VIRGINIA
COUNCIL
ON
Women

Executive Recommendations 2023

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2022-2023 Virginia Council on Women

Members

- Ashley Reynolds Marshall, M.P.A., J.D.
- Mary Kate Andris, Ed.D.
- Heather Caputo
- Katrina L. Chase, Ph.D.
- Pastor Valerie R. Coley
- Anh Tu Do
- Kristina Hagen
- Courtney Hill
- Aisha Johnson
- Alencia Johnson
- Elizabeth J. Level
- Georganne W. Long, M.D.
- Joely K. Mauck
- Aesha Mehta
- Karishma Merchant
- Marisol Morales-Diaz
- Kara Moran
- Teresa Pregnall
- Honorable Donna Price
- Honorable Erin Rayner
- Honorable Nikki Thacker
- Brigitta Toruno
- Advisory Member: Kelley Powell

Ex Officio Members

- The Honorable Kay Cole James, Secretary of the Commonwealth

Administration

- Ms. Suzanne M. Holland, Special Assistant for Advisory Board Administration
- Ms. Gloria Senecal, Director of Board Administration

2023-2024 Virginia Council on Women

Members

- Ashley Reynolds Marshall, M.P.A., J.D.
- Mary Kate Andris, Ed.D.
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- Honorable Donna Price
- Honorable Erin Rayner
- Honorable Nikki Thacker
- Advisory Member: Kelley Powell

Ex Officio Members

- The Honorable Kay Cole James, Secretary of the Commonwealth
- The Honorable Kelly Gee, Secretary of the Commonwealth

Administration

- Ms. Gloria Senecal, Director of Board Administration
- Ms. Emma Williams Jensen, Director of Advisory Board Administration

About the Virginia Council on Women

The Virginia Council on Women (Council) is established by § 2.2-2630 as an advisory council in the Executive branch of state government. The purpose of the Council is to identify ways in which women can reach their full potential and make their full contribution to society and the Commonwealth.

The Council consists of eighteen or more members from around the state, who are appointed by the Governor, as well as one of the Governor's Secretaries who serves as an ex-officio member with full voting privileges. Members serve a term up to a term of four years and may be reappointed up to two terms. Over the past several years, the Council has focused its efforts on engaging and empowering women through STEM, healthcare, support in the workforce, and convening.

Purpose

1. Determine the studies and research to be conducted by the Council;
2. Collect and disseminate information regarding the status of women in the Commonwealth and the nation;
3. Advise the Governor, General Assembly and the Governor's Secretaries on matters pertaining to women in the Commonwealth and the nation;
4. Establish and award scholarships pursuant to regulations and conditions prescribed by the Council;
5. Review and comment on all budgets, appropriation requests and grant applications concerning the Council, prior to their submission to the Secretary of Health and Human Resources or the Governor; and
6. Develop programs and projects on matters pertaining to women in the Commonwealth and the nation through public-private partnerships.

The Council focuses its work on four key areas that are important to the prosperity of women and girls in the Commonwealth. Board members serve on committees to help advance these areas.

Committees

Civic Engagement Subcommittee

The Civic Engagement Subcommittee assesses the engagement of the adults and children in the Commonwealth who identify as women in the areas of public services and programs, voter engagement, and civic participation. We explore the barriers to awareness and access for women & girls, as well as improving communication between the Administration, service and program providers, and our disparate communities.

- 2021-2022 Chairwoman: **Secretary Aisha Johnson**
- 2021-2022 Chairwoman: **Courtney Hill & Kelley Powell**
  2022-2023 Chairwoman: **Kelley Powel & Joely Mauck**

Education Equity Subcommittee

The Education Equity Subcommittee, formerly known as the Science, Technology, Engineering, and Mathematics (STEM) Initiative Subcommittee, is focused on ensuring that the adults and children in the Commonwealth who identify as women have fair and inclusive opportunities across the spectrum of educational opportunities. The subcommittee's most notable contribution is their annual STEAM-H Essay Contest which began in 2012 under Governor Bob McDonnell's administration. The contest awards high school seniors who identify as women and wish to pursue STEAM-H majors and careers with scholarships to aid with their tuition at higher education institutions, including four-year colleges and universities, community colleges, and career and technical schools in the Commonwealth and throughout the United States. The Council has awarded more than $150,000 in scholarships.

- STEAM-H Essay Contest: Each year the Virginia Council on Women (Council) will provide two merit-based and need-based scholarships in each of five geographic regions across the Commonwealth. Award amounts may vary and are determined by the Council annually.
  - 2021-2022 Chairwoman: **Da'Shaun Joseph**
  - 2022-2023 Chairwoman: **Vice Chair Kristina Hagen**

Healthcare Equity Subcommittee

The Health Equity Subcommittee, formerly the Healthcare Initiative Subcommittee, works to ensure that all adults and children in the Commonwealth who identify as women have fair, inclusive, and culturally competent holistic healthcare access in the Commonwealth of Virginia. The subcommittee develops recommendations on what the state government can achieve to improve access to quality healthcare for women, girls, citizens who identify as women, and families across the state since its establishment in August 2013.

- 2021-2022 Chairwoman: **Diana Gates**
- 2022-2023 Chairwoman: **Kara Moran**

Workforce Equity Subcommittee

The Workforce Equity Subcommittee, established by the Council in 2020, is committed to creating and cultivating a fair, inclusive, and just workforce for all adults and children in the Commonwealth who identify as women. The increased amplification and elevation of diverse women will be achieved in several ways, including through partnerships and mentorship programs to ensure women have access to fair wage employment, entrepreneurial opportunities, employer or quality self-paid healthcare, quality multi-shift childcare, and pay equity.

- 2021-2022 Chairwomen: **Ramunda Lark-Young & Brigitta Toruñ**
- 2022-2023 Chairwomen: **Secretary Aisha Johnson & Karisma Merchant**

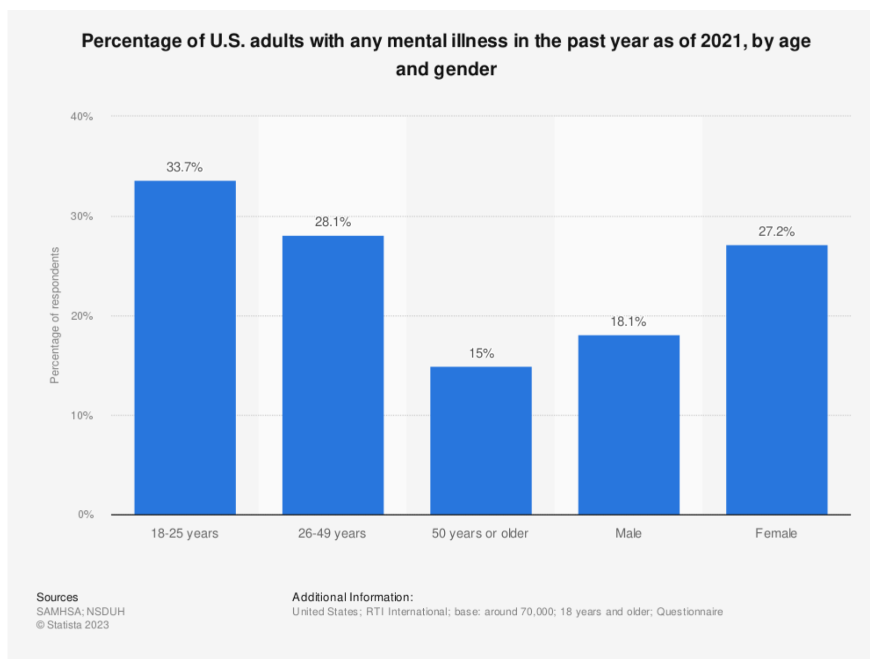
Executive Summary

Pursuant to Section 2.2-2630 of the Code of Virginia, the Virginia Council on Women (VCW) is pleased to submit to the Honorable Glenn Youngkin this annual executive summary of its activities, findings, and recommendations which will be focused on the Council's 2022-2023 holistic exploration of the needs of the adults and children in the Commonwealth who identify as women.

"When you need help, every moment matters." - Governor Glenn Youngkin[1]

Mental Health and Illness in America for Adults & Youth

We all strive to be healthy both physically and mentally. The CDC defines mental health as including "our emotional, psychological, and social well-being" and that it "affects how we think, feel, and act…[as well as] helps determine how we handle stress, relate to others, and make healthy choices.[2]" Further, data shows that mental health and physical health are equally as important given that poor mental health may negatively impact our physical health. By way of an example, the CDC cites that depression can increase the risk for physical ailments including chronic diseases such as diabetes, heart disease, and stroke. Further, the presence of those same chronic diseases can increase a person's risk for mental health concerns.[3] Mental illness, according to the American Psychiatric Association, can be defined as "health conditions involving changes in emotion, thinking or behavior (or a combination of these) [that] can be associated with distress and/or problems functioning in social, work or family activities.[4]"



Unfortunately, mental health concerns are common health conditions in the United States with more than 1 in 5 American adults having a diagnosable mental health condition in any given year, and roughly 1 in 25 U.S. adults will live with a serious mental illness like schizophrenia or bipolar disorder.[5] Further, over 45% of Americans will meet the criteria for a diagnosable mental health condition sometime in their life with half developing a mental health condition by the age of 14.[6] Here in the United States, there are nearly 43 million adults with anxiety disorders, which is among the most common mental illnesses in America.

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[1] Roderick-Fitch, "Youngkin Signs 'historic' Legislation to Improve Behavioral Health Care Access."
[2] Centers for Disease Control and Prevention, "About Mental Health."
[3] Centers for Disease Control and Prevention.
[4] Njoku, M.D., "What Is Mental Illness?"
[5] Centers for Disease Control and Prevention, "About Mental Health;" Elflenin, "Mental Illness in Past Year Male vs Female U.S. 2021."
[6] Mental Health America, "Quick Facts and Statistics About Mental Health."

Further, over 3 million adults have been diagnosed with bipolar disorder, and 21 million adults with depression.[7] Causes of mental illnesses can vary given there are multiple factors that can contribute to the risks including chronic medical conditions like cancer or diabetes, biological factors or chemical imbalances in the brain, use of substances like alcohol or illegal drugs, and histories of trauma or abuse, like being a child witness of domestic violence or experiencing sexual assault.[8]

For children, mental health disorders are defined as "serious changes in the way children typically learn, behave, or handle their emotions, which cause distress and problems getting through the day.[9]" While all children will have occasional fears, worries, or disruptive behaviors; the concerns that arise to a diagnosable mental disorder are "serious and persistent" symptoms that "interfere with school, home, or play activities.[10]" **For our little ones, over 1 in 5 youth aged 13-18 currently have a seriously debilitating mental illness or will have one in their lifetime.[11]** Just as in adults, mental health disorders in children are chronic health conditions that can impact physical health and proper psychosocial growth such as learning how to make friends successfully.

From 2016-2019 roughly 6.0 million or 9.8% of children aged 3-17 in the United States were found to have ADHD, 5.8 million or 9.4% were diagnosed with anxiety, 5.5 million or 8.9% were diagnosed with behavioral problems, and 2.7 million or 4.4% were diagnosed with depression.[12] Further, the rates of mental health concerns have increased over time with youth aged 6-17 years rates of depression and anxiety increasing from 5.4% in 2003 to 8% in 2007 and 8.4% in 2011-2012.[13] Specific to teens, the Youth Risk Behavior Survey in 2021 found that 42% of high school students experienced persistent feelings of hopelessness and sadness; and 20% reported experiencing poor mental health in the past 30 days. Even more alarming, 22% of teens had "seriously considered attempting suicide," 18% have made a suicide plan; and 10% attempted suicide.[14]

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[7] Mental Health America.
[8] Centers for Disease Control and Prevention, "About Mental Health."
[9] Centers for Disease Control and Prevention, "Children's Mental Health."
[10] Centers for Disease Control and Prevention.
[11] Mental Health America, "Quick Facts and Statistics About Mental Health."
[12] CDC, "Data and Statistics on Children's Mental Health | CDC."
[13] CDC.
[14] Centers for Disease Control, "Youth Risk Behavior Surveillance System (YRBSS)."

Substance Use Disorder

Substance	% Usership	
	Youth 12-17	Adults 18+
Marijuana	10.1%	18.7%
Opioids	1.6%	3.6%
Prescription pain medication	1.6%	3.5%
Prescription stimulants	1.2%	1.9%
LSD	0.9%	1.0%
Cocaine	0.3%	2.0%
Prescription sedatives	0.1%	2.4%
Methamphetamines	0.1%	1.0%
Heroin	*	0.4%

Substance Usership Rates, 12-Month Usage

**Insufficient data.*

One mental health concern that has been present in the news, daily, is substance use disorder. Substance use disorder can be defined as "using illicit drugs or meeting criteria for alcohol dependance or abuse" which is based on "a pattern of substance use leading to clinically significant impairment or distress.[15]" ***In 2020, data found that roughly 37.309 million persons aged 12 and older were considered current illegal drug users (e.g. have used within the last 30 days) in the United States which equals 13.5% of Americans.*** Further, 59,277 million persons, or 21.4% of Americans aged twelve and over, have used illegal drugs or misused prescription drugs within one year of 2020, and roughly 138.545 million people of the same age group had illegally used drugs in their lifetime.[16]

General Barriers to Accessing Mental Health Care

Access to quality care for medical needs can be difficult in the United States. ***In a 2023 Harris Poll, Time Magazine reported that more than 70% of U.S. adults believe that the healthcare system is failing to meet their needs in at least one way, although the nation spends more money per capita on healthcare than any other wealthy country on the globe.***[17] Americans find that they have issues obtaining appointments, paying for care, accessing needed care due to insurance coverage limitations, and a lack of focus on preventive care and health wellness versus illness.[18] Specific to mental health, roughly 163 million Americans reside in a Mental Health Professional Shortage Area (MHHSPA), and an estimated 8,252 practitioners would be needed to meet those needs.[19] Health Professional Shortage Areas can be geographic areas, populations, or facilities with a shortage of primary, dental, or mental health care professional providers.[20] Mental health professionals include not only psychiatrists and psychologists but also psychiatric nurses, addiction counselors, youth and adult counselors, as well as family and marriage counselors.[21] ***To resolve the Mental Health Care Health Professional Shortage in the United States as a whole would require the addition of 7,871 practitioners, and currently only 27.1% of need for mental health professionals is met nationwide.***[22]

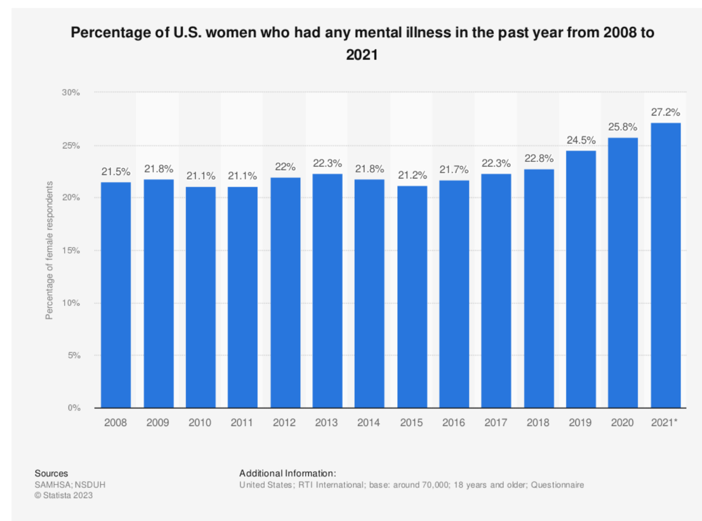
One other barrier to health that the Council on Women wished to explicitly note is access to mental health care during incarceration.[23] Mental Health America reports that roughly 1.2

[15] KFF, "Mental Health and Substance Use State Fact Sheets: Mental Health in Virginia."
[16] National Center for Drug Abuse Statistics, "NCDAS."
[17] Ducharme, "Exclusive: More Than 70% of Americans Feel Failed by the Health Care System."
[18] Ducharme.
[19] U.S. Health Resources & Services Administration, "Health Workforce Shortage Areas."
[20] U.S. Department of Health & Human Services, "Health Professional Shortage Areas (HPSAs) and Medically Underserved Areas/Populations (MUA/P) Shortage Designation Types."
[21] KFF, "Mental Health and Substance Use State Fact Sheets: Mental Health in Virginia."
[22] KFF.
[23] Hidayati et al., "Women Behind Bars."

million individuals are currently living with mental illness and incarcerated.[24] In 2021, the National Association for Mental Illness (NAMI) reported that 1 in 4 people with a serious mental illness have been arrested at some point in their life, which leads to over 2 million jail bookings of people with serious mental illness annually. Further, two (2) in every five (5) adults in jail or prison have a history of mental illness, and seven (7) in every ten (10) youth in the juvenile justice system have a mental health condition.[25] ***Due to these startling facts, the Council on Women would like to bring the impact of mental health on our prison population to the Governor's attention to a specific area of mental health where women are impacted.***

[24] Mental Health America, "Access to Mental Health Care and Incarceration."
[25] NAMI, "Mental Illness and the Criminal Justice System."

Women and Girls: The Impact of Mental Health and Illness



The American Psychiatric Association reports that annually nearly one in every five women in the United States has a mental health problem including depression and eating disorders.[26] By way of illustration, in 2021, more women had any mental illness than men - specifically at a rate of 50% more women with prevalence than men (27.2% women versus 18.1% men).[27] Further, the table shows that this rate of mental illness has only decreased from a low of 21.1% in 2010 and 2011 to a high of 27.2% in 2021.[28] Specifically, data indicates that women are twice as likely to be impacted by Generalized Anxiety Disorder (GAD) and panic disorder than men. Further, the prevalence of serious mental illness is 70% greater in women than men.[29]

Women also suffer from substance use disorder. ***The National Institute on Drug Abuse reports that nearly 27 million women aged 18 or older reported using illicit drugs in the past 12 months, which equals nearly 20.4% of the population.***[30] Further, from 1999-2014 the prevalence of opioid use in expecting women increased 333% from 1.5 cases per 1,000 delivery hospitalizations to 6.5 cases per 1,000 delivery hospitalizations.[31] Additionally, women's initiation of substance use can be complex as they are often related to family or partner use, a co-occurring disorder such as depression or anxiety, or an eating disorder.[32] Further, despite the higher prevalence of substance use disorder (SUD) among men, the rates of substance use by gender is age-dependent. In 2019, young women aged 12-17 were more likely than young men to report having a SUD in the past year (5.0% vs. 4.0%). Overall, women still constitute roughly 1⁄3 of adults with an SUD, yet fewer than 11% of women with an SUD received treatment in 2019.[33] And while women will often terminate or reduce their substance use during pregnancy, there is a high propensity to return to the substance use after the birth of their child.[34]

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[26] American Psychiatric Association, "Diversity & Health Equity Education: Women."
[27] National Institute of Mental Health, "Mental Illness."
[28] Elflenin, "Mental Illness among Females U.S. 2008-2021."
[29] Regis College, "Women's Mental Health 101."
[30] NIDA, "Substance Use in Women Drug Facts | National Institute on Drug Abuse (NIDA)."
[31] Haight et al., "Opioid Use Disorder Documented at Delivery Hospitalization — United States, 1999–2014."
[32] Substance Abuse and Mental Health Services Administration., "Addressing the Specific Needs of Women for Treatment of Substance Use Disorders."
[33] Krug, "Women Less Likely to Seek Substance Use Treatment Due to Stigma, Logistics | Penn State University."
[34] Substance Abuse and Mental Health Services Administration., "Addressing the Specific Needs of Women for Treatment of Substance Use Disorders."

For youth, while boys are more likely to be diagnosed with mental, behavioral, or developmental disorders, young women have emerged as the highest-risk group for mental illness health concerns.[35] ***In 2023 the CDC released a report noting that nearly 3 in 5 or 57% of U.S. teen girls felt persistently sad or hopeless, whereas for boys only 29% felt the same.*** Girls also reported a higher rate of experiencing poor mental health in the past 30 days - with 41% of the teen girls reporting poor mental health as compared to 18% of teen boys.[36] Further, the same Youth Risk Behavior Survey revealed that nearly 1 in 3 young women have seriously considered attempting suicide, a statistic which is up almost 60% from 2001. ***In addition, the rate of sexual violence against teen girls had increased 20% between 2017 and 2021, with 1 in 5 teen girls experiencing sexual violence in 2021.***

Specific Issues and Needs of Women and Girls for Mental Health Diagnostics & Treatment

Women and girls can face mental health concerns that are gender specific due to societal pressures and expectations. Further, there can be complexities due to biology given the impact of hormones on health and wellness. Specific to societal impacts, unfortunately more women than men will experience trauma such as sexual harassment in their lifetime. Worldwide, 70% of all women will experience violence from an intimate partner at some point in their life and that violence can lead to mental health concerns such as depression. Studies have found that woman who have experienced intimate partner violence can be up to 70% more likely to attempt suicide, and women who have experienced violence in the home are also at elevated risk for depression, anxiety, and borderline personality disorder. Further, such trauma may cause access to treatment to be even more difficult to achieve, as women are often financially reliant on their abuser due a method of power and control that keeps the victim dependent and more likely to stay and endure the abuse.[37]

In addition, a woman's biology can also impact her mental health and wellness. Hormones are "chemicals made in glands of the endocrine system" and regulate many processes in the body including metabolism and mood, in addition to reproductive functions. Hormone imbalances in women can cause or worsen the impact of mental health concerns including anxiety and depression. For example, drops in estrogen and progesterone can create irritability and anxiousness, and cortisol can cause mild to severe anxiety and depression. This hormonal dysregulation can lead to stress, and stress exacerbates hormonal imbalances.[38] Women are twice as likely to be diagnosed with depression and anxiety, and one of the many factors of why, can also be linked to the use of progesterone and estrogen which is widely found in birth control or hormone replacement therapy. Harvard Health reports that 2.2 out of 100 women develop depression when using hormonal birth control as opposed to the 1.7 out of 100 women who develop depression without the use of birth control.[39]

Gender can also impact the diagnosis and treatment of those suffering with mental health concerns. Research has found that women who have severe mental illness ("SMI") are often over

[35] CDC, "Data and Statistics on Children's Mental Health | CDC;" Agenda Alliance, "Women's Mental Health Facts."
[36] Centers for Disease Control, "Youth Risk Behavior Surveillance System (YRBSS)."
[37] Annieuser, "Women's Mental Health Treatment."
[38] Borst, "Here's What a Change in Hormones Can Mean for Women's Health."
[39] MPH, "Can Hormonal Birth Control Trigger Depression?"

diagnosed with affective and personality disorders, while being underdiagnosed with substance use disorders, as clinicians have a perception that women suffer more from emotional health issues than men. Gender has been found to impact provider perceptions of SMI in women when it comes to the symptoms, behaviors, and service use, to the point that some clinicians believe women with SMI are hard to work with, they do not feel comfortable treating them, and may even avoid working with them.[40] Women also have been found to have barriers to care despite their tendency to be more cooperative with providers and holding higher rates of attendance for treatments. Women's lack of social support, their socioeconomic status, and their fear of discrimination often cause them to be reluctant to engage the healthcare industry for their SMI.[41]

Specific to lack of support is the issue of stigma. Stigmas surrounding mental health issues have an even more profound impact on women. Societal expectations and gender norms lead to the harmful notions that women should be constantly self-sacrificing and emotionally resilient, or that mental illnesses are signs of personal weakness, which discourages women from openly speaking about any mental health struggles they may be experiencing. This additional pressure can lead to internalizing guilt and shame when women experience any conditions like depression, anxiety, or postpartum depression. Women may also fear that acknowledging their mental health issues will be seen as a sign of instability or incompetence in work settings, careers, personal relationships and even in parenting roles.[42]Data has proven that minority women cite systemic racism leading to higher levels of stress and trauma, transportation, lack of insurance, cultural differences with providers and how their community will view them as valid reasons why they shy away from seeking mental health help, even though they realize they could benefit from the assistance.[43]

For women, substance use disorder can require a unique perspective to successfully assess and treat their mental health concerns. Beginning with screening, women do better with self-administered screening tools over face-to-face interviews. This is because of the concerns noted above with stigma, which is great when it comes to substance use. Further, it is important that women should be screened for other mental health concerns simultaneously including eating disorders.

Pregnancy is also a specific issue that can impact women and their children's mental health in unique ways versus men who also suffer from mental health concerns. One of our most vulnerable populations of women that have barriers to access is expectant women or fourth trimester/postpartum women who cannot find access to care and often mental health concerns may reveal themselves postpartum. Up to 85% of new mothers may experience what is known as the "baby blues' ' which are caused by hormonal changes that can result in anxiety, crying, and restlessness within the first two weeks after giving birth. Postpartum blues or the "baby blues" is a temporary form of depression that will resolve itself once the mothers' hormonal changes

[40] Mizock and Brubaker, "Treatment Experiences with Gender and Discrimination among Women with Serious Mental Illness."
[41] Mizock and Brubaker.
[42] Hunter, "Understanding and Reducing the Stigma of Mental Illness in Women"; Theravive, "How To Reduce and End Mental Health Stigma."
[43] Kant, MSc and Sorkhou, PhD (Cand.), "Mental Health Care for Women of Color: Risk Factors, Barriers, and Clinical Recommendations."

resolve.[44] However, some new mothers may have either postpartum depression or postpartum psychosis - a far more serious mental health concern that impacts birthing persons and the care they can give to themselves and their new child.

Postpartum depression is defined as "a serious mental health condition that involves the brain and affects your behavior and physical health" according to the Office on Women's Health.[45] ***Nearly one (1) in every seven (7) new parents will experience postpartum depression, and individuals who have had postpartum depression before will have a 30% higher likelihood of the disease each subsequent pregnancy. Further, this depression can impact surrogates and adoptive parents as well, so even more women may be impacted by this type of depression than just women who have recently given birth to a child they are now directly caring for.***[46] It is important to note that the exact causes of postpartum depression are not known, and research attributes many different factors to a woman developing the mental health concern such as the changes that are hormonal, physical, financial, social, and also emotional that occur after having a baby or adopting a child.[47]

Postpartum Psychosis on the other hand is extremely rare, but quite severe. This disorder impacts roughly 0.1 per cent of new mothers without bipolar disorder. For new mothers with bipolar disorder, it can impact nearly 30 per cent. Postpartum psychosis can be displayed with mothers losing consciousness, hallucinating, or delusions, and displaying erratic disorganized behavior. Mothers with this disorder should be provided access to emergency medical care, as suicidal ideation is common, and the impacted mental state of the mother could end in harm to the baby or others. Treatment for postpartum psychosis includes a regimen of certain medications. The medications, if properly monitored, will not harm the child if the mother is breastfeeding.[48] Healthcare providers can work to remove the barriers that postpartum blues, depression, and psychosis can cause to engage in screening all postpartum women with an objective depression scale, such as the Edinburgh Postnatal Depression Scale, within the first week postpartum.[49] As it stands, most postpartum women do not see their physician until 6 weeks postpartum, which could delay a diagnosis and lead to unnecessary suffering.[50]

Further, women who are expecting, need assistance to help juggle those additional stressors that can exacerbate SUD along with the inherent guilt that she may feel by having the disorder and being unable to stop using it during pregnancy. Further, women with postpartum depression often have an existing substance use disorder or other co-occurring mood disorder, and lifetime drug use has been associated with postpartum anxiety, stress, and other disorders. Finally, even treatment can differ by gender as women with children will often need additional support to secure childcare or to gain access to treatment programs that allow women to also

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[44] Johns Hopkins Medicine, "Baby Blues and Postpartum Depression."
[45] Office on Women's Health, "Postpartum Depression."
[46] Cleveland Clinic, "Postpartum Depression."
[47] Cleveland Clinic.
[48] Johns Hopkins Medicine, "Baby Blues and Postpartum Depression."
[49] Cox, Holden, and Sagovsky, "Detection of Postnatal Depression. Development of the 10-Item Edinburgh Postnatal Depression Scale."
[50] American College of OBGYN, "Optimizing Postpartum Care."

bring their little ones.[51] Treatment also should potentially include medication as expecting women have better outcomes when provided buprenorphine during SUD treatment.[52]

[51] Substance Abuse and Mental Health Services Administration., "Addressing the Specific Needs of Women for Treatment of Substance Use Disorders."
[52] Substance Abuse and Mental Health Services Administration., 4.

Mental Health in the Commonwealth

As our Governor has acknowledged, Virginians young and old also struggle with mental health concerns. Per the United Health Foundation's America's Health Rankings data, 14.7% of Virginians reported that their mental health was not good 14 or more days in the past 30 days, and even more specifically 7.0% of adults ages sixty-five or older reported that their mental health was not good 14 or more days in the past 30 days. NAMI found that 1,115,000 adults in Virginia have a mental health condition as of 2021.[53] February 1 to 13, 2023, 32.0% of adults in Virginia reported symptoms of anxiety and/or depressive disorder from the U.S. Census Bureau Household Pulse Survey.[54] Further, 264,000 adults in the state have a serious mental illness.[55] For women in the Commonwealth, 21.9% of 18-44 year olds indicated that their mental health was not good 14 or more days in the past 30 days which continues our unfortunate upward trend since the 2016-2017 CDC Behavioral Risk Factor Surveillance System.

Further, as we highlighted earlier - mental health diagnosis, treatment, and access while incarcerated is a problem not just nationwide, but also here in the Commonwealth. The Virginia Compensation Board noted in their 2022 report that 5,102 women were present in the survey population versus 23,967 men and twenty-one gender unidentified persons.[56] Of that population, 44% were reported to be mentally ill, equaling 2,230 female inmates. The table above provides the data by gender from 2012 through 2022 for longitudinal perspective.

Unfortunately, the Commonwealth is not without its battle against substance use disorder. The Virginia Department of Health (VDH) reports that there were over 21,600 overdose visits to the Emergency Departments in the Commonwealth in 2021, and specifically nearly 10,900 were due to opioids. KFF reports that overdose death rates increased in the state from 9.7 per 100,000 in 2011 to 30.5 per 100,000 in 2021. Over the same period, drug overdose death rates increased in Virginia from 13.2 to 32.4 per 100,000 in the U.S.[57] Specific to the opioid crisis, the VDH noted that there was an average of 7 Virginians who died of an overdose every day in 2021 which equates to 2,622 deaths that year; up 29% from 2020.[58]

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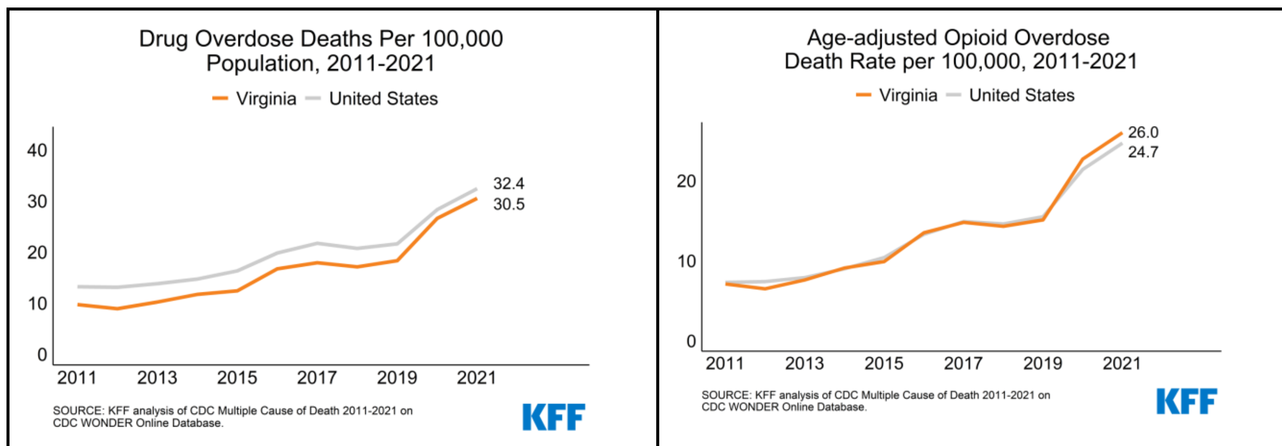
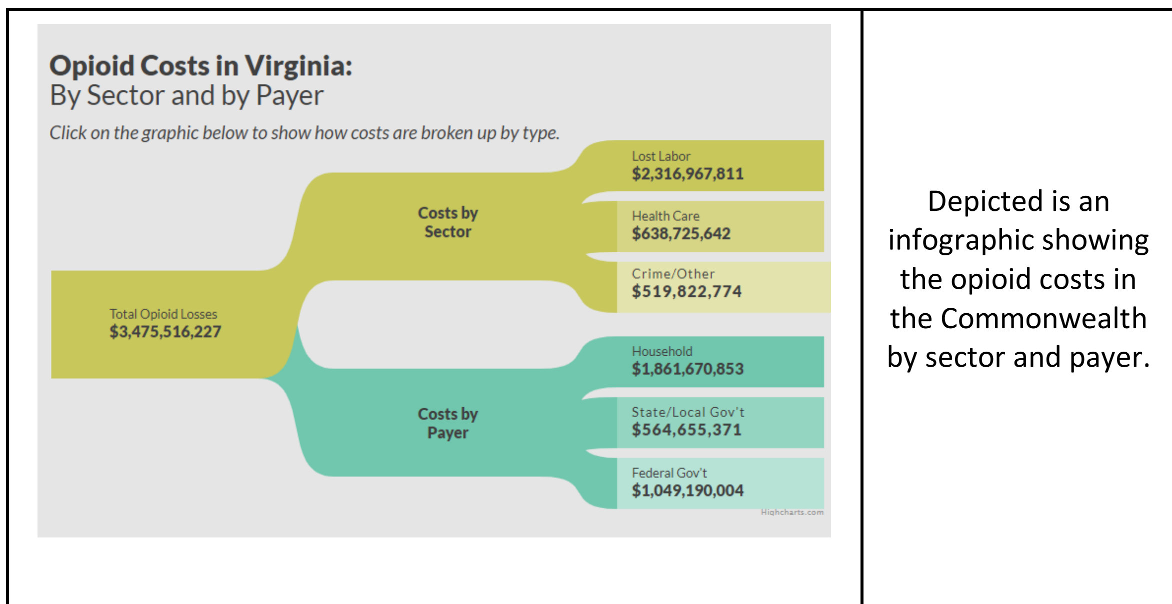
[53] NAMI, "Mental Health in Virginia."
[54] KFF, "Mental Health and Substance Use State Fact Sheets: Mental Health in Virginia."
[55] NAMI, "Mental Health in Virginia."
[56] Compensation Board Commonwealth of Virginia, "2022 Mental Illness in Jails Report," 5.
[57] KFF, "Mental Health and Substance Use State Fact Sheets: Mental Health in Virginia."
[58] Virginia Department of Health and Human Resources, "Drug Overdose and Related Health Outcomes."



Despite the need for diagnosis, treatment, and care, many of our neighbors and friends are unable to access proper care. In May of 2022, 28.1% of adults[59] reported needing counseling or therapy, but not receiving it in the past four weeks after experiencing symptoms of anxiety and/or depressive disorder.[60] Further, often cost was prohibitive to an adult receiving care as of the 382,000 adults in the Commonwealth who did not receive needed mental health care in 2021, 41.7% was due to the cost of care, and Virginia residents are over seven (7) times more likely to be forced out-of-network for mental health care than for primary health care.[61] **The Commonwealth as a whole has also suffered losses in revenue due to this crisis. In total over $3.4 billion dollars have been lost due to opioids, and specifically over $2.3 billion are in lost labor costs by sector, and nearly $564 million has been lost by state and local governments as payors.[62]**



Depicted is an infographic showing the opioid costs in the Commonwealth by sector and payer.

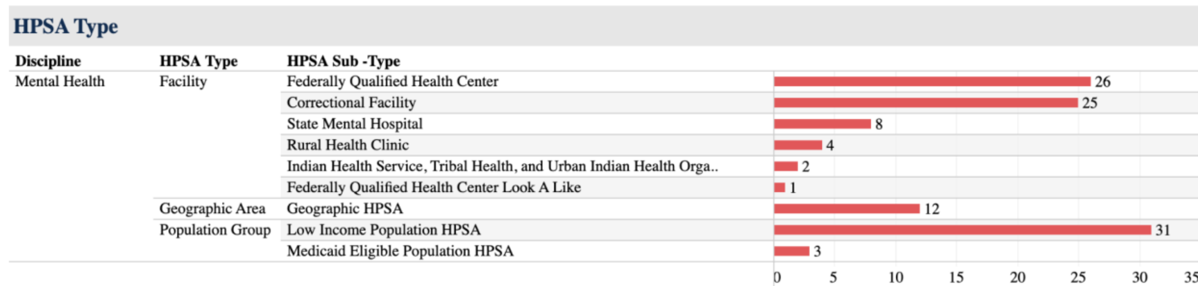
[59] For youth, however, 13.6% of children 3-17 received mental health care in Virginia which is higher than the national average. (KFF n.d.)

[60] KFF, "Mental Health and Substance Use State Fact Sheets: Mental Health in Virginia."

[61] NAMI, "Mental Health in Virginia."

[62] KFF, "Mental Health and Substance Use State Fact Sheets: Mental Health in Virginia."

For our youth, over 56% of children aged 12-17 who have depression reported in February 2021 that they did not receive any care in the past year.[63] This is even with 64.7% of adults in the Commonwealth having access to private health insurance in 2021, and 12.6% of adults with any mental illness in Virginia reported having access to Medicaid coverage in 2019.[64] To add to the complex landscape, as stated above, there are Mental Health Professional Shortage Areas across the nation, including Virginia. In the Commonwealth, there are facility, geographic, and population-based HPSAs for mental health - meaning that some Virginians cannot access mental health care easily. As noted below, the U.S. Department of Health and Human Services indicates sixty-six facility HPSAs, twelve geographic area HPSAs, and thirty-four population group HPSAs in the Commonwealth.[65]



This data is compelling as it details which citizens may have difficulties accessing care simply due to their location or income. For example, seven (7) designated geographical health professional shortage areas in the Commonwealth,[66] spanning thirty-eight separate counties and municipal corporations, as provided in Appendix A. Further, twenty-eight (28) designated low-income population HPSAs are in the commonwealth, spanning eighty-four separate counties and municipal corporations, as provided in Appendix B.[67]

Further, access to our State Community Service Boards (CSB) is difficult. In the Commonwealth, the CSB system is "the state's primary approach to providing publicly funded behavioral health services in local communities" that includes both emergency and non-emergency mental health and substance use disorder services.[68] I40 CSBs that serve between 1-

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[63] NAMI, "Mental Health in Virginia."

[64] KFF, "Mental Health and Substance Use State Fact Sheets: Mental Health in Virginia."

[65] U.S. Health Resources & Services Administration, "Health Workforce Shortage Areas."

[66] The HPSA table indicates that there are twelve geographic area HPSAs. However, the raw data revealed that five (5) HPSAs are proposed for withdrawal. Those areas are: Craig-Botetourt Counties; Fredericksburg City/Caroline/King George/Spotsylvania/Stafford Counties; Mount Rogers Service Area; Shenandoah/Page Counties; and Southside Planning District. These areas proposed for withdrawal encompass eighteen separate unduplicated counties and municipal corporations.

[67] The HPSA table indicates that there are thirty-one low-income area HPSAs. However, the raw data reveals that five (5) HPSA areas are proposed for withdrawal. Those areas are: LI-Louisa County; LI-Southampton County/Franklin City; LI-Fairfax/Alexandria/Arlington Junction Mental; LI-Petersburg-Dinwiddie; and LI-Roanoke-Salem. These areas proposed for withdrawal encompass eleven separate counties and municipal corporations, and further detail multiple areas within one jurisdiction (for example 13 separate areas in Arlington are designated as "proposed for withdrawal". Finally, some localities have alleviated their HPSA status in some parts of their full jurisdiction but not others - for example some of Roanoke City and County are proposed for withdrawal, but some areas are still designated (LI-Valley MHCA).

[68] Joint Legislative Audit and Review Commission, "Report to the Governor and the General Assembly of Virginia: CSB Behavioral Health Services 2022," i.

10 localities; and those services are delivered through over 500 offices.[69] CSB's are a "single point of entry" to the publicly funded health services system, and every city or county must establish or join a CSB.

In December 2020, the Joint Legislative Audit and Review Commission (JLARC) noted that as the number of individuals facing a mental illness increases in the Commonwealth, the state's CSB case load also increases. CSBs served 20% more consumers with a serious mental illness (SMI) in FY22 than a decade ago, and those with SMI require more services and more intensive services.[70] Further, while the majority of CSB consumers experience improvements after receiving CSB services, 41% of consumers experience declines in functioning while receiving CSB services. In addition to the care provided, CSBs struggle with recruitment and retention of staff. JLARC found that most of the CSBs reported having difficulties in hiring and retaining qualified staff over the past year, and those struggles clustered in the areas of emergency services staff and crisis services staff. During 2022, 1⁄3 of surveyed emergency services staff noted that they were considering leaving their jobs in the next 12 months, and the average turnover rate within the CSBs where data was available increased from 15% in FY13 to 27% in FY22 with an average vacancy rate of 20% with direct care staff.

These staff shortages directly impact consumers who are experiencing long wait times for services - specifically psychiatric and mental health outpatient therapy for adults, children, and adolescents, as well as long waits for outpatient substance use disorder therapy. ***JLARC found that only 4 of the 40 CSBs were able to truly provide "same day assessments" for all consumers on the day they are sought, and 9 CSBs reported that they were able to conduct same day assessments for only half or less of the consumers who sought them.***[71] JLARC found that compensation was a key reason for the CSB recruitment and retention problems, with the majority of licensed clinical social workers and licensed professional counselors at CSBs were paid at least 10% less than what they could make at other employers in Virginia. For retention. JLARC identified administrative burdens on the care staff that caused them to spend less time providing direct care to patients due to how arduous the administrative tasks are in comparison to other behavioral health employers.[72]

As noted above, the recruitment and retention for CSB's impacts emergency care access, but there are also additional barriers in the Commonwealth for those who are suffering from Under law, an individual suffering from a mental health crisis may be placed under an Emergency Commitment Order (ECO) and if found to need in-patient care may be placed under a subsequent Temporary Detention Order (TDO) under §37.800 et seq. and §16.1-335 et seq. of the Code of Virginia.[73] After changes to the response system in 2014 that were intended to provide additional access to emergency care for Virginians, additional issues arose that complicated access. For example, JLARC found that between FY12-FY21 state psychiatric hospital admissions increased 68%, and they are operating at or near capacity with waitlists.

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[69] Joint Legislative Audit and Review Commission, i.
[70] Joint Legislative Audit and Review Commission, i.
[71] Joint Legislative Audit and Review Commission, ii–iii.
[72] Joint Legislative Audit and Review Commission, iv.
[73] Commonwealth of Virginia, "Code of Virginia Code - Chapter 8. Emergency Custody and Voluntary and Involuntary Civil Admissions."

In a June 2022 report, it was noted that 232 state hospital beds were offline at that time due to a lack of staff to operate them safely, which adds to the bed capacity concerns.[74] TDOs are determined by CSB staff and require admission to state psychiatric hospitals, and those increases correlate with the increase in admissions as well.[75] Further, like CSBs, the Commonwealth's psychiatric hospitals also have recruitment and retention problems due to compensation issues as well as the general stress of the role and workplace.[76] Prior to the global pandemic, state hospitals had over 1,000 vacancies but had a statewide bed census of 112% of total capacity.[77] This is despite the fact that optimal bed capacity for both patients and staff is at 85% utilization.[78]

Figure 1. Evaluations, TDOs, and TDO Admissions, FY2013 – FY2022

	Average Daily Evaluations	Average Daily Issues TDOs	Average Daily TDO admissions	Total Evaluations	Total TDOs Issued	Total TDO Admissions	% Evaluations resulting in TDOs	% Estimated TDO admits to private/community hospitals**	% TDO Admits to State Hospitals
FY2013	-	-	3.7	-	-	1,359	-	-	-
FY2014	-	-	4.3	-	-	1,579	-	-	-
FY2015	229	68	6	83,701	24,889	2,192	29.7%	91.2%	8.8%
FY2016	262	71	9.6	96,041	25,798	3,497	26.9%	86.5%	13.5%
FY2017	256	71	10.5	93,482	25,852	3,827	27.7%	84.6%	15.4%
FY2018	251	70	14.7	91,718	25,679	5,357	28.0%	80.6%	19.4%
FY2019	239	69	18.2	87,490	25,205	6,649	28.8%	76.1%	23.9%
FY2020	208	64	14.8	75,805	23,512	5,412	31.0%	77.0%	23.0%
FY2021	187	63	14.4	68,421	22,864	5,240	33.4%	77.1%	22.9%
FY2022	178	58	6.3	48,837	15,828	1,734	32.4%	89.0%	10.96%

Temporary detention order admissions in Virginia, FY2013-22. (Virginia Department of Behavioral Health and Developmental Services)

Efforts in the Commonwealth: Right Help, Right Now

The Virginia Council on Women is thankful that in our Commonwealth, efforts to impact mental health access, diagnosis, and treatment are not new. In fact, the Department of Behavioral Health & Developmental Services began to establish mental hygiene clinics across the state in the late 1940s. In the late 1960's the General Assembly established Chapter 10 of Title 37.1 of the Code of Virginia which is the enabling legislation that created Community Service Boards or CSBs. CSBs are a point of entry into state and locality funded mental health, development, and substance use disorder services that absorbed the former mental hygiene clinics and added additional areas of service. The first two CSBs were established in Arlington and Prince William Counties in 1968, and today there are 40 CSBs (one of which is a Behavioral Health Authority or BHA) that provide services to all 133 cities and counties in the Commonwealth.[79] In 2019, the Commonwealth invested over $344 million dollars into all CSBs and localities invested over $330 million for a total budget including fees, federal investments, and other dollars of over

[74] Virginia Department of Behavioral Health and Developmental Services, "Annual Report on the Implementation of 2014 ECO and TDO Law Changes," 3.

[75] Joint Legislative Audit and Review Commission, "Report to the Governor and the General Assembly of Virginia: CSB Behavioral Health Services 2022," v.

[76] Vogelsong, "Youngkin Proposes $230 Million Behavioral Health Overhaul." (Citation is also for table)

[77] Masters, "Staffing Shortages Are Overwhelming Virginia's Psychiatric Hospitals."

[78] Virginia Department of Behavioral Health and Developmental Services, "Annual Report on the Implementation of 2014 ECO and TDO Law Changes," 8.

[79] Virginia Department of Behavioral Health and Developmental Services, "2020 Overview of Community Services in Virginia," 1–2.

$1.3 billion dollars.[80] Further, in 2019 the Commonwealth's CSBs staffed over 13,700 full-time equivalent professionals, including over 10,100 direct care staff members and over 260 peers.[81] In FY2009, the Commonwealth provided access to services for 218,851 unduplicated Virginians' which is a 10% increase from 2010s service totals of over 194,662 unduplicated Virginians. During that year services were provided in the program areas of mental health (123,413 individuals), developmental services (23,064 individuals), substance use disorders (29,837 individuals), as well services available outside of a program area (SAOPA) which includes emergency services (60,003 individuals) and ancillary services (99,324 individuals).[82]

Further, our legislature also has recently acted by providing support to Senator Creigh Deeds 2014 bills focused on mental health reform that increased the duration of emergency psychiatric holds from 4 hours to 12 hours, and added in a safety net clause that state mental health hospitals were to accept patients for temporary detention after 9 hours. SB260 also increased the time period a person could be helped involuntarily under a temporary detention order (often called a TDO) from 48 to 72 hours.[83] Other legislative work includes 2020's Mental Health Awareness Response and Community Understanding Services (MARCUS) Alert System bill introduced by former Delegate Jeffery Bourne, Esq in memory of Mr. Markus-David Peters who was a 24-year old high school biology teacher that was shot and killed by a law enforcement officer during a mental health crisis in 2018. The goal of the MARCUS Alert System is to provide mechanisms to divert law enforcement involvement in mental health crises and route supportive services from trained clinicians and peers.[84]

From the desk of our current Governor, in 2022, Governor Youngkin proposed to overall the state behavioral health program through his six-pillar "Right Help, Right Now" (RHRN) plan. With a proposed investment of $230 million dollars, the RHRN plan seeks to identify and rectify the barriers facing adults and children seeking mental health diagnosis and treatment.[85] The RHRN plan was in response to the issues and barriers that consumers were facing to access mental health care with Governor Youngkin stating clearly that "[t]he commonwealth's behavioral health safety net is not equity to address the demands that are being placed upon it."[86] The three year plan is focused on deconstructing and reconstructing Virginia's overburdened health care system. The RHRN plan consist of attainable goals broken into six pillars which include the following goals and enhancements: Offering Same Day Care for Behavioral Health Crisis, Relieve Law Enforcement Burdens and Reduce Criminalization of Mental Health, Expand Capacity to Serve People, Support for Substance Use Disorders and Overdose, Strengthen Behavioral Health Workforce, and Identify Innovations to Close Capacity Gaps. Its goals were to make sure that all Virginians can "be able to access behavioral health care when they need it; have prevention and management services personalized to their needs, particularly for children and youth; know who to call, who will help, and where to go when in crisis; and have

[80] Virginia Department of Behavioral Health and Developmental Services, 9.
[81] Virginia Department of Behavioral Health and Developmental Services, 13.
[82] Virginia Department of Behavioral Health and Developmental Services, 22.
[83] Mondics, "Gov. McAuliffe Signs Bill Spearheaded by Sen. Deeds."
[84] Legislative Information System, "LIS > Bill Tracking > HB 5043 > 2020 Session"; Edwards, "Diverting Mental Health Crisis from Law Enforcement."
[85] Vogelsong, "Youngkin Proposes $230 Million Behavioral Health Overhaul."
[86] Vogelsong.

paths to reentry and stabilization when transitioning from crisis."[87] Further, in 2023 Governor Youngkin signed twenty-four bills as part of the Right Help, Right Now plan that included focuses on wait times for individuals being held under Temporary Detention Orders (TDOs), private health insurance coverage for mobile crisis teams, and a keen focus on increasing the behavioral healthcare workforce.[88]

Future Potential Partnership with James Madison University

The Council on Women would also like to highlight work from their prior executive summary focused on rural health care access for women and girls in the Commonwealth that applies to the need for mental health access. Members of the Council on Women's Civic Engagement subcommittee worked to bring a potential program to the Governor and his Cabinet. That program would engage one of our top state universities to help train their students to work with rural populations, while simultaneously giving access to care for those communities. The James Madison University School of Nursing within the College of Health and Behavioral Sciences has proposed a program that would provide more access to mental health care for women 18-35 years old in rural communities of Virginia. The program would use mobile units to provide mental health services in those areas with lower access to mental health care. Students in JMUs master's and doctoral programs would provide critical mental health service access during their educational training and would pledge to provide mental health access when they return home to those rural communities after graduation. The program would be piloted in Paige County to provide their residents' access. The goal for the students accepted into the mobile clinic program would be to eventually provide tuition assistance to help support their pursuit of becoming a healthcare professional. In addition, the program has the support of the Virginia Rural Health Association[89] for placement and advertising of the mobile units, and other future identified needs and locations.

James Madison University has proposed naming this program EMBARC, (Enhancing Mental and Behavioral Access in Rural Communities) for women. The EMBARC program would also eventually encourage the participation of other Virginia state colleges and universities to participate collaboratively to enhance mental health in the state, but especially in rural underserved communities. The purposes of this proposed EMBARC program are to first, address health concerns of women residing in rural, medically underserved areas in the Commonwealth of Virginia; second, address social determinants of health (SDoH) and other barriers to seeking and receiving behavioral health services in rural, diverse, and socioeconomically disadvantaged populations; third, to increase preparedness for behavioral health issues in primary care for students seeking to become healthcare professionals; and fourth, to measure outcomes of

[87] Virginia Department of Health and Human Resources, "Right Help. Right Now. Transforming Behavioral Health Care for Virginians."
[88] Graham, "Virginia Delivers for Behavioral Health, Signing Bills to Support Workforce, Individuals in Crisis."
[89] https://vrha.org/

depression, anxiety, and substance use (focusing on the fentanyl crisis) over time using GAD-7[90] and PHQ 9[91] screening measures.

Proposed EMBARC for Women Program

Enhancing Mental and Behavioral Access in Rural Communities for Women

Supporting Data

A survey from key stakeholders in the most recent Community Assessment for the Page County region identified Behavioral/Mental Health needs as the number one major area of concern (89.8% of respondents) with 47.5% of respondents identifying Health Equity and Disparities as the primary concern for access to care. Moreover, 71.2% of respondents stated that access to outpatient counseling services for depression, anxiety and other mental health disorders was the major concern related to Behavior Health needs. Transportation was the most often cited area of concern. This proposed community intervention will buffer the lack of mental health care treatment through additional actions that address SDoH and assist the target population to circumvent identified obstacles of food/housing insecurity and transportation.

After analysis of year one outcomes, Leadership students will examine needs assessments of counties with similar profiles. In selected counties leadership students will initiate contacts in rural areas that meet criteria for replication. Leadership students will collaborate with community stakeholders to establish a plan for capacity building in the identified areas and submit recommendations for program replicability to the Governor's office.

Target Population

Self-Identified Women ages 18-45 living in state designated rural areas with behavioral health diagnoses or complaints.

Objectives Year 1 and Year 2

I. Mobile Care Unit

To provide primary care and student training in rural women's behavioral health to communities in the established county (Page County). Care will include screening, diagnosis, medication management, counseling, and resource allocation provided through face to face and telehealth visits. Mobile care unit locations within Page County will include community centers, libraries, and public gathering areas.

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[90] *The GAD 7 is a validated screening tool for assessing the presence of generalized anxiety disorder and the severity of depression. The scale is 89% sensitive and has an 82% specificity. More information can be reviewed at:* *https://adaa.org/sites/default/files/GAD-7_Anxiety-updated_0.pdf*

[91] *The Patient Health Questionnaire (PHQ 9) is a validated tool for initial diagnosis of depression. The screening tool is based on the nine criteria for Major depressive disorder. More information can be reviewed at:* *https://www.apa.org/depression-guideline/patient-health-questionnaire.pdf*

II. Leadership projects

Students in the JMU Leadership master's and doctoral programs will develop projects aligned with Governor Youngkin's priorities to increase access to behavioral health services for rural women to improve outcomes. Projects would include a needs assessment, identifying referral contacts and practice partners in the local area, and evaluation of program outcomes with recommendations and planning for sustainability for Page County. In addition, leadership students and stakeholders will make recommendations for replication in counties with similar profiles.

III. Advanced Practice Nursing (APN) training program

MSN family nurse practitioner (FNP) and adult-gerontology primary care nurse practitioner (AGPCNP) students will receive additional training on unique care needs of women living in rural areas presenting with behavioral health concerns. MSN FNP/AGPCNP students will receive additional didactic training in the classroom and specialty practicum hours at designated behavioral health facilities (i.e., community service boards, state mental health facilities, telehealth, etc.) while being precepted by a psychiatric health care professional (MD, DO, or NP). This training will be implemented at JMU School of Nursing (SON) as a prototype with plans to roll out similar initiatives at other state universities and schools of nursing. This program will create a sustainable long-term solution aimed at meeting the unique healthcare needs of rural women in Virginia by training the providers who work in these communities to better care for patients presenting with mental health concerns.

Project Outcomes

I. Decreased reported rates of depression, anxiety, or behavioral health concerns in the pilot county areas as measured by GAD-7 and PHQ 9 screening measures.

II. Increased access to sustainable behavioral health for residents as measured by mobile health encounters (new clients, patient contacts) and telehealth encounters.

III. Increased the number of leadership graduate students graduating with working knowledge of project planning, implementation, and evaluation in rural areas for women with behavioral health issues.

IV. Increased the number of nurse practitioner students graduating with practicum experiences and training specific to diagnosis and management of common behavioral health concerns for women in rural areas.

EMBARC Program for Women-Request for Continued Consideration and Support

We respectfully ask the Youngkin administration for support and reconsideration of this program. The Council on Women requested guidance and financial assistance, whether through aid with federal and state grants or budgetary allocation, to move forward with the proposed program as we believe it would complement and enhance the Governor's Right Help, Right Now Initiative.

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VIRGINIA
COUNCIL
ON
Women

Recommendations to Support Increased Mental Health and Wellness Access and Opportunities for Women, Girls, and Families in the Commonwealth

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The Virginia Council on Women (VCW) recommends the following actions that are under the purview of the Governor of the Commonwealth of Virginia or could be incorporated into legislative action.

The VCW recommends the following actions as delineated by subcommittee for the Governor of the Commonwealth of Virginia's consideration in his budgeting process and advocacy work:

Civic Engagement Subcommittee

The Council on Women has the following recommendations focused on healthcare equity. These recommendations are suggested to be reviewed by the Governor and his team and by the Chief Diversity Officer and Director of the Office of Diversity, Opportunity, and Inclusion, Martin D. Brown.

- The Virginia Council on Women recommends that the work on the James Madison University Partnership continue, as discussed by the Council on Women during their 2022 submission to Governor Youngkin. The partnership would deploy mobile health units staffed by student professionals from the College of Health and Behavioral Sciences at James Madison University to rural communities in need of health care services, including mental health care, through the proposed EMBARC program, which would focus on women's mental health needs in rural communities as was presented in March of 2023. More information is in the full executive summary, and additional fund allocations need budget approval to proceed in the approximate amount of $980,580. (see Appendix C for detailed budget)

Education Equity Subcommittee

The Council on Women has the following recommendations on education equity. These recommendations are suggested to be reviewed not only by the Governor and his team but also by the Secretary of Education Aimee Rogstad Guidera, Chancellor David Doré of Virginia's Community Colleges, as well as the Chief Diversity Officer and Director of the Office of Diversity, Opportunity, and Inclusion Martin D. Brown.

SUPPORTING MENTAL HEALTH PROFESSIONAL EDUCATION ATTAINMENT

The Council on Women's Education Equity subcommittee believes that a key to the Commonwealth leading the nation in accessible mental health diagnosis, care, and treatment is that more Virginians can obtain higher education in behavioral health care, such as social work, counseling, psychiatry, and nursing. Therefore:

- The Council on Women's Education Equity subcommittee would recommend approving the Virginia Association of Community Service Boards (VACSB) funding request for CSBs to be able to provide compensation for internships, clinical supervision hours, student loan repayment programs, and scholarship programs to increase recruitment and retention of the Community Service Boards critical staff.

- The Council on Women's Education Equity subcommittee further supports the current Virginia Department of Health study focused on the Behavioral Health Loan Repayment program that could ensure all eligible behavioral health professional types are included and that there is a focus on these loans in underserved areas as discussed during the Right Help, Right Now, November 2023 stakeholder call.

- The Education Equity subcommittee also supports the development and creation of educational programs that teach behavioral health skills and/or improve licensure rates.
    - This includes the work that the Virginia Department of Education (VDOE) is doing to increase the use of Mental Health First Aid and Mental Health CTE, as discussed in the November 2023 Right Help, Right Now Stakeholder call.

COMMUNITY SERVICE BOARDS STAFFING SUPPORT THROUGH EDUCATION

The Council on Women's Education Equity subcommittee would like to fully endorse the acceptance of the priorities for the 2024-2026 State Budget by the Virginia Association of Community Service Boards (VACSB)[92]

- The Council wholeheartedly supports budget language to authorize DMAS to conduct a rate study for school-based services for children and youth with behavioral health service needs to fulfill phase two of Project BRAVO as noted by VACSB's 2024-2026 State Budget priorities document.

[92] https://vacsb.org/wp-content/uploads/2023/10/VACSB-Budget-Priorities-for-2024-Session.pdf

- Additionally, the Council supports VACSB's request to increase funding for Early Intervention Services to serve children needing those services. VACSB notes that there is an expected increase in the need for those services due to the rise in autism spectrum disorder and substance-exposed infants.

- Further, the Virginia Council on Women supports VACSB's request for budgetary language that directs DMAS to conduct a rebase of the Developmental Disability (DD) waiver services reimbursement rates before each biennial budget.

- Finally, the Council additionally supports VACSB's request for ongoing funds to engage in underage cannabis use prevention program development and provision given the 2021 legalization of simple possession of cannabis, at least until the revenues from those retail sales provide sufficient support for these critical education pursuits to protect the youth of the Commonwealth.

Healthcare Equity Subcommittee

The Council on Women has the following recommendations on healthcare equity. These recommendations are suggested to be reviewed not only by the Governor and his team but also by the Secretary of Health and Human Resources, John Littel, as well as with the Chief Diversity Officer and Director of the Office of Diversity, Opportunity, and Inclusion, Martin D. Brown.

RIGHT HELP RIGHT NOW CONTINUED SUPPORT AND FUNDING ALLOCATION

The Council on Women recommends continued support and work towards the Governor's Right Help, Right Now plan. We support and endorse the six pillars of the plan and hope to see continued efforts to enact and enhance this plan.

- The Council on Women would request consideration of the following items related to the Marcus Alert program, which also is a focus of Pillar 2 in the Right Help, Right Now plan:
    - Provide essential and additional guidance, clarification, and support to local governments and CSBs to ensure the Commonwealth-wide implementation of quality co-responder programs or other alternatives to 9-1-1 responses to mental health emergencies.
    - Continue to support the creation of local co-responder models and other alternatives to traditional 911 response to mental health emergencies as noted in the initiatives of pillar 2 of the Right Help, Right Now plan for all jurisdictions in the Commonwealth on a pre-scheduled basis where localities can plan for the potential increase in budgetary allocation and work to ensure hiring success.

BOARD OF MEDICINE RECOMMENDATIONS FOR EQUITABLE SERVICE PROVISION

- The Council on Women suggests that recommendations be made to ensure the Board of Medicine (under DHP) will 'adopt and implement policies that require each practitioner licensed pursuant to have direct contact with persons who are or may be needing help during a mental health crisis to complete two hours of continuing education related to implicit bias and cultural competency in health care at least once every other license renewal cycle.' As noted above, women are often misdiagnosed and mistreated due to gender bias - so this implicit bias training is intended to help ensure awareness of those issues and save the lives of women and girls in the Commonwealth.

SUPPORT FOR COMMUNITY SERVICE BOARDS TO PROVIDE ACCESSIBLE CARE

The Council on Women would like to fully endorse the acceptance of the priorities for the 2024-2026 State Budget by the Virginia Association of Community Service Boards (VACSB).[93] Specifically, the Council on Women would recommend:

[93] https://vacsb.org/wp-content/uploads/2023/10/VACSB-Budget-Priorities-for-2024-Session.pdf

- Approving VACSB's funding request for CSBs to be able to provide compensation for internships, clinical supervision hours, student loan repayment programs, and scholarship programs to increase recruitment and retention of the Community Service Board's critical staff and future staff members. In their report for their budget priorities for the 2022-2024 biennium, VACSB notes that a $167.5 million investment in recruitment and retention is a top priority for them to ensure that there are adequate current staff in the pipeline to serve the mental health needs of the citizens of the Commonwealth.[94]

- Supporting VACSB's request for a 12.5% rate increase for the Substance Use Disorder (SUD) services that did not receive the permanent 12.5% rate increase that other behavioral health services received. Those services would include Office Based Addiction Treatment (OBAT), Opioid Treatment Program (OTP), Partial Hospitalization Program (PHP), and Intensive Outpatient Program (IOP).

- Providing full-fledged funding is needed for every locality CSB to serve as the accessible, equitable, and proper front-line community-based behavioral health system to avoid deeper end, costly, more restrictive settings for behavioral health care like hospitals and residential treatment centers and improve well-being.

ENSURING THE SUCCESS FOR CERTIFIED PEER SUPPORT WORKERS

The Council on Women's Healthcare Equity subcommittee believes that peer support workers can make an enormous difference in stabilizing citizens with mental health concerns and providing access to meaningful work for peers.

- The Council should continue to develop and support peer support programs to grow the peer recovery specialist workforce where individuals with lived experiences can become certified to support others in recovery.

- The Council would also point to the impact that barrier crime laws have on the ability of individuals with past mental health concerns to become gainfully employed and productive members of society. ***The Healthcare Equity subcommittee partners with the Workforce Equity subcommittee to recommend reconsideration of barrier crimes that can prevent the attainment of peer certification for those with mental health concerns, as well as the barrier to the attainment of other key licensures to provide quality care to those suffering in the Commonwealth.***

[94] https://vacsb.org/wp-content/uploads/2021/10/VACSB-Budget-Priorities-for-2022-GA-Session.pdf

WORKING TO INCENTIVIZE INTEGRATED CARE MODELS

The Council on Women Healthcare subcommittee believes that mental health care is a part of our complete health, not a subsection. Therefore,

- The Council would suggest incentivizing the development of integrated care models so the women and girls of Virginia can expect and receive high-quality behavioral health care from their primary care physicians, including OB/GYNs, particularly in the case of postpartum depression and psychosis. This includes support for those primary care physicians to be able to prescribe medication treatments to the women, girls, and families of Virginia if that treatment is deemed to be supportive.

SPECIFIC SUPPORT FOR THE EXPECTING AND NEW MOTHERS OF THE COMMONWEALTH

Virginia Council on Women's Healthcare subcommittee also supports ensuring behavioral health access for pregnant and postpartum/fourth-trimester women by:

- Expanding insurance coverage for wraparound supports needed to access behavioral healthcare, which also includes transportation and childcare, which is frequently a barrier for women that need to access help.

- Increasing and expanding insurance coverage for Perinatal Depression screening and maternal mental health screenings managed at pediatric visits.

- Expanding use of telehealth to improve access for women and maternal mental health outcomes which may also require continued expansion of broadband access and access to home computing technology for underserved communities.

Workforce Equity Subcommittee

The Council on Women has the following recommendations for workforce equity. These recommendations are suggested to be reviewed not only by the Governor and his team but also by the Secretary of Labor, G. Bryan Slater, Secretary of Commerce and Trade, Caren Merrick, as well as with the Chief Diversity Officer and Director of the Office of Diversity, Opportunity, and Inclusion Martin D. Brown.

SUPPORT & FUNDING FOR VIRGINIA SCHOOLS TO HAVE ACCESS TO MENTAL HEALTH PROFESSIONALS

The Council on Women's Workforce Equity subcommittee believes that the natural increase in access to mental health professionals also means an increase in access to living wages and meaningful work for Virginians. Therefore,

- The Workforce Equity subcommittee supports the efforts that are being made to incentivize K-12 division and school participation in increasing the Behavioral Healthcare pipeline by also addressing barriers to access. The subcommittee requests that the budget reflect the needed funding for schools and districts to hire professionals that can provide needed and equitable access to mental health services for youth through the recruitment and retention of BH professionals such as Mental Health Technicians, Registered Behavioral Technicians, Nationally Certified Psychiatric Technicians, VA Certified Substance Abuse Counselor Assistants, and Qualified Cultural Navigators, as discussed in the November 2023 Right Help, Right Now Stakeholder call.

SUPPORT & FUNDING FOR ALTERNATIVE RESPONSE MODELS OF CRISIS CARE

Given that in 2020, the annual economic burden of the opioid epidemic in Virginia was $3.5 billion dollars[95], the Council on Women's Workforce Equity subcommittee recommends that fiscal allocations work to provide continued support to alternative response models and co-responder models as alternatives to traditional 911 responses to mental health emergencies as laid out in both the Governor's Right Help Right No Plan's Pillar 2 and the Marcus Alert legislation.

- Specifically, these alternative response models can provide an increased behavioral health workforce and additional opportunities for behavioral health professionals, including certified peer support workers.
- Further, funding efforts should support hiring VA Certified Substance Abuse Counselor Assistants and VA Certified Peer Support Specialists for these alternative response models to provide needed access to gainful and meaningful employment for those who have experienced mental health concerns and data-driven support for those in crisis.

[95] Virginia Department of Health and Human Resources, "Virginia Opioid Data."

SUPPORT & FUNDING FOR MEDICAL AND BEHAVIORAL HEALTH RESERVE CORPS

The Council on Women's Workforce Equity Subcommittee supports the continued work and efforts to create and stand up a Behavioral Health Reserve Corps (BHRC), like the Virginia Medical Reserve Corps (VMRC)[96], as discussed during the Right Help, Right Now November 2023 Stakeholder Call.

- The Council would like to provide further encouragement for the state to assist local governments in standing up their own VMRC or BHRC such as has been done in Arlington County[97], Fairfax County[98], Loudoun County[99], and the City of Virginia Beach[100] as all localities cannot set up such services. Still, all citizens deserve equal access to these services in the case of an emergency.

CONTINUED SUPPORT FOR THE COMMONWEALTH'S COMMUNITY SERVICE BOARDS

The Council on Women's Workforce Equity Subcommittee also recognizes the importance of Community Service Boards (CSB) and the proper staffing of those organizations.

- In 2022, the Joint Legislative Audit Review (JLARC) reported that the average turnover rate among CSB direct care staff in FY22 was 25.2%. Further, some CSBs have vacancy rates above 30%. The Council believes that there must be a significant investment in CSB workforce development initiatives to decrease individual waiting time without treatment in our emergency departments, to increase the capacity to provide substance use disorder treatments, to reduce delays for individuals and families who need to access developmental disability services and to ensure the survival of programs and facilities that support mental wellness in our communities that make up our workforce.[101]

- The Council's Workforce Equity subcommittee would also like to provide continued enforcement to reduce administrative burdens for clinicians that may often cause seasoned behavioral health professionals to leave our CSBs. Specifically, as discussed in the November 2023 Right Help, Right Now stakeholder call, we fully support the tentative 2024 launch of a technical assistance tool to help alleviate administrative burden, streamline administrative processes, and improve efficiencies so that providers can provide clinical care to Virginians versus completing paperwork that does not resolve mental health crises, and the enhancement of opportunities for patient-face time versus administrative workload that is not present in other mental health organizations that may be private or for profit in the Commonwealth. We hope that the

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[96] Virginia Medical Reserve Corps (MRC) https://www.vdh.virginia.gov/mrc/

[97] https://www.arlingtonva.us/Government/Programs/Health/Medical-Reserve-Corps/mrc-teams-advanced-training

[98] https://www.fairfaxcounty.gov/health/medical-reserve-corps

[99] https://www.loudoun.gov/1352/Medical-Reserve-Corps

[100] https://www.facebook.com/VBMRC/

[101] https://vacsb.org/wp-content/uploads/2023/10/2023-VACSB-FINAL-PP-Brochure-for-Printing-Out.pdf

work to level the playing field and make public service work the career of choice is fully funded and continues quickly before more professionals are lost to other providers or employment opportunities.

RECONSIDERATION OF BARRIER CRIMES TO INCREASE WORKFORCE & PEER ACCESS

The Council on Women's Workforce Equity Subcommittee also encourages the consideration of the removal of certain barrier crimes that prevent formerly incarcerated people from becoming gainfully employed in many professions, including mental health care.

- The Council suggests that research be done to consider expanding upon HB 1525 (2023) and SB 846 (2023) that permitted Department of Behavioral Health and Developmental Services (DBHDS), direct service care providers, and community boards to hire peer recovery specialists who had been convicted of certain barrier crimes where the office would not pose a risk in the work of a peer recovery specialist. While the Governor signed this into law after the 2023 General Assembly session, further research could illuminate whether additional restrictions could be lifted to allow individuals with certain barrier crimes to engage in more professionalized mental health care services in the commonwealth through proper licensure obtainment.[102]

National and Commonwealth-Wide Resource Page

Given the seriousness of this topic, the Council on Women would like to provide national and Commonwealth specific information for individuals who may see this report and need help, support, and care access.

Mental Health

If you or someone you know is struggling or in crisis, help is available. Please **call or text 988** or chat online at **988lifeline.org**

Text HOME to 741741 to connect to a Crisis Counselor

[102] Legislative Information System, "LIS > Bill Tracking > HB 1525 > 2023 Session."

In Virginia, you can dial the Mental Health America of Virginia Warm Line at **1-866-400-MHAV (6428)** at the following hours:

- Monday-Friday: 9am to 9pm
- Saturday, Sunday, and Holidays: 5pm to 9pm
- Spanish Services every Friday and Saturday from 5pm-9pm (call or text)

You can also **text 1-866-400-6428** for support Wednesday, Friday, and Saturday from 5pm-9pm

If you are a member of the military or a veteran, please reach out to their crisis line by dialing **988 and then press #1** (24/7; 365 days a year) [website: https://www.veteranscrisisline.net/]

In cases of disasters, please reach out to the SAMHSA Disaster Distress Line at **1-800-985-5990** or text **TalkWithUs to 66746** to speak to a trained crisis council (24/7, 365 days-a-year for people who are experiencing emotional distress related to any natural or human-caused disaster, multilingual)
Español: Llama o envía un mensaje de texto **1-800-985-5990** presiona “2.”
For Deaf and Hard of Hearing ASL Callers: call **1-800-985-5990** from your videophone. ASL Support is available 24/7.

SAMHSA’s National Helpline is a free, confidential, 24/7, 365 day a year treatment referral and information service in English and Spanish. Please dial **1-800-662-HELP (4357)** or TTY: **1-800-487-4889**

The referral service is free of charge, and you do not need health insurance to call.

Domestic Violence and Sexual Assault

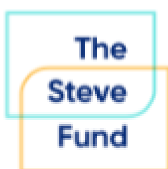
In the Commonwealth you can reach out to the Virginia Sexual Assault and Domestic Violence Hotline for help, please dial **1-800-838-8238 (Language Line Available) or text 804-793-9999** (website: https://vsdvalliance.org/get-help-ayuda/hotlines/)

Nationally, if you are a victim of domestic violence, please dial **1-800-799-7233 or text LOVEIS to 22522**

Children & Teens

ChildHelp provides 24/7 assistance in 170 languages to adults, children and youth with information and questions regarding child abuse – all calls are anonymous and confidential – please dial **1-800-4AChild (1-800-442-4453) or text 1-800-422-4453**

The Boys Town National Hotline is open 24/7, 365 days a year to help. **Dial 1-800-448-300 or text VOICE to 20121**. Spanish speaking counselors and translation services for more than one hundred languages available. Speech and hearing-impaired teens can contact them via email at hotline@boystown.org



Are you a young person of color? Feeling down, stressed, or overwhelmed? **Text STEVE to 741741**

Loveisrespect.org has peer advocates 24/7 to support teens with concerns about dating violence. **Call 1-800-311-9474, text loveis to 22522 or chat on their website www.loveisrespect.org**

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APPENDIX A:
Proposed Timeline for EMBARC Program for Women

Budget Year	Objectives	Milestone Activities	Outcome
Y1	Leadership Projects	Establish faculty to work with MSN/DNP leadership students. Meet with local providers and leaders of BH in identified areas- Page County Valley Health. MOU agreements with CSB in identified areas. Collaborate with community leaders to identify locations or facilities for mobile health visits. Develop and implement a mentorship program with leaders in rural health clinics, medically underserved areas, for leadership students.	Increased leadership graduate students with working knowledge of project implementation in rural areas for women with behavioral health issues (Outcome III). Increased access to behavioral health for residents as measured by mobile health encounters (new clients, patient contacts) and telehealth encounters (Outcome II).

Y1	Mobile Unit	Establish availability of mobile units from state resources. Refurbish mobile unit with equipment for telehealth and face to face visit in communities. Hire autonomous practice PMHNP to staff mobile unit and precept EMBARC Scholar APRN students assigned to the Mobile Unit. Hire social workers for resource allocation in identified areas OR hire scheduler assistant with rural health expertise. Obtain laptop computers and software to support rural telehealth and face-to-face visits. Initiate marketing in identified areas for mobile unit visits. Enact initial mental health mobile visits 3 days in the identified area. Initiate data collection on screenings for GAD-7 and PHQ.	Active mobile unit to provide care to rural areas on regularly scheduled basis (Outcome II). Increased access to behavioral health for residents as measured by mobile health encounters (new clients, patient contacts) and telehealth (Outcome II).

Y1	APRN training	Evaluate learning objectives across APRN programs to promote capacity building for addressing the behavioral needs of rural and underserved women. Create didactic learning modules to be embedded in practicum courses for content and knowledge assessment activities for EMBARC Scholar students. Identify and develop speaker series focusing on equitable behavioral healthcare in rural and underserved areas. Map course assignments to engage EMBARC Scholars in content on SDoH and diagnosis and management of common women's behavioral health concerns. Identify ten students to be participants in EMBARC scholarships and stipends. Identify psych/behavioral health community providers to precept and supervise EMBARC Scholar students for 80 hours during practicum. Develop and implement a mentorship program with APRN's practicing in rural health clinics, medically underserved areas, for APRN students.	Course curriculum enhancements planned. Speaker series planned and implemented. Evaluate process of speaker series and curriculum enhancements (Outcomes III and IV). Provide scholarships and stipends to PMHNP, AGPCNP and FNP students.

Y2	Leadership Projects	Analyze data from GAD-7 & and PHQ 9 screenings to document trends in rates of depression, anxiety, or behavioral health concerns. Evaluate outcomes: increased contact with patients, lower costs of visits, rates of medication refills, and lower ED visits for BH hospitalizations and patient service. Initiate stakeholders' partnership with Page County to support sustainability. Expand collaboration with stakeholders in identified counties with similar needs for replication and capacity building planning with recommendations for the governor's office.	Decreased reported rates of depression, anxiety, or behavioral health concerns in the pilot county areas as measured by GAD-7 and PHQ screening measures. (Outcome II and Outcome III).

Y2	Mobile Unit	Increase number of encounters with rural women related to behavioral health concerns, depression, and anxiety. Increase referral capacity and local community contact points for sustainable care for clients. Support sustainability in year one project in initial county	Decreased reported rates of depression, anxiety, or behavioral health concerns in the pilot county areas as measured by GAD-7 and PHQ screening measures. (Outcome I).

Y2	APRN training	Evaluate outcomes/competency of student knowledge gained from didactic modules and speakers series embedded in NP Practicum courses for EMBARC Scholar students. Assess student competence in screening for, diagnosing, managing, and treating behavioral health concerns in rural women. Revise series content and curriculum based on findings from the evaluation. Retain APRN graduates in rural, under-served areas by strengthening community connection through experiences each semester. Imbed sustainable curricula for all APRN students on rural women's behavioral health. Initiate recruitment fairs for graduating students' employment in rural areas. Disseminate successful program outcomes with VACN participating schools	Increased knowledge and competence of graduating JMU APRN students in the diagnosis, management, and treatment of common behavioral health concerns of rural women. Increased number of nurse practitioner students graduating with practicum experiences and training specific to diagnosis and management of behavioral health for women. (Outcome IV).

A B

APPENDIX B
Virginia HPSA Type Detail for Geographic Area HPSA by HPSA Name[103]

Discipline	HPSA Subtype	County	HPSA Name	HPSA Status	Last Update Date
Mental Health	Geographic HPSA	Cumberland	Crossroads MHCA	Designated	09/10/2021
Mental Health	Geographic HPSA	Amelia	Crossroads MHCA	Designated	09/10/2021
Mental Health	Geographic HPSA	Charlotte	Crossroads MHCA	Designated	09/10/2021
Mental Health	Geographic HPSA	Buckingham	Crossroads MHCA	Designated	09/10/2021
Mental Health	Geographic HPSA	Nottoway	Crossroads MHCA	Designated	09/10/2021
Mental Health	Geographic HPSA	Lunenburg	Crossroads MHCA	Designated	09/10/2021
Mental Health	Geographic HPSA	Prince Edward	Crossroads MHCA	Designated	09/10/2021
Mental Health	Geographic HPSA	Russell	Cumberland Mountain/Dickerson MHCAs	Designated	09/10/2021
Mental Health	Geographic HPSA	Dickenson	Cumberland Mountain/Dickerson MHCAs	Designated	09/10/2021
Mental Health	Geographic HPSA	Buchanan	Cumberland Mountain/Dickerson MHCAs	Designated	09/10/2021
Mental Health	Geographic HPSA	Tazewell	Cumberland Mountain/Dickerson MHCAs	Designated	09/10/2021
Mental Health	Geographic HPSA	Northampton	Eastern Shore Service Area	Designated	08/06/2021
Mental Health	Geographic HPSA	Accomack	Eastern Shore Service Area	Designated	08/06/2021
Mental Health	Geographic HPSA	Galax City	HN-Mount Rogers MHCA	Designated	08/18/2021
Mental Health	Geographic HPSA	Bland	HN-Mount Rogers MHCA	Designated	08/18/2021
Mental Health	Geographic HPSA	Carroll	HN-Mount Rogers MHCA	Designated	08/18/2021
Mental Health	Geographic HPSA	Grayson	HN-Mount Rogers MHCA	Designated	08/18/2021

[103] U.S. Health Resources & Services Administration, "Health Workforce Shortage Areas."

Mental Health	Geographic HPSA	Smyth	HN-Mount Rogers MHCA	Designated	08/18/2021
Mental Health	Geographic HPSA	Wythe	HN-Mount Rogers MHCA	Designated	08/18/2021
Mental Health	Geographic HPSA	Gloucester	Middle Peninsula/Northern Neck MHCA	Designated	09/10/2021
Mental Health	Geographic HPSA	King and Queen	Middle Peninsula/Northern Neck MHCA	Designated	09/10/2021
Mental Health	Geographic HPSA	Westmoreland	Middle Peninsula/Northern Neck MHCA	Designated	09/10/2021
Mental Health	Geographic HPSA	Mathews	Middle Peninsula/Northern Neck MHCA	Designated	09/10/2021
Mental Health	Geographic HPSA	Lancaster	Middle Peninsula/Northern Neck MHCA	Designated	09/10/2021
Mental Health	Geographic HPSA	King William	Middle Peninsula/Northern Neck MHCA	Designated	09/10/2021
Mental Health	Geographic HPSA	Richmond	Middle Peninsula/Northern Neck MHCA	Designated	09/10/2021
Mental Health	Geographic HPSA	Essex	Middle Peninsula/Northern Neck MHCA	Designated	09/10/2021
Mental Health	Geographic HPSA	Northumberland	Middle Peninsula/Northern Neck MHCA	Designated	09/10/2021
Mental Health	Geographic HPSA	Middlesex	Middle Peninsula/Northern Neck MHCA	Designated	09/10/2021
Mental Health	Geographic HPSA	Scott	Planning District I MHCA	Designated	08/18/2021
Mental Health	Geographic HPSA	Norton City	Planning District I MHCA	Designated	08/18/2021
Mental Health	Geographic HPSA	Wise	Planning District I MHCA	Designated	08/18/2021
Mental Health	Geographic HPSA	Lee	Planning District I MHCA	Designated	08/18/2021
Mental Health	Geographic HPSA	Fauquier	Rappahannock/Rapidan	Designated	08/06/2021
Mental Health	Geographic HPSA	Orange	Rappahannock/Rapidan	Designated	08/06/2021
Mental Health	Geographic HPSA	Culpeper	Rappahannock/Rapidan	Designated	08/06/2021
Mental Health	Geographic HPSA	Madison	Rappahannock/Rapidan	Designated	08/06/2021
Mental Health	Geographic HPSA	Rappahannock	Rappahannock/Rapidan	Designated	08/06/2021

APPENDIX C:
Virginia HPSA Type Detail for Low Income Population HPSA by County/City[104]

Discipline	HPSA Type	HPSA Subtype	County	HPSA Name	HPSA Status	Last Update Date
Mental Health	Population Group	Low Income Population HPSA	Albemarle	LI-Region 10 MHCA	Designated	08/06/2021
Mental Health	Population Group	Low Income Population HPSA	Alleghany	LI - Alleghany Highlands MHCA	Designated	09/10/2021
Mental Health	Population Group	Low Income Population HPSA	Amherst	LI - Horizon/Central Virginia MHCA	Designated	09/10/2021
Mental Health	Population Group	Low Income Population HPSA	Appomattox	LI - Horizon/Central Virginia MHCA	Designated	09/10/2021
Mental Health	Population Group	Low Income Population HPSA	Augusta	LI-Valley MHCA	Designated	08/06/2021
Mental Health	Population Group	Low Income Population HPSA	Bath	LI - Rockbridge Service Area	Designated	09/10/2021
Mental Health	Population Group	Low Income Population HPSA	Bedford	LI - Horizon/Central Virginia MHCA	Designated	09/10/2021
Mental Health	Population Group	Low Income Population HPSA	Botetourt	LI - Blueridge MHCA	Designated	04/04/2023
Mental Health	Population Group	Low Income Population HPSA	Bristol City	LI - Highlands Service Area	Designated	09/10/2021
Mental Health	Population Group	Low Income Population HPSA	Brunswick	LI - Southside MHCA	Designated	12/10/2021
Mental Health	Population Group	Low Income Population HPSA	Buena Vista City	LI - Rockbridge Service Area	Designated	09/10/2021
Mental Health	Population Group	Low Income Population HPSA	Campbell	LI - Horizon/Central Virginia MHCA	Designated	09/10/2021
Mental Health	Population Group	Low Income Population HPSA	Caroline	LI - Rappahannock Area MHCA	Designated	12/10/2021
Mental Health	Population Group	Low Income Population HPSA	Charles City	LI - Henrico MHCA 20	Designated	03/01/2022

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Mental Health	Population Group	Low Income Population HPSA	Charlottesville City	LI-Region 10 MHCA	Designated	08/06/2021
Mental Health	Population Group	Low Income Population HPSA	Chesterfield	LI-Chesterfield MHCA	Designated	05/04/2022
Mental Health	Population Group	Low Income Population HPSA	Clarke	Northwestern MHCA	Designated	09/08/2021
Mental Health	Population Group	Low Income Population HPSA	Colonial Heights City	LI-Region19-MHCA	Designated	08/06/2021
Mental Health	Population Group	Low Income Population HPSA	Covington City	LI - Alleghany Highlands MHCA	Designated	09/10/2021
Mental Health	Population Group	Low Income Population HPSA	Craig	LI - Blueridge MHCA	Designated	04/04/2023
Mental Health	Population Group	Low Income Population HPSA	Danville City	LI - Danville City/Pittsylvania County	Designated	09/10/2021
Mental Health	Population Group	Low Income Population HPSA	Dinwiddie	LI-Region19-MHCA	Designated	08/06/2021
Mental Health	Population Group	Low Income Population HPSA	Emporia City	LI-Region19-MHCA	Designated	08/06/2021
Mental Health	Population Group	Low Income Population HPSA	Floyd	LI - New River Valley MHCA	Designated	09/10/2021
Mental Health	Population Group	Low Income Population HPSA	Fluvanna	LI-Region 10 MHCA	Designated	08/06/2021
Mental Health	Population Group	Low Income Population HPSA	Franklin	LI - Piedmont MHCA	Designated	08/18/2021
Mental Health	Population Group	Low Income Population HPSA	Franklin City	West Tidewater-MHCA	Designated	08/17/2021
Mental Health	Population Group	Low Income Population HPSA	Frederick	Northwestern MHCA	Designated	09/08/2021
Mental Health	Population Group	Low Income Population HPSA	Fredericksburg City	LI - Rappahannock Area MHCA	Designated	12/10/2021
Mental Health	Population Group	Low Income Population HPSA	Giles	LI - New River Valley MHCA	Designated	09/10/2021

Mental Health	Population Group	Low Income Population HPSA	Goochland	LI - Goochland-Powhatan MHCA	Designated	03/01/2022
Mental Health	Population Group	Low Income Population HPSA	Greene	LI-Region 10 MHCA	Designated	08/06/2021
Mental Health	Population Group	Low Income Population HPSA	Greensville	LI-Region19-MHCA	Designated	08/06/2021
Mental Health	Population Group	Low Income Population HPSA	Halifax	LI - Southside MHCA	Designated	12/10/2021
Mental Health	Population Group	Low Income Population HPSA	Hampton City	Hampton-Newport News MHCA-LI	Designated	09/08/2021
Mental Health	Population Group	Low Income Population HPSA	Hanover	LI - Hanover County MHCA 18	Designated	06/02/2023
Mental Health	Population Group	Low Income Population HPSA	Harrisonburg City	LI-Rockingham County/Harrisonburg City	Designated	09/10/2021
Mental Health	Population Group	Low Income Population HPSA	Henrico	LI - Henrico MHCA 20	Designated	03/01/2022
Mental Health	Population Group	Low Income Population HPSA	Henry	LI - Piedmont MHCA	Designated	08/18/2021
Mental Health	Population Group	Low Income Population HPSA	Highland	LI-Valley MHCA	Designated	08/06/2021
Mental Health	Population Group	Low Income Population HPSA	Hopewell City	LI-Region19-MHCA	Designated	08/06/2021
Mental Health	Population Group	Low Income Population HPSA	Isle of Wight	West Tidewater-MHCA	Designated	08/17/2021
Mental Health	Population Group	Low Income Population HPSA	James City	LI - Colonial MHCA 8	Designated	03/01/2022
Mental Health	Population Group	Low Income Population HPSA	King George	LI - Rappahannock Area MHCA	Designated	12/10/2021
Mental Health	Population Group	Low Income Population HPSA	Lexington City	LI - Rockbridge Service Area	Designated	09/10/2021
Mental Health	Population Group	Low Income Population HPSA	Louisa	LI-Region 10 MHCA	Designated	08/06/2021

Mental Health	Population Group	Low Income Population HPSA	Lynchburg City	LI - Horizon/Central Virginia MHCA	Designated	09/10/2021
Mental Health	Population Group	Low Income Population HPSA	Martinsville City	LI - Piedmont MHCA	Designated	08/18/2021
Mental Health	Population Group	Low Income Population HPSA	Mecklenburg	LI - Southside MHCA	Designated	12/10/2021
Mental Health	Population Group	Low Income Population HPSA	Montgomery	LI - New River Valley MHCA	Designated	09/10/2021
Mental Health	Population Group	Low Income Population HPSA	Nelson	LI-Region 10 MHCA	Designated	08/06/2021
Mental Health	Population Group	Low Income Population HPSA	New Kent	LI - Henrico MHCA 20	Designated	03/01/2022
Mental Health	Population Group	Low Income Population HPSA	Newport News City	Hampton-Newport News MHCA-LI	Designated	09/08/2021
Mental Health	Population Group	Low Income Population HPSA	Norfolk City	LI - Norfolk City	Designated	09/08/2021
Mental Health	Population Group	Low Income Population HPSA	Page	Northwestern MHCA	Designated	09/08/2021
Mental Health	Population Group	Low Income Population HPSA	Patrick	LI - Piedmont MHCA	Designated	08/18/2021
Mental Health	Population Group	Low Income Population HPSA	Petersburg City	LI-Region19-MHCA	Designated	08/06/2021
Mental Health	Population Group	Low Income Population HPSA	Pittsylvania	LI - Danville City/Pittsylvania County	Designated	09/10/2021
Mental Health	Population Group	Low Income Population HPSA	Poquoson City	LI - Colonial MHCA 8	Designated	03/01/2022
Mental Health	Population Group	Low Income Population HPSA	Portsmouth City	LI-Portsmouth	Designated	09/08/2021
Mental Health	Population Group	Low Income Population HPSA	Powhatan	LI - Goochland-Powhatan MHCA	Designated	03/01/2022
Mental Health	Population Group	Low Income Population HPSA	Prince George	LI-Region19-MHCA	Designated	08/06/2021

Mental Health	Population Group	Low Income Population HPSA	Pulaski	LI - New River Valley MHCA	Designated	09/10/2021
Mental Health	Population Group	Low Income Population HPSA	Radford City	LI - New River Valley MHCA	Designated	09/10/2021
Mental Health	Population Group	Low Income Population HPSA	Richmond City	LI-Richmond City	Designated	08/06/2021
Mental Health	Population Group	Low Income Population HPSA	Roanoke	LI - Blueridge MHCA	Designated	04/04/2023
Mental Health	Population Group	Low Income Population HPSA	Roanoke City	LI - Blueridge MHCA	Designated	04/04/2023
Mental Health	Population Group	Low Income Population HPSA	Rockbridge	LI - Rockbridge Service Area	Designated	09/10/2021
Mental Health	Population Group	Low Income Population HPSA	Rockingham	LI-Rockingham County/Harrisonburg City	Designated	09/10/2021
Mental Health	Population Group	Low Income Population HPSA	Salem City	LI - Blueridge MHCA	Designated	04/04/2023
Mental Health	Population Group	Low Income Population HPSA	Shenandoah	Northwestern MHCA	Designated	09/08/2021
Mental Health	Population Group	Low Income Population HPSA	Southampton	West Tidewater-MHCA	Designated	08/17/2021
Mental Health	Population Group	Low Income Population HPSA	Spotsylvania	LI - Rappahannock Area MHCA	Designated	12/10/2021
Mental Health	Population Group	Low Income Population HPSA	Stafford	LI - Rappahannock Area MHCA	Designated	12/10/2021
Mental Health	Population Group	Low Income Population HPSA	Staunton City	LI-Valley MHCA	Designated	08/06/2021
Mental Health	Population Group	Low Income Population HPSA	Suffolk City	West Tidewater-MHCA	Designated	08/17/2021
Mental Health	Population Group	Low Income Population HPSA	Surry	LI-Region19-MHCA	Designated	08/06/2021
Mental Health	Population Group	Low Income Population HPSA	Sussex	LI-Region19-MHCA	Designated	08/06/2021

Mental Health	Population Group	Low Income Population HPSA	Warren	Northwestern MHCA	Designated	09/08/2021
Mental Health	Population Group	Low Income Population HPSA	Washington	LI - Highlands Service Area	Designated	09/10/2021
Mental Health	Population Group	Low Income Population HPSA	Waynesboro City	LI-Valley MHCA	Designated	08/06/2021
Mental Health	Population Group	Low Income Population HPSA	Williamsburg City	LI - Colonial MHCA 8	Designated	03/01/2022
Mental Health	Population Group	Low Income Population HPSA	Winchester City	Northwestern MHCA	Designated	09/08/2021
Mental Health	Population Group	Low Income Population HPSA	York	LI - Colonial MHCA 8	Designated	03/01/2022