to sign.

"Skills training" means systematic skill building through curriculum-based psychoeducational and cognitive-behavioral interventions. These interventions break down complex objectives for role performance into simpler components, including basic cognitive skills such as attention, to facilitate learning and competency.

"Sponsored residential home" means a service where providers arrange for, supervise, and provide programmatic, financial, and service support to families or persons (sponsors) providing care or treatment in their own homes for individuals receiving services.

"State methadone authority" means the Virginia Department of Behavioral Health and Developmental Services, which is authorized by the federal Center for Substance Abuse Treatment to exercise the responsibility and authority for governing the treatment of opiate addiction with an opioid drug.

"Substance abuse (substance use disorders)" means, as defined by § 37.2-100 of the Code of Virginia, the use of drugs enumerated in the Virginia Drug Control Act (§ 54.1-3400 et seq.) without a compelling medical reason or alcohol that (i) results in psychological or physiological dependence or danger to self or others as a function of continued and compulsive use or (ii) results in mental, emotional, or physical impairment that causes socially dysfunctional or socially disordering behavior; and (iii), because of such substance abuse, requires care and treatment for the health of the individual. This care and treatment may include counseling, rehabilitation, or medical or psychiatric care.

"Substance abuse intensive outpatient service" or "Level of care 2.1" means structured treatment provided to individuals who require more intensive services than is normally provided in an outpatient service but do not require inpatient services. Treatment consists primarily of

counseling and education about addiction-related and mental health challenges delivered a minimum of nine to 19 hours of services per week for adults or six to 19 hours of services per week for children and adolescents. Within this level of care an individual's needs for psychiatric and medical services are generally addressed through consultation and referrals.

"Substance abuse outpatient service" or "Level of care 1.0" means a center-based substance abuse treatment delivered to individuals for fewer than nine hours of service per week for adults or fewer than six hours per week for adolescents on an individual, group, or family basis. Substance abuse outpatient services may include diagnosis and evaluation, screening and intake, counseling, psychotherapy, behavior management, psychological testing and assessment, laboratory and other ancillary services, medical services, and medication services. Substance abuse outpatient service includes substance abuse services or an office practice that provides professionally directed aftercare, individual, and other addiction services to individuals according to a predetermined regular schedule of fewer than nine contact hours a week. Substance abuse outpatient service also includes:

1. Substance abuse services operated by a community services board or a behavioral health authority established pursuant to Chapter 5 (§ 37.2-500 et seq.) or Chapter 6 (§ 37.2-600 et seq.) of Title 37.2 of the Code of Virginia;

2. Substance abuse services contracted by a community services board or a behavioral health authority established pursuant to Chapter 5 (§ 37.2-500 et seq.) or Chapter 6 (§ 37.2-600 et seq.) of Title 37.2 of the Code of Virginia; or

3. Substance abuse services that are owned, operated, or controlled by a corporation organized pursuant to the provisions of either Chapter 9 (§ 13.1-601 et seq.) or Chapter 10 (§ 13.1-801 et seq.) of Title 13.1 of the Code of Virginia.

"Substance abuse partial hospitalization services" or "Level of care 2.5" means a short-term, nonresidential substance use treatment program provided for a minimum of 20 hours a week that uses multidisciplinary staff and is provided for individuals who require a more intensive treatment experience than intensive outpatient treatment but who do not require residential treatment. This level of care is designed to offer highly structured intensive treatment to those individuals whose condition is sufficiently stable so as not to require 24-hour-per-day monitoring and care, but whose illness has progressed so as to require consistent near-daily treatment intervention.

"Suicide attempt" means a nonfatal, self-directed, potentially injurious behavior with an intent to die as a result of the behavior regardless of whether it results in injury.

"Supervised living residential service" means the provision of significant direct supervision and community support services to individuals living in apartments or other residential settings. These services differ from supportive in-home service because the provider assumes responsibility for management of the physical environment of the residence, and staff supervision and monitoring are daily and available on a 24-hour basis. Services are provided based on the needs of the individual in areas such as food preparation, housekeeping, medication administration, personal hygiene, treatment, counseling, and budgeting.

"Supportive in-home service" (formerly supportive residential) means the provision of community support services and other structured services to assist individuals, to strengthen individual skills, and that provide environmental supports necessary to attain and sustain independent community residential living. Services include drop-in or friendly-visitor support and counseling to more intensive support, monitoring, training, in-home support, respite care, and family support services. Services are based on the needs of the individual and include training and assistance. These services normally do not involve overnight care by the provider; however, due to the flexible nature of these services, overnight care may be provided on an occasional basis.

"Systemic deficiency" means violations of regulations documented by the department that demonstrate multiple or repeat defects in the operation of one or more services.

"Telehealth" shall have the same meaning as "telehealth services" in § 32.1-122.03:1 of the Code of Virginia.

“Telemedicine" shall have the same meaning as "telemedicine services" in § 38.2-3418.16 of the Code of Virginia.

"Therapeutic day treatment for children and adolescents" means a treatment program that serves (i) children and adolescents from birth through 17 years of age and under certain circumstances up to 21 years of age with serious emotional disturbances, substance use, or co-occurring disorders or (ii) children from birth through seven years of age who are at risk of serious emotional disturbance, in order to combine psychotherapeutic interventions with education and mental health or substance abuse treatment. Services include: evaluation; medication education and management; opportunities to learn and use daily living skills and to enhance social and interpersonal skills; and individual, group, and family counseling.

"Time out" means the involuntary removal of an individual by a staff person from a source of reinforcement to a different, open location for a specified period of time or until the problem behavior has subsided to discontinue or reduce the frequency of problematic behavior.

"Volunteer" means a person who, without financial remuneration, provides services to individuals on behalf of the provider.

"Written," "writing," and "in writing" include any representation of words, letters, symbols, numbers, or figures, whether (i) printed or inscribed on a tangible medium or (ii) stored in an electronic or other medium and retrievable in a perceivable form and whether an electronic signature authorized by Chapter 42.1 (§ 59.1-479 et seq.) of Title 59.1 of the Code of Virginia is or is not affixed.

12VAC35-105-30. Licenses.

A. Licenses are issued to providers who offer services to individuals who have mental illness, a developmental disability, or substance abuse (substance use disorders) or have brain injury and are receiving residential services.

B. Providers shall be licensed to provide specific services as defined in this chapter or as determined by the commissioner. These services include:

1. Assertive community treatment (ACT);
2. Case management;
3. Clinically managed high-intensity residential care or Level of care 3.5;
4. Clinically managed low-intensity residential care or Level of care 3.1;
5. Clinically managed population specific high-intensity residential or Level of care 3.3;
6. Community gero-psychiatric residential;
7. Community-based crisis stabilization;
8. Community psychiatric support and treatment for children and adolescents;
9. Community psychiatric support and treatment;
~~8.~~ 10. Crisis receiving center;
~~9.~~ 11. Crisis stabilization unit;
~~10.~~ 12. Day support;
~~11.~~ 13. Day treatment, including therapeutic day treatment for children and adolescents;
~~12.~~ 14. Group home and community residential;
~~13.~~ 15. ICF/IID;

~~14.~~16. Inpatient psychiatric;

~~15.~~17. Intensive in-home;

~~16.~~18. Medically managed intensive inpatient service or Level of care 4.0;

~~17.~~19. Medically monitored intensive inpatient treatment or Level of care 3.7;

~~18.~~20. Medication assisted opioid treatment;

~~19.~~21. Mental health community support;

~~20.~~22. Mental health intensive outpatient;

~~21.~~23. Mental health outpatient;

~~22.~~24. Mental health partial hospitalization;

~~23.~~25. Psychosocial rehabilitation;

~~24.~~26. REACH CTH;

~~25.~~27. REACH mobile crisis response;

~~26.~~28. Residential treatment;

~~27.~~29. Respite care;

~~28.~~30. Sponsored residential home;

~~29.~~31. Substance abuse intensive outpatient;

~~30.~~32. Substance abuse outpatient;

~~31.~~33. Substance abuse partial hospitalization;

~~32.~~34. Supervised living residential; and

~~33.~~35. Supportive in-home.

C. A license addendum shall describe the services licensed, the disabilities of individuals who may be served, the specific locations where services are to be provided or administered, and the terms and conditions for each service offered by a licensed provider. For residential and inpatient services, the license identifies the number of individuals each residential location may serve at a given time.

Article 8

Community Psychiatric Support and Treatment (CPST)

12VAC35-105-1421. Admission criteria.

A. Before a CPST provider may admit an individual to Tier 1 CPST, the individual shall meet the criteria for admission as defined by this chapter and the provider's policies. The provider's policy regarding admission to Tier 1 CPST shall, at a minimum, meet the requirements of 12VAC35-105-650 and the assessment required by that section shall document that the individual:

1. Has a primary ICD diagnosis or DSM diagnosis for mental illness; or

2. An unspecified or provisional diagnosis indicating behavioral health needs; and

3. For children and adolescents, an identified caregiver who lives in the same household shall be willing to participate in the service, as clinically appropriate.

B. Before a CPST provider may admit an individual to Tier 2 CPST, the individual shall meet the criteria for admission as defined by this chapter and the provider's policies. The provider's policy regarding admission to Tier 2 CPST shall, at a minimum, meet the requirements of 12VAC35-105-650 and the assessment required by that section shall document that the individual:

1. Has a primary ICD diagnosis or DSM diagnosis for mental illness;

2. Meets the criteria for early serious mental illness, serious mental illness, or serious emotional disturbance; and

3. For children and adolescents, an identified caregiver who lives in the same household shall be willing to participate in the service, as clinically appropriate.

12VAC35-105-1422. Discharge criteria.

Before a CPST provider may discharge an individual, the individual shall meet the criteria for discharge as defined by this chapter and the provider's policies. The provider's policy regarding discharge shall, at a minimum, meet the requirements of 12VAC35-105-693 and also require the individual to:

1. No longer meet admission criteria; or

2. Successfully met the specific goals outlined in the treatment plan for discharge; or

3. Have not made progress on established service goals, nor is there expectation of any progress with continued service; or

4. No longer be engaged in the service, despite multiple attempts on the part of the provider to apply engagement strategies as defined within their policies; or

5. No longer need the service, as the individual is obtaining similar benefit through other services and resources.

12VAC35-105-1423. Treatment team and staffing.

A. CPST providers shall have sufficient staffing composition to meet the varied needs of individuals served by the provider as required by this section. Each CPST provider shall meet the following minimum position requirements:

1. A full-time clinical director who is a LMHP.

2. A LMHP with at least one year of experience working with individuals experiencing SMI or SED shall be available for consultation 24 hours a day, seven days a week.

B. Each CPST team shall meet the following minimum staffing requirements:

1. A LMHP who shall supervise the team, oversee the assessment and the ISP, and authorize the ISP. Assessments and ISPs may be completed by an LMHP, LMHP-R, LMHP-RP or LMHP-S; and

2. Every LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP, and QMHP-T shall be trained in in evidence-based practices and decision models for assessment, treatment planning, and implementation of behavioral health interventions.

C. All CPST staff shall provide services under the direct supervision of an LMHP.

D. Applicants for an initial conditional CPST license may submit a transition plan to the department for approval that will allow for "start-up" when newly forming providers are not in full compliance with the CPST model relative to staffing patterns and individuals receiving services capacity. A transition plan must be approved prior to the issuance of the license. Approved transition plans shall be limited to a six-month period.

12VAC35-105-1424. Service delivery and location.

A. CPST Tier 1 and Tier 2 programs shall meet the following programmatic requirements. The program shall provide:

1. Crisis support 24 hours a day, seven days per week. Crisis support shall include the development and implementation of a crisis mitigation plan, any additional crisis planning necessary for the individual, crisis avoidance, and crisis intervention. Crisis support shall be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP, or QMHP-T. Before referring to any external crisis resource, the provider shall attempt internal crisis support.

a. Crisis support may occur via telephone or telemedicine. The individual's needs and preferences shall be the determining factor regarding whether crisis support is provided in person, via telemedicine, or via telephone.

b. If the individual's condition progresses and requires a higher level of care the individual shall be referred to the appropriate level of care.

2. Restorative evidence-based therapeutic interventions by a LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP, or QMHP-T. If restorative evidence-based therapeutic Interventions is provided in a group with multiple individuals the ratio of team members to individuals served shall not exceed 1:8 for children and adolescents and 1:12 for adults.

3. Psychotherapy or counseling by a LMHP, LMHP-S, LMHP-R, or LMHP-RP acting within his scope of practice. If psychotherapy or counseling is provided in a group with multiple individuals the ratio of team members to individuals served shall not exceed 1:8 for children and adolescents and 1:12 for adults.

4. Care coordination on an individual basis by an LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP, or QMHP-T.

B. CPST Tier 2 programs shall provide all the programmatic elements within A 1-4 and rehabilitation skills practice by a LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP, QMHP-T, or BHT. Rehabilitation skills practice shall be provided on an individual basis.

C. CPST programming shall take place in:

1. An individual's home;

2. An individual's community or natural settings; or

3. A provider's department-licensed office location. Services provided in the provider's department-licensed office location shall not exceed 50 percent of service delivery hours a week per individual served and shall be for the benefit of the individual.

12VAC35-105-1425. Location requirements.

A. All CPST providers shall have an office location. The office location shall be within the Commonwealth of Virginia and have regular business hours. The office location shall be staffed during regular business hours.

B. The CPST office location shall be appropriate for storage of records and group programming. Records storage space shall meet the requirements of 12VAC35-105-870. Programming space shall ensure the privacy of individuals served.

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Emergency Regulation and Notice of Intended Regulatory Action (NOIRA) Agency Background Document

Agency name	Department of Behavioral Health and Developmental Services (DBHDS)
Virginia Administrative Code (VAC) Chapter citation(s)	12VAC35-105
VAC Chapter title(s)	Rules and Regulations for Licensing Providers by the Department of Behavioral Health and Developmental Services (12VAC35-105)
Action title	2026 Coordinated Specialty Care (CSC) alignment with Medicaid behavioral health services redesign
Date this document prepared	July 14, 2026

This information is required for executive branch review and the Virginia Registrar of Regulations, pursuant to the Virginia Administrative Process Act (APA), Executive Order 19 (2022) (EO 19), any instructions or procedures issued by the Office of Regulatory Management (ORM) or the Department of Planning and Budget (DPB) pursuant to EO 19, the Regulations for Filing and Publishing Agency Regulations (1 VAC 7-10), and the *Form and Style Requirements for the Virginia Register of Regulations and Virginia Administrative Code*.

Brief Summary

Provide a brief summary (preferably no more than 2 or 3 paragraphs) of the subject matter, intent, and goals of this regulatory change (i.e., new regulation, amendments to an existing regulation, or repeal of an existing regulation). Alert the reader to all substantive matters or changes. If applicable, generally describe the existing regulation.

In 2025, the General Assembly directed the Department of Behavioral Health and Developmental Services (DBHDS) through the budget bill to utilize emergency authority to align licensing regulations with the modifications being made to Medicaid behavioral health services by July 1, 2026. During the 2026 Special Session I, the 2026-2028 Appropriation Act extended the implementation deadline for behavioral health redesign by one year and reauthorized the directive for emergency regulations (Item 297).

To comply with the legislative mandates, the State Board of Behavioral Health and Developmental Services must adopt three separate emergency actions that conform DBHDS Licensing Regulations with changes to be made by the Department of Medical Assistance Services (DMAS) replacing legacy

services with Community Psychiatric Support and Treatment (CPST); Coordinated Specialty Care (CSC); and Mental Health Clubhouse Services (Clubhouse).

This regulatory action will establish the newly licensed service of CSC.

Acronyms and Definitions

Define all acronyms used in this form, and any technical terms that are not also defined in the "Definitions" section of the regulation.

Coordinated Specialty Care (CSC)
Department of Behavioral Health and Development Services (DBHDS)
Department of Medical Assistance Services (DMAS)
State Board of Behavioral Health and Developmental Services (State Board)

Mandate and Impetus (Necessity for Emergency)

Explain why this rulemaking is an emergency situation in accordance with § 2.2-4011 A and B of the Code of Virginia. In doing so, either:

a) Indicate whether the Governor's Office has already approved the use of emergency regulatory authority for this regulatory change.
b) Provide specific citations to Virginia statutory law, the appropriation act, federal law, or federal regulation that require that a regulation be effective in 280 days or less from its enactment.

As required by § 2.2-4011, also describe the nature of the emergency and of the necessity for this regulatory change. In addition, delineate any potential issues that may need to be addressed as part of this regulatory change.

Item 297 of the 2026-2028 Appropriation Act directs DBHDS to promulgate emergency regulations, in collaboration with DMAS, to "align licensing regulations with the modifications being made to Medicaid behavioral health services." A regulatory action to establish permanent regulations will follow this emergency action.

Legal Basis

Identify (1) the promulgating agency, and (2) the state and/or federal legal authority for the regulatory change, including the most relevant citations to the Code of Virginia or Acts and Assembly chapter number(s), if applicable. Your citation must include a specific provision, if any, authorizing the promulgating agency to regulate this specific subject or program, as well as a reference to the agency's overall regulatory authority.

DBHDS was directed by the General Assembly during the 2026 Special Session I to promulgate emergency regulations that align its provider licensing regulations with the modifications being made by DMAS to Medicaid behavioral health services. Item 297 of the 2026-2028 Appropriation Act mandates the changes within this regulatory action.

Section 37.2-203 of the Code of Virginia gives the State Board the authority to adopt regulations that may be necessary to carry out the provisions of Title 37.2 of the Code and other laws of the Commonwealth administered by the DBHDS commissioner. The State Board voted to adopt this regulatory action at its meeting on July 15, 2026.

Purpose

Describe the specific reasons why the agency has determined that this regulation is essential to protect the health, safety, or welfare of citizens. In addition, explain any potential issues that may need to be addressed as the regulation is developed.

The purpose of this action is to comply with the legislative mandate by aligning DBHDS licensing regulations with anticipated DMAS changes to Medicaid by establishing the new behavioral health service of CSC.

The goal of CSC is to provide comprehensive and recovery-oriented treatment for individuals experiencing a first episode of psychosis. CSC aims to improve the quality of life and social and clinical outcomes for individuals served by offering a team-based approach that includes collaborative treatment planning, individual and family therapy, medication management, and support for education and employment goals.

Substance

Briefly identify and explain the new substantive provisions, the substantive changes to existing sections, or both. A more detailed discussion is provided in the "Detail of Changes" section below.

The substantive provisions of this regulatory action include:

1) Definitions necessary for the integration of CSC into the Licensing Regulations;
2) Admission criteria for CSC;
3) Discharge criteria for CSC;
4) Minimum service delivery requirements for CSC; and
5) Minimum requirements for treatment teams and staffing.

Issues

Identify the issues associated with the regulatory change, including: 1) the primary advantages and disadvantages to the public, such as individual private citizens or businesses, of implementing the new or amended provisions; 2) the primary advantages and disadvantages to the agency or the Commonwealth; and 3) other pertinent matters of interest to the regulated community, government officials, and the public. If there are no disadvantages to the public or the Commonwealth, include a specific statement to that effect.

Virginia's behavioral health system is undergoing a multi-phased, interagency process of transformation to enhance the service delivery system. This requires coordination among agencies with responsibilities for licensing, funding, and oversight behavioral health services in the Commonwealth.

The primary advantages of this regulatory action include (1) improving access to a continuum of high-quality behavioral health services for Virginians; (2) ensuring CSC providers adhere to a base level of model fidelity; and (3) reducing administrative burden by aligning provider licensing regulations with Medicaid service expectations.

There are no known disadvantages to the public or the Commonwealth.

Alternatives to Regulation

Describe any viable alternatives to the regulatory change that were considered, and the rationale used by the agency to select the least burdensome or intrusive alternative that meets the essential purpose of the regulatory change. Also, include discussion of less intrusive or less costly alternatives for small businesses, as defined in § 2.2-4007.1 of the Code of Virginia, of achieving the purpose of the regulatory change.

There are no alternatives to the regulatory changes contained herein that could achieve the essential purpose of this action, which itself is mandated by the General Assembly.

The amendments are limited to those that are necessary to avoid conflict between DBHDS licensing regulations and planned DMAS modifications to Medicaid behavioral health services. Misalignment would be problematic for licensed providers of behavioral health services seeking DMAS enrollment, many of which are small businesses, as well as for individuals receiving services and their families.

Periodic Review and Small Business Impact Review Announcement

This NOIRA is not being used to announce a periodic review or a small business impact review.

Public Participation

Indicate how the public should contact the agency to submit comments on this regulation, and whether a public hearing will be held, by completing the text below. In addition, as required by § 2.2-4007.02 of the Code of Virginia describe any other means that will be used to identify and notify interested parties and seek their input, such as regulatory advisory panels or general notices.

The Department of Behavioral Health and Developmental Services is providing an opportunity for comments on this regulatory proposal, including but not limited to (i) the costs and benefits of the regulatory proposal, (ii) any alternative approaches, and (iii) the potential impacts of the regulation.

Anyone wishing to submit written comments for the public comment file may do so through the Public Comment Forums feature of the Virginia Regulatory Town Hall web site at: https://townhall.virginia.gov. Comments may also be submitted by mail or email to Susan Puglisi, 1220 Bank Street, Richmond Virginia, 23219, or susan.puglisi@dbhds.virginia.gov. In order to be considered, comments must be received by 11:59 pm on the last day of the public comment period.

A public hearing will not be held following the publication of the proposed stage of this regulatory action.

Detail of Changes

List all regulatory changes and the consequences of the changes. Explain the new requirements and what they mean rather than merely quoting the text of the regulation. For example, describe the intent of the language and the expected impact. Describe the difference between existing requirement(s) and/or agency practice(s) and what is being proposed in this regulatory change. Use all tables that apply, but delete inapplicable tables.

If an existing VAC Chapter(s) is being amended or repealed, use Table 1 to describe the changes between existing VAC Chapter(s) and the emergency regulation. If existing VAC Chapter(s) or sections are being repealed and replaced, ensure Table 1 clearly shows both the current number and the new number for each repealed section and the replacement section.

Table 1: Changes to Existing VAC Chapter(s)

Current chapter-section number	New chapter-section number, if applicable	Current requirements in VAC	Change, intent, rationale, and likely impact of new requirements
12VAC35-105-20. Definitions		Definitions for the Licensing Regulations.	Addition of the following terms: "Coordinated specialty care" or "CSC" means an evidence-based treatment approach that supports the recovery of adolescents and young adults experiencing an initial onset of psychosis. CSC provides coordinated, targeted treatment in the early stages of mental illness through integrated medical, psychological, and rehabilitative interventions. "CSC rehabilitation skill-building" means facilitating wellness and autonomy through the restoration of skills, as set forth in the plan of care, in symptom management, interpersonal relationships, communication, problem solving, coping skills, and community integration. "Designated employee" means a provider's named employee or contractor who is at least 18 years of age and who has met the appropriate prerequisites as specified in 12VAC35-105. "Health literacy support" means both (i) medication administration by licensed professional working within the scope of their practice and (ii) support regarding mental health and associated health risks, monitoring for adverse side effects or results of that medication, support regarding the role of prescription medications and their effects, including side effects, and the importance of compliance and adherence. Services are provided with family or caregivers when they are for the direct benefit of the individual. "LMHP-resident in psychology" or "LMHP-RP" means an individual in a residency as

			that term is defined in 18VAC125-20-10 for clinical psychologists. An LMHP-RP shall be in continuous compliance with the regulatory requirements for supervised experience as found in 18VAC125-20-65. LMHP-RPs also include licensed psychological practitioners working under supervision of a licensed clinical psychologist in accordance with 18VAC125-20-58 and 18VAC125-20-59. "Psychotherapy" means the application of principles, standards, and methods of the counseling profession in (i) conducting assessments and diagnoses for the purpose of establishing treatment goals and objectives and (ii) planning, implementing, and evaluating treatment plans using treatment interventions to facilitate human development and to identify and remediate mental, emotional, or behavioral disorders and associated distresses that interfere with mental health. Edits to the term: "Credentialed addiction treatment professional" means a person who possesses one of the following credentials issued by the appropriate health regulatory board: (i) an addiction-credentialed physician or physician with experience or training in addiction medicine; (ii) a licensed nurse practitioner or a licensed physician assistant with experience or training in addiction medicine; (iii) a licensed psychiatrist; (iv) a licensed clinical psychologist; (v) a licensed clinical social worker; (vi) a licensed professional counselor; (vii) a licensed nurse practitioner with experience or training in psychiatry or mental health; (viii) a licensed marriage and family therapist; (ix) a licensed substance abuse treatment practitioner; (x) a resident who is under the supervision of a licensed professional counselor (18VAC115-20-10), licensed marriage and family therapist (18VAC115-50-10), or licensed substance abuse treatment practitioner (18VAC115-60-10) and is registered with the Virginia Board of Counseling; (xi) a resident in psychology who is under supervision of a licensed clinical psychologist and is

			registered with the Virginia Board of Psychology (18VAC125-20-10); or (xii) a supervisee in social work who is under the supervision of a licensed clinical social worker and is registered with the Virginia Board of Social Work (18VAC140-20-10); or (xiii) a licensed psychological practitioner working under supervision of a licensed clinical psychologist in accordance with 18VAC125-20-58 and 18VAC125-20-59. Likely impact: Clearer regulations. Alignment with Medicaid service changes and current evidence-based practices and terminology to provide person-centered treatment.
12VAC35-105-30. Licenses.			Addition of the license type: Coordinated specialty care Likely impact: Clearer regulations. Alignment with Medicaid service changes and current evidence-based practices to provide person-centered treatment.
	12VAC35-105-1426. Admission Criteria.		Intent: Provide clear admission requirements within CSC programs. Impact: Robust, effective mental health treatment within the Commonwealth that is appropriately administered.
	12VAC35-105-1427. Discharge criteria.		Intent: Provide clear discharge requirements within CSC programs. Impact: Robust, effective mental health treatment within the Commonwealth that is appropriately administered.
	12VAC35-105-1428. Service delivery.		Intent: Provide clear service delivery requirements within CSC programs. Impact: Robust, effective mental health treatment within the Commonwealth.
	12VAC35-105-1429. Treatment team and staffing.		Intent: Provide clear requirements to providers of CSC services specifically related to personnel. Impact: Robust, effective mental health treatment within the Commonwealth that is appropriately administered.

Project 8524 - Emergency/NOIRA

Department of Behavioral Health And Developmental Services

Alignment with Medicaid behavioral health services redesign; Coordinated Specialty Care (CSC)

12VAC35-105-20. Definitions.

The following words and terms when used in this chapter shall have the following meanings unless the context clearly indicates otherwise:

"Abuse" means, as defined by § 37.2-100 of the Code of Virginia, any act or failure to act by an employee or other person responsible for the care of an individual in a facility or program operated, licensed, or funded by the department, excluding those operated by the Virginia Department of Corrections, that was performed or was failed to be performed knowingly, recklessly, or intentionally, and that caused or might have caused physical or psychological harm, injury, or death to an individual receiving care or treatment for mental illness, developmental disabilities, or substance abuse. Examples of abuse include acts such as:

1. Rape, sexual assault, or other criminal sexual behavior;
2. Assault or battery;
3. Use of language that demeans, threatens, intimidates, or humiliates the individual;
4. Misuse or misappropriation of the individual's assets, goods, or property;
5. Use of excessive force when placing an individual in physical or mechanical restraint;
6. Use of physical or mechanical restraints on an individual that is not in compliance with federal and state laws, regulations, and policies, professional accepted standards of practice, or the individual's individualized services plan; or
7. Use of more restrictive or intensive services or denial of services to punish an individual or that is not consistent with the individual's individualized services plan.

"Activities of daily living" or "ADLs" means personal care activities and includes bathing, dressing, transferring, toileting, grooming, hygiene, feeding, and eating. An individual's degree of independence in performing these activities is part of determining the appropriate level of care and services.

"Addiction" means a primary, chronic disease of brain reward, motivation, memory, and related circuitry. Addiction is defined as the inability to consistently abstain, impairment in behavioral control, persistence of cravings, diminished recognition of significant problems with one's behaviors and interpersonal relationships, and a dysfunctional emotional response. Like other chronic diseases, addiction often involves cycles of relapse and remission. Without treatment or engagement in recovery activities, addiction is progressive and can result in disability or premature death.

"Admission" means the process of acceptance into a service as defined by the provider's policies.

"Allied health professional" means a professional who is involved with the delivery of health or related services pertaining to the identification, evaluation, and prevention of diseases and disorders, such as a certified substance abuse counselor, certified substance abuse counseling assistant, peer recovery support specialist, certified nurse aide, or occupational therapist.

"ASAM" means the American Society of Addiction Medicine.

"Assertive community treatment service" or "ACT" means a self-contained interdisciplinary community-based team of medical, behavioral health, and rehabilitation professionals who use a

team approach to meet the needs of an individual with severe and persistent mental illness. ACT teams:

1. Provide person-centered services addressing the breadth of an individual's needs, helping the individual achieve his personal goals;

2. Serve as the primary provider of all the services that an individual receiving ACT services needs;

3. Maintain a high frequency and intensity of community-based contacts;

4. Maintain a very low individual-to-staff ratio;

5. Offer varying levels of care for all individuals receiving ACT services and appropriately adjust service levels according to each individual's needs over time;

6. Assist individuals in advancing toward personal goals with a focus on enhancing community integration and regaining valued roles, such as worker, family member, resident, spouse, tenant, or friend;

7. Carry out planned assertive engagement techniques, including rapport-building strategies, facilitating meeting basic needs, and motivational interviewing techniques;

8. Monitor the individual's mental status and provide needed supports in a manner consistent with the individual's level of need and functioning;

9. Deliver all services according to a recovery-based philosophy of care; and

10. Promote self-determination, respect for the individual receiving ACT as an individual in such individual's own right, and engage peers in promoting recovery and regaining meaningful roles and relationships in the community.

"Authorized representative" means a person permitted by law or 12VAC35-115 to authorize the disclosure of information or consent to treatment and services or participation in human research.

"Behavior intervention" means those principles and methods employed by a provider to help an individual receiving services to achieve a positive outcome and to address challenging behavior in a constructive and safe manner. Behavior intervention principles and methods shall be employed in accordance with the individualized services plan and written policies and procedures governing service expectations, treatment goals, safety, and security.

"Behavioral treatment plan," "functional plan," or "behavioral support plan" means any set of documented procedures that are an integral part of the individualized services plan and are developed on the basis of a systematic data collection, such as a functional assessment, for the purpose of assisting individuals to achieve the following:

1. Improved behavioral functioning and effectiveness;

2. Alleviation of symptoms of psychopathology; or

3. Reduction of challenging behaviors.

"Board" or "state board" means, as defined by § 37.2-100 of the Code of Virginia, the State Board of Behavioral Health and Developmental Services. The board has statutory responsibility for adopting regulations that may be necessary to carry out the provisions of Title 37.2 of the Code of Virginia and other laws of the Commonwealth administered by the commissioner or the department.

"Brain injury" means any injury to the brain that occurs after birth that is acquired through traumatic or nontraumatic insults. Nontraumatic insults may include anoxia, hypoxia, aneurysm, toxic exposure, encephalopathy, surgical interventions, tumor, and stroke. Brain injury does not include hereditary, congenital, or degenerative brain disorders or injuries induced by birth trauma.

"Care," "treatment," or "support" means the individually planned therapeutic interventions that conform to current acceptable professional practice and that are intended to improve or maintain functioning of an individual receiving services delivered by a provider.

"Case management service" or "support coordination service" means services that can include assistance to individuals and their family members in accessing needed services that are responsive to the individual's needs. Case management services include identifying potential users of the service; assessing needs and planning services; linking the individual to services and supports; assisting the individual directly to locate, develop, or obtain needed services and resources; coordinating services with other providers; enhancing community integration; making collateral contacts; monitoring service delivery; discharge planning; and advocating for individuals in response to their changing needs. "Case management service" does not include assistance in which the only function is maintaining service waiting lists or periodically contacting or tracking individuals to determine potential service needs.

"Clinical experience" means providing direct services to individuals with mental illness or the provision of direct geriatric services or special education services. Experience may include supervised internships, practicums, and field experience.

"Clinically managed high-intensity residential care" or "Level of care 3.5" means a substance use treatment program that offers 24-hour supportive treatment of individuals with significant psychological and social problems by credentialed addiction treatment professionals in an interdisciplinary treatment approach. A clinically managed high-intensity residential care program provides treatment to individuals who present with significant challenges, such as physical, sexual, or emotional trauma; past criminal or antisocial behaviors, with a risk of continued criminal behavior; an extensive history of treatment; inadequate anger management skills; extreme impulsivity; and antisocial value system.

"Clinically managed low-intensity residential care" or "Level of care 3.1" means providing an ongoing therapeutic environment for individuals requiring some structured support in which treatment is directed toward applying recovery skills; preventing relapse; improving emotional functioning; promoting personal responsibility; reintegrating the individual into work, education, and family environments; and strengthening and developing adaptive skills that may not have been achieved or have been diminished during the individual's active addiction. A clinically managed low-intensity residential care program also provides treatment for individuals suffering from chronic, long-term alcoholism or drug addiction and affords an extended period of time to establish sound recovery and a solid support system.

"Clinically managed population specific high-intensity residential services" or "Level of care 3.3" means a substance use treatment program that provides a structured recovery environment in combination with high-intensity clinical services provided in a manner to meet the functional limitations of individuals. The functional limitations of individuals who are placed within this level of care are primarily cognitive and can be either temporary or permanent.

"Collaborative behavioral health services" means the same as the term is defined in § 54.1-3500 of the Code of Virginia.

"Commissioner" means the Commissioner of the Department of Behavioral Health and Developmental Services.

"Community-based crisis stabilization" means services that are short term and designed to support an individual and the individual's natural support system following contact with an initial crisis response service or as a diversion to a higher level of care. Providers deliver community-based crisis stabilization services in an individual's natural environment and provide referrals and linkage to other community-based services at the appropriate level of care. Interventions may include mobile crisis response, brief therapeutic and skill-building interventions, engagement of natural supports, interventions to integrate natural supports in the de-escalation and stabilization

of the crisis, and coordination of follow-up services. Coordination of specialized services to address the needs of co-occurring developmental disabilities and substance use disorders are also available through this service. Services include advocacy and networking to provide linkages and referrals to appropriate community-based services and assist the individual and the individual's family or caregiver in accessing other benefits or assistance programs for which the individual may be eligible. Community-based crisis stabilization is a non-center, community-based service. The goal of community-based crisis stabilization services is to stabilize the individual within the community and support the individual or the individual's support system (i) as part of an initial mobile crisis response; (ii) during the period between an initial mobile crisis response and entry into an established follow-up service at the appropriate level of care; (iii) as a transitional step-down from a higher level of care if the next level of care service is identified but not immediately available for access; or (iv) as a diversion to a higher level of care.

"Community gero-psychiatric residential services" means 24-hour care provided to individuals with mental illness, behavioral problems, and concomitant health problems who are usually 65 years of age or older in a geriatric setting that is less intensive than a psychiatric hospital but more intensive than a nursing home or group home. Services include assessment and individualized services planning by an interdisciplinary services team, intense supervision, psychiatric care, behavioral treatment planning and behavior interventions, nursing, and other health-related services.

"Complaint" means an allegation of a violation of this chapter or a provider's policies and procedures related to this chapter.

"Conveyance" means a motor vehicle that serves as the mobile component of a mobile MAT program.

"Co-occurring disorders" means the presence of more than one and often several of the following disorders that are identified independently of one another and are not simply a cluster of symptoms resulting from a single disorder: mental illness, a developmental disability, substance abuse (substance use disorders), or brain injury.

"Co-occurring services" means individually planned therapeutic treatment that addresses in an integrated concurrent manner the service needs of individuals who have co-occurring disorders.

"Coordinated specialty care" or "CSC" means an evidence-based treatment approach that supports the recovery of adolescents and young adults experiencing an initial onset of psychosis. CSC provides coordinated, targeted treatment in the early stages of mental illness through integrated medical, psychological, and rehabilitative interventions.

"Corrective action plan" means the provider's pledged corrective action in response to cited areas of noncompliance documented by the regulatory authority.

"Correctional facility" means a facility operated under the management and control of the Virginia Department of Corrections.

"Credentialed addiction treatment professional" means a person who possesses one of the following credentials issued by the appropriate health regulatory board: (i) an addiction-credentialed physician or physician with experience or training in addiction medicine; (ii) a licensed nurse practitioner or a licensed physician assistant with experience or training in addiction medicine; (iii) a licensed psychiatrist; (iv) a licensed clinical psychologist; (v) a licensed clinical social worker; (vi) a licensed professional counselor; (vii) a licensed nurse practitioner with experience or training in psychiatry or mental health; (viii) a licensed marriage and family therapist; (ix) a licensed substance abuse treatment practitioner; (x) a resident who is under the supervision of a licensed professional counselor (18VAC115-20-10), licensed marriage and family therapist (18VAC115-50-10), or licensed substance abuse treatment practitioner (18VAC115-60-10) and is registered with the Virginia Board of Counseling; (xi) a resident in psychology who is

under supervision of a licensed clinical psychologist and is registered with the Virginia Board of Psychology (18VAC125-20-10); or (xii) a supervisee in social work who is under the supervision of a licensed clinical social worker and is registered with the Virginia Board of Social Work (18VAC140-20-10); or (xiii) a licensed psychological practitioner working under supervision of a licensed clinical psychologist in accordance with 18VAC125-20-58 and 18VAC125-20-59.

"Crisis" means a deteriorating or unstable situation often developing suddenly or rapidly that produces acute, heightened, emotional, mental, physical, medical, or behavioral distress.

"Crisis education and prevention plan" or "CEPP" means a department-approved, individualized, client-specific document that provides a concise, clear, and realistic set of supportive interventions to prevent or de-escalate a crisis and assist an individual who may be experiencing a behavioral loss of control. The goal of the CEPP is to identify problems that have arisen in the past or are emergent in order to map out strategies that offer tools for the natural support system to assist the individual in addressing and de-escalating problems in a healthy way and provide teaching skills that the individual can apply independently.

"Crisis planning team" means the team who is consulted to plan the individual's safety plan or crisis ISP. The crisis planning team consists, at a minimum, of the individual receiving services, the individual's legal guardian or authorized representative, and a member of the provider's crisis staff. The crisis planning team may include the individual's support coordinator, case manager, the individual's family, or other identified persons, as desired by the individual, such as the individual's family of choice.

"Crisis receiving center," "CRC," or "23-hour crisis stabilization" means a community-based, nonhospital facility providing short-term assessment, observation, and crisis stabilization services for up to 23 hours. This service is accessible 24 hours per day, seven days per week, 365 days per year, and is indicated when an individual requires a safe environment for initial assessment and intervention. This service includes a thorough assessment of an individual's behavioral health crisis, psychosocial needs, and supports in order to determine the least restrictive environment most appropriate for stabilization. Key service functions include rapid assessment, crisis intervention, de-escalation, short-term stabilization, and appropriate referrals for ongoing care. This distinct service may be co-located with other services such as crisis stabilization units.

"Crisis stabilization" means direct, intensive nonresidential or residential care and treatment to nonhospitalized individuals experiencing an acute crisis that may jeopardize their current community living situation. Crisis stabilization is intended to avert hospitalization or rehospitalization; provide normative environments with a high assurance of safety and security for crisis intervention; stabilize individuals in crisis; and mobilize the resources of the community support system, family members, and others for ongoing rehabilitation and recovery.

"Crisis stabilization unit," "CSU," or "residential crisis stabilization unit" is a community-based, short-term residential treatment unit. CSUs serve as primary alternatives to inpatient hospitalization for individuals who are in need of a safe, secure environment for assessment and crisis treatment. CSUs also serve as a step-down option from psychiatric inpatient hospitalization and function to stabilize and reintegrate individuals who meet medical necessity criteria back into their communities.

"CSC rehabilitation skill-building" means facilitating wellness and autonomy through the restoration of skills, as set forth in the plan of care, in symptom management, interpersonal relationships, communication, problem solving, coping skills, and community integration.

"Day support service" means structured programs of training, assistance, and specialized supervision in the acquisition, retention, or improvement of self-help, socialization, and adaptive skills for adults with a developmental disability provided to groups or individuals in nonresidential community-based settings. Day support services may provide opportunities for peer interaction and community integration and are designed to enhance the following: self-care and hygiene,

eating, toileting, task learning, community resource utilization, environmental and behavioral skills, social skills, medication management, prevocational skills, and transportation skills. The term "day support service" does not include services in which the primary function is to provide employment-related services, general educational services, or general recreational services.

"Department" means the Virginia Department of Behavioral Health and Developmental Services.

"Designated employee" means a provider's named employee or contractor who is at least 18 years of age and who has met the appropriate prerequisites as specified in 12VAC35-105.

"Developmental disability" means a severe, chronic disability of an individual that (i) is attributable to a mental or physical impairment or a combination of mental and physical impairments other than a sole diagnosis of mental illness; (ii) is manifested before the individual reaches 22 years of age; (iii) is likely to continue indefinitely; (iv) results in substantial functional limitations in three or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, or economic self-sufficiency; and (v) reflects the individual's need for a combination and sequence of special interdisciplinary or generic services, individualized supports, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated. An individual from birth to nine years of age, inclusive, who has a substantial developmental delay or specific congenital or acquired condition may be considered to have a developmental disability without meeting three or more of the criteria described in clauses (i) through (v) if the individual without services and supports has a high probability of meeting those criteria later in life.

"Developmental services" means planned, individualized, and person-centered services and supports provided to individuals with developmental disabilities for the purpose of enabling these individuals to increase their self-determination and independence, obtain employment, participate fully in all aspects of community life, advocate for themselves, and achieve their fullest potential to the greatest extent possible.

"Diagnostic and Statistical Manual of Mental Disorders" or "DSM" means the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition, DSM-5, of the American Psychiatric Association.

"Direct care position" means any position that includes responsibility for (i) treatment, case management, health, safety, development, or well-being of an individual receiving services or (ii) immediately supervising a person in a position with this responsibility.

"Discharge" means the process by which the individual's active involvement with a service is terminated by the provider, individual, or individual's authorized representative.

"Discharge plan" means the written plan that establishes the criteria for an individual's discharge from a service and identifies and coordinates delivery of any services needed after discharge.

"Dispense" means to deliver a drug to an ultimate user by or pursuant to the lawful order of a practitioner, including the prescribing and administering, packaging, labeling, or compounding necessary to prepare the substance for that delivery (§ 54.1-3400 et seq. of the Code of Virginia).

"Emergency service" means unscheduled and sometimes scheduled crisis intervention, stabilization, and referral assistance provided over the telephone or face-to-face, if indicated, available 24 hours a day and seven days per week. Emergency services also may include walk-ins, home visits, jail interventions, and preadmission screening activities associated with the judicial process.

"Group home or community residential service" means a congregate service providing 24-hour supervision in a community-based home having eight or fewer residents. Services include supervision, supports, counseling, and training in activities of daily living for individuals whose

individualized services plan identifies the need for the specific types of services available in this setting.

"HCBS Waiver" means a Medicaid Home and Community Based Services Waiver.

"Health literacy support" means both (i) medication administration by a licensed professional working within the scope of their practice and (ii) support regarding mental health and associated health risks, monitoring for adverse side effects or results of that medication, support regarding the role of prescription medications and their effects, including side effects, and the importance of compliance and adherence. Services are provided with family or caregivers when they are for the direct benefit of the individual.

"Home and noncenter based" means that a service is provided in the individual's home or other noncenter-based setting. This includes noncenter-based day support, supportive in-home, and intensive in-home services.

"Individual" or "individual receiving services" means a current direct recipient of public or private mental health, developmental, or substance abuse treatment, rehabilitation, or habilitation services and includes the terms "consumer," "patient," "resident," "recipient," or "client". When the term is used in this chapter, the requirement applies to every individual receiving licensed services from the provider.

"Individualized services plan" or "ISP" means a comprehensive and regularly updated written plan that describes the individual's needs, the measurable goals and objectives to address those needs, and strategies to reach the individual's goals. An ISP is person-centered, empowers the individual, and is designed to meet the needs and preferences of the individual. The ISP is developed through a partnership between the individual and the provider and includes an individual's treatment plan, habilitation plan, person-centered plan, or plan of care, which are all considered individualized service plans.

"Informed choice" means a decision made after considering options based on adequate and accurate information and knowledge. These options are developed through collaboration with the individual and the individual's authorized representative, as applicable, and the provider with the intent of empowering the individual and the individual's authorized representative to make decisions that will lead to positive service outcomes.

"Informed consent" means the voluntary written agreement of an individual or that individual's authorized representative to surgery, electroconvulsive treatment, use of psychotropic medications, or any other treatment or service that poses a risk of harm greater than that ordinarily encountered in daily life or for participation in human research. To be voluntary, informed consent must be given freely and without undue inducement; any element of force, fraud, deceit, or duress; or any form of constraint or coercion.

"Initial assessment" means an assessment conducted prior to or at admission to determine whether the individual meets the service's admission criteria; what the individual's immediate service, health, and safety needs are; and whether the provider has the capability and staffing to provide the needed services.

"Inpatient psychiatric service" means intensive 24-hour medical, nursing, and treatment services provided to individuals with mental illness or substance abuse (substance use disorders) in a hospital as defined in § 32.1-123 of the Code of Virginia or in a special unit of a hospital.

"Instrumental activities of daily living" or "IADLs" means meal preparation, housekeeping, laundry, and managing money. A person's degree of independence in performing these activities is part of determining appropriate level of care and services.

"Intellectual disability" means a disability originating before 18 years of age, characterized concurrently by (i) significant subaverage intellectual functioning as demonstrated by performance on a standardized measure of intellectual functioning administered in conformity with

accepted professional practice that is at least two standard deviations below the mean and (ii) significant limitations in adaptive behavior as expressed in conceptual, social, and practical adaptive skills.

"Intensity of service" means the number, type, and frequency of staff interventions and other services provided during treatment at a particular level of care.

"Intensive in-home service" means family preservation interventions for children and adolescents who have or are at risk of serious emotional disturbance, including individuals who also have a diagnosis of developmental disability. Intensive in-home service is usually time-limited and is provided typically in the residence of an individual who is at risk of being moved to out-of-home placement or who is being transitioned back home from an out-of-home placement. The service includes 24-hour per day emergency response; crisis treatment; individual and family counseling; life, parenting, and communication skills; and case management and coordination with other services.

"Intermediate care facility/individuals with intellectual disability" or "ICF/IID" means a facility or distinct part of a facility certified by the Virginia Department of Health as meeting the federal certification regulations for an intermediate care facility for individuals with intellectual disability and persons with related conditions and that addresses the total needs of the residents, which include physical, intellectual, social, emotional, and habilitation, providing active treatment as defined in 42 CFR 435.1010 and 42 CFR 483.440.

"Investigation" means a detailed inquiry or systematic examination of the operations of a provider or its services regarding an alleged violation of regulations or law. An investigation may be undertaken as a result of a complaint, an incident report, or other information that comes to the attention of the department.

"Licensed mental health professional" or "LMHP" means a physician, licensed clinical psychologist, licensed professional counselor, licensed clinical social worker, licensed substance abuse treatment practitioner, licensed marriage and family therapist, certified psychiatric clinical nurse specialist, licensed behavior analyst, ~~or~~ licensed psychiatric/mental health nurse practitioner, or a licensed psychological practitioner.

"LMHP-resident in psychology" or "LMHP-RP" means an individual in a residency as that term is defined in 18VAC125-20-10 for clinical psychologists. An LMHP-RP shall be in continuous compliance with the regulatory requirements for supervised experience as found in 18VAC125-20-65. LMHP-RPs also include licensed psychological practitioners working under supervision of a licensed clinical psychologist in accordance with 18VAC125-20-58 and 18VAC125-20-59.

"Location" means a place where services are or could be provided.

"Mandatory outpatient treatment order" means an order issued by a court pursuant to § 37.2-817 of the Code of Virginia.

"Medical evaluation" means the process of assessing an individual's health status that includes a medical history and a physical examination of an individual conducted by a licensed medical practitioner operating within the scope of his license.

"Medically managed intensive inpatient service" or "Level of care 4.0" means an organized service delivered in an inpatient setting, including an acute care general hospital, psychiatric unit in a general hospital, or a freestanding psychiatric hospital. This service is appropriate for individuals whose acute biomedical and emotional, behavioral, and cognitive problems are so severe that they require primary medical and nursing care. Services at this level of care are managed by a physician who is responsible for diagnosis, treatment, and treatment plan decisions in collaboration with the individual.

"Medically monitored intensive inpatient treatment" or "Level of care 3.7" means a substance use treatment program that provides 24-hour care in a facility under the supervision of medical

personnel. The care provided includes directed evaluation, observation, medical monitoring, and addiction treatment in an inpatient setting. The care provided may include the use of medication to address the effects of substance use. This service is appropriate for an individual whose subacute biomedical, emotional, behavioral, or cognitive problems are so severe that they require inpatient treatment but who does not need the full resources of an acute care general hospital or a medically managed intensive inpatient treatment program.

"Medication" means prescribed or over-the-counter drugs or both.

"Medication administration" means the legally permitted direct application of medications, as enumerated by § 54.1-3408 of the Code of Virginia, by injection, inhalation, ingestion, or any other means to an individual receiving services by (i) persons legally permitted to administer medications or (ii) the individual at the direction and in the presence of persons legally permitted to administer medications.

"Medication-assisted treatment" or "MAT" means the use of U.S. Food and Drug Administration approved medications in combination with counseling and behavioral therapies to provide treatment of substance use disorders. Medication-assisted treatment includes medications for opioid use disorder as well as medications for treatment of alcohol use disorder.

"Medication error" means an error in administering a medication to an individual and includes when any of the following occur: (i) the wrong medication is given to an individual, (ii) the wrong individual is given the medication, (iii) the wrong dosage is given to an individual, (iv) medication is given to an individual at the wrong time or not at all, or (v) the wrong method is used to give the medication to the individual.

"Medication for opioid use disorder" or "MOUD" means medications, including opioid agonist medications, approved by the U.S. Food and Drug Administration for the use in the treatment of opioid use disorder.

"Medication storage" means any area where medications are maintained by the provider, including a locked cabinet, locked room, or locked box.

"Mental Health Community Support Service" or "MCHSS" means the provision of recovery-oriented services to individuals with long-term, severe mental illness. MHCSS includes skills training and assistance in accessing and effectively utilizing services and supports that are essential to meeting the needs identified in the individualized services plan and development of environmental supports necessary to sustain active community living as independently as possible. MHCSS may be provided in any setting in which the individual's needs can be addressed, skills training applied, and recovery experienced.

"Mental health intensive outpatient service" means a structured program of skilled treatment services focused on maintaining and improving functional abilities through a time-limited, interdisciplinary approach to treatment. This service is provided over a period of time for individuals requiring more intensive services than an outpatient service can provide and may include individual, family, or group counseling or psychotherapy; skill development and psychoeducational activities; certified peer support services; medication management; and psychological assessment or testing.

"Mental health outpatient service" means treatment provided to individuals on an hourly schedule, on an individual, group, or family basis, and usually in a clinic or similar facility or in another location. Mental health outpatient services may include diagnosis and evaluation, screening and intake, counseling, psychotherapy, behavior management, psychological testing and assessment, laboratory, and other ancillary services, medical services, and medication services. Mental health outpatient service specifically includes:

1. Mental health services operated by a community services board or a behavioral health authority established pursuant to Chapter 5 (§ 37.2-500 et seq.) or Chapter 6 (§ 37.2-600 et seq.) of Title 37.2 of the Code of Virginia;

2. Mental health services contracted by a community services board or a behavioral health authority established pursuant to Chapter 5 (§ 37.2-500 et seq.) or Chapter 6 (§ 37.2-600 et seq.) of Title 37.2 of the Code of Virginia; or

3. Mental health services that are owned, operated, or controlled by a corporation organized pursuant to the provisions of either Chapter 9 (§ 13.1-601 et seq.) or Chapter 10 (§ 13.1-801 et seq.) of Title 13.1 of the Code of Virginia.

"Mental health partial hospitalization service" means time-limited active treatment interventions that are more intensive than outpatient services, designed to stabilize and ameliorate acute symptoms and serve as an alternative to inpatient hospitalization or to reduce the length of a hospital stay. Partial hospitalization is provided through a minimum of 20 hours per week of skilled treatment services focused on individuals who require intensive, highly coordinated, structured, and interdisciplinary ambulatory treatment within a stable environment that is of greater intensity than intensive outpatient, but of lesser intensity than inpatient.

"Mental illness" means, as defined by § 37.2-100 of the Code of Virginia, a disorder of thought, mood, emotion, perception, or orientation that significantly impairs judgment, behavior, capacity to recognize reality, or ability to address basic life necessities and requires care and treatment for the health, safety, or recovery of the individual or for the safety of others.

"Missing" means a circumstance in which an individual is not physically present when and where he should be and his absence cannot be accounted for or explained by his supervision needs or pattern of behavior.

"Mobile crisis response" means a type of community-based crisis stabilization service that is available 24 hours per day, seven days per week, 365 days per year to provide rapid response, assessment, and early intervention to individuals experiencing a behavioral health crisis. Services are deployed in real time to the location of the individual experiencing a behavioral health crisis. The purpose of this service is to (i) de-escalate the behavioral health crisis and prevent harm to the individual or others; (ii) assist in the prevention of the individual's acute exacerbation of symptoms; (iii) develop an immediate plan to maintain safety; and (iv) coordinate care and linking to appropriate treatment services to meet the needs of the individual.

"Mobile medication-assisted treatment program" or "mobile MAT program" means a MAT operating from a motor vehicle or conveyance that serves as a mobile component to a licensed MAT location registered with the U.S. Drug Enforcement Administration as required by 21 CFR 1301.11 et seq.

"Motivational enhancement" means a person-centered approach that is collaborative, employs strategies to strengthen motivation for change, increases engagement in substance use services, resolves ambivalence about changing substance use behaviors, and supports individuals to set goals to change their substance use.

"Neglect" means, as defined by § 37.2-100 of the Code of Virginia, the failure by a person or a program or facility operated, licensed, or funded by the department, excluding those operated by the Department of Corrections, responsible for providing services to do so, including nourishment, treatment, care, goods, or services necessary to the health, safety, or welfare of an individual receiving care or treatment for mental illness, developmental disabilities, or substance abuse.

"Neurobehavioral services" means the assessment, evaluation, and treatment of cognitive, perceptual, behavioral, and other impairments caused by brain injury that affect an individual's ability to function successfully in the community.

"Office of Human Rights" means the Department of Behavioral Health and Developmental Services Office of Human Rights.

"Opioid treatment practitioner" means a health care professional who is appropriately licensed to prescribe or dispense medications in Virginia for opioid use disorders and, as a result, is authorized to practice within an opioid treatment program.

"Person-centered" means focusing on the needs and preferences of the individual; empowering and supporting the individual in defining the direction for his life; and promoting self-determination, community involvement, and recovery.

"Provider" means, as defined by § 37.2-403 of the Code of Virginia, any person, entity, or organization, excluding an agency of the federal government by whatever name or designation, that delivers (i) services to individuals with mental illness, developmental disabilities, or substance abuse (substance use disorders) or (ii) residential services for individuals with brain injury. The person, entity, or organization shall include a hospital as defined in § 32.1-123 of the Code of Virginia, community services board, behavioral health authority, private provider, and any other similar or related person, entity, or organization. It shall not include any individual practitioner who holds a license issued by a health regulatory board of the Department of Health Professions or who is exempt from licensing pursuant to §§ 54.1-2901, 54.1-3001, 54.1-3501, 54.1-3601, and 54.1-3701 of the Code of Virginia.

"Psychosocial rehabilitation service" means a program of two or more consecutive hours per day provided to groups of adults in a nonresidential setting. Individuals must demonstrate a clinical need for the service arising from a condition due to mental, behavioral, or emotional illness that results in significant functional impairments in major life activities. This service provides education to teach the individual about mental illness, substance abuse, and appropriate medication to avoid complication and relapse and opportunities to learn and use independent skills and to enhance social and interpersonal skills within a consistent program structure and environment. Psychosocial rehabilitation includes skills training, peer support, vocational rehabilitation, and community resource development oriented toward empowerment, recovery, and competency.

"Psychotherapy" means the application of principles, standards, and methods of the counseling profession in (i) conducting assessments and diagnoses for the purpose of establishing treatment goals and objectives and (ii) planning, implementing, and evaluating treatment plans using treatment interventions to facilitate human development and to identify and remediate mental, emotional, or behavioral disorders and associated distresses that interfere with mental health.

"Qualified developmental disability professional" or "QDDP" means a person who possesses at least one year of documented experience working directly with individuals who have a developmental disability and who possesses one of the following credentials: (i) a doctor of medicine or osteopathy licensed in Virginia, (ii) a registered nurse licensed in Virginia, (iii) a licensed occupational therapist, or (iv) completion of at least a bachelor's degree in a human services field, including sociology, social work, special education, rehabilitation counseling, or psychology.

"Qualified individual" means a named individual who (i) is at least 18 years of age; (ii) is a full-time employee or contractor of the provider; and (iii) has met the appropriate prerequisites as specified in 12VAC35-105.

"Qualified mental health professional" or "QMHP" means the same as the term is defined in § 54.1-3500 of the Code of Virginia.

"Qualified mental health professional-trainee" or "QMHP-T" means the same as the term is defined in § 54.1-3500 of the Code of Virginia.

"Qualified paraprofessional in mental health" or "QPPMH" means a person who meets at least one of the following criteria: (i) is registered with the United States Psychiatric Association (USPRA) as an Associate Psychiatric Rehabilitation Provider (APRP); (ii) has an associate degree in a related field (social work, psychology, psychiatric rehabilitation, sociology, counseling, vocational rehabilitation, human services counseling) and at least one year of experience providing direct services to individuals with a diagnosis of mental illness; (iii) is licensed as an occupational therapy assistant, and supervised by a licensed occupational therapist, with at least one year of experience providing direct services to individuals with a diagnosis of mental illness; or (iv) has a minimum of 90 hours classroom training and 12 weeks of experience under the direct personal supervision of a QMHP providing services to individuals with mental illness and at least one year of experience, including the 12 weeks of supervised experience.

"Quality improvement plan" means a detailed work plan developed by a provider that defines steps the provider will take to review the quality of services it provides and to manage initiatives to improve quality. A quality improvement plan consists of systematic and continuous actions that lead to measurable improvement in the services, supports, and health status of the individuals receiving services.

"Recovery" means a journey of healing and transformation enabling an individual with a mental illness to live a meaningful life in a community of his choice while striving to achieve his full potential. For individuals with substance abuse (substance use disorders), recovery is an incremental process leading to positive social change and a full return to biological, psychological, and social functioning. For individuals with a developmental disability, the concept of recovery does not apply in the sense that individuals with a developmental disability will need supports throughout their entire lives although these may change over time. With supports, individuals with a developmental disability are capable of living lives that are fulfilling and satisfying and that bring meaning to themselves and others they know.

"REACH crisis therapeutic home" or "REACH CTH" means a residential home with crisis stabilization REACH service for individuals with a developmental disability and who are experiencing a mental health or behavior crisis.

"REACH mobile crisis response" means a REACH service that provides mobile crisis response for individuals with a developmental disability and who are experiencing a mental health or behavior crisis.

"Referral" means the process of directing an applicant or an individual to a provider or service that is designed to provide the assistance needed.

"Regional education assessment crisis services habilitation" or "REACH" means the statewide crisis system of care that is designed to meet the crisis support needs of individuals who have a developmental disability and are experiencing mental health or behavior crisis events that put the individuals at risk for homelessness, incarceration, hospitalization, or danger to self or others.

"Residential" or "residential service" means providing 24-hour support in conjunction with care and treatment or a training program in a setting other than a hospital or training center. Residential services provide a range of living arrangements from highly structured and intensively supervised to relatively independent and requiring a modest amount of staff support and monitoring. Residential services include residential treatment, group homes, supervised living, community gero-psychiatric residential, ICF/IID, sponsored residential homes, withdrawal management, and neurobehavioral services.

"Residential crisis stabilization service" means (i) providing short-term, intensive treatment to nonhospitalized individuals who require multidisciplinary treatment in order to stabilize acute psychiatric symptoms and prevent admission to a psychiatric inpatient unit; (ii) providing normative environments with a high assurance of safety and security for crisis intervention; and

(iii) mobilizing the resources of the community support system, family members, and others for ongoing rehabilitation and recovery.

"Residential treatment service" means providing an intensive and highly structured clinically based mental health, substance abuse, or neurobehavioral service for co-occurring disorders in a residential setting other than an inpatient service.

"Respite care service" means providing for a short-term, time-limited period of care of an individual for the purpose of providing relief to the individual's family, guardian, or regular caregiver. Persons providing respite care are recruited, trained, and supervised by a licensed provider. These services may be provided in a variety of settings including residential, day support, in-home, or a sponsored residential home.

"Restraint" means the use of a mechanical device, medication, physical intervention, or hands-on hold to prevent an individual receiving services from moving his body to engage in a behavior that places him or others at imminent risk. There are three kinds of restraints:

1. Mechanical restraint means the use of a mechanical device that cannot be removed by the individual to restrict the individual's freedom of movement or functioning of a limb or portion of an individual's body when that behavior places him or others at imminent risk.

2. Pharmacological restraint means the use of a medication that is administered involuntarily for the emergency control of an individual's behavior when that individual's behavior places him or others at imminent risk and the administered medication is not a standard treatment for the individual's medical or psychiatric condition.

3. Physical restraint, also referred to as manual hold, means the use of a physical intervention or hands-on hold to prevent an individual from moving his body when that individual's behavior places him or others at imminent risk.

"Restraints for behavioral purposes" means using a physical hold, medication, or a mechanical device to control behavior or involuntarily restrict the freedom of movement of an individual in an instance when all of the following conditions are met: (i) there is an emergency; (ii) nonphysical interventions are not viable; and (iii) safety issues require an immediate response.

"Restraints for medical purposes" means using a physical hold, medication, or mechanical device to limit the mobility of an individual for medical, diagnostic, or surgical purposes, such as routine dental care or radiological procedures and related post-procedure care processes, when use of the restraint is not the accepted clinical practice for treating the individual's condition.

"Restraints for protective purposes" means using a mechanical device to compensate for a physical or cognitive deficit when the individual does not have the option to remove the device. The device may limit an individual's movement, for example, bed rails or a gerichair, and prevent possible harm to the individual or it may create a passive barrier, such as a helmet to protect the individual.

"Restriction" means anything that limits or prevents an individual from freely exercising his rights and privileges.

"Risk management" means an integrated system-wide program to ensure the safety of individuals, employees, visitors, and others through identification, mitigation, early detection, monitoring, evaluation, and control of risks.

"Root cause analysis" means a method of problem solving designed to identify the underlying causes of a problem. The focus of a root cause analysis is on systems, processes, and outcomes that require change to reduce the risk of harm.

"Screening" means the process or procedure for determining whether the individual meets the minimum criteria for initial assessment.

"Seclusion" means the involuntary placement of an individual alone in an area secured by a door that is locked or held shut by a staff person, by physically blocking the door, or by any other physical means so that the individual cannot leave the area.

"Serious incident" means any event or circumstance that causes or could cause harm to the health, safety, or well-being of an individual. The term "serious incident" includes death and serious injury.

"Level I serious incident" means a serious incident that occurs or originates during the provision of a service or on the premises of the provider and does not meet the definition of a Level II or Level III serious incident. Level I serious incidents do not result in significant harm to individuals but may include events that result in minor injuries that do not require medical attention or events that have the potential to cause serious injury, even when no injury occurs.

"Level II serious incident" means a serious incident that occurs or originates during the provision of a service or on the premises of the provider that results in a significant harm or threat to the health and safety of an individual that does not meet the definition of a Level III serious incident. "Level II serious incident" includes a significant harm or threat to the health or safety of others caused by an individual. Level II serious incidents include:

1. A serious injury;

2. An individual who is or was missing;

3. An emergency room visit;

4. An unplanned psychiatric or unplanned medical hospital admission of an individual receiving services other than licensed emergency services, except that a psychiatric admission in accordance with an individual's wellness plan shall not constitute an unplanned admission for the purposes of this chapter;

5. Choking incidents that require direct physical intervention by another person;

6. Ingestion of any hazardous material; or

7. A diagnosis of:

a. A decubitus ulcer or an increase in severity of level of previously diagnosed decubitus ulcer;

b. A bowel obstruction; or

c. Aspiration pneumonia.

"Level III serious incident" means a serious incident, whether or not the incident occurs while in the provision of a service or on the provider's premises, that results in:

1. Any death of an individual;

2. A sexual assault of an individual; or

3. A suicide attempt by an individual admitted for services, other than licensed emergency services, that results in a hospital admission.

"Serious injury" means any injury resulting in bodily hurt, damage, harm, or loss that requires medical attention by a licensed physician, doctor of osteopathic medicine, physician assistant, or nurse practitioner.

"Service" means, as defined by § 37.2-403 of the Code of Virginia, (i) planned individualized interventions intended to reduce or ameliorate mental illness, developmental disabilities, or substance abuse (substance use disorders) through care, treatment, training, habilitation, or other supports that are delivered by a provider to individuals with mental illness, developmental disabilities, or substance abuse (substance use disorders). Services include outpatient services, intensive in-home services, medication for opioid use disorder treatment services, inpatient psychiatric hospitalization, community gero-psychiatric residential services, assertive community

treatment and other clinical services; day support, day treatment, partial hospitalization, psychosocial rehabilitation, and habilitation services; case management services; and supportive residential, special school, halfway house, in-home services, crisis stabilization, and other residential services; and (ii) planned individualized interventions intended to reduce or ameliorate the effects of brain injury through care, treatment, or other supports provided in residential services for persons with brain injury.

"Shall" means an obligation to act is imposed.

"Shall not" means an obligation not to act is imposed.

"Signed" or "signature" means a handwritten signature, an electronic signature, or a digital signature, as long as the signer showed clear intent to sign.

"Skills training" means systematic skill building through curriculum-based psychoeducational and cognitive-behavioral interventions. These interventions break down complex objectives for role performance into simpler components, including basic cognitive skills such as attention, to facilitate learning and competency.

"Sponsored residential home" means a service where providers arrange for, supervise, and provide programmatic, financial, and service support to families or persons (sponsors) providing care or treatment in their own homes for individuals receiving services.

"State opioid treatment authority" or "SOTA" means the Virginia Department of Behavioral Health and Developmental Services, which is authorized by the federal Center for Substance Abuse Treatment to exercise the responsibility and authority for governing the treatment of opioid use disorder with MOUD.

"Substance abuse (substance use disorders)" means, as defined by § 37.2-100 of the Code of Virginia, the use of drugs enumerated in the Virginia Drug Control Act (§ 54.1-3400 et seq.) without a compelling medical reason or alcohol that (i) results in psychological or physiological dependence or danger to self or others as a function of continued and compulsive use or (ii) results in mental, emotional, or physical impairment that causes socially dysfunctional or socially disordering behavior; and (iii), because of such substance abuse, requires care and treatment for the health of the individual. This care and treatment may include counseling, rehabilitation, or medical or psychiatric care.

"Substance abuse intensive outpatient service" or "Level of care 2.1" means structured treatment provided to individuals who require more intensive services than is normally provided in an outpatient service but do not require inpatient services. Treatment consists primarily of counseling and education about addiction-related and mental health challenges delivered a minimum of nine to 19 hours of services per week for adults or six to 19 hours of services per week for children and adolescents. Within this level of care an individual's needs for psychiatric and medical services are generally addressed through consultation and referrals.

"Substance abuse outpatient service" or "Level of care 1.0" means a center-based substance abuse treatment delivered to individuals for fewer than nine hours of service per week for adults or fewer than six hours per week for adolescents on an individual, group, or family basis. Substance abuse outpatient services may include diagnosis and evaluation, screening and intake, counseling, psychotherapy, behavior management, psychological testing and assessment, laboratory and other ancillary services, medical services, and medication services. Substance abuse outpatient service includes substance abuse services or an office practice that provides professionally directed aftercare, individual, and other addiction services to individuals according to a predetermined regular schedule of fewer than nine contact hours a week. Substance abuse outpatient service also includes:

1. Substance abuse services operated by a community services board or a behavioral health authority established pursuant to Chapter 5 (§ 37.2-500 et seq.) or Chapter 6 (§ 37.2-600 et seq.) of Title 37.2 of the Code of Virginia;

2. Substance abuse services contracted by a community services board or a behavioral health authority established pursuant to Chapter 5 (§ 37.2-500 et seq.) or Chapter 6 (§ 37.2-600 et seq.) of Title 37.2 of the Code of Virginia; or

3. Substance abuse services that are owned, operated, or controlled by a corporation organized pursuant to the provisions of either Chapter 9 (§ 13.1-601 et seq.) or Chapter 10 (§ 13.1-801 et seq.) of Title 13.1 of the Code of Virginia.

"Substance abuse partial hospitalization services" or "Level of care 2.5" means a short-term, nonresidential substance use treatment program provided for a minimum of 20 hours a week that uses multidisciplinary staff and is provided for individuals who require a more intensive treatment experience than intensive outpatient treatment but who do not require residential treatment. This level of care is designed to offer highly structured intensive treatment to those individuals whose condition is sufficiently stable so as not to require 24-hour-per-day monitoring and care, but whose illness has progressed so as to require consistent near-daily treatment intervention.

"Suicide attempt" means a nonfatal, self-directed, potentially injurious behavior with an intent to die as a result of the behavior regardless of whether it results in injury.

"Supervised living residential service" means the provision of significant direct supervision and community support services to individuals living in apartments or other residential settings. These services differ from supportive in-home service because the provider assumes responsibility for management of the physical environment of the residence, and staff supervision and monitoring are daily and available on a 24-hour basis. Services are provided based on the needs of the individual in areas such as food preparation, housekeeping, medication administration, personal hygiene, treatment, counseling, and budgeting.

"Supportive in-home service" (formerly supportive residential) means the provision of community support services and other structured services to assist individuals, to strengthen individual skills, and that provide environmental supports necessary to attain and sustain independent community residential living. Services include drop-in or friendly-visitor support and counseling to more intensive support, monitoring, training, in-home support, respite care, and family support services. Services are based on the needs of the individual and include training and assistance. These services normally do not involve overnight care by the provider; however, due to the flexible nature of these services, overnight care may be provided on an occasional basis.

"Systemic deficiency" means violations of regulations documented by the department that demonstrate multiple or repeat defects in the operation of one or more services.

"Telehealth" shall have the same meaning as "telehealth services" in § 32.1-122.03:1 of the Code of Virginia.

“Telemedicine" shall have the same meaning as "telemedicine services" in § 38.2-3418.16 of the Code of Virginia.

"Therapeutic day treatment for children and adolescents" means a treatment program that serves (i) children and adolescents from birth through 17 years of age and under certain circumstances up to 21 years of age with serious emotional disturbances, substance use, or co-occurring disorders or (ii) children from birth through seven years of age who are at risk of serious emotional disturbance, in order to combine psychotherapeutic interventions with education and mental health or substance abuse treatment. Services include: evaluation; medication education and management; opportunities to learn and use daily living skills and to enhance social and interpersonal skills; and individual, group, and family counseling.

"Time out" means the involuntary removal of an individual by a staff person from a source of reinforcement to a different, open location for a specified period of time or until the problem behavior has subsided to discontinue or reduce the frequency of problematic behavior.

"Volunteer" means a person who, without financial remuneration, provides services to individuals on behalf of the provider.

"Withdrawal management" means the dispensing of MOUD in decreasing doses to an individual to alleviate adverse physical effects incident to withdrawal from the continuous or sustained use of an opioid and as a method of bringing the individual to an opioid-free state within such a period. Long-term withdrawal management refers to the process of medication tapering that exceeds 30 days.

"Written," "writing," and "in writing" include any representation of words, letters, symbols, numbers, or figures, whether (i) printed or inscribed on a tangible medium or (ii) stored in an electronic or other medium and retrievable in a perceivable form and whether an electronic signature authorized by Chapter 42.1 (§ 59.1-479 et seq.) of Title 59.1 of the Code of Virginia is or is not affixed.

12VAC35-105-30. Licenses.

A. Licenses are issued to providers who offer services to individuals who have mental illness, a developmental disability, or substance abuse (substance use disorders) or have brain injury and are receiving residential services.

B. Providers shall be licensed to provide specific services as defined in this chapter or as determined by the commissioner. These services include:

1. Assertive community treatment (ACT);
2. Case management;
3. Clinically managed high-intensity residential care or Level of care 3.5;
4. Clinically managed low-intensity residential care or Level of care 3.1;
5. Clinically managed population specific high-intensity residential or Level of care 3.3;
6. Community gero-psychiatric residential;
7. Community-based crisis stabilization;
8. Coordinated specialty care;
~~8.~~9. Crisis receiving center;
~~9.~~10. Crisis stabilization unit;
~~10.~~11. Day support;
~~11.~~12. Day treatment, including therapeutic day treatment for children and adolescents;
~~12.~~13. Group home and community residential;
~~13.~~14. ICF/IID;
~~14.~~15. Inpatient psychiatric;
~~15.~~16. Intensive in-home;
~~16.~~17. Medically managed intensive inpatient service or Level of care 4.0;
~~17.~~18. Medically monitored intensive inpatient treatment or Level of care 3.7;
~~18.~~19. Medication for opioid use disorder treatment;
~~19.~~20. Mental health community support;
~~20.~~21. Mental health intensive outpatient;
~~21.~~22. Mental health outpatient;
~~22.~~23. Mental health partial hospitalization;

~~23.~~24. Psychosocial rehabilitation;

~~24.~~25. REACH CTH;

~~25.~~26. REACH mobile crisis response;

~~26.~~27. Residential treatment;

~~27.~~28. Respite care;

~~28.~~29. Sponsored residential home;

~~29.~~30. Substance abuse intensive outpatient;

~~30.~~31. Substance abuse outpatient;

~~31.~~32. Substance abuse partial hospitalization;

~~32.~~33. Supervised living residential; and

~~33.~~34. Supportive in-home.

C. A license addendum shall describe the services licensed, the disabilities of individuals who may be served, the specific locations where services are to be provided or administered, and the terms and conditions for each service offered by a licensed provider. For residential and inpatient services, the license identifies the number of individuals each residential location may serve at a given time.

12VAC35-105-1426. Admission Criteria.

A. Before a CSC provider may admit an individual to the service, the individual shall meet the criteria for admission as defined by this chapter and the provider's policies.

B. The policy regarding admission to CSC, shall at a minimum, meet the requirements of 12VAC35-105-650 and the assessment required by that section shall:

1. Be conducted by a LMHP, LMHP-R, LMHP-RP or LMHP-S. Assessments completed by a LMHP-R, LMHP-RP or LMHP-S shall be signed by a LMHP;

2. Be conducted in person in the individual's home or another location of the individual's choice;

3. Document that the individual:

a. Is between the ages of 15 and 30 at admission;

b. Exhibited psychotic symptoms for less than five years at admission;

c. Has a diagnosis of schizophrenia, schizoaffective disorder, schizophreniform disorder, other specified schizophrenia spectrum, affective disorder with psychosis, bipolar disorder with psychotic features, major depression with psychotic features, or other psychotic disorder. Individuals may also have a co-occurring diagnosis of a substance use disorder or developmental disability; and

d. Is experiencing symptoms of a mental, behavioral, or emotional illness that results in functional impairments in major life activities. Such symptoms may include auditory or visual hallucinations, delusions, or a thought disorder that causes significant disruptions in at least one of the following areas: (i) educational functioning, (ii) occupational functioning, (iii) relationships with family members, or (iv) building a social support network.

12VAC35-105-1427. Discharge criteria.

Before a CSC provider may discharge an individual, the individual shall meet the criteria for discharge as defined by this chapter and the provider's policies, which shall meet all the requirements of 12VAC35-105-693. The provider's policy regarding discharge shall require that an individual be discharged when one of the following conditions is met:

1. The individual has successfully completed the CSC program and has transitioned to a lower level of care adequate to support recovery;

2. The individual is unable to achieve the goals of treatment but could progress with a different type of treatment;

3. The individual has achieved the original treatment goals but has developed new treatment challenges that can only be adequately addressed in a different type of treatment; or

4. The individual chooses to be discharged from the program or has not participated in treatment for six months.

12VAC35-105-1428. Service delivery.

A. A CSC program shall meet the following programmatic requirements in accordance with the individual's assessment and ISP.

1. Treatment planning may be developed through a team approach, but the ISP shall be signed and overseen by a LMHP.

2. Psychiatric services to include a comprehensive psychiatric evaluation, medication prescription monitoring, and contact with the individual. The psychiatric evaluation shall be completed as soon as possible but no later than 30 days after admission. Psychiatric services shall be provided by a psychiatrist, psychiatric nurse practitioner, or nurse practitioner or physician assistant working under the supervision of a psychiatrist.

3. Psychotherapy provided by a LMHP, LMHP-R, LMHP-RP, or LMHP-S.

4. Family education and support provided by any team member acting within the scope of their practice.

5. Health Literacy Support. The medication administration component shall be performed by a RN or LPN. The support component shall be performed by a LMHP, LMHP-R, LMHP-RP, LMHP-S, nurse practitioner, occupational therapist, CSAC, CSAC-S, RN, or LPN.

6. CSC rehabilitation skill-building by a LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP, QMHP-T, occupational therapist, CSAC, CSAC-S, or registered PRS.

7. Care coordination by a LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP, QMHP-T, CSAC, CSAC-S, RN, LPN, or registered PRS.

8. Crisis support provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP, or QMHP-T. Crisis support shall include the development of the individual’s crisis mitigation plan.

a. Crisis support shall be available 24 hours a day, seven days a week.

b. If the individual's condition progresses to require a higher level of care, the individual shall be referred to the appropriate level of care. Before referring to any external crisis resource, the provider shall attempt internal crisis support.

9. Peer recovery support services by a registered PRS.

B. A CSC program shall participate in the completion of quality service reviews conducted by DBHDS.

C. A CSC program shall furnish information and documentation on request and in the form requested by DBHDS.

12VAC35-105-1429. Treatment team and staffing.

Each CSC provider shall have sufficient staffing composition to meet the varying needs of individuals served by the provider as required by this section. CSC services shall be delivered by a multidisciplinary team and the provider shall meet the following minimum position requirements:

1. Team leader who is a designated employee and LMHP with at least three years of experience in the provision of mental health services.

a. The team leader shall oversee all aspects of team operation.

b. The team leader shall routinely provide direct services to individuals in the community.

c. The team leader shall monitor, oversee, and supervise the team-based process.

2. Psychiatric provider who is a designated employee and a psychiatrist, psychiatric nurse practitioner, nurse practitioner with sufficient training and mental health experience, or nurse practitioner or physician assistant working under the supervision of a psychiatrist.

a. The psychiatric provider shall be available to the team to provide assessments and medication management.

b. The psychiatric provider shall serve as fully integrated team member who attends clinical team meetings.

3. An additional clinician who is a LMHP, LMHP-R, LMHP-RP, or LMHP-S. The clinician shall provide psychotherapy.

4. A registered peer recovery support specialist who is a designated employee.

5. Supported employment and education specialist. There shall be one full-time supported employment and education specialist, who shall be a registered QMHP with demonstrated expertise in supported employment and supported education through experience or education.

6. General clinical staff as appropriate to meet the needs of individuals served. Additional staff may include QMHPs, QMHP-Ts, CSACs, CSAC-Ss, occupational therapists, RNs, and LPNs.

7. At least one of the CSC provider team members shall have training working with individuals with substance use disorders.

8. All team members shall complete initial and annual training approved by DBHDS in core and evidence-based practices that support high-fidelity CSC practice.

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Emergency Regulation and Notice of Intended Regulatory Action (NOIRA) Agency Background Document

Agency name	Department of Behavioral Health and Developmental Services (DBHDS)
Virginia Administrative Code (VAC) Chapter citation(s)	12VAC35-105
VAC Chapter title(s)	Rules and Regulations for Licensing Providers by the Department of Behavioral Health and Developmental Services (12VAC35-105)
Action title	2026 Recovery and Empowerment Center (REC) alignment with Medicaid behavioral health services redesign
Date this document prepared	July 14, 2026

This information is required for executive branch review and the Virginia Registrar of Regulations, pursuant to the Virginia Administrative Process Act (APA), Executive Order 19 (2022) (EO 19), any instructions or procedures issued by the Office of Regulatory Management (ORM) or the Department of Planning and Budget (DPB) pursuant to EO 19, the Regulations for Filing and Publishing Agency Regulations (1 VAC 7-10), and the *Form and Style Requirements for the Virginia Register of Regulations and Virginia Administrative Code*.

Brief Summary

Provide a brief summary (preferably no more than 2 or 3 paragraphs) of the subject matter, intent, and goals of this regulatory change (i.e., new regulation, amendments to an existing regulation, or repeal of an existing regulation). Alert the reader to all substantive matters or changes. If applicable, generally describe the existing regulation.

In 2025, the General Assembly directed the Department of Behavioral Health and Developmental Services (DBHDS) through the budget bill to utilize emergency authority to align licensing regulations with the modifications being made to Medicaid behavioral health services by July 1, 2026. During the 2026 Special Session I, the 2026-2028 Appropriation Act extended the implementation deadline for behavioral health redesign by one year and reauthorized the directive for emergency regulations (Item 297).

To comply with the legislative mandates, the State Board of Behavioral Health and Developmental Services must adopt three separate emergency actions that conform DBHDS Licensing Regulations with changes to be made by the Department of Medical Assistance Services (DMAS) replacing legacy

services with Community Psychiatric Support and Treatment (CPST); Coordinated Specialty Care (CSC); and Mental Health Clubhouse Services (Clubhouse).

This regulatory action will establish the newly licensed service to align with Clubhouse, which in Virginia will be entitled Recovery and Empowerment Center (REC).

Acronyms and Definitions

Define all acronyms used in this form, and any technical terms that are not also defined in the "Definitions" section of the regulation.

Department of Behavioral Health and Development Services (DBHDS)
Department of Medical Assistance Services (DMAS)
Recovery and Empowerment Center (REC)
State Board of Behavioral Health and Developmental Services (State Board)

Mandate and Impetus (Necessity for Emergency)

Explain why this rulemaking is an emergency situation in accordance with § 2.2-4011 A and B of the Code of Virginia. In doing so, either:

a) Indicate whether the Governor's Office has already approved the use of emergency regulatory authority for this regulatory change.
b) Provide specific citations to Virginia statutory law, the appropriation act, federal law, or federal regulation that require that a regulation be effective in 280 days or less from its enactment.

As required by § 2.2-4011, also describe the nature of the emergency and of the necessity for this regulatory change. In addition, delineate any potential issues that may need to be addressed as part of this regulatory change.

Item 297 of the 2026-2028 Appropriation Act directs DBHDS to promulgate emergency regulations, in collaboration with DMAS, to "align licensing regulations with the modifications being made to Medicaid behavioral health services." A regulatory action to establish permanent regulations will follow this emergency action.

Legal Basis

Identify (1) the promulgating agency, and (2) the state and/or federal legal authority for the regulatory change, including the most relevant citations to the Code of Virginia or Acts and Assembly chapter number(s), if applicable. Your citation must include a specific provision, if any, authorizing the promulgating agency to regulate this specific subject or program, as well as a reference to the agency's overall regulatory authority.

DBHDS was directed by the General Assembly during the 2026 Special Session I to promulgate emergency regulations that align its provider licensing regulations with the modifications being made by DMAS to Medicaid behavioral health services. Item 297 of the 2026-2028 Appropriation Act mandates the changes within this regulatory action.

Section 37.2-203 of the Code of Virginia gives the State Board the authority to adopt regulations that may be necessary to carry out the provisions of Title 37.2 of the Code and other laws of the Commonwealth

administered by the DBHDS commissioner. The State Board voted to adopt this regulatory action at its meeting on July 15, 2026.

Purpose

Describe the specific reasons why the agency has determined that this regulation is essential to protect the health, safety, or welfare of citizens. In addition, explain any potential issues that may need to be addressed as the regulation is developed.

The purpose of this action is to comply with the legislative mandate by aligning DBHDS licensing regulations with anticipated DMAS changes to Medicaid by establishing the new behavioral health service of REC (Mental Health Clubhouse Services).

The goal of REC is to support the recovery of individuals living with serious mental illness by creating a community-based environment that fosters social connection, meaningful engagement, and skill development.

Substance

Briefly identify and explain the new substantive provisions, the substantive changes to existing sections, or both. A more detailed discussion is provided in the "Detail of Changes" section below.

The substantive provisions of this regulatory action include:

1) Definitions necessary for the integration of REC into the Licensing Regulations;
2) Admission criteria for REC;
3) Discharge criteria for REC;
4) Service delivery requirements for REC;
5) Minimum requirements for REC staffing; and
6) REC physical environment standards.

Issues

Identify the issues associated with the regulatory change, including: 1) the primary advantages and disadvantages to the public, such as individual private citizens or businesses, of implementing the new or amended provisions; 2) the primary advantages and disadvantages to the agency or the Commonwealth; and 3) other pertinent matters of interest to the regulated community, government officials, and the public. If there are no disadvantages to the public or the Commonwealth, include a specific statement to that effect.

Virginia's behavioral health system is undergoing a multi-phased, interagency process of transformation to enhance the service delivery system. This requires coordination among agencies with responsibilities for licensing, funding, and oversight behavioral health services in the Commonwealth.

The primary advantages of this regulatory action include (1) improving access to a continuum of high-quality behavioral health services for Virginians; (2) ensuring REC providers adhere to a base level of model fidelity; and (3) reducing administrative burden by aligning provider licensing regulations with Medicaid service expectations.

There are no known disadvantages to the public or the Commonwealth.

Alternatives to Regulation

Describe any viable alternatives to the regulatory change that were considered, and the rationale used by the agency to select the least burdensome or intrusive alternative that meets the essential purpose of the regulatory change. Also, include discussion of less intrusive or less costly alternatives for small businesses, as defined in § 2.2-4007.1 of the Code of Virginia, of achieving the purpose of the regulatory change.

There are no alternatives to the regulatory changes contained herein that could achieve the essential purpose of this action, which itself is mandated by the General Assembly.

The amendments are limited to those that are necessary to avoid conflict between DBHDS licensing regulations and planned DMAS modifications to Medicaid behavioral health services. Misalignment would be problematic for licensed providers of behavioral health services seeking DMAS enrollment, many of which are small businesses, as well as for individuals receiving services and their families.

Periodic Review and Small Business Impact Review Announcement

This NOIRA is not being used to announce a periodic review or a small business impact review.

Public Participation

Indicate how the public should contact the agency to submit comments on this regulation, and whether a public hearing will be held, by completing the text below. In addition, as required by § 2.2-4007.02 of the Code of Virginia describe any other means that will be used to identify and notify interested parties and seek their input, such as regulatory advisory panels or general notices.

The Department of Behavioral Health and Developmental Services is providing an opportunity for comments on this regulatory proposal, including but not limited to (i) the costs and benefits of the regulatory proposal, (ii) any alternative approaches, and (iii) the potential impacts of the regulation.

Anyone wishing to submit written comments for the public comment file may do so through the Public Comment Forums feature of the Virginia Regulatory Town Hall web site at: https://townhall.virginia.gov. Comments may also be submitted by mail or email to Susan Puglisi, 1220 Bank Street, Richmond Virginia, 23219, or susan.puglisi@dbhds.virginia.gov. In order to be considered, comments must be received by 11:59 pm on the last day of the public comment period.

A public hearing will not be held following the publication of the proposed stage of this regulatory action.

Detail of Changes

List all regulatory changes and the consequences of the changes. Explain the new requirements and what they mean rather than merely quoting the text of the regulation. For example, describe the intent of the language and the expected impact. Describe the difference between existing requirement(s) and/or agency practice(s) and what is being proposed in this regulatory change. Use all tables that apply, but delete inapplicable tables.

If an existing VAC Chapter(s) is being amended or repealed, use Table 1 to describe the changes between existing VAC Chapter(s) and the emergency regulation. If existing VAC Chapter(s) or sections are being repealed and replaced, ensure Table 1 clearly shows both the current number and the new number for each repealed section and the replacement section.

Table 1: Changes to Existing VAC Chapter(s)

Current chapter-section number	New chapter-section number, if applicable	Current requirements in VAC	Change, intent, rationale, and likely impact of new requirements
12VAC35-105-20. Definitions		Definitions for the Licensing Regulations.	Addition of the following terms: "Member" means an individual who participates in Recovery and Empowerment Center services. "Recovery and Empowerment Center" means evidence-based practices that provide side-by-side engagement between members and staff in supporting restoration of skills in symptom management, interpersonal relationships, communication, problem solving, coping skills, and community integration for members living with mental illness. Each Recovery and Empowerment Center provider shall allow members opportunities for skills development, improved wellness, and achieving person-centered goals identified in the individualized services plan. Interventions are designed to alleviate emotional or behavioral symptoms associated with a mental illness with the goal of reintegrating the member into the community and increasing social connectedness beyond a clinical setting. Recovery and Empowerment Centers emphasize long-term support and provide a supportive environment for members with serious mental illness to thrive in their recovery journeys, regardless of how long they are engaged in daily activities. "Work-ordered day" means the structure of day-to-day activity within Recovery and Empowerment Center services. A work-ordered day means that members collaborate with staff as colleagues to perform critical tasks for the Recovery and Empowerment Center community. Members and staff share responsibility for running every aspect of the Recovery and

			Empowerment Center environment, such as filing, maintenance, and participation in consensus-based decision-making regarding all important matters related to the Recovery and Empowerment Center operations. Likely impact: Clearer regulations. Alignment with Medicaid service changes and current evidence-based practices and terminology to provide person-centered treatment.
12VAC35-105-30. Licenses.			Addition of the license type: Recovery and Empowerment Center Likely impact: Clearer regulations. Alignment with Medicaid service changes and current evidence-based practices and terminology to provide person-centered treatment.
	12VAC35-105-1055. Admission.		Intent: Provide clear admission requirements within REC programs. Impact: Robust, effective mental health treatment within the Commonwealth that is appropriately administered.
	12VAC35-105-1060. Discharge.		Intent: Provide clear discharge requirements within REC programs. Impact: Robust, effective mental health treatment within the Commonwealth that is appropriately administered.
	12VAC35-105-1070. Service delivery.		Intent: Provide clear service delivery requirements within REC programs. Impact: Robust, effective mental health treatment within the Commonwealth.
	12VAC35-105-1080. Staffing requirements.		Intent: Provide clear requirements to providers of REC services specifically related to personnel. Impact: Robust, effective mental health treatment within the Commonwealth that is appropriately administered.
	12VAC35-105-1090. Physical environment.		Intent: Provide clear physical environment requirements within REC programs. Impact: Robust, effective mental health treatment within the Commonwealth that is appropriately administered.

Project 8525 - Emergency/NOIRA

Department of Behavioral Health And Developmental Services

Alignment with Medicaid behavioral health services redesign; Recovery and Empowerment Center (REC)

12VAC35-105-20. Definitions.

The following words and terms when used in this chapter shall have the following meanings unless the context clearly indicates otherwise:

"Abuse" means, as defined by § 37.2-100 of the Code of Virginia, any act or failure to act by an employee or other person responsible for the care of an individual in a facility or program operated, licensed, or funded by the department, excluding those operated by the Virginia Department of Corrections, that was performed or was failed to be performed knowingly, recklessly, or intentionally, and that caused or might have caused physical or psychological harm, injury, or death to an individual receiving care or treatment for mental illness, developmental disabilities, or substance abuse. Examples of abuse include acts such as:

1. Rape, sexual assault, or other criminal sexual behavior;
2. Assault or battery;
3. Use of language that demeans, threatens, intimidates, or humiliates the individual;
4. Misuse or misappropriation of the individual's assets, goods, or property;
5. Use of excessive force when placing an individual in physical or mechanical restraint;
6. Use of physical or mechanical restraints on an individual that is not in compliance with federal and state laws, regulations, and policies, professional accepted standards of practice, or the individual's individualized services plan; or
7. Use of more restrictive or intensive services or denial of services to punish an individual or that is not consistent with the individual's individualized services plan.

"Activities of daily living" or "ADLs" means personal care activities and includes bathing, dressing, transferring, toileting, grooming, hygiene, feeding, and eating. An individual's degree of independence in performing these activities is part of determining the appropriate level of care and services.

"Addiction" means a primary, chronic disease of brain reward, motivation, memory, and related circuitry. Addiction is defined as the inability to consistently abstain, impairment in behavioral control, persistence of cravings, diminished recognition of significant problems with one's behaviors and interpersonal relationships, and a dysfunctional emotional response. Like other chronic diseases, addiction often involves cycles of relapse and remission. Without treatment or engagement in recovery activities, addiction is progressive and can result in disability or premature death.

"Admission" means the process of acceptance into a service as defined by the provider's policies.

"Allied health professional" means a professional who is involved with the delivery of health or related services pertaining to the identification, evaluation, and prevention of diseases and disorders, such as a certified substance abuse counselor, certified substance abuse counseling assistant, peer recovery support specialist, certified nurse aide, or occupational therapist.

"ASAM" means the American Society of Addiction Medicine.

"Assertive community treatment service" or "ACT" means a self-contained interdisciplinary community-based team of medical, behavioral health, and rehabilitation professionals who use a

team approach to meet the needs of an individual with severe and persistent mental illness. ACT teams:

1. Provide person-centered services addressing the breadth of an individual's needs, helping the individual achieve his personal goals;

2. Serve as the primary provider of all the services that an individual receiving ACT services needs;

3. Maintain a high frequency and intensity of community-based contacts;

4. Maintain a very low individual-to-staff ratio;

5. Offer varying levels of care for all individuals receiving ACT services and appropriately adjust service levels according to each individual's needs over time;

6. Assist individuals in advancing toward personal goals with a focus on enhancing community integration and regaining valued roles, such as worker, family member, resident, spouse, tenant, or friend;

7. Carry out planned assertive engagement techniques, including rapport-building strategies, facilitating meeting basic needs, and motivational interviewing techniques;

8. Monitor the individual's mental status and provide needed supports in a manner consistent with the individual's level of need and functioning;

9. Deliver all services according to a recovery-based philosophy of care; and

10. Promote self-determination, respect for the individual receiving ACT as an individual in such individual's own right, and engage peers in promoting recovery and regaining meaningful roles and relationships in the community.

"Authorized representative" means a person permitted by law or 12VAC35-115 to authorize the disclosure of information or consent to treatment and services or participation in human research.

"Behavior intervention" means those principles and methods employed by a provider to help an individual receiving services to achieve a positive outcome and to address challenging behavior in a constructive and safe manner. Behavior intervention principles and methods shall be employed in accordance with the individualized services plan and written policies and procedures governing service expectations, treatment goals, safety, and security.

"Behavioral treatment plan," "functional plan," or "behavioral support plan" means any set of documented procedures that are an integral part of the individualized services plan and are developed on the basis of a systematic data collection, such as a functional assessment, for the purpose of assisting individuals to achieve the following:

1. Improved behavioral functioning and effectiveness;

2. Alleviation of symptoms of psychopathology; or

3. Reduction of challenging behaviors.

"Board" or "state board" means, as defined by § 37.2-100 of the Code of Virginia, the State Board of Behavioral Health and Developmental Services. The board has statutory responsibility for adopting regulations that may be necessary to carry out the provisions of Title 37.2 of the Code of Virginia and other laws of the Commonwealth administered by the commissioner or the department.

"Brain injury" means any injury to the brain that occurs after birth that is acquired through traumatic or nontraumatic insults. Nontraumatic insults may include anoxia, hypoxia, aneurysm, toxic exposure, encephalopathy, surgical interventions, tumor, and stroke. Brain injury does not include hereditary, congenital, or degenerative brain disorders or injuries induced by birth trauma.

"Care," "treatment," or "support" means the individually planned therapeutic interventions that conform to current acceptable professional practice and that are intended to improve or maintain functioning of an individual receiving services delivered by a provider.

"Case management service" or "support coordination service" means services that can include assistance to individuals and their family members in accessing needed services that are responsive to the individual's needs. Case management services include identifying potential users of the service; assessing needs and planning services; linking the individual to services and supports; assisting the individual directly to locate, develop, or obtain needed services and resources; coordinating services with other providers; enhancing community integration; making collateral contacts; monitoring service delivery; discharge planning; and advocating for individuals in response to their changing needs. "Case management service" does not include assistance in which the only function is maintaining service waiting lists or periodically contacting or tracking individuals to determine potential service needs.

"Clinical experience" means providing direct services to individuals with mental illness or the provision of direct geriatric services or special education services. Experience may include supervised internships, practicums, and field experience.

"Clinically managed high-intensity residential care" or "Level of care 3.5" means a substance use treatment program that offers 24-hour supportive treatment of individuals with significant psychological and social problems by credentialed addiction treatment professionals in an interdisciplinary treatment approach. A clinically managed high-intensity residential care program provides treatment to individuals who present with significant challenges, such as physical, sexual, or emotional trauma; past criminal or antisocial behaviors, with a risk of continued criminal behavior; an extensive history of treatment; inadequate anger management skills; extreme impulsivity; and antisocial value system.

"Clinically managed low-intensity residential care" or "Level of care 3.1" means providing an ongoing therapeutic environment for individuals requiring some structured support in which treatment is directed toward applying recovery skills; preventing relapse; improving emotional functioning; promoting personal responsibility; reintegrating the individual into work, education, and family environments; and strengthening and developing adaptive skills that may not have been achieved or have been diminished during the individual's active addiction. A clinically managed low-intensity residential care program also provides treatment for individuals suffering from chronic, long-term alcoholism or drug addiction and affords an extended period of time to establish sound recovery and a solid support system.

"Clinically managed population specific high-intensity residential services" or "Level of care 3.3" means a substance use treatment program that provides a structured recovery environment in combination with high-intensity clinical services provided in a manner to meet the functional limitations of individuals. The functional limitations of individuals who are placed within this level of care are primarily cognitive and can be either temporary or permanent.

"Collaborative behavioral health services" means the same as the term is defined in § 54.1-3500 of the Code of Virginia.

"Commissioner" means the Commissioner of the Department of Behavioral Health and Developmental Services.

"Community-based crisis stabilization" means services that are short term and designed to support an individual and the individual's natural support system following contact with an initial crisis response service or as a diversion to a higher level of care. Providers deliver community-based crisis stabilization services in an individual's natural environment and provide referrals and linkage to other community-based services at the appropriate level of care. Interventions may include mobile crisis response, brief therapeutic and skill-building interventions, engagement of natural supports, interventions to integrate natural supports in the de-escalation and stabilization

of the crisis, and coordination of follow-up services. Coordination of specialized services to address the needs of co-occurring developmental disabilities and substance use disorders are also available through this service. Services include advocacy and networking to provide linkages and referrals to appropriate community-based services and assist the individual and the individual's family or caregiver in accessing other benefits or assistance programs for which the individual may be eligible. Community-based crisis stabilization is a non-center, community-based service. The goal of community-based crisis stabilization services is to stabilize the individual within the community and support the individual or the individual's support system (i) as part of an initial mobile crisis response; (ii) during the period between an initial mobile crisis response and entry into an established follow-up service at the appropriate level of care; (iii) as a transitional step-down from a higher level of care if the next level of care service is identified but not immediately available for access; or (iv) as a diversion to a higher level of care.

"Community gero-psychiatric residential services" means 24-hour care provided to individuals with mental illness, behavioral problems, and concomitant health problems who are usually 65 years of age or older in a geriatric setting that is less intensive than a psychiatric hospital but more intensive than a nursing home or group home. Services include assessment and individualized services planning by an interdisciplinary services team, intense supervision, psychiatric care, behavioral treatment planning and behavior interventions, nursing, and other health-related services.

"Complaint" means an allegation of a violation of this chapter or a provider's policies and procedures related to this chapter.

"Conveyance" means a motor vehicle that serves as the mobile component of a mobile MAT program.

"Co-occurring disorders" means the presence of more than one and often several of the following disorders that are identified independently of one another and are not simply a cluster of symptoms resulting from a single disorder: mental illness, a developmental disability, substance abuse (substance use disorders), or brain injury.

"Co-occurring services" means individually planned therapeutic treatment that addresses in an integrated concurrent manner the service needs of individuals who have co-occurring disorders.

"Corrective action plan" means the provider's pledged corrective action in response to cited areas of noncompliance documented by the regulatory authority.

"Correctional facility" means a facility operated under the management and control of the Virginia Department of Corrections.

"Credentialed addiction treatment professional" means a person who possesses one of the following credentials issued by the appropriate health regulatory board: (i) an addiction-credentialed physician or physician with experience or training in addiction medicine; (ii) a licensed nurse practitioner or a licensed physician assistant with experience or training in addiction medicine; (iii) a licensed psychiatrist; (iv) a licensed clinical psychologist; (v) a licensed clinical social worker; (vi) a licensed professional counselor; (vii) a licensed nurse practitioner with experience or training in psychiatry or mental health; (viii) a licensed marriage and family therapist; (ix) a licensed substance abuse treatment practitioner; (x) a resident who is under the supervision of a licensed professional counselor (18VAC115-20-10), licensed marriage and family therapist (18VAC115-50-10), or licensed substance abuse treatment practitioner (18VAC115-60-10) and is registered with the Virginia Board of Counseling; (xi) a resident in psychology who is under supervision of a licensed clinical psychologist and is registered with the Virginia Board of Psychology (18VAC125-20-10); or (xii) a supervisee in social work who is under the supervision of a licensed clinical social worker and is registered with the Virginia Board of Social Work (18VAC140-20-10).

"Crisis" means a deteriorating or unstable situation often developing suddenly or rapidly that produces acute, heightened, emotional, mental, physical, medical, or behavioral distress.

"Crisis education and prevention plan" or "CEPP" means a department-approved, individualized, client-specific document that provides a concise, clear, and realistic set of supportive interventions to prevent or de-escalate a crisis and assist an individual who may be experiencing a behavioral loss of control. The goal of the CEPP is to identify problems that have arisen in the past or are emergent in order to map out strategies that offer tools for the natural support system to assist the individual in addressing and de-escalating problems in a healthy way and provide teaching skills that the individual can apply independently.

"Crisis planning team" means the team who is consulted to plan the individual's safety plan or crisis ISP. The crisis planning team consists, at a minimum, of the individual receiving services, the individual's legal guardian or authorized representative, and a member of the provider's crisis staff. The crisis planning team may include the individual's support coordinator, case manager, the individual's family, or other identified persons, as desired by the individual, such as the individual's family of choice.

"Crisis receiving center," "CRC," or "23-hour crisis stabilization" means a community-based, nonhospital facility providing short-term assessment, observation, and crisis stabilization services for up to 23 hours. This service is accessible 24 hours per day, seven days per week, 365 days per year, and is indicated when an individual requires a safe environment for initial assessment and intervention. This service includes a thorough assessment of an individual's behavioral health crisis, psychosocial needs, and supports in order to determine the least restrictive environment most appropriate for stabilization. Key service functions include rapid assessment, crisis intervention, de-escalation, short-term stabilization, and appropriate referrals for ongoing care. This distinct service may be co-located with other services such as crisis stabilization units.

"Crisis stabilization" means direct, intensive nonresidential or residential care and treatment to nonhospitalized individuals experiencing an acute crisis that may jeopardize their current community living situation. Crisis stabilization is intended to avert hospitalization or rehospitalization; provide normative environments with a high assurance of safety and security for crisis intervention; stabilize individuals in crisis; and mobilize the resources of the community support system, family members, and others for ongoing rehabilitation and recovery.

"Crisis stabilization unit," "CSU," or "residential crisis stabilization unit" is a community-based, short-term residential treatment unit. CSUs serve as primary alternatives to inpatient hospitalization for individuals who are in need of a safe, secure environment for assessment and crisis treatment. CSUs also serve as a step-down option from psychiatric inpatient hospitalization and function to stabilize and reintegrate individuals who meet medical necessity criteria back into their communities.

"Day support service" means structured programs of training, assistance, and specialized supervision in the acquisition, retention, or improvement of self-help, socialization, and adaptive skills for adults with a developmental disability provided to groups or individuals in nonresidential community-based settings. Day support services may provide opportunities for peer interaction and community integration and are designed to enhance the following: self-care and hygiene, eating, toileting, task learning, community resource utilization, environmental and behavioral skills, social skills, medication management, prevocational skills, and transportation skills. The term "day support service" does not include services in which the primary function is to provide employment-related services, general educational services, or general recreational services.

"Department" means the Virginia Department of Behavioral Health and Developmental Services.

"Developmental disability" means a severe, chronic disability of an individual that (i) is attributable to a mental or physical impairment or a combination of mental and physical

impairments other than a sole diagnosis of mental illness; (ii) is manifested before the individual reaches 22 years of age; (iii) is likely to continue indefinitely; (iv) results in substantial functional limitations in three or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, or economic self-sufficiency; and (v) reflects the individual's need for a combination and sequence of special interdisciplinary or generic services, individualized supports, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated. An individual from birth to nine years of age, inclusive, who has a substantial developmental delay or specific congenital or acquired condition may be considered to have a developmental disability without meeting three or more of the criteria described in clauses (i) through (v) if the individual without services and supports has a high probability of meeting those criteria later in life.

"Developmental services" means planned, individualized, and person-centered services and supports provided to individuals with developmental disabilities for the purpose of enabling these individuals to increase their self-determination and independence, obtain employment, participate fully in all aspects of community life, advocate for themselves, and achieve their fullest potential to the greatest extent possible.

"Diagnostic and Statistical Manual of Mental Disorders" or "DSM" means the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition, DSM-5, of the American Psychiatric Association.

"Direct care position" means any position that includes responsibility for (i) treatment, case management, health, safety, development, or well-being of an individual receiving services or (ii) immediately supervising a person in a position with this responsibility.

"Discharge" means the process by which the individual's active involvement with a service is terminated by the provider, individual, or individual's authorized representative.

"Discharge plan" means the written plan that establishes the criteria for an individual's discharge from a service and identifies and coordinates delivery of any services needed after discharge.

"Dispense" means to deliver a drug to an ultimate user by or pursuant to the lawful order of a practitioner, including the prescribing and administering, packaging, labeling, or compounding necessary to prepare the substance for that delivery (§ 54.1-3400 et seq. of the Code of Virginia).

"Emergency service" means unscheduled and sometimes scheduled crisis intervention, stabilization, and referral assistance provided over the telephone or face-to-face, if indicated, available 24 hours a day and seven days per week. Emergency services also may include walk-ins, home visits, jail interventions, and preadmission screening activities associated with the judicial process.

"Group home or community residential service" means a congregate service providing 24-hour supervision in a community-based home having eight or fewer residents. Services include supervision, supports, counseling, and training in activities of daily living for individuals whose individualized services plan identifies the need for the specific types of services available in this setting.

"HCBS Waiver" means a Medicaid Home and Community Based Services Waiver.

"Home and noncenter based" means that a service is provided in the individual's home or other noncenter-based setting. This includes noncenter-based day support, supportive in-home, and intensive in-home services.

"Individual" or "individual receiving services" means a current direct recipient of public or private mental health, developmental, or substance abuse treatment, rehabilitation, or habilitation services and includes the terms "consumer," "patient," "resident," "recipient," or "client". When the

term is used in this chapter, the requirement applies to every individual receiving licensed services from the provider.

"Individualized services plan" or "ISP" means a comprehensive and regularly updated written plan that describes the individual's needs, the measurable goals and objectives to address those needs, and strategies to reach the individual's goals. An ISP is person-centered, empowers the individual, and is designed to meet the needs and preferences of the individual. The ISP is developed through a partnership between the individual and the provider and includes an individual's treatment plan, habilitation plan, person-centered plan, or plan of care, which are all considered individualized service plans.

"Informed choice" means a decision made after considering options based on adequate and accurate information and knowledge. These options are developed through collaboration with the individual and the individual's authorized representative, as applicable, and the provider with the intent of empowering the individual and the individual's authorized representative to make decisions that will lead to positive service outcomes.

"Informed consent" means the voluntary written agreement of an individual or that individual's authorized representative to surgery, electroconvulsive treatment, use of psychotropic medications, or any other treatment or service that poses a risk of harm greater than that ordinarily encountered in daily life or for participation in human research. To be voluntary, informed consent must be given freely and without undue inducement; any element of force, fraud, deceit, or duress; or any form of constraint or coercion.

"Initial assessment" means an assessment conducted prior to or at admission to determine whether the individual meets the service's admission criteria; what the individual's immediate service, health, and safety needs are; and whether the provider has the capability and staffing to provide the needed services.

"Inpatient psychiatric service" means intensive 24-hour medical, nursing, and treatment services provided to individuals with mental illness or substance abuse (substance use disorders) in a hospital as defined in § 32.1-123 of the Code of Virginia or in a special unit of a hospital.

"Instrumental activities of daily living" or "IADLs" means meal preparation, housekeeping, laundry, and managing money. A person's degree of independence in performing these activities is part of determining appropriate level of care and services.

"Intellectual disability" means a disability originating before 18 years of age, characterized concurrently by (i) significant subaverage intellectual functioning as demonstrated by performance on a standardized measure of intellectual functioning administered in conformity with accepted professional practice that is at least two standard deviations below the mean and (ii) significant limitations in adaptive behavior as expressed in conceptual, social, and practical adaptive skills.

"Intensity of service" means the number, type, and frequency of staff interventions and other services provided during treatment at a particular level of care.

"Intensive in-home service" means family preservation interventions for children and adolescents who have or are at risk of serious emotional disturbance, including individuals who also have a diagnosis of developmental disability. Intensive in-home service is usually time-limited and is provided typically in the residence of an individual who is at risk of being moved to out-of-home placement or who is being transitioned back home from an out-of-home placement. The service includes 24-hour per day emergency response; crisis treatment; individual and family counseling; life, parenting, and communication skills; and case management and coordination with other services.

"Intermediate care facility/individuals with intellectual disability" or "ICF/IID" means a facility or distinct part of a facility certified by the Virginia Department of Health as meeting the federal

certification regulations for an intermediate care facility for individuals with intellectual disability and persons with related conditions and that addresses the total needs of the residents, which include physical, intellectual, social, emotional, and habilitation, providing active treatment as defined in 42 CFR 435.1010 and 42 CFR 483.440.

"Investigation" means a detailed inquiry or systematic examination of the operations of a provider or its services regarding an alleged violation of regulations or law. An investigation may be undertaken as a result of a complaint, an incident report, or other information that comes to the attention of the department.

"Licensed mental health professional" or "LMHP" means a physician, licensed clinical psychologist, licensed professional counselor, licensed clinical social worker, licensed substance abuse treatment practitioner, licensed marriage and family therapist, certified psychiatric clinical nurse specialist, licensed behavior analyst, or licensed psychiatric/mental health nurse practitioner.

"Location" means a place where services are or could be provided.

"Mandatory outpatient treatment order" means an order issued by a court pursuant to § 37.2-817 of the Code of Virginia.

"Medical evaluation" means the process of assessing an individual's health status that includes a medical history and a physical examination of an individual conducted by a licensed medical practitioner operating within the scope of his license.

"Medically managed intensive inpatient service" or "Level of care 4.0" means an organized service delivered in an inpatient setting, including an acute care general hospital, psychiatric unit in a general hospital, or a freestanding psychiatric hospital. This service is appropriate for individuals whose acute biomedical and emotional, behavioral, and cognitive problems are so severe that they require primary medical and nursing care. Services at this level of care are managed by a physician who is responsible for diagnosis, treatment, and treatment plan decisions in collaboration with the individual.

"Medically monitored intensive inpatient treatment" or "Level of care 3.7" means a substance use treatment program that provides 24-hour care in a facility under the supervision of medical personnel. The care provided includes directed evaluation, observation, medical monitoring, and addiction treatment in an inpatient setting. The care provided may include the use of medication to address the effects of substance use. This service is appropriate for an individual whose subacute biomedical, emotional, behavioral, or cognitive problems are so severe that they require inpatient treatment but who does not need the full resources of an acute care general hospital or a medically managed intensive inpatient treatment program.

"Medication" means prescribed or over-the-counter drugs or both.

"Medication administration" means the legally permitted direct application of medications, as enumerated by § 54.1-3408 of the Code of Virginia, by injection, inhalation, ingestion, or any other means to an individual receiving services by (i) persons legally permitted to administer medications or (ii) the individual at the direction and in the presence of persons legally permitted to administer medications.

"Medication-assisted treatment" or "MAT" means the use of U.S. Food and Drug Administration approved medications in combination with counseling and behavioral therapies to provide treatment of substance use disorders. Medication-assisted treatment includes medications for opioid use disorder as well as medications for treatment of alcohol use disorder.

"Medication error" means an error in administering a medication to an individual and includes when any of the following occur: (i) the wrong medication is given to an individual, (ii) the wrong individual is given the medication, (iii) the wrong dosage is given to an individual, (iv) medication

is given to an individual at the wrong time or not at all, or (v) the wrong method is used to give the medication to the individual.

"Medication for opioid use disorder" or "MOUD" means medications, including opioid agonist medications, approved by the U.S. Food and Drug Administration for the use in the treatment of opioid use disorder.

"Medication storage" means any area where medications are maintained by the provider, including a locked cabinet, locked room, or locked box.

"Member" means an individual who participates in Recovery and Empowerment Center services.

"Mental Health Community Support Service" or "MCHSS" means the provision of recovery-oriented services to individuals with long-term, severe mental illness. MHCSS includes skills training and assistance in accessing and effectively utilizing services and supports that are essential to meeting the needs identified in the individualized services plan and development of environmental supports necessary to sustain active community living as independently as possible. MHCSS may be provided in any setting in which the individual's needs can be addressed, skills training applied, and recovery experienced.

"Mental health intensive outpatient service" means a structured program of skilled treatment services focused on maintaining and improving functional abilities through a time-limited, interdisciplinary approach to treatment. This service is provided over a period of time for individuals requiring more intensive services than an outpatient service can provide and may include individual, family, or group counseling or psychotherapy; skill development and psychoeducational activities; certified peer support services; medication management; and psychological assessment or testing.

"Mental health outpatient service" means treatment provided to individuals on an hourly schedule, on an individual, group, or family basis, and usually in a clinic or similar facility or in another location. Mental health outpatient services may include diagnosis and evaluation, screening and intake, counseling, psychotherapy, behavior management, psychological testing and assessment, laboratory, and other ancillary services, medical services, and medication services. Mental health outpatient service specifically includes:

1. Mental health services operated by a community services board or a behavioral health authority established pursuant to Chapter 5 (§ 37.2-500 et seq.) or Chapter 6 (§ 37.2-600 et seq.) of Title 37.2 of the Code of Virginia;

2. Mental health services contracted by a community services board or a behavioral health authority established pursuant to Chapter 5 (§ 37.2-500 et seq.) or Chapter 6 (§ 37.2-600 et seq.) of Title 37.2 of the Code of Virginia; or

3. Mental health services that are owned, operated, or controlled by a corporation organized pursuant to the provisions of either Chapter 9 (§ 13.1-601 et seq.) or Chapter 10 (§ 13.1-801 et seq.) of Title 13.1 of the Code of Virginia.

"Mental health partial hospitalization service" means time-limited active treatment interventions that are more intensive than outpatient services, designed to stabilize and ameliorate acute symptoms and serve as an alternative to inpatient hospitalization or to reduce the length of a hospital stay. Partial hospitalization is provided through a minimum of 20 hours per week of skilled treatment services focused on individuals who require intensive, highly coordinated, structured, and interdisciplinary ambulatory treatment within a stable environment that is of greater intensity than intensive outpatient, but of lesser intensity than inpatient.

"Mental illness" means, as defined by § 37.2-100 of the Code of Virginia, a disorder of thought, mood, emotion, perception, or orientation that significantly impairs judgment, behavior, capacity

to recognize reality, or ability to address basic life necessities and requires care and treatment for the health, safety, or recovery of the individual or for the safety of others.

"Missing" means a circumstance in which an individual is not physically present when and where he should be and his absence cannot be accounted for or explained by his supervision needs or pattern of behavior.

"Mobile crisis response" means a type of community-based crisis stabilization service that is available 24 hours per day, seven days per week, 365 days per year to provide rapid response, assessment, and early intervention to individuals experiencing a behavioral health crisis. Services are deployed in real time to the location of the individual experiencing a behavioral health crisis. The purpose of this service is to (i) de-escalate the behavioral health crisis and prevent harm to the individual or others; (ii) assist in the prevention of the individual's acute exacerbation of symptoms; (iii) develop an immediate plan to maintain safety; and (iv) coordinate care and linking to appropriate treatment services to meet the needs of the individual.

"Mobile medication-assisted treatment program" or "mobile MAT program" means a MAT operating from a motor vehicle or conveyance that serves as a mobile component to a licensed MAT location registered with the U.S. Drug Enforcement Administration as required by 21 CFR 1301.11 et seq.

"Motivational enhancement" means a person-centered approach that is collaborative, employs strategies to strengthen motivation for change, increases engagement in substance use services, resolves ambivalence about changing substance use behaviors, and supports individuals to set goals to change their substance use.

"Neglect" means, as defined by § 37.2-100 of the Code of Virginia, the failure by a person or a program or facility operated, licensed, or funded by the department, excluding those operated by the Department of Corrections, responsible for providing services to do so, including nourishment, treatment, care, goods, or services necessary to the health, safety, or welfare of an individual receiving care or treatment for mental illness, developmental disabilities, or substance abuse.

"Neurobehavioral services" means the assessment, evaluation, and treatment of cognitive, perceptual, behavioral, and other impairments caused by brain injury that affect an individual's ability to function successfully in the community.

"Office of Human Rights" means the Department of Behavioral Health and Developmental Services Office of Human Rights.

"Opioid treatment practitioner" means a health care professional who is appropriately licensed to prescribe or dispense medications in Virginia for opioid use disorders and, as a result, is authorized to practice within an opioid treatment program.

"Person-centered" means focusing on the needs and preferences of the individual; empowering and supporting the individual in defining the direction for his life; and promoting self-determination, community involvement, and recovery.

"Provider" means, as defined by § 37.2-403 of the Code of Virginia, any person, entity, or organization, excluding an agency of the federal government by whatever name or designation, that delivers (i) services to individuals with mental illness, developmental disabilities, or substance abuse (substance use disorders) or (ii) residential services for individuals with brain injury. The person, entity, or organization shall include a hospital as defined in § 32.1-123 of the Code of Virginia, community services board, behavioral health authority, private provider, and any other similar or related person, entity, or organization. It shall not include any individual practitioner who holds a license issued by a health regulatory board of the Department of Health Professions or who is exempt from licensing pursuant to §§ 54.1-2901, 54.1-3001, 54.1-3501, 54.1-3601, and 54.1-3701 of the Code of Virginia.

"Psychosocial rehabilitation service" means a program of two or more consecutive hours per day provided to groups of adults in a nonresidential setting. Individuals must demonstrate a clinical need for the service arising from a condition due to mental, behavioral, or emotional illness that results in significant functional impairments in major life activities. This service provides education to teach the individual about mental illness, substance abuse, and appropriate medication to avoid complication and relapse and opportunities to learn and use independent skills and to enhance social and interpersonal skills within a consistent program structure and environment. Psychosocial rehabilitation includes skills training, peer support, vocational rehabilitation, and community resource development oriented toward empowerment, recovery, and competency.

"Qualified developmental disability professional" or "QDDP" means a person who possesses at least one year of documented experience working directly with individuals who have a developmental disability and who possesses one of the following credentials: (i) a doctor of medicine or osteopathy licensed in Virginia, (ii) a registered nurse licensed in Virginia, (iii) a licensed occupational therapist, or (iv) completion of at least a bachelor's degree in a human services field, including sociology, social work, special education, rehabilitation counseling, or psychology.

"Qualified mental health professional" or "QMHP" means the same as the term is defined in § 54.1-3500 of the Code of Virginia.

"Qualified mental health professional-trainee" or "QMHP-T" means the same as the term is defined in § 54.1-3500 of the Code of Virginia.

"Qualified paraprofessional in mental health" or "QPPMH" means a person who meets at least one of the following criteria: (i) is registered with the United States Psychiatric Association (USPRA) as an Associate Psychiatric Rehabilitation Provider (APRP); (ii) has an associate degree in a related field (social work, psychology, psychiatric rehabilitation, sociology, counseling, vocational rehabilitation, human services counseling) and at least one year of experience providing direct services to individuals with a diagnosis of mental illness; (iii) is licensed as an occupational therapy assistant, and supervised by a licensed occupational therapist, with at least one year of experience providing direct services to individuals with a diagnosis of mental illness; or (iv) has a minimum of 90 hours classroom training and 12 weeks of experience under the direct personal supervision of a QMHP providing services to individuals with mental illness and at least one year of experience, including the 12 weeks of supervised experience.

"Quality improvement plan" means a detailed work plan developed by a provider that defines steps the provider will take to review the quality of services it provides and to manage initiatives to improve quality. A quality improvement plan consists of systematic and continuous actions that lead to measurable improvement in the services, supports, and health status of the individuals receiving services.

"Recovery" means a journey of healing and transformation enabling an individual with a mental illness to live a meaningful life in a community of his choice while striving to achieve his full potential. For individuals with substance abuse (substance use disorders), recovery is an incremental process leading to positive social change and a full return to biological, psychological, and social functioning. For individuals with a developmental disability, the concept of recovery does not apply in the sense that individuals with a developmental disability will need supports throughout their entire lives although these may change over time. With supports, individuals with a developmental disability are capable of living lives that are fulfilling and satisfying and that bring meaning to themselves and others they know.

"Recovery and Empowerment Center" means evidence-based practices that provide side-by-side engagement between members and staff in supporting restoration of skills in symptom management, interpersonal relationships, communication, problem solving, coping skills, and

community integration for members living with mental illness. Each Recovery and Empowerment Center provider shall allow members opportunities for skills development, improved wellness, and achieving person-centered goals identified in the individualized services plan. Interventions are designed to alleviate emotional or behavioral symptoms associated with a mental illness with the goal of reintegrating the member into the community and increasing social connectedness beyond a clinical setting. Recovery and Empowerment Centers emphasize long-term support and provide a supportive environment for members with serious mental illness to thrive in their recovery journeys, regardless of how long they are engaged in daily activities.

"REACH crisis therapeutic home" or "REACH CTH" means a residential home with crisis stabilization REACH service for individuals with a developmental disability and who are experiencing a mental health or behavior crisis.

"REACH mobile crisis response" means a REACH service that provides mobile crisis response for individuals with a developmental disability and who are experiencing a mental health or behavior crisis.

"Referral" means the process of directing an applicant or an individual to a provider or service that is designed to provide the assistance needed.

"Regional education assessment crisis services habilitation" or "REACH" means the statewide crisis system of care that is designed to meet the crisis support needs of individuals who have a developmental disability and are experiencing mental health or behavior crisis events that put the individuals at risk for homelessness, incarceration, hospitalization, or danger to self or others.

"Residential" or "residential service" means providing 24-hour support in conjunction with care and treatment or a training program in a setting other than a hospital or training center. Residential services provide a range of living arrangements from highly structured and intensively supervised to relatively independent and requiring a modest amount of staff support and monitoring. Residential services include residential treatment, group homes, supervised living, community gero-psychiatric residential, ICF/IID, sponsored residential homes, withdrawal management, and neurobehavioral services.

"Residential crisis stabilization service" means (i) providing short-term, intensive treatment to nonhospitalized individuals who require multidisciplinary treatment in order to stabilize acute psychiatric symptoms and prevent admission to a psychiatric inpatient unit; (ii) providing normative environments with a high assurance of safety and security for crisis intervention; and (iii) mobilizing the resources of the community support system, family members, and others for ongoing rehabilitation and recovery.

"Residential treatment service" means providing an intensive and highly structured clinically based mental health, substance abuse, or neurobehavioral service for co-occurring disorders in a residential setting other than an inpatient service.

"Respite care service" means providing for a short-term, time-limited period of care of an individual for the purpose of providing relief to the individual's family, guardian, or regular caregiver. Persons providing respite care are recruited, trained, and supervised by a licensed provider. These services may be provided in a variety of settings including residential, day support, in-home, or a sponsored residential home.

"Restraint" means the use of a mechanical device, medication, physical intervention, or hands-on hold to prevent an individual receiving services from moving his body to engage in a behavior that places him or others at imminent risk. There are three kinds of restraints:

1. Mechanical restraint means the use of a mechanical device that cannot be removed by the individual to restrict the individual's freedom of movement or functioning of a limb or portion of an individual's body when that behavior places him or others at imminent risk.

2. Pharmacological restraint means the use of a medication that is administered involuntarily for the emergency control of an individual's behavior when that individual's behavior places him or others at imminent risk and the administered medication is not a standard treatment for the individual's medical or psychiatric condition.

3. Physical restraint, also referred to as manual hold, means the use of a physical intervention or hands-on hold to prevent an individual from moving his body when that individual's behavior places him or others at imminent risk.

"Restraints for behavioral purposes" means using a physical hold, medication, or a mechanical device to control behavior or involuntarily restrict the freedom of movement of an individual in an instance when all of the following conditions are met: (i) there is an emergency; (ii) nonphysical interventions are not viable; and (iii) safety issues require an immediate response.

"Restraints for medical purposes" means using a physical hold, medication, or mechanical device to limit the mobility of an individual for medical, diagnostic, or surgical purposes, such as routine dental care or radiological procedures and related post-procedure care processes, when use of the restraint is not the accepted clinical practice for treating the individual's condition.

"Restraints for protective purposes" means using a mechanical device to compensate for a physical or cognitive deficit when the individual does not have the option to remove the device. The device may limit an individual's movement, for example, bed rails or a gerichair, and prevent possible harm to the individual or it may create a passive barrier, such as a helmet to protect the individual.

"Restriction" means anything that limits or prevents an individual from freely exercising his rights and privileges.

"Risk management" means an integrated system-wide program to ensure the safety of individuals, employees, visitors, and others through identification, mitigation, early detection, monitoring, evaluation, and control of risks.

"Root cause analysis" means a method of problem solving designed to identify the underlying causes of a problem. The focus of a root cause analysis is on systems, processes, and outcomes that require change to reduce the risk of harm.

"Screening" means the process or procedure for determining whether the individual meets the minimum criteria for initial assessment.

"Seclusion" means the involuntary placement of an individual alone in an area secured by a door that is locked or held shut by a staff person, by physically blocking the door, or by any other physical means so that the individual cannot leave the area.

"Serious incident" means any event or circumstance that causes or could cause harm to the health, safety, or well-being of an individual. The term "serious incident" includes death and serious injury.

"Level I serious incident" means a serious incident that occurs or originates during the provision of a service or on the premises of the provider and does not meet the definition of a Level II or Level III serious incident. Level I serious incidents do not result in significant harm to individuals but may include events that result in minor injuries that do not require medical attention or events that have the potential to cause serious injury, even when no injury occurs.

"Level II serious incident" means a serious incident that occurs or originates during the provision of a service or on the premises of the provider that results in a significant harm or threat to the health and safety of an individual that does not meet the definition of a Level III serious incident. "Level II serious incident" includes a significant harm or threat to the health or safety of others caused by an individual. Level II serious incidents include:

1. A serious injury;

2. An individual who is or was missing;

3. An emergency room visit;

4. An unplanned psychiatric or unplanned medical hospital admission of an individual receiving services other than licensed emergency services, except that a psychiatric admission in accordance with an individual's wellness plan shall not constitute an unplanned admission for the purposes of this chapter;

5. Choking incidents that require direct physical intervention by another person;

6. Ingestion of any hazardous material; or

7. A diagnosis of:

a. A decubitus ulcer or an increase in severity of level of previously diagnosed decubitus ulcer;

b. A bowel obstruction; or

c. Aspiration pneumonia.

"Level III serious incident" means a serious incident, whether or not the incident occurs while in the provision of a service or on the provider's premises, that results in:

1. Any death of an individual;

2. A sexual assault of an individual; or

3. A suicide attempt by an individual admitted for services, other than licensed emergency services, that results in a hospital admission.

"Serious injury" means any injury resulting in bodily hurt, damage, harm, or loss that requires medical attention by a licensed physician, doctor of osteopathic medicine, physician assistant, or nurse practitioner.

"Service" means, as defined by § 37.2-403 of the Code of Virginia, (i) planned individualized interventions intended to reduce or ameliorate mental illness, developmental disabilities, or substance abuse (substance use disorders) through care, treatment, training, habilitation, or other supports that are delivered by a provider to individuals with mental illness, developmental disabilities, or substance abuse (substance use disorders). Services include outpatient services, intensive in-home services, medication for opioid use disorder treatment services, inpatient psychiatric hospitalization, community gero-psychiatric residential services, assertive community treatment and other clinical services; day support, day treatment, partial hospitalization, psychosocial rehabilitation, and habilitation services; case management services; and supportive residential, special school, halfway house, in-home services, crisis stabilization, and other residential services; and (ii) planned individualized interventions intended to reduce or ameliorate the effects of brain injury through care, treatment, or other supports provided in residential services for persons with brain injury.

"Shall" means an obligation to act is imposed.

"Shall not" means an obligation not to act is imposed.

"Signed" or "signature" means a handwritten signature, an electronic signature, or a digital signature, as long as the signer showed clear intent to sign.

"Skills training" means systematic skill building through curriculum-based psychoeducational and cognitive-behavioral interventions. These interventions break down complex objectives for role performance into simpler components, including basic cognitive skills such as attention, to facilitate learning and competency.

"Sponsored residential home" means a service where providers arrange for, supervise, and provide programmatic, financial, and service support to families or persons (sponsors) providing care or treatment in their own homes for individuals receiving services.

"State opioid treatment authority" or "SOTA" means the Virginia Department of Behavioral Health and Developmental Services, which is authorized by the federal Center for Substance Abuse Treatment to exercise the responsibility and authority for governing the treatment of opioid use disorder with MOUD.

"Substance abuse (substance use disorders)" means, as defined by § 37.2-100 of the Code of Virginia, the use of drugs enumerated in the Virginia Drug Control Act (§ 54.1-3400 et seq.) without a compelling medical reason or alcohol that (i) results in psychological or physiological dependence or danger to self or others as a function of continued and compulsive use or (ii) results in mental, emotional, or physical impairment that causes socially dysfunctional or socially disordering behavior; and (iii), because of such substance abuse, requires care and treatment for the health of the individual. This care and treatment may include counseling, rehabilitation, or medical or psychiatric care.

"Substance abuse intensive outpatient service" or "Level of care 2.1" means structured treatment provided to individuals who require more intensive services than is normally provided in an outpatient service but do not require inpatient services. Treatment consists primarily of counseling and education about addiction-related and mental health challenges delivered a minimum of nine to 19 hours of services per week for adults or six to 19 hours of services per week for children and adolescents. Within this level of care an individual's needs for psychiatric and medical services are generally addressed through consultation and referrals.

"Substance abuse outpatient service" or "Level of care 1.0" means a center-based substance abuse treatment delivered to individuals for fewer than nine hours of service per week for adults or fewer than six hours per week for adolescents on an individual, group, or family basis. Substance abuse outpatient services may include diagnosis and evaluation, screening and intake, counseling, psychotherapy, behavior management, psychological testing and assessment, laboratory and other ancillary services, medical services, and medication services. Substance abuse outpatient service includes substance abuse services or an office practice that provides professionally directed aftercare, individual, and other addiction services to individuals according to a predetermined regular schedule of fewer than nine contact hours a week. Substance abuse outpatient service also includes:

1. Substance abuse services operated by a community services board or a behavioral health authority established pursuant to Chapter 5 (§ 37.2-500 et seq.) or Chapter 6 (§ 37.2-600 et seq.) of Title 37.2 of the Code of Virginia;

2. Substance abuse services contracted by a community services board or a behavioral health authority established pursuant to Chapter 5 (§ 37.2-500 et seq.) or Chapter 6 (§ 37.2-600 et seq.) of Title 37.2 of the Code of Virginia; or

3. Substance abuse services that are owned, operated, or controlled by a corporation organized pursuant to the provisions of either Chapter 9 (§ 13.1-601 et seq.) or Chapter 10 (§ 13.1-801 et seq.) of Title 13.1 of the Code of Virginia.

"Substance abuse partial hospitalization services" or "Level of care 2.5" means a short-term, nonresidential substance use treatment program provided for a minimum of 20 hours a week that uses multidisciplinary staff and is provided for individuals who require a more intensive treatment experience than intensive outpatient treatment but who do not require residential treatment. This level of care is designed to offer highly structured intensive treatment to those individuals whose condition is sufficiently stable so as not to require 24-hour-per-day monitoring and care, but whose illness has progressed so as to require consistent near-daily treatment intervention.

"Suicide attempt" means a nonfatal, self-directed, potentially injurious behavior with an intent to die as a result of the behavior regardless of whether it results in injury.

"Supervised living residential service" means the provision of significant direct supervision and community support services to individuals living in apartments or other residential settings.

These services differ from supportive in-home service because the provider assumes responsibility for management of the physical environment of the residence, and staff supervision and monitoring are daily and available on a 24-hour basis. Services are provided based on the needs of the individual in areas such as food preparation, housekeeping, medication administration, personal hygiene, treatment, counseling, and budgeting.

"Supportive in-home service" (formerly supportive residential) means the provision of community support services and other structured services to assist individuals, to strengthen individual skills, and that provide environmental supports necessary to attain and sustain independent community residential living. Services include drop-in or friendly-visitor support and counseling to more intensive support, monitoring, training, in-home support, respite care, and family support services. Services are based on the needs of the individual and include training and assistance. These services normally do not involve overnight care by the provider; however, due to the flexible nature of these services, overnight care may be provided on an occasional basis.

"Systemic deficiency" means violations of regulations documented by the department that demonstrate multiple or repeat defects in the operation of one or more services.

"Telehealth" shall have the same meaning as "telehealth services" in § 32.1-122.03:1 of the Code of Virginia.

“Telemedicine" shall have the same meaning as "telemedicine services" in § 38.2-3418.16 of the Code of Virginia.

"Therapeutic day treatment for children and adolescents" means a treatment program that serves (i) children and adolescents from birth through 17 years of age and under certain circumstances up to 21 years of age with serious emotional disturbances, substance use, or co-occurring disorders or (ii) children from birth through seven years of age who are at risk of serious emotional disturbance, in order to combine psychotherapeutic interventions with education and mental health or substance abuse treatment. Services include: evaluation; medication education and management; opportunities to learn and use daily living skills and to enhance social and interpersonal skills; and individual, group, and family counseling.

"Time out" means the involuntary removal of an individual by a staff person from a source of reinforcement to a different, open location for a specified period of time or until the problem behavior has subsided to discontinue or reduce the frequency of problematic behavior.

"Volunteer" means a person who, without financial remuneration, provides services to individuals on behalf of the provider.

"Work-ordered day" means the structure of day-to-day activity within Recovery and Empowerment Center services. A work-ordered day means that members collaborate with staff as colleagues to perform critical tasks for the Recovery and Empowerment Center community. Members and staff share responsibility for running every aspect of the Recovery and Empowerment Center environment, such as filing, maintenance, and participation in consensus-based decision-making regarding all important matters related to the Recovery and Empowerment Center operations.

"Withdrawal management" means the dispensing of MOUD in decreasing doses to an individual to alleviate adverse physical effects incident to withdrawal from the continuous or sustained use of an opioid and as a method of bringing the individual to an opioid-free state within such a period. Long-term withdrawal management refers to the process of medication tapering that exceeds 30 days.

"Written," "writing," and "in writing" include any representation of words, letters, symbols, numbers, or figures, whether (i) printed or inscribed on a tangible medium or (ii) stored in an electronic or other medium and retrievable in a perceivable form and whether an electronic

signature authorized by Chapter 42.1 (§ 59.1-479 et seq.) of Title 59.1 of the Code of Virginia is or is not affixed.

12VAC35-105-30. Licenses.

A. Licenses are issued to providers who offer services to individuals who have mental illness, a developmental disability, or substance abuse (substance use disorders) or have brain injury and are receiving residential services.

B. Providers shall be licensed to provide specific services as defined in this chapter or as determined by the commissioner. These services include:

1. Assertive community treatment (ACT);
2. Case management;
3. Clinically managed high-intensity residential care or Level of care 3.5;
4. Clinically managed low-intensity residential care or Level of care 3.1;
5. Clinically managed population specific high-intensity residential or Level of care 3.3;
6. Community gero-psychiatric residential;
7. Community-based crisis stabilization;
8. Crisis receiving center;
9. Crisis stabilization unit;
10. Day support;
11. Day treatment, including therapeutic day treatment for children and adolescents;
12. Group home and community residential;
13. ICF/IID;
14. Inpatient psychiatric;
15. Intensive in-home;
16. Medically managed intensive inpatient service or Level of care 4.0;
17. Medically monitored intensive inpatient treatment or Level of care 3.7;
18. Medication for opioid use disorder treatment;
19. Mental health community support;
20. Mental health intensive outpatient;
21. Mental health outpatient;
22. Mental health partial hospitalization;
23. Psychosocial rehabilitation;
24. REACH CTH;
25. REACH mobile crisis response;
26. Recovery and Empowerment Center;
~~26.~~27. Residential treatment;
~~27.~~28. Respite care;
~~28.~~29. Sponsored residential home;
~~29.~~30. Substance abuse intensive outpatient;
~~30.~~31. Substance abuse outpatient;
~~31.~~32. Substance abuse partial hospitalization;
~~32.~~33. Supervised living residential; and
~~33.~~34. Supportive in-home.

C. A license addendum shall describe the services licensed, the disabilities of individuals who may be served, the specific locations where services are to be provided or administered, and the terms and conditions for each service offered by a licensed provider. For residential and inpatient services, the license identifies the number of individuals each residential location may serve at a given time.

Article 2

Recovery and Empowerment Center

12VAC35-105-1055. Admission.

Before a Recovery and Empowerment Center provider may admit a member to the service, the member shall meet the criteria for admission as defined by this chapter and the provider's policies. The policy regarding admission to a Recovery and Empowerment Center shall at a minimum meet the requirements of 12VAC35-105-650 and the assessment by that section shall:

1. Be completed face-to-face by a LMHP, LMHP-R, LMHP-S, or LMHP-RP no more than 12 months prior to admission. Assessments completed by a LMHP-R, LMHP-S, or LMHP-RP require a co-signature by a LMHP. Assessments completed more than 30 days prior to admission shall be reviewed and confirmed for accuracy by an LMHP prior to admission.

2. Document a DSM diagnosis that is consistent with a serious mental illness.

3. Document that the member does not pose a significant and current threat to the general safety of the Recovery and Empowerment Center community.

12VAC35-105-1060. Discharge.

Before a Recovery and Empowerment Center provider may discharge a member, the member shall meet the criteria for discharge as defined by this chapter and the provider's policies, which shall meet all the requirements of 12VAC35-105-693. The provider's policy regarding discharge shall require the member meet one of the following requirements:

1. The member no longer meets admission criteria.

2. The member has successfully met the specific goals outlined in the treatment plan for discharge.

3. The member requires a more intensive level of care or service.

4. The member is no longer engaged in the service, despite multiple attempts on the part of the provider to engage the member.

5. The member no longer needs the service.

6. The member chooses to discharge.

12VAC35-105-1070. Service delivery.

A Recovery and Empowerment Center shall meet the following programmatic requirements:

1. General. The Recovery and Empowerment Center shall be member-run with voluntary participation.

a. Reassessments shall be performed annually until discharge.

b. Service planning shall be conducted in collaboration with the member by a LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP, or QMHP-T.

c. The program shall create and implement an outreach policy to contact members who are not attending.

2. Crisis support. Crisis support shall include the development of a crisis mitigation plan and connecting the member to other behavioral health services.

a. Crisis support shall be available in person during Recovery and Empowerment Center hours of operation.

b. At least one staff person qualified to provide crisis support shall be available in-person during all program hours to respond to onsite member crises without delay.

3. Work-ordered day. The Recovery and Empowerment Center shall be open at a minimum five days a week for five hours each day and shall offer a schedule of structured activities.

a. The provider shall establish a policy governing how the Recovery and Empowerment Center will offer and support a work-ordered day. The policy shall specify the work units and associated activities the provider will offer to carry out the work of the Recovery Empowerment Center which may include administration, governance, programming, physical site maintenance, food service, human resources, and center development.

b. Work shall be generated exclusively by the Recovery and Empowerment Center. Work for outside individuals and agencies shall not be permitted except through the offered employment programs.

c. Members shall not be paid for Recovery and Empowerment Center work. There shall not be artificial reward systems for Recovery and Empowerment Center work.

d. The Recovery and Empowerment Center shall be organized into one or more work units. Unit meetings shall be held to organize and plan the work of the day.

4. Transitional employment. The Recovery and Empowerment Center provider shall offer a transitional employment program to provide opportunities for members to experience job placements in the labor market.

a. The Recovery and Empowerment Center shall not provide employment to members through in-house businesses, segregated Recovery and Empowerment Center enterprises, or sheltered workshops.

b. The Recovery and Empowerment Center shall establish a policy documenting how the provider will encourage and support attendance, address member absences, and ensure coverage of all placements.

c. Placement opportunities shall continue to be available regardless of the level of success in previous placements.

d. There shall be no transitional employment placements within the Recovery and Empowerment Center. Members shall attend and participate at the employer's place of business.

e. Members shall be paid the prevailing wage rate but at least minimum wage, directly by the employer.

5. Supported and independent employment. The Recovery and Empowerment Center provider shall offer a supported employment program.

a. Within the supported employment program, staff shall maintain and document a relationship with the member and the member's employer.

b. Members and staff shall work in partnership to determine and document the type, frequency, and location of desired supports.

6. Supportive education. The Recovery and Empowerment Center provider shall establish a policy regarding supportive education. The policy shall:

a. Document how the provider will support members in taking advantage of educational opportunities in the community; and

b. State whether the provider will offer an in-house education program. If the provider does provide an in-house education program, the policy must describe how the program will utilize the teaching and tutoring skills of the Recovery and Empowerment Center's members.

7. Rehabilitative skill building. Rehabilitative skill building shall be provided in person by a LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP, QMHP-T, BHT, or RPRS. Rehabilitative skill building will assist members with learning the skills necessary to seek and obtain employment, to pursue their educational goals, to find housing opportunities, and to reintegrate into their community.

8. Care coordination. Care coordination shall be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP, QMHP-T, or RPRS.

12VAC35-105-1080. Staffing requirements.

A Recovery and Empowerment Center provider shall meet the following minimum position requirements:

1. A full-time program director who is a LMHP, LMHP-R, LMHP-RP, LMHP-S, or QMHP. The program director shall complete Clubhouse International training or a substantially equivalent program approved by DBHDS in evidence-based practices that support high-fidelity psychosocial rehabilitation services.

2. Additional staff as appropriate to meet the needs of individuals served. Additional staff may include LMHPs, LMHP-Rs, LMHP-RPs, LMHP-Ss, QMHPs, QMHP-Ts, PRSs, and BHTs.

3. The Recovery and Empowerment Center program director, staff, members, and other appropriate persons shall participate in a Recovery and Empowerment Center training program.

12VAC35-105-1090. Physical environment.

A. The Recovery and Empowerment Center shall have its own physical space. The Recovery and Empowerment Center space shall be separate and distinct from all other provider services.

B. The Recovery and Empowerment Center shall have an administrative office which houses personnel and member records. Due to confidentiality requirements the administrative office shall only be accessible to staff.

C. Every other area of the Recovery and Empowerment Center shall be accessible to all members and staff.

D. The Recovery and Empowerment Center shall have spaces which can provide privacy when needed.

REGULATORY ACTIVITY STATUS REPORT

	VAC CITATION Chapter and Title	SHORT DESCRIPTION	Action Summary	Regulatory Stage	Current Status
RECENT/UPCOMING ACTIONS					
1	Chapter 115 (12VAC35-115): Regulations to Assure the Rights of Individuals	Updates to Human Rights Regulations; conform to Health Care Decisions Act	Amendments to improve the ability of the Office of Human Rights to protect individuals receiving services; also makes necessary updates to align with Code of Virginia where applicable.	**Proposed** *filing deadline 12/28/2026*	*NOIRA ended 7/1/2026*
2	Chapter 105 (12VAC35-105): Provider Licensing Regulations	MOUD Central Registry	Mandatory participation by medication for opioid use disorder (MOUD) treatment service providers in a central registry.	**NOIRA**	**PENDING BOARD ACTION**
UNDER EXECUTIVE BRANCH REVIEW					
Governor's Office					
1	Chapter 105 (12VAC35-105): Provider Licensing Regulations	Alignment with Medicaid behavioral health redesign: CPST	Pursuant to 2024-2026 Appropriation Act, aligns Licensing Regulations with modifications made by DMAS to Medicaid behavioral health services for Community Psychiatric Support and Treatment (CPST).	**Emergency/ NOIRA** *Sept. 2025 Board Vote*	HHR approved 5/12/26 *DPB approved 4/17/26; OAG certified 3/23/26*
Secretary's Office					
1	Chapter 105 (12VAC35-105): Provider Licensing Regulations	Mandatory reporting of previous negative actions by applicants	Pursuant to HB 597 (2020), incorporates statutory requirements for initial provider applicants to report prior disciplinary or other negative actions.	**Fast-Track** *July 2024 Board Vote*	DPB approved 5/5/25 *OAG certified 3/17/25*
2	Chapter 105 (12VAC35-105): Provider Licensing Regulations	Mandatory valid discharge plans by substance abuse treatment facilities	Pursuant to HB 434 (2024), incorporates additional statutory requirement for substance use disorder treatment facilities upon discharging an individual from services or when an individual withdraws from a program.	**Fast-Track** *Sept. 2024 Board Vote*	DPB approved 5/2/25 *OAG certified 3/17/25*
3	Chapter 105 (12VAC35-105): Provider Licensing Regulations	Alignment with Medicaid behavioral health redesign: CSC	Pursuant to 2024-2026 Appropriation Act, aligns Licensing Regulations with modifications made by DMAS to Medicaid behavioral health services for Coordinated Specialty Care (CSC).	**Emergency/ NOIRA** *April 2026 Board Vote*	DPB approved 6/12/26 *OAG certified 5/1/26*
4	Chapter 105 (12VAC35-105): Provider Licensing Regulations + Chapter 250 (12VAC35-250): Peer Recovery Specialists	Mandatory Peer Recovery Specialist-Trainee (PRS-T) designation	Pursuant to 2024-2026 Appropriation Act, creates a trainee designation to allow individuals to bill for services while working on the 500 hours of experience necessary for full Peer Recovery Specialist certification.	**Emergency/ NOIRA** *Sept. 2025 Board Vote*	DPB approved 5/11/26 OAG certified 3/23/26

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5	Chapter 105 (12VAC35-105): Provider Licensing Regulations	Technical and clarifying revisions for crisis services	Reduces administrative burden, clarifies provisions, and makes technical amendments to newly implemented crisis services regulations.	**Fast-Track** *July 2025 Board Vote*	DPB approved 5/2/26 OAG certified 3/23/26
6	Chapter 105 (12VAC35-105): Provider Licensing Regulations + Chapter 46 (12VAC35-46): Regulations for Children's Residential Facilities	Amendments to align with VDH Regulations	Technical and clarifying amendments to reflect current practice and update outdated references.	**Fast-Track** *April 2025 Board Vote*	DPB approved 5/1/26 OAG certified 3/20/26
7	Chapter 105 (12VAC35-105): Provider Licensing Regulations	Alignment with Medicaid behavioral health redesign: REC	Pursuant to 2024-2026 Appropriation Act, aligns Licensing Regulations with modifications made by DMAS to Medicaid behavioral health services for Recovery and Empowerment Center (REC).	**Emergency/ NOIRA** *Dec. 2025 Board Vote*	DPB approved 4/27/26 OAG certified 3/23/26
	Office of Attorney General				
1	Chapter 105 (12VAC35-105): Provider Licensing Regulations + Chapter 46 (12VAC35-46): Regulations for Children's Residential Facilities	Regulatory Restructuring Seven actions: 1. General Chapter 2. Residential 3. NonCenter-Based 4. Center-Based 5. Crisis Services 6. Case Management 7. Repeal and replace	Appliable provisions of existing licensing regulations are reenacted within a new "umbrella" General Chapter and five service-specific chapters, with corrections, streamlining, and strengthening of regulations where appropriate. (Seventh action repeals current chapters when newly restructured chapters become effective.)	**Proposed** *Dec. 2025 Board Vote*	Submitted to OAG 12/17/25

State Board of Behavioral Health and Developmental Services

PROPOSED MEETING PLAN FOR FISCAL YEAR 2027

Bylaws Article V. Section 1:
The Board at its first regular meeting following the beginning of the state fiscal year shall adopt an annual meeting schedule.

QUARTERLY MEETING DATE	LOCATION
2026	
Wednesday, April 22, 2026	Northern Virginia Mental Health Institute – Falls Church
Wednesday, July 15, 2026	~~Piedmont Geriatric Hospital/VCBR~~ DBHDS Central Office – Richmond
Wednesday, September 23, 2026	Piedmont Geriatric Hospital/VCBR – Burkeville *Last visited Sept. 2023*
Wednesday, December 9, 2026	DBHDS Central Office – Richmond
2027	
Wednesday, April 21, 2027	Southwestern Virginia Mental Health Institute – Marion *(last visited March 2023)*
Wednesday, July 14, 2027 **TENTATIVE Biennial Planning meeting at DBHDS on Tuesday, July 13, 2027**	Central State Hospital/HWDMC – Petersburg *Last visited July 2023*
FALL *Date TBD*	Catawba Hospital – Roanoke *Last visited April 2024*
WINTER *Date TBD*	DBHDS Central Office – Richmond
2028	
SPRING *Date TBD*	Eastern State Hospital – Williamsburg *Last visited July 2024*
SUMMER *Date TBD*	Southern Virginia Mental Health Institute – Danville *Last visited September 2024*
FALL *Date TBD*	Western State Hospital/CCWA – Staunton *Last visited April 2025*
WINTER *Date TBD*	DBHDS Central Office – Richmond

NOTE: For quarterly meetings held outside the Richmond Metro area, Board members should plan to arrive the day before to participate in late afternoon/early evening community events on Tuesday.

Tanelka Goldman
State Human Rights Director
Tanelka.Goldman@dbhds.virginia.gov

Office of Human Rights
1220 Bank Street
Richmond, VA 23219

P.O. Box 1797
Richmond, VA 23218

www.dbhds.virginia.gov

COMMONWEALTH of VIRGINIA

Department of Behavioral Health and Developmental Services
Post Office Box 1797
Richmond, Virginia 23218-1797

DARYL WASHINGTON, LCSW, COMMISSIONER

June 26, 2026

R. Blake Andis, Chair
State Board of Behavioral Health and Developmental Services
Post Office Box 1797
Richmond, Virginia 23218

Dear Chair Andis:

On May 21, and June 25, 2026, the State Human Rights Committee (SHRC) voted to recommend the appointment of Valjean M. Roberts and the reappointment of Renee F. Valdez and John B. Shepherd respectively.

Mr. Roberts holds a bachelor's degree in Science-Psychology from Christopher Newport College and a master's degree in Social Work from Norfolk State University. He has over three decades of distinguished service with the Commonwealth of Virginia, culminating in his role as Chief Executive Officer of the Central Virginia Training Center in 2020. Mr. Roberts has demonstrated a long-standing commitment to civic engagement through volunteerism with organizations like the Newport News Advisory Committee on Disabilities; Goodwill Industries of Tidewater; and the Virginia Association of Nonprofit Homes for the Aging, where he contributed expertise to advocacy, program development, and community outreach. He has over a dozen years of germane experience as a member of several Local Human Rights Committees (LHRC). His extensive administrative and clinical background rooted in ethical governance, human rights, and the advancement of quality care within public institutions is well suited for the SHRC. If appointed, he would serve in the role of a Professional fulfilling the Virginia Code mandate per §37.2-204 for SHRC members with "interest, knowledge and training in the mental health, developmental, or substance abuse services field". Mr. Roberts resides in Smithfield.

Ms. Valdez has worked in behavioral health in various capacities since 1985 and retired from American Systems, Inc. where she was an Independent Consultant in Workforce Training and Development. She has extensive experience working with at-risk youth, HIV/AIDS prevention, long-term care and post-secondary education, in addition to prior service at the LHRC level. As an individual with lived experience she fulfills the Virginia Code mandate to have at least two individuals who are "receiving or who have received public or private mental health, developmental, or substance abuse treatment or habilitation services".

Mr. Shepherd was previously employed as an Adult Protective Services worker and Medicaid Eligibility worker with the Albemarle County Department of Social Services. He has widespread experience interpreting regulations as a Zoning Official and Board of Zoning Appeals member, and has served on the Board of Children, Youth and Family Services Inc. and the Oakland School. Mr. Shepherd is a former member and Chairperson of several LHRC's and has satisfied the Virginia Code mandate for remaining appointments to include other professionals who "have interest, knowledge and training in the mental health, developmental, or substance abuse services field".

The SHRC respectfully requests that Mr. Valjean M. Roberts be appointed to serve in his first term, and that Ms. Renee F. Valdez and Mr. John B. Shepherd be reappointed to serve a second term effective July 1, 2026, to June 30, 2029. On behalf of the State Human Rights Committee, I respectfully ask that you consider these appointments at your July 15, 2026, Board meeting. Applications and a current SHRC roster are attached for your review. Thank you for your consideration.

Respectfully submitted,

Will Childers, Chairperson
State Human Rights Committee

c: Taneika Goldman, State Human Rights Director

State Human Rights Committee
Department of Behavioral Health and Developmental Services

Chair **Will Childers** Hardy Region 3 Appointed July 2018 7/1/2017 – 6/30/2020 Vacancy 7/1/2020 - 6/30/2023 Term 1 7/1/2023 - 6/30/2026 Term 2 →Professional	**Vice-Chair** **Betty Crance** Fincastle Region 1 Appointed March 2022 7/1/2021 – 6/30/2024 Vacancy 7/1/2024 – 6/30/2027 Term 1 → Family Member/Healthcare Provider	**John B. Shepherd** Charlottesville Region 1 Appointed June 2023 7/1/2023 – 6/30/2026 Term 1 →Professional
Renee F. Valdez Alexandria Region 2 Appointed June 2023 7/1/2023 – 6/30/2026 Term 1 →Individual	**Christopher Olivo** Yorktown Region 5 Appointed September 2024 7/1/2024 – 6/30/2027 Vacancy → Family Member	**D. Bruce Ellsworth** Crozet Region 1 Appointed April 2025 7/1/2024 – 6/30/2027 Vacancy → Professional
Kimberly Hunt Roanoke Region 3 Appointed April 2025 7/1/2024 – 6/30/2027 Vacancy → Individual/Healthcare Provider	**Betsy Lang** Hampton Region 5 Appointed September 2025 7/1/2025 – 6/30/2028 Vacancy → Healthcare Provider	

State Human Rights Committee
C/o Taneika Goldman, State Human Rights Director
P.O. Box 1797
Richmond, VA 23218

Fax: 804-371-4609
www.dbhds.virginia.gov
shrc@dbhds.virginia.gov

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§ 37.2-204. Appointments to state and local human rights committees

The Board shall appoint a state human rights committee that shall appoint local human rights committees to address alleged violations of human rights of individuals receiving services. One-third of the appointments made to the state or local human rights committees shall be individuals who are receiving or who have received services or family members of such individuals, with at least two individuals who are receiving or who have received public or private mental health, developmental, or substance abuse treatment or habilitation services within five years of the date of their initial appointment on each committee. In addition, at least one appointment to the state and each local human rights committee shall be a health care provider. Remaining appointments shall include lawyers and persons with interest, knowledge, or training in the mental health, developmental, or substance abuse services field. No current employee of the Department, a community services board, or a behavioral health authority shall serve as a member of the state human rights committee. No current employee of the Department, a community services board, a behavioral health authority, or any facility, program, or organization licensed or funded by the Department or funded by a community services board or behavioral health authority shall serve as a member of any local human rights committee that serves an oversight function for the employing facility, program, or organization.

1999, c. 969, § 37.1-84.3; 2001, c. 453;2005, cc. 201, 716;2012, cc. 476, 507.

The chapters of the acts of assembly referenced in the historical citation at the end of this section(s) may not constitute a comprehensive list of such chapters and may exclude chapters whose provisions have expired.

State Board of Behavioral Health and Developmental Services

DRIVING DIRECTIONS

DBHDS Central Office, Jefferson Building
1220 Bank Street, Richmond, VA 23219

! The Jefferson Building is located on the southeast corner of Capitol Square, at the intersection of 13th/Governor Street and Bank Street.

! View maps of Capitol Square or public parking lots.

FROM I-64 EAST OR WEST OF RICHMOND:

- Following I-64, get onto I-95 South and continue toward downtown
- Take **Exit 74B**, Franklin Street
- Turn right onto Franklin Street
- Go through the next intersection at 14th Street (Franklin Street becomes Bank Street)
    - Look for on-street meter parking on 14th or Main Street
    - If you do not find street parking, other parking options are available

FROM I-95 NORTH OF RICHMOND:

- Follow I-95 South toward downtown Richmond
- Take **Exit 74B**, Franklin Street
- Turn right onto Franklin Street
- Go through the next intersection at 14th Street (Franklin Street becomes Bank Street)
    - Look for on-street meter parking on 14th or Main Street
    - If you do not find street parking, other parking options are available

FROM I-95 SOUTH OF RICHMOND:

- Follow I-95 North toward downtown Richmond
- Cross the bridge over the James River
- Take **Exit 74C** on your right (17th Street is one-way) and continue to Broad Street
- Turn right onto Broad Street
- Turn left onto 14th Street at the first light after crossing over I-95
- Turn right onto Franklin Street
- Go through the next intersection at 14th Street (Franklin Street becomes Bank Street)
    - Look for on-street meter parking on 14th or Main Street
    - If you do not find street parking, other parking options are available

If you have questions about the information in this meeting packet,
contact Mary Broz Vaughan at mary.broz-vaughan@dbhds.virginia.gov or 804-903-1390.