FINAL REPORT OF THE
VIRGINIA COMMISSION ON YOUTH

Youth with Emotional Disturbance Requiring Out-of-Home Treatment

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

HOUSE DOCUMENT NO. 23

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COMMONWEALTH of VIRGINIA
Commission on Youth

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January 9, 2002

TO: The Honorable James S. Gilmore, III, Governor of Virginia

and

Members of the Virginia General Assembly

The 2000 General Assembly, through House Joint Resolution 119, requested that the Virginia Commission on Youth "be directed to study youth with Emotional Disturbance Requiring Out-of-Home Treatment."

Enclosed for your review and consideration is the final report for this two-year study, which has been prepared in response to this request. The Commission received assistance from all affected agencies and gratefully acknowledges their input into this report.

Respectfully submitted,

Phillip A. Hamilton

Phillip A. Hamilton
Chairman

MEMBERS OF THE VIRGINIA COMMISSION ON YOUTH

From the Virginia House of Delegates

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L. Karen Darner
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Robert F. McDonnell
John S. Reid
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Appendices

I. Authority for Study

Section 30-174 of the *Code of Virginia* establishes the Commission on Youth and directs it to "... study and provide recommendations addressing the needs of and services to the Commonwealth's youth and their families." This section also directs it to "...encourage the development of uniform policies and services to youth across the Commonwealth and provide a forum for continuing review and study of such services." Furthermore, "in addition to its own proposals, the Commission shall coordinate the proposals and recommendations of all commissions and agencies as to legislation affecting youth."

The 2000 General Assembly conveyed House Joint Resolution 119 to the Commission by way of letter from the Speaker of the House of Delegates. The resolution directed the Commission to study children and youth with serious emotional disturbance requiring out-of-home placement.

In fulfilling its legislative mandate, the Commission undertook the two-year study. An interim report of the first year study efforts was published as House Document 49, 2001. The second year of the study concludes with this report to the 2002 General Assembly Session.

II. Members

The authorizing legislation required the Commission on Youth to study children and youth with serious emotional disturbances requiring out-of-home placement. The Commission received briefings and presentations during the spring and fall of 2000 and the spring, summer and fall of 2001. Members of the Commission on Youth are:

Del. Phillip A. Hamilton, Chair, Newport News
Del. L. Karen Darner, Arlington
Sen. R. Edward Houck, Spotsylvania
Del. Jerrauld C. Jones, Norfolk
Del. Robert F. McDonnell, Virginia Beach
Sen. Yvonne B. Miller, Norfolk
Del. John S. Reid, Chesterfield
Sen. D. Nick Rerras, Norfolk
Del. Robert Tata, Virginia Beach
Mr. Steve Cannizzarro, Norfolk
Mr. Gary Close, Vice Chair, Culpeper
Mr. Douglas Jones, Alexandria

III. Executive Summary

House Joint Resolution 119 directed the Commission on Youth to conduct a two-year study of children and youth with serious emotional disturbance requiring out-of-home placement (SED-OH). The resolution instructed the Commission to develop and implement a methodology for accurately determining the number of children who were determined to be SED-OH. The resolution outlined goals for both the first year and second year of the study.

First Year Study

During the first year, the Commission established a 19-member Advisory Group to provide oversight and direction. The Advisory Group, whose composition was defined in the HJR 119 resolution, identified both child and family characteristics which define the children and youth with serious emotional disturbance in need of out-of-home placement. To be included in the study, the child was required to meet certain personal characteristics, as well as to have resided with a caregiver that exhibited certain family characteristics.

A child met the criteria for SED-OH if s/he was found to:

- have a DSM-IV Diagnosis and/or have at least two functional child characteristics* which have lasted or are expected to last at least one year without treatment; and
- live with a caregiver that exhibited certain family characteristics*

** A complete listing of the child and family characteristics that were considered for the purposes of this study is provided in Section VI.*

The Commission contracted with the Applied Social Psychology Research Institute in the Department of Psychology at the College of William and Mary to assist in the data collection effort. In the fall of 2000 and the spring of 2001, the principal investigator, John B. Nezlek, Ph.D., of the College of William and Mary, conducted surveys that were designed to provide the Commission with an estimate of the number of children in the Commonwealth who experienced severe emotional disturbance in need of out-of-home placement (SED-OH). The Advisory Group identified Virginia officials integrally involved with children with SED-OH who could provide this information for each region.

Surveys were sent to the following Virginia officials:

- Chair, Community Policy and Management Team (CPMT)
- Director, Department of Social Services (DSS)
- Director, Court Service Unit (CSU)
- Director, Community Services Board (CSB)
- Director, Special Education Services (SpEd)

The survey asked respondents in 26 selected communities in five regions to describe the SED-OH cases with which they were familiar. The SED-OH rates then were obtained by comparing these reports to population estimates. At the Commission on Youth's December 19, 2000 meeting, the survey results were presented. At this meeting, recommendations were made to strengthen the data collected and provide a more accurate representation of the number of children with SED-OH. Three administrative recommendations for the second year study were developed at the direction of the Commission.

Recommendations

The Commission on Youth, in conjunction with the College of William and Mary, should examine the reports of local agencies in which no qualifying cases were reported in the initial survey results from local Departments of Social Services, Court Services Units, Community Services Boards, and Special Education Departments to determine their accuracy.

The Commission on Youth, in conjunction with the College of William and Mary, should consider investigating reports from individual agencies that constituted less than 5% of the total reports in their respective communities.

The Commission on Youth, in conjunction with the College of William and Mary, should organize the data by regions (not locality) as the unit of analysis.

The initial findings and recommendations were published as an interim report in House Document 49, 2001. Updated first year report data is provided as Section V in this report. No legislation for the study was introduced in the 2001 Session.

Second Year Study

The Advisory Group established in the first year was reconvened with the addition of a representative from the Virginia Department of Medical Assistance Services. Upon opening the discussion and establishing the work plan for the second year of the study, it became clear that any study of children and youth with SED-OH could not be limited to a child's needs while in an out-of-home placement. Since a child's need for residential placement is only a moment in time within the full continuum of the child's treatment needs, a thorough examination of the issue necessarily would include a review of the full continuum of services that has been shown to be effective in treating children and youth with serious emotional disturbance. An examination of the needs of these children revealed that there are opportunities to help the child and his/her family prior to a residential placement that may, in fact, prevent or reduce the likelihood that the child will need residential placement. Likewise, there are opportunities to help the child and his/her family after the child returns from a residential placement that may prevent reentry into a residential placement.

In conducting the second year study, Commission staff reviewed numerous national and state publications and reports, convened four meetings of its 20-member advisory group, called a fifth meeting of advisors having special knowledge of related budgets and expertise in ascertaining fiscal impact, conducted five regional focus group meetings, and reviewed data collected during the first year of the study and data regarding service capacities.

Based upon an analysis of the data collected, reviews of related reports and publications and the input and expertise of the advisory and focus groups, the following recommendations were offered:

CAPACITY

Child and Adolescent Acute Psychiatric Beds

Recommendation 1

Direct the Department of Mental Health, Mental Retardation and Substance Abuse Services to identify and create opportunities for public-private partnerships and the incentives necessary to establish and maintain an adequate supply of acute care psychiatric beds for children and adolescents, while acknowledging the Commonwealth's responsibility to serve this population.

Recommendation 2

Direct Virginia Health Information to provide the number of licensed and staffed acute care psychiatric beds and residential treatment beds for children and adolescents in public and private facilities, as well as the actual demand for these beds, to the General Assembly by December 1, 2002.

Residential Treatment

Recommendation 3

Direct the Department of Mental Health, Mental Retardation and Substance Abuse Services and the Department of Juvenile Justice, where appropriate, to identify and create opportunities for public-private partnerships and the necessary incentives to establish and maintain an adequate supply of residential beds for the treatment of juveniles with mental health treatment needs, including those who are mentally retarded, aggressive, or sex offenders and those juveniles who need short-term crisis stabilization short of psychiatric hospitalization.

Community-based Treatment Services

Recommendation 4

Amend Virginia Code §37.1-194 (Purpose; services to be provided), which specifies the CORE services and other services that may be available through a Community Services Board (CSB), to specify that the services available will be provided to adults, children and adolescents rather than to "persons" as it is currently written.

Recommendation 5

Support and endorse the concept of KOKAH[1] or other similar models in which an array of community-based services is emphasized. Support the continuation of existing funding levels for the KOKAH model implemented by Blue Ridge Community Services.

Recommendation 6

Amend and continue in the current biennium budget and in the 2002-2004 budget the current biennium language (323 K) that requires "the Department of Mental Health, Mental Retardation and Substance Abuse Services, *the Department of Juvenile Justice*[2] and the Department of Medical Assistance Services, in cooperation with the Office of Comprehensive Services, Community Services Boards, and Court Service Units" to "develop an integrated policy and plan, including the necessary legislation and budget

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[1] The Keep Our Kids At Home (KOKAH) project demonstrated success in reducing state inpatient hospitalization; the project also recognized a need for a broader array of community-based diversion and step-down services.

[2] Amendment proposed by the Commission on Youth

amendments, to provide and improve access by children, *including juvenile offenders*[3], to mental health, substance abuse and mental retardation services…" Require the Departments to report on the plan to the Senate Committee on Finance and House Committee on Appropriations by June 30, 2002.

MENTAL HEALTH PROFESSIONAL AND TEACHER SHORTAGE

Recommendation 7

Direct the Virginia Department of Health (VDH) to expand the Virginia Physicians Loan Repayment Program to include more psychiatrists, including child psychiatrists, and appropriate additional funds to support such an expansion, including support for VDH staff to administer the program.

Recommendation 8

Appropriate $50,000 for and direct the Virginia Department of Health (VDH) to pursue the expansion of the National Health Service Corp (NHSC) - Virginia Loan Repayment Program to include mental health professionals (as defined by the NHSC). Financial support should include support for VDH staff to administer the program.

Recommendation 9

Direct the Virginia Department of Health (VDH) to expand the Virginia Physicians Loan Repayment Program to include other types of mental health professionals beyond psychiatrists, including doctoral clinical psychologist, clinical social worker, or psychiatric nurse specialist. The Virginia Department of Health Professions should also ensure that $1 be set aside from the state license fees of each of the participants in order to provide continued financial support for the program. Financial support should include support for VDH staff to administer the program

Recommendation 10

Request that the Virginia Department of Health explore the expanded use of telepsychiatry for underserved areas.

Recommendation 11

Continue the current funding level for recruitment and retention of psychiatrists under the Gilmore Fellows Program (2000 Budget Item 323G), in which psychiatry residents are paid a stipend to work in under served areas with a portion designated for the recruitment and retention of child psychiatrists.

Recommendation 12

Direct the Virginia Department of Education (DOE) to expand the Virginia Teaching Scholarship Loan Program to enable more teachers seeking an emotional disturbance endorsement to receive funding. Financial support should include support for DOE staff to administer the program.

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[3] Amendment proposed by the Commission on Youth

COMPREHENSIVE SERVICES ACT

Service Fee Directory

Recommendation 13

Request the State Executive Council to improve the information available in and revise the system through which provider information is placed in the Directory, including the procedures by which the information is updated and verified, and make Information about this process available to the public by July 1, 2002.

Mandated versus Non-mandated

Recommendation 14

Request that the Department of Juvenile Justice provide information to localities on opportunities for using Virginia Juvenile Community Crime Control Act (VJCCCA) funds that address mental health treatment services, including the provision of intensive individual and family treatment, and structured day treatment and structured residential programs as authorized in Virginia Code §16.1-309.3.

Recommendation 15

Request that the Department of Juvenile Justice, the Department of Mental Health, Mental Retardation and Substance Abuse Services, and the Department of Criminal Justice Services examine opportunities to leverage non-general fund sources of funding to meet the need for mental health and substance abuse assessment and treatment services of juveniles, including those within local detention homes.

Recommendation 16

Direct the Joint Legislative Audit and Review Commission (JLARC) to conduct a study that identifies viable incentives that encourage localities to enhance or maintain levels of funding for non-mandated children.

Recommendation 17

Support the current level of funding that was appropriated for non-mandated children and adolescents in the 2000-2002 biennium through Budget Item 325B.

MEDICAID AND FAMIS (Family Access to Medical Insurance Security)

Recommendation 18

The Commission on Youth shall monitor the Joint Legislative Audit and Review Commission's study of the Department of Medical Assistance Services, and request that particular attention be given to Virginia's Medicaid provisions related to mental health services for children and adolescents.

Recommendation 19

Direct the Department of Medical Assistance Services to continue outreach efforts to enroll a greater number of children eligible for participation in Medicaid or FAMIS and report annually to the Commission on Youth by December 1.

EARLY INTERVENTION

Recommendation 20

Request that the Department of Medical Assistance Services continue their efforts to provide information to physicians and mental health providers about the comprehensive picture of services available through the Early and Periodic Screening, Diagnosis and Treatment (EPSDT). The Department of Medical Assistance Services shall inform the Commission on Youth of its progress prior to the 2003 Session of the General Assembly.

Recommendation 21

Request the Department of Medical Assistance Services, together with the Virginia Department of Education, to provide information and training, including information on available services, to school nurses, school counselors and school social workers. The Department of Medical Assistance Services shall inform the Commission on Youth of its progress prior to the 2003 Session of the General Assembly.

Recommendation 22

Request the Department of Medical Assistance Services to encourage physicians to make referrals to mental health providers, when appropriate, so that a full assessment of the child's mental health treatment needs can be made. The Department of Medical Assistance Services shall inform the Commission on Youth of its progress prior to the 2003 Session of the General Assembly.

DATA COLLECTION, EVALUATION AND INFORMATION SHARING

Recommendation 23

Direct the Virginia Commission on Youth to coordinate the collection and dissemination of empirically-based information that would identify the treatment modalities and practices recognized as effective for the treatment of children, including juvenile offenders, with mental health treatment needs, symptoms and disorders. An Advisory Committee comprised of state and local representatives from the Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services, Virginia Department of Social Services, Virginia Department of Medical Assistance Services, Virginia Department of Juvenile Justice, Virginia Department of Education, Virginia Department of Health, Virginia Office of Comprehensive Services, private providers and parent representatives should assist in and guide this effort.

Upon completion, client specific information on the types of services utilized for certain conditions and behaviors in Virginia should be collected. This information should be shared with entities involved in efforts to develop a policy and plan for children's improved access to mental health services as required under current biennium language (Item 323 K).

The results of the study shall be used to plan future services and resources within the Commonwealth for children with serious emotional disturbance or at risk of serious emotional disturbance; to identify effective models that could be replicated; and to identify effective means to transfer technology regarding effective programs, such as education, training and program development to public and private providers.

IV. Study Goals and Objectives

The study mandate establishing the goals of this study was set out in the HJR 119 resolution. In order to meet the study mandate, issues pertinent to the study and activities were developed by staff and the Advisory Group and approved by the Commission on Youth.

The first year study mandate was to develop and implement a methodology for accurately determining the number of children with serious emotional disturbance in need of out-of-home placement.

In the second year, the study mandate was two-fold: assess the service capacity for children and youth with serious emotional disturbance in need of out-of-home placement; and determine strategies to increase the system's effectiveness and efficiency.

A number of issues were identified as central to this study, including:

- ☐ Lack of consensus on definition of the population
  - Services provided by multiple agencies
  - Multiple funding streams
  - Conflicting criteria for eligibility
- ☐ Inadequate service capacity
- ☐ State and local fiscal implications
- ☐ Coordination with Virginia Department of Mental Health, Mental Retardation, and Substance Abuse Services activities pursuant to the Budget Bill, including
  - mandate to plan mental health/mental retardation services for children; and
  - $4.2 million in additional funds to serve children at risk through Comprehensive Services Act structure.
- ☐ System and case factors responsible for unmet needs
  - Funding
  - Service capacity/availability
  - Agency cooperation
  - Family/child cooperation
  - Family preference

In response to the study mandate, the Commission undertook the following activities:

1. Convened an Advisory Group;
2. Formulated and achieved consensus on a description of the population;
3. Identified existing data sources;
4. Reviewed and summarized previous analysis and reports on the issue;
5. Selected localities for data collection;

6. Collected data
    - Number of children who meet criteria
    - Service needs
    - Service provided
    - Funding sources
    - Current and projected costs
7. Analyzed data
8. Developed recommendations for interim report;
9. Implemented recommendations from interim report;
10. Compiled a description of state and local services available in the Commonwealth;
11. Conducted five regional focus groups;
12. Identified and analyzed funding sources;
13. Assessed unmet needs
    - System and case factors responsible for unmet needs
    - Current and projected costs; and
14. Developed recommendations.

V. 2001 Interim Report Update: Determining the Number of Children with Serious Emotional Disturbance in Need of Out-of-home Placement

As indicated earlier, the first year study mandate was to develop and implement a methodology for accurately determining the number of children with serious emotional disturbance in need of out-of-home placement. Understanding that the accuracy and completeness of the data were essential to the full study, Commission staff - in the second year - took action on the first year study recommendations outlined in the Executive Summary.

This section describes the process and outcome of that effort, and then provides relevant sections of the Interim Report using revised data.

A. REVISIONS TO DATA AS FOLLOWUP TO FIRST YEAR STUDY

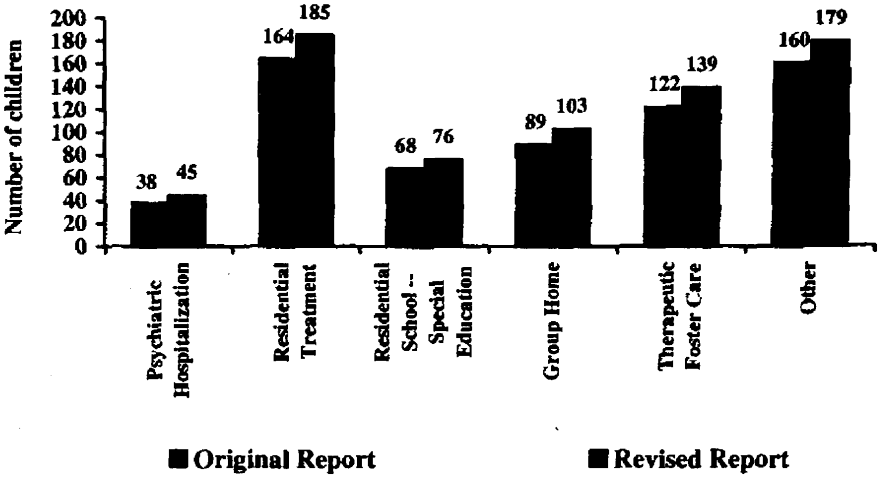
In response to the first year study recommendations, researchers with the College of William and Mary contacted by mail and telephone the local agencies that did not provide any qualifying cases in the initial survey or provided less than 5% of the total reports in their respective communities. They requested additional information to supplement any previous submissions. Responses to these requests produced descriptions of an additional 438 cases, strengthening the data base on which findings in the second year study would be based. While it is likely that some underreporting occurred, these estimates should provide a strong basis for understanding the circumstances for youth with serious emotional disturbance in Virginia.

The inclusion of these additional 438 cases had an impact on the analyses conducted. In total, 2,947 surveys were returned, of which 219 were eliminated either as duplicate cases (as matched by identification number and date of birth) or due to the fact that the children described were too old (age greater than 18.5 years). The final sample therefore increased from 2,283 to 2,728 cases. Moreover, the number of children estimated to be "in need" of out-of-home placement increased from 2,228 to 2,307 following the inclusion of these cases. It should be noted, however, that the increase in sample size did not impact the proportion of children with SED-OH who were intended to receive but did not receive services: overall, one-fifth of the identified children (22%) did not receive at least one recommended out-of-home service.

Researchers with the College of William and Mary also changed the primary unit of data analysis from locality to region. Data from localities were geographically divided to represent the following regions: Northern, Piedmont, Western, Central, and Eastern. Further analysis revealed that the Piedmont region displayed the highest SED-OH rate in the state, with an average of 11.89 SED-OH cases per 1,000 children. This rate was more than twice the statewide average of 4.71 cases per 1,000 children.

Chart 1

Comparison of Original to Revised Data
Services Recommended and Not Received



Source: Virginia Commission on Youth Graphic Analysis Fall 2001

Additional analysis was also performed in order to obtain a better perspective of those unreceived services encompassed within the "Other" category, which was the second most frequent response (n=179, 31%). Further analysis determined that many of those respondents who marked the "Other" category were referring to non-residential services, rather than out-of-home placements. Respondents indicating "Other" specifically mentioned residential services that were encompassed within the larger categories named, such as sex offender treatment, substance abuse treatment, and independent living programs. Also cited were specific services such as residential camps, Department of Juvenile Justice facilities, and crisis care for younger children and families.

B. INTERIM REPORT STUDY EFFORT SHOWING REVISED DATA

Provided are three sections from House Document 49, 2001 (Methodology; Diagnostic Criteria, and Services) re-presented in this final report using revised information, plus a fourth (Data Analysis), which is added for clarity. Appendices appearing in HD 49 are provided alongside second year appendices at the end of this report. One of these - Mailing Lists - has been revised since its original publication in HD 49.

1. METHODOLOGY

The findings of HJR 119 are based on several different methodologies. The first year of the study was dedicated to establishing a definition of the population and then accurately determining the number of children in Virginia who meet this definition.

Advisory Group

An Advisory Group was established to assist the Commission and staff by providing guidance and direction in the study. The Advisory Group was comprised of 18 members as follows: one representative from the State Executive Council for the Comprehensive Services Act; one representative from the Office of Comprehensive Services; two representatives from local Community Policy and Management Teams; two representatives from the Virginia Association of Community Services Boards; one representative of the League of Social Services Directors; one representative from the Virginia Mental Health Planning Council; two representatives from the Virginia Municipal League; two representatives from the Virginia Association of Counties; one representative from the Virginia Mental Health Association; one representative from a private psychiatric hospital; and the designees of the Commissioner of the Department of Mental Health, Mental Retardation and Substance Abuse Services, the Commissioner of the Department of Social Services, the Director of the Department of Juvenile Justice, and the Superintendent of Public Instruction.

Data Collection

a. Survey Method and Rationale

In preliminary discussions between the contractor and Commission staff, two different survey methods were considered. The first was a random dial survey of households in Virginia. This was rejected on two grounds: prohibitive cost, and the likely inability of untrained citizens to make the types of judgments and provide the type of information needed to provide a meaningful description of SED-OH among the youth of Virginia. In light of this, the following method was chosen.

The Advisory Group decided that five key professional agencies in a selected sample of Virginia communities would be asked to provide detailed descriptions of children who were on their caseload and who met certain characteristics. Children meeting these characteristics then would be identified as SED-OH. The local agencies who were asked to provide data about youth in their localities diagnosed as SED-OH were the Community Policy Management Team (CPMT), the Community Service Board (CSB), the Department of Social Service (DSS), the Court Service Unit (CSU), and the Special Education Department (SpEd) of the local school district.

For a child to be considered, he or she must:

- ☐ have a DSM-IV Diagnosis;[4]

  and/or

- ☐ have at least two of the following functional child characteristics which have lasted and/or are expected to last at least one year without treatment:
  - One or more suicide attempts or a specific plan for committing suicide;
  - Hospitalization in a public or private psychiatric facility;
  - Special education services for children with emotional disturbance;
  - Special education services for a disability other than emotional disturbance;
  - Missing two or more days of school per month as a direct result of symptoms associated with his/her mental illness;
  - A drop in school performance/productivity to the point that there is a risk of failing at least half the courses;
  - Behavior that is so disruptive/aggressive that youth presents threat to the safety of others in the home or in the community;
  - Persistent problems or difficulties relating to peers that result in few, if any, positive peer relationships;
  - At least one family/caregiver relationship characterized by constant conflict that is disruptive to the family/caregiver environment; and/or
  - Intervention by at least two different agencies.

For the case to be considered pertinent to the survey, that child who meets the above characteristics must also live with a family that exhibits one of the following family characteristics:

- Socio-familial setting is potentially dangerous to the youth;
- Youth is at risk because of lack of resources required to meet youth's needs/demands;
- Family has exhausted emotional and/or economic resources and is unable to care for the child;
- Gross impairment in caregiver's judgment or functioning (may be related to psychosis, substance abuse, severe personality disorder, mental retardation, etc.);
- Caregiver is hostile, rejecting, or does not want youth to return to home;
- Youth is subjected to sexual abuse in the home;
- Youth is subjected to physical/emotional abuse or neglect in the home;
- Caregiver "kicks" youth out of the home without trying to make other living arrangements;
- Youth currently removed from the home due to sexual, physical or emotional abuse or neglect;
- Failure of caregiver to provide an environment safe from possible abuse to a youth previously abused or traumatized;
- Severe or frequent domestic violence takes place in the home;
- Caregiver is openly involved in unlawful behavior;
- Caregiver contributes to or approves of youth's involvement in potentially unlawful behavior; and/or
- Caregiver does not take an active role in supervision of child.

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[4] *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition*

In short, if a child has a DSM-IV diagnosis and/or two or more of the child characteristics *and* she/he lives with a caregiver that meets one or more of the family characteristics; *then* the child is considered to have serious emotional disturbance requiring an out-of-home placement (SED-OH).

It was assumed that given the nature of the SED-OH (as defined herein) it was highly unlikely that children would not have had contact with at least one of these entities at some point in time. Moreover, it was assumed that children might have contact with more than one of these entities, and so provisions were made to detect duplicate records while guarding the specific identity of the children being described. The last four digits of children's social security numbers were utilized to detect duplicate records.

The study was implemented as designed and described in a contract between the Commission on Youth and the College of William and Mary. In October of 2000 forms describing SED-OH cases and instructions were sent with surveys to agencies in 26 communities, selected to represent the different regions of the State (e.g., Northern Virginia, Tidewater, etc.) and to represent both rural (e.g., Accomack County) and urban (e.g., City of Richmond) areas. A list of the agencies receiving surveys is provided as Appendix D. The number of communities was intentionally over-sampled so that the survey would be able to provide an accurate estimate even if all communities did not participate fully.

Each person listed in Appendix D was sent a packet of surveys and postage-paid, return envelopes for completed forms. As described below, respondents were asked to return surveys by November 3, 2000, although any survey returned by December 1 was included in the preliminary report. (This survey effort was continued during the second year study period with a follow-up survey focused on agencies reporting none (0) or very few cases.)

b. Survey Instrument

The survey was initially designed by the Advisory Group and then was modified following the Contractor's recommendations. Surveys were accompanied by a letter of introduction that explained the purpose of the study and provided instructions for completing the survey form. A copy of this letter is contained in the Survey Package provided as Appendix C. The survey instrument had four parts. The first requested demographic information about the child; the second requested a description of the problems the child had experienced (DSM-IV diagnosis and other characteristics); the third section requested information about the child's family environment; and the fourth requested information about the service plan for the child.

This survey set forth two sets of criteria that must be met for a case to be classified as having a child with serious emotional disturbance who required out-of-home placement (SED-OH). The combination of child and family characteristics reflects the fact that the need for out-of-home placement is a joint function of the severity of the problems a child is experiencing, the family's ability to cope or deal with these problems, and the community's ability to provide services that might not require the child to leave the home. That is, different children experiencing the same level of distress might or might not need out-of-home placement as a function of their families' and their communities' abilities to cope with or provide support to ameliorate this distress.

The survey also asked respondents to describe the service plan for each child. These included descriptions of services recommended and received, and services that were recommended but not received. Furthermore, for services that were recommended and not received, respondents indicated the extent to which case factors (characteristics of the child or the child's family) and system factors (such as availability of or access to services) were responsible for the failure for a recommended service to be provided.

DATA ANALYSIS

The Sample

Across both surveys, a total of 2,947 surveys were returned. Of these, 191 were eliminated because they represented duplicate cases (matched by identification number and date of birth), and 28 were eliminated because the children they described were too old (age greater than 18.5 years). This left a final sample of 2,728 cases.

With these 2,728, SED-OH rates varied considerably by different ages. SED-OH cases per 1,000 for children aged 10 and under were below 4.0, whereas for children in their teen years, rates were as high as 11.0. In addition, respondents described the out-of-home services children with SED-OH received and were intended to receive but did not receive. Over one-fifth (22%) of the identified children did not receive at least one recommended out-of-home service.

Figure 1

Percent of Cases Reported by Different Agencies for Each Region

Region	Total	CPMT	DSS	CSU	CSB	SpEd	Miss
Northern	1104	2%	35%	16%	21%	25%	1%
Piedmont	594	0%	38%	12%	48%	1%	1%
Western	167	0%	28%	37%	33%	2%	0%
Central	388	0%	53%	8%	31%	7%	0%
Eastern	475	0%	37%	20%	41%	2%	0%
Total/Average	2728	1%	38%	16%	32%	12%	1%

As shown above, there was some variability across regions in the source of cases. The demographic characteristics of the entire sample are summarized in Figure 2. Approximately two thirds of the sample were teenagers; approximately 60% were male; about half were Caucasian; 40% were African American; and just under two thirds came from homes with a family income of less than $20,000. The population of Virginia is about 70% Caucasian, 20% African American, 3.4% Hispanic, nearly half male, and with an average per capita income of around $28,000. In addition, there is relatively little change in the total population of children of different ages (child mortality is relatively low). The survey shows that children who experience SED-OH are more likely to be teen-aged, poor, African American, and male.

Estimating Rates of Children with SED-OH

To estimate the rates of children, who experience SED-OH across Virginia, the number of cases obtained from the survey was compared to the estimated number of children

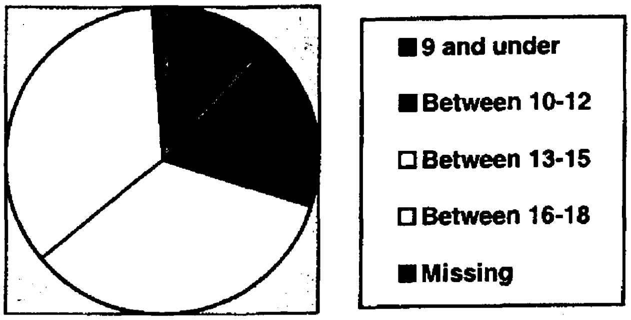
Figure 2

Demographic Characteristics of Sample (N=2506)

Age

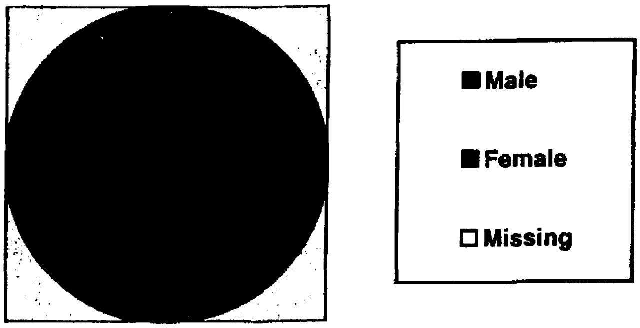
Mean age 13.7

9 and under	328	12%
Between 10-12	487	18%
Between 13-15	936	34%
Between 16-18	951	35%
Missing	26	1%



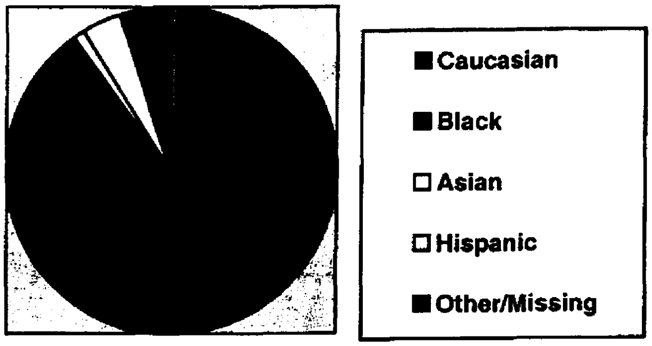
Sex

Male	1,691	62%
Female	1,030	38%
Missing	7	0%



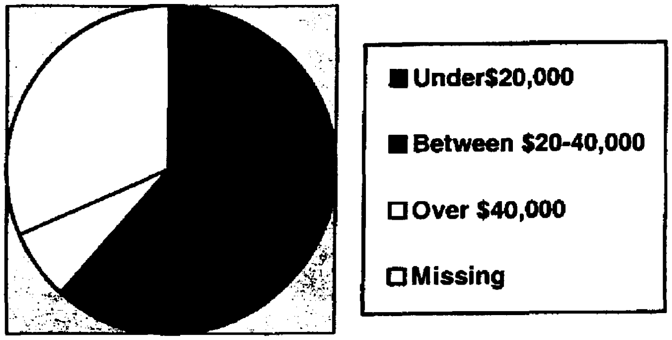
Ethnicity

Caucasian	1,341	49%
Black	1,141	42%
Asian	18	1%
Hispanic	101	4%
Other/Missing	119	5%



Income

Under $20,000	1,204	46%
Between $20-40,000	404	16%
Over $40,000	169	7%
Missing	863	32%



Source: Virginia Commission on Youth Graphic Analysis Fall 2001 within each age category. Population estimates were obtained from the US Census. These estimates were for 1999 because estimates for 2000 were not available.[5] The age of each child described by the initial survey was determined as of November 1, 2000. For the follow-up survey, the date was March 1, 2001. The age assigned to the child reflected a 12-month period with the target age in the middle of the period. For example, children who were 6.5 years or older and younger than 7.5 years were classified as 7 years old.

A summary of the estimated rates of SED-OH (per 1,000 children) is presented in Figure 3 for children aged 2 through 18. As can be seen from these data, SED-OH rates were lower for younger children and higher for teenagers. SED-OH was more common for boys than girls at all ages. Although it would appear the difference between boys and girls was greater for younger children than for teens, the relatively small samples for younger children make it difficult to draw a firm conclusion about such a trend.

Figure 3

SED-OH Cases by Age and Sex: All Regions Combined

Age	Cases	Pop.	Cases per 1000	Boys		Girls		Statewide Estimate	
				N	%	N	%	Pop.	Cases
Missing	*33*			*19*		*7*			
2	1	33,692	0.030	0	0.0	1	100.0	89,515	3
3	6	33,250	0.180	1	16.7	5	83.3	88,985	16
4	23	33,903	0.678	14	60.9	9	39.1	91,031	62
5	25	33,981	0.736	19	76.0	6	24.0	92,093	68
6	36	33,990	1.059	18	50.0	18	50.0	92,727	98
7	57	34,778	1.639	40	70.2	17	29.8	94,680	155
8	78	33,536	2.326	49	62.8	29	37.2	92,019	214
9	102	35,767	2.852	72	70.6	30	29.4	99,704	284
10	139	34,769	3.998	94	67.6	45	32.4	96,725	387
11	154	33,437	4.606	110	71.4	44	28.6	93,269	430
12	193	32,489	5.940	124	64.2	69	35.8	91,748	545
13	240	32,927	7.289	162	67.5	78	32.5	91,906	670
14	299	32,903	9.087	178	59.5	121	40.5	91,398	831
15	395	32,299	12.229	248	62.8	147	37.2	89,270	1,092
16	424	33,054	12.827	242	57.1	182	42.9	91,516	1,174
17	331	35,796	9.247	182	55.0	149	45.0	97,117	898
18	192	38,259	5.018	119	62.0	73	38.0	94,969	477
Total/Avg	2,728	578,830	4.715	1,691	62.0	1,030	37.7	1,578,672	7,443

In the last column in Figure 3, estimates for the total number of cases for the state of Virginia are provided. These estimates were created by taking the case rate per 1,000 children for each age group and multiplying that by the number of children for each age as estimated by the 1999 U.S. Census. This procedure estimated that approximately

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[5] However, changes in population from year to year tend to be small. For example, the total population of Virginia increased approximately 1.2% from 1998 to 1999, and so the 1999 estimates provided an accurate baseline for purposes of estimating the rates of SED-OH among the youth of Virginia.

7,443 children experience SED-OH across the state. This number includes children who are receiving out-of-home services and those who are not receiving out-of-home services.

HJR 119 specifically directed the Commission on Youth to determine how many children are "in need" of out-of-home placement. The survey results suggest that approximately 31% of children meeting the criteria for SED-OH are not receiving out-of-home services. Therefore, the best estimate is that 2,307 children with serious emotional disturbance (31% of 7,443) are "in need" of out-of-home placement and are not receiving such treatment. It is important to note also that as the number of children increases, the number of estimated SED-OH cases will also increase. Moreover, it is likely that these figures slightly underestimate the number of children experiencing SED-OH. Although duplicate reports were eliminated, there is no method to identify unreported cases. The exact scope of any under-reporting cannot be known, but it is likely that some under-reporting occurred.

SED-OH Rates by DSS Region

The survey allowed the estimation of SED-OH rates for each region represented in the study, using the Virginia Department of Social Services regional designations, and rates for the five regions are presented in Figures 4 and 5. The rates in Figure 4 represents the number of cases per 1,000 children aged 2 through 18. Age 2 was chosen as the youngest age because it was the youngest age of any child in the

Figure 4

SED-OH Rates per 1000 Children for Each Region for All Children Ages 2-18

Region	Pop.	Case	Rate
Northern	269,571	1,104	4.10
Piedmont	49,948	594	11.89
Western	28,103	167	5.94
Central	122,358	388	3.17
Eastern	108,850	475	4.36
Total/Average	578,830	2,729	4.71

Figure 5

SED-OH Rates Per 1000 Children for Each Region for Different Age Groups

Region	Total Cases	Age less than 7			Ages 7 to 12			Ages 13 to 15			Ages 16 to 18		
		Pop.	Case	Rate	Pop.	Case	Rate	Pop.	Case	Rate	Pop.	Case	Rate
Northern	1,097	79,668	32	0.40	95,136	294	3.09	46,671	363	7.78	48,096	408	8.48
Piedmont	582	14,057	35	2.49	17,388	186	10.70	8,685	180	20.73	9,818	181	18.44
Western	165	7,002	3	0.43	8,835	38	4.30	4,576	45	9.83	7,690	79	10.27
Central	386	35,043	9	0.26	44,258	102	2.30	20,721	162	7.82	22,336	113	5.06
Eastern	472	33,046	12	0.36	39,159	104	2.66	17,476	186	10.64	19,169	170	8.87
Total/Avg	2,702	168,816	91	0.54	204,776	724	3.54	98,129	936	9.54	107,109	951	8.88

survey. Four rates are presented in Figure 5, which represent the number of cases per 1,000 children aged 6 and younger; through 7 through 12; 13 through 15; and 16 through 18. These age groups correspond roughly to preschool, elementary, middle and high school years, respectively. Although it is tempting to compare rates across regions, considerable caution must exercised when doing so. Communities within different regions may deliver services in different ways, allowing for different reporting, and different communities may have more service options for children experiencing severe emotional disturbance.

Sources of SED-OH Cases by Region

The frequency of reporting SED-OH by region is presented in Figure 1. Across all cases, Departments of Social Services (DSS) and Community Service Boards (CSB) each accounted for approximately one third of the cases, with the remaining third being divided relatively equally between Court Service Units (CSU) and Departments of Special Education (SpEd). As was the case with SED-OH rates, caution must be exercised when comparing percentages across regions.

3. DIAGNOSTIC CRITERIA

DSM-IV Diagnostic Criteria of SED-OH Cases

Children were classified as experiencing SED-OH using two different criteria, either a DSM-IV diagnosis or meeting at least two of twelve child characteristics. In addition to the child characteristics, the child needed to meet at least one of the family characteristics. The number and percentage of children who received a DSM-IV diagnosis are presented in Figure 6. The purpose of DSM-IV is "to provide clear descriptions of diagnostic categories in order to enable clinicians and investigators to diagnose, communicate about, study, and treat people with various mental disorders." [6] Of the children who received a DSM-IV diagnosis, the percentage of children who received an Axis 1, Axis 2, or "other" DSM-IV diagnosis are also presented in Figure 6. Across the entire sample, approximately two-thirds received some form of DSM-IV diagnosis. Of this two thirds, virtually all (95%) had been given an Axis 1 diagnosis.[7] Slightly more than a third (37%) had been given an Axis 2 diagnosis,[8] while approximately one-quarter (24%) had received an "Other" DSM-IV diagnosis.

Figure 6

DSM-IV Diagnoses by Region

		Any DSM		Percent of DSM		
Region	**Total**	**N**	**Pct.**	**Axis1**	**Axis2**	**Other**
Northern	1,104	617	56%	95%	33%	26%
Piedmont	594	473	80%	95%	38%	27%
Western	167	99	59%	98%	30%	22%
Central	388	292	75%	92%	42%	29%
Eastern	475	371	78%	96%	37%	16%
Total/Avg	2,728	1,852	68%	95%	37%	24%

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[6] American Psychiatric Association, 1994. *Quick reference to the diagnostic criteria from DSM-IV.*

[7] Clinical disorders or other conditions that may be a focus of clinical attention

[8] Personality disorders and mental retardation

Other Diagnostic Criteria of SED-OH Cases

Children also could have been classified as experiencing SED-OH if they met at least two of ten functional child characteristics within the past 12 months, along with meeting one of the family characteristics. The average number of these specific characteristics and the percent of children meeting each of these criteria are summarized in Figure 7. Across the entire sample, the average number of criteria met was 4.2. The most common criterion was "required intervention by two or more agencies." Approximately three-fourths (71%) of children met this criterion. Approximately half (49%) required special education for emotional disturbance; half (50%) were identified as aggressive; half (55%) had problems with peers; and half (55%) had problems with caregivers. Approximately one-quarter had been hospitalized in a psychiatric facility (27%), missed excessive amounts of school due to mental illness (25%), or required special education for something other than emotional disturbance (27%). Slightly more than one-third (36%) had experienced a drop in school performance.

Figure 7

Other Child Diagnostic Criteria by Region

Region	Mean	Suic	Hosp	SpEd	SpEd2	Miss	Drop	Aggr	Peer	Care	TwoA
Northern	4.1	12%	22%	48%	32%	22%	35%	48%	56%	55%	70%
Piedmont	4.3	12%	28%	50%	25%	29%	37%	51%	60%	56%	74%
Western	4.2	19%	31%	35%	23%	22%	40%	51%	47%	69%	73%
Central	4.8	11%	39%	63%	31%	30%	40%	56%	65%	56%	72%
Eastern	3.6	11%	25%	44%	14%	23%	32%	47%	44%	47%	67%
Total/Avg	4.2	12%	27%	49%	27%	25%	36%	50%	55%	55%	71%

Key for column labels

Mean – Mean number of individual items checked
Suic – attempted suicide
Hosp – been hospitalized in psychiatric facility
SpEd – special education for emotional disturbance
SpEd2 – other special education
Miss – routinely miss school due to mental illness
Drop – drop in school performance
Aggr – dangerously aggressive
Peer – persistent problem with peer relations
Care – disruptive conflict with caregiver
TwoA – required intervention by two different agencies

Family Diagnostic Criteria of SED-OH Cases

In addition to meeting the criteria for child characteristics, for a child to be classified as experiencing SED-OH, the child's family/caregiving environment needed to meet one of fourteen criteria. The average number of these specific criteria and the percent of children meeting each of these criteria are summarized in Figure 8. Across the entire sample, the average number of criteria met was 3.1. The most commonly mentioned characteristic was "inadequate resources to meet the child's needs" (43%). This was followed by "impaired caregiver functioning" (37%), "inactive supervision by caregivers" (34%), "exhausted family resources" (32%), "emotional abuse" (29%), "a dangerous family setting" (29%), and "a child removed from the home" (21%).

Figure 8

Family Diagnosis

Region	Mean	Fam	Res	Exh	Imp	Host	SexA	EmoA	Kout	Rem	NoS	DomV	Ulaw	Cont	Inac
Northern	3.0	29%	46%	35%	37%	14%	6%	28%	3%	19%	13%	10%	8%	6%	33%
Piedmont	3.4	24%	38%	31%	33%	20%	7%	30%	4%	22%	16%	10%	8%	6%	34%
Western	3.1	29%	28%	29%	41%	20%	9%	27%	4%	22%	20%	16%	9%	8%	33%
Central	3.2	31%	49%	27%	40%	16%	4%	28%	5%	23%	15%	13%	9%	5%	34%
Eastern	3.2	31%	42%	31%	39%	16%	7%	32%	5%	23%	15%	9%	11%	6%	36%
Total/Avg	3.1	29%	43%	32%	37%	16%	6%	29%	4%	21%	15%	11%	9%	6%	34%

Key for column labels

Mean – Mean number of individual items checked
Fam – dangerous family setting
Res – inadequate resources to meet client's needs
Exh – family has exhausted resources
Imp – impaired caregiver functioning
Host – caregiver is hostile
SexA – sexual abuse in the home
EmoA – emotional abuse in the home
Kout – caregiver kicks client out
Rem – client removed from home
NoS – caregiver does not provide safe environment
DomV – domestic violence in home
Ulaw – caregiver involved in unlawful activity
Cont – caregiver contributes to client's unlawful behavior
Inac – caregiver inactive supervisor

4. SERVICES

Services Received and Not Received

Respondents described the services each child had received within the past six months. A summary of these received services is in Figure 9. The mean number of services received was 1.0. Of the 2,728 cases in the sample, 840 (31%) received no service; 1,221 (45%) received one service; 425 (16%) received two services; 174 (6%) received three services; 53 (2%) received four services; and 15 (1%) received five or more.

Figure 9

Number of Children for Whom Each of the Targeted Services were Recommended and Received and were Recommended but not Received

	Recommended and Received		Recommended and Not Received	
Service	**N**	**%**	**N**	**%**
Psychiatric hospitalization	487	18%	45	8%
Residential treatment	558	21%	185	32%
Residential school – Special education	426	16%	76	13%
Group home	242	9%	103	18%
Therapeutic foster care	465	17%	139	24%
Other	702	26%	179	31%

Specific System and Case Factors Responsible for Services Being Recommended but not Received

For services that were recommended but not received, respondents indicated (using a 1 to 5 scale where 1=not at all responsible and 5=very responsible) how important system and case factors were for why a service was not received. These responses are summarized in Figure 10. System factors were seen as more associated with recommendations related to hospitalization, residential school, and group home; whereas, case factors were more responsible for the failure to provide residential treatment.

Figure 10

Importance of Case and System Factors for Why Services Were Recommended but not Received

Service	N	Case factors	System factors
Psychiatric hospitalization	45	2.8	4.0
Residential treatment	185	3.8	3.5
Residential school – Special education	76	3.1	3.4
Group home	103	3.3	3.7
Therapeutic foster care	139	3.6	3.6
Other	179	3.3	3.5

Reasons for Non-Receipt of Services

When services were recommended but not received, respondents provided a global description of which system and case factors were responsible for this failure. At least one system factor was mentioned for 435 of the 573 cases for which at least one service was recommended and not received. For these 435 cases, the average number of system factors cited was 1.9. The three most commonly cited reasons were "service not available" (29%), "no funds available for the service" (33%), and "no funds available for the child" (32%). Just under a quarter of respondents (23%) indicated that community support for the child to stay at home was responsible for the lack of service. A summary of these responses is presented in Figure 11.

Figure 11

Specific System Factors Responsible for Services Being Recommended but not Received

Factor	N	Pct.
Safety	22	5.1%
Service not available	126	29.0%
Agencies do not work together	71	16.3%
Community intolerance toward SED-OH	38	8.7%
No funds for service	144	33.1%
No funds for child	138	31.7%
Community support for child to stay home	100	23.0%
Public safety	29	6.7%
Legal requirements/court order	58	13.3%
Other	115	26.4%
Total	435	

At least one case factor was mentioned for 480 of the 573 cases for which at least one service was recommended and not received. For these 480 cases, the average number of case factors cited was 1.8. The most commonly cited reason was an "uncooperative family" (43%) followed by an "uncooperative child" (38%). A lack of caregiver resources, child ineligibility, and family preference were cited in approximately a quarter of cases. A summary of these responses is presented in Figure 12.

Figure 12

Specific Case Factors Responsible for why Services were Recommended but not Received

Factor	N	%
Placement ineffective	27	5.6%
Uncooperative child	183	38.1%
Family uncooperative	206	42.9%
Caregiver lacks resources	126	26.3%
Family preference	122	25.4%
Child ineligible	111	23.1%
Facility could not design treatment plan	37	7.7%
Other	39	8.1%
Total	**480**	

VI. Second Year Study Methodology

The findings of HJR 119 are based on several different methodologies. The first year of the study was dedicated to establishing a definition of the population and then accurately determining the number of children in Virginia who meet this definition. During the second year of the study, the Commission assessed the service capacity for children and youth with SED-OH with the goal of suggesting reform to increase the system's effectiveness and efficiency. To meet this mandate, the Commission assimilated data from a number of different sources. These sources are briefly outlined in Section B which follows.

A. RESEARCH AND LITERATURE REVIEW

Since 1988, numerous studies and publications of both national and state significance have addressed the treatment needs of children with serious emotional disturbance. An extensive review of these publications was conducted, including both Internet and library sources. Specifically, studies previously conducted in the Commonwealth addressing the availability of mental health services for children and the scope and efficacy of the Comprehensive Services Act were given particular attention. A summary of the documents is provided as Appendix E.

B. ADVISORY GROUP MEETINGS

The Advisory Group established in the first year was reconvened to provide oversight and direction to the study. The composition of the 19-member group was established by resolution, which is provided as Appendix A. Activities of the Advisory Group in the first year are described in Section V.

In the second year, an additional representative from the Virginia Department of Medical Assistance Services was included. A list of Advisory Group members is included as Appendix B. The Advisory group met on four occasions to provide guidance and feedback to Commission staff. In addition, a smaller workgroup of individuals with specific knowledge of funding issues met once to address available financial resources in the Commonwealth.

C. FOCUS GROUPS

The Commission conducted five focus groups in various regions of the state in order to gain perspective of the issues considered most significant to local child service providers. These group meetings were conducted in Bristol, Charlottesville, Fairfax, Norfolk, and Prince Edward County. Representatives of state, local, and private child-serving agencies were invited to participate. Groups were asked to identify the treatment needs and the gaps in services in the Commonwealth for children with serious emotional disturbance. They were also asked to provide recommendations for increased efficiency and effectiveness of services for SED children in Virginia. Summaries of the focus group meetings, along with the composition of each group, are provided in Appendix F.

D. DATA COLLECTION AND ANALYSIS

As directed by the Commission, staff, in cooperation with the College of William and Mary Applied Social Psychology Research Institute, revisited the original 2000 survey findings to amend the number of severe emotional disturbance in need of out-of-home placement (SED-OH) for the second year study.

In addition, service capacities were requested from numerous state agencies, including the Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS), the Department of Social Services, the Department of Education, the Department of Health, the Office of Comprehensive Services, Virginia Health Information, and the Virginia Hospital and Healthcare Association. Much of this data was collected and analyzed, and a summary of the findings is provided in this report.

The Commission also collected data regarding the number of placements made by localities to facilities outside of the Commonwealth. A survey was distributed to local Community Policy and Management Team (CPMT) chairs in order to ascertain the number of out-of-state placements made by their agencies. The survey also asked respondents to describe the case factors that most strongly influence the decisions to make these placements. A copy of the survey is included as Appendix G, and an analysis of the results is provided in this report.

Prior to the presentation of study recommendations to the Commission on Youth on November 27, 2001, the Commission provided copies of the draft recommendations to all agency heads and solicited comments. In addition, a copy was posted on the Commission's website and interested individuals and organizations were invited to submit written comment or testimony to the Commission.

VII. Background

While developing the work plan for the second year of the study, it became apparent that a study of children and youth with serious emotional disturbance requiring out-of-home placement could not be limited to a child's needs while in an out-of-home placement, and that the scope of the study would need to be expanded. A thorough examination would necessarily include a review of the myriad of issues that impact a child's placement in and return from a residential setting. Many expressed concern that a child's need for residential placement is only a moment in time within the full continuum of the child's treatment needs and thus would limit the validity of conclusions. A look at the needs of these children revealed that there are opportunities to help the child and his/her family prior to a residential placement that may prevent or reduce the likelihood that the child will need residential placement. Likewise, there are opportunities to help the child and his/her family after the child returns from a residential placement that may prevent reentry into a residential placement.

The Commission conducted an extensive literature review in order to determine the current status of research related to children with serious emotional disturbance. During the course of this review, it was revealed that this topic is not new to Virginia government. Twenty documents and reports were identified that provided information on this and related issues. These documents date from 1988 to 2000 and cover a wide range of topics. Included in many of these reports were analyses of the services incorporated in a continuum of care and the funding resources necessary for these services. A summary of each document is provided as Appendix E. Further analysis revealed that there were several key findings and recommendations that were repeatedly addressed in the literature. These include:

- The importance of early identification and early intervention in a community system of care;
- The need for increased case management;
- The reduction of state psychiatric beds for children without increased support for alternatives in the community;
- The distinction between "mandated" and "non-mandated" children;
- The impact of the "mandated" distinction on funding for services;
- The importance of an increased and improved use of Medicaid; and
- The importance of training, technical assistance and outcome evaluation in developing a system of care.

It also is important to note that considerable resources of both time and money were consumed to conduct the numerous studies of this topic and to generate the reports associated with them. The Department of Planning and Budget study specifically addressed this issue, noting that "various state agencies, consultants, General Assembly, local governments, and other have completed at least 12 other studies. Many of which have similar recommendations and conclusions."[9] The same sentiment may be expressed regarding the current study, as this report revisits many of the issues previously addressed in the literature.

It is unlikely that the dilemmas presented in prior studies or the decisions to be made will become easier with time. In fact, many have expressed concern that the Commonwealth will see increased costs related to serving the needs of these youth in the future. Service providers across Virginia have reported an increase in the number

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1. [9] Virginia Department of Planning and Budget, *A Review of the Budget for the Comprehensive Services Act for At-Risk Youth and Families*, September 2000.

of younger children entering the system with more severe needs. Several social issues have been cited that may contribute to this result, such as the increase in drug-addicted mothers, teen pregnancy rates, poverty rates, and the growing immigrant/refugee populations in which children have been raised in severe poverty. While the exact causes of this increase have yet to be determined, current circumstances suggest that these children will remain in the system for longer periods of time and require more extensive treatment efforts. Consequently, the overall costs to the Commonwealth for treating these children can be expected to rise in the future.

This section continues with the following discussions:

- assessment of the statewide capacity of facilities that serve SED-OH in the Commonwealth. This evaluation will not only include residential facilities, but will also address statewide availability of wraparound services that are intended to prevent out-of-home placements;
- shortage of mental health professionals and teachers for the SED-OH population;
- funding issues that impact the availability of services for this population, including the Comprehensive Services Act, Medicaid, and the FAMIS program;
- evaluation of the early intervention efforts that are currently in place in Virginia; and
- discussion of the need for enhanced data collection, evaluation, and information sharing efforts among state and local service agencies.

A. STATEWIDE CAPACITY OF FACILITIES SERVING SED CHILDREN AND YOUTH

HJR 119 specifically directed the Commission to determine the capacity of services for SED-OH children and youth. In order to perform this analysis, staff members collected data from a number of sources, including the Department of Education, the Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS), the Department of Social Services (DSS), the Virginia Hospital and Health Care Association, and Virginia Health Information.

The wraparound system of care is generally considered among service providers to be the most effective and cost-efficient way to treat children and youth with serious mental health needs.[10] Specifically, an effective community-based system of care may eliminate the need for many out-of-home placements.[11] In order to assess Virginia's ability to meet the needs children and youth with SED within this larger context, the Commission extended the analysis beyond residential services to include community-based treatments such as transition services, family support services, and therapeutic day treatment.

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[10] Kimberly Kendziora, Eric Burns, David Osher, Debra Pacchiano, Brenda Mejia, *Systems of Care: Promising Practices in Children's Mental Health, Volume I*, U.S. Department of Health and Human Services, 2001; U.S. Department of Health and Human Services, *Mental Health: A Report of the Surgeon General*, 1999; *Wraparound Milwaukee: Aiding Youth With Mental Health Needs*, Juvenile Justice Journal, Volume VII (1), 2000.

[11] Ibid.

This section will first address the statewide capacity of residential facilities. It will examine state and private acute psychiatric facilities, as well as the residential facilities operated by DMHMRSAS, DSS, and DOE. This is followed by an evaluation of the availability of community-based services in Virginia. The section concludes with a discussion of the gaps in the overall system of care that have been identified by service providers.

1. CHILD AND ADOLESCENT ACUTE PSYCHIATRIC BEDS

Acute care facilities generally treat children and adolescents who are in immediate psychiatric crisis and demonstrate self-injurious behavior or behavior capable of hurting others.[12] These facilities provide intensive, short-term psychiatric treatment in a highly structured and supervised setting. Acute care services typically include:

- stabilization,
- evaluation,
- chemotherapy,
- psychiatric and psychological services, and
- other supportive therapies.[13]

These acute psychiatric facilities are a necessary component of any continuum of care for children and adolescents, as they are an immediate source of crisis intervention for children and adolescents exhibiting dangerous or self-destructive behaviors.

In order to obtain an accurate perspective of the availability of acute care beds for children and youth in Virginia, the Commission collected various reports from DMHMRSAS, the Virginia Hospital and Health Care Association, Virginia Health Information, and facilities such as Hallmark Youth Care–Richmond.

The data provided by Hallmark Youth Care–Richmond indicates that there are 23 hospitals in Virginia that operate adolescent acute psychiatric beds, including two state facilities. These facilities report that there are 461 beds available to adolescents. However, this number is misleading because not all hospitals reserve beds for adolescent use. Some hospitals "swing" their beds to serve any age group. While these hospitals have the ability to serve children and adolescents, only one or two adolescents may be admitted in a year. The result is that there are fewer acute psychiatric beds available for adolescents than is officially reported.

It is also important to note that certain populations of children and youth are at a particular disadvantage with respect to the availability and locations of acute care beds. For example, approximately 184 of the 461 available acute care beds licensed in the state are specifically restricted to children over the age of 12. Consequently, younger children may be at a disadvantage when seeking acute care placements. Of additional concern is the fact that many of these facilities are concentrated in metropolitan areas such as Northern Virginia, Richmond, and the Tidewater area, while regions such as Southwestern Virginia have few, if any, acute care facilities for children and

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[12] Melissa Hays-Smith, *Continuum of Care for Children and Adolescents: A Presentation to HJR 225 by the Child and Family Services Task Force of the VACSB*, August 1999.

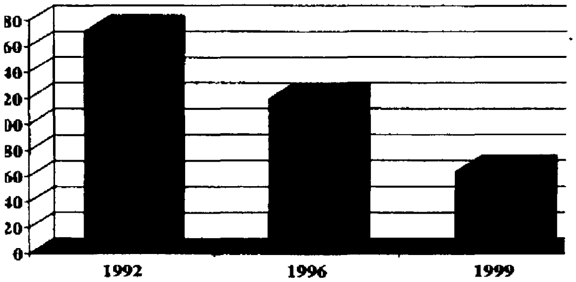
[13] Comprehensive State Plan: 2000-2006, Department of Mental Health, Mental Retardation, and Substance Abuse Services.

adolescents. As a result, children living in many areas of Virginia have to travel great distances to receive the necessary psychiatric care. Not only is this geographic distance troublesome with regards to crisis stabilization efforts, but it also limits the ability of families to participate in treatment efforts.

The continuous decrease in the availability of inpatient psychiatric beds also serves as a significant barrier to child and youth services. As depicted in Chart 1, currently there are 64 inpatient beds in Virginia available for juveniles in state mental health facilities. This number represents a reduction of 108 beds since 1992.[14]

Chart 1

Reduction of State Psychiatric Beds:
1992 - 1999



Sources: Child and Family Services Council, *Virginia's Continuing Policy to Take Away State Psychiatric Hospitals for Children Without Increasing Community Service Options*, November 1999; Community Services Board Planning Committee, *The Impact of Downsizing Virginia's State Psychiatric Hospitals for Children Without Increased Community Care Options*, December 1994.

This dramatic decrease in the availability of state psychiatric beds for children reflects the philosophy that residential placements should be replaced with community services. However, there is a continuing need for psychiatric hospitalization as a component of a local array of care.

Advisory Group and Focus Group members provided accounts of significant difficulties in finding available beds in acute care facilities. In March 2001, there was a five-day period in which the Commonwealth Center for Children and Adolescents was unable to assist in the placement of 35 children, ranging in age from five to seventeen years, in *any* psychiatric hospital in Virginia. This limitation in the availability of psychiatric beds could have a significant impact on the treatment efforts for children with immediate mental health needs.

The Commission encountered considerable difficulty in obtaining an accurate count of the number of acute psychiatric adolescent beds. One of the most significant barriers to obtaining comprehensive capacity information was the fact the capacity data is currently reported based on the more general categories of "pediatric" and "psychiatric" beds, without being further broken down into the subcategory of "adolescent psychiatric." Moreover, because the information is spread among various agencies, the

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[14] Richard Redding, Barriers to Meeting the Mental Health Needs of Juvenile Offenders, Developments in Mental Health Law 19, 1999.

data had to be intensely scrutinized to eliminate duplication of entries and to identify the gaps that exist in data collection efforts.

Commission staff also found that simply accessing licensure data does not provide an accurate picture of facility capacity. This data contains the number of beds licensed for the facility, rather than the number of beds actually staffed to receive patients. Furthermore, licensure data does not provide the number of licensed beds that are specifically intended for use by children and adolescents. Both of these elements are necessary in order to gain an accurate picture of bed availability for children and youth.

Another factor contributing to the difficulty in documenting the number of beds is the reliance on Certificates of Need (CON), to ascertain the supply of acute care beds. Certificates of Need authorize a certain number of inpatient, acute care beds for specific facilities. The number of beds licensed under the CON remains the official record; however, it is possible for hospitals to use these beds for residential treatment or other purposes. Furthermore, the licensure of residential treatment beds does not require a CON, as they are licensed through CORE requirements. The conversion of acute care beds to residential treatment beds further complicated the Commission staff's ability to gain an accurate count of the number of available acute and residential beds for children and youth in Virginia.

2. RESIDENTIAL TREATMENT BEDS

Residential facilities provide overnight care in a structured, supervised setting in conjunction with treatment or training services. The level of treatment and supervision varies, with some programs providing highly intensive treatment services in therapeutic environments, while others provide supportive, unstructured assistance to individuals in their own housing arrangements.[15] Residential treatment services may include crisis stabilization units, therapeutic foster care, community group homes, and programs for independent living skills.[16]

There are three primary agencies that are responsible for licensing residential treatment centers in Virginia: DMHMRSAS, DSS and DOE. The following analyses are based on the information reported by these agencies regarding facility capacities for licensure purposes.

Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS)

DMHMRSAS provided the Commission with the official capacities of all facilities that are licensed through that agency to serve children and youth. The data included facilities that may serve children with mental retardation, mental illness, substance abuse, emotional disturbance and other related disabilities. However, due to a facility's ability to care for a specific population, not all facilities are appropriate for certain children with serious emotional disturbance.

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[15] Comprehensive State Plan: 2000-2006.
[16] Hays-Smith.

Overall, the licensed capacity for residential treatment services of this type was 1,810 beds. However, as previously discussed in regards to acute care facilities, these beds are not distributed throughout the state. Instead, they tend to be concentrated in metropolitan areas. As reported in the data, the Tidewater region, including the cities of Norfolk, Virginia Beach, Hampton, and Portsmouth, has a total capacity of 777 beds, while regions such as Winchester and the Central Southside contain no mental health residential facilities.

Appendix H provides a listing of the localities included in the regions used in this and other Commission on Youth data analyses.

Table 1

Availability of Residential Treatment by Region

Region	Geographic Area*	Number of Beds
1	Southwestern	16
2	Roanoke	38
3	Shenandoah Valley	48
4	Winchester	0
5	Western Southside	136
6	Charlottesville	72
7	Northern Valley	49
8	Central Southside	0
9	Eastern Southside	178
10	Richmond	247
11	Tidewater and Eastern Shore	777
12	Northern Neck	0
13	Northern Virginia	243
	State Total	**1,810**

Source: Virginia Commission on Youth Analysis and Graphic of Survey of Out-of-state Placements, September 2001

Focus group members reported that this geographic disparity can have a significant impact on treatment programs for children in rural regions. Children are placed far from home, often in a metropolitan environment that is foreign to them. Furthermore, it is more difficult for families to visit and be incorporated into treatment efforts due to the distance that must be traveled. Moreover, this geographic separation makes transition back into the community more difficult. It is because of these difficulties that several focus groups, particularly those held in Bristol and Farmville, cited the need for more residential treatment centers in rural regions of Virginia. Specifically, several providers called for an additional facility to be constructed in the Southwestern region of the state. This discussion is described in more detail in Appendix F.

The data also supports the positions put forth by focus group members that other populations of children in Virginia, such as younger children and females, encounter difficulties in locating available residential placements. An analysis of the data shows that only 793 of the 1,810 available beds are open to children under the age of 10. Furthermore, while 278 of the available residential beds are appropriated for males, only 122 are specifically designated for females. The special needs of these populations must be considered when determining whether the mental health residential facilities are adequately meeting the needs of children in Virginia.

Department of Social Services (DSS)

DSS provides two types of out-of-home placements for children and youth: foster care and child serving institutions. The availability of both of these services is analyzed further below.

Foster Care

Virginia's "[f]oster care program assists to maintain family unity and keep children in their own homes." [17] Foster care prevention services are initially provided to children and families when it appears that removal of the child from the home may be imminent. When these services are not adequate to improve circumstances in the home, placement of a child in foster care then may be pursued. Once the child is removed, the goal of the program is to provide services to enable the child to return to his or her home, or alternatively, to find another permanent home for the child. The removal of a child to a foster care home is intended to serve only as a temporary solution to difficulties in the family situation, and not as a long-term placement. Efforts are made to place the child in the most suitable family-life setting available, and, when possible, the child is placed in close proximity to the parent's home. This allows for continued contact between the parent(s) and provides circumstances in which the familial relationship may continue and grow.[18]

Once removed from the home, a child may be placed in either regular or therapeutic foster care, based on their current physical and emotional needs. Therapeutic foster care provides individualized treatment in a foster home in which the parents are part of a treatment "team," and can be provided with support from outside resources 24 hours a day, 7 days a week.[19]

Before the specific numbers regarding foster care capacity are addressed, it is important to note that these data differ from other information provided in this report. The foster care numbers are based on utilization, rather than official capacity. Because these services are provided based on need, no official statewide capacity is available. Furthermore, only state and regional totals of foster care placements are available. This data is not further divided into the number of regular versus therapeutic placements.

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[17] Department of Social Services, *Foster Care, available at:* http://www.dss.state.va.us/family/fostercare.html
[18] Ibid.
[19] Hays-Smith.

As of May 31, 2001, there were 7,606 children residing in foster care in Virginia.[20] Slightly more than half of these children were male, and approximately 52% were African-American.[21] The majority of the children placed in foster care were adolescents, with 47% aged 13-18.[22] Of these children, 38% had the goal of reunification with parents or relatives, while adoption was being sought in 21% of the cases.[23] An additional 12% were older adolescents with the goal of independent living.[24]

Table 2

Foster Care Services by Region
As of May 31, 2001

Region	Geographic Area*	Placements
1	Southwestern	651
2	Roanoke	602
3	Shenandoah Valley	299
4	Winchester	199
5	Western Southside	469
6	Charlottesville	451
7	Northern Valley	81
8	Central Southside	67
9	Eastern Southside	224
10	Richmond	1,067
11	Tidewater and Eastern Shore	2,165
12	Northern Neck	314
13	Northern Virginia	1,017
	State Totals	**7,606**

Source: Virginia Commission on Youth Analysis and Graphic, September 2001

As seen in Table 2, the areas in Virginia that display the highest utilization of foster care services in 2001 are Tidewater/Eastern Shore, Richmond, and Northern Virginia. The region that uses foster care services the least is the Central Southside. This lack of foster care utilization in these areas may be due to a shortage of available foster care families. Members of the Prince Edward focus group specifically stated that difficulties in recruiting foster care families is one of the major barriers to service in that region.

Moreover, it is difficult to determine how many children are impacted by the reduced availability of foster care families. When these services are unavailable in a community, it is possible that these children instead are placed in a more restrictive placement, thereby increasing the cost to the state and local agencies.

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[20] Department of Social Services, *Virginia Foster Care Statewide Statistics*, June 2001.
[21] Ibid.
[22] Ibid.
[23] Ibid.
[24] Ibid.

Child Caring Institutions

Unlike foster care services, child caring institutions provide long-term residential care guidance, and supervision to children ranging in age from birth through seventeen.[2] Children are placed in these facilities by their parents or guardians and may remain as long as necessary, with placements sometimes extending for several years.

DSS reports that there are 1,038 child caring beds available as listed in the Children's Residential Facility Directory.[26] There are an additional 99 beds available in six child caring institutions that operated under the Minimum Standards for Licensed Child-Caring Institutions.[27] This listing is provided as Appendix I.

Once again, there are certain regions of the state that do not contain any local child caring institutions. These include the Northern Neck and Central Southside regions. It is also important to note that there are significantly fewer beds available for females than for males. There are 351 beds, public and private, that are designated for male use, while there are only 140 that are designated for use by females.

Department of Education (DOE)

Residential Facilities

The Department of Education provides residential services for children in need of intensive special education accommodations. In order for a child to be placed in a residential facility, the contents of his/her Individual Education Plan (IEP) must call for this type of placement.[28] The IEP is established by members of the school system and the parent, and addresses the particular special education needs of a child.[29] Once the IEP team determines that residential services are necessary, this placement will be submitted to the local Family Assessment and Planning Team.

There are 11 private residential schools in Virginia that serve children with special education needs.[30] These facilities, which are listed in Table 3 are concentrated in the Central (Richmond and Charlottesville areas) and Winchester (Shenandoah, Warren, Frederick and Clark counties) regions of Virginia, and provide a total of 526 residential beds.[31] It is important to note that the same concerns regarding placements for younger children and females are raised by the data. Approximately 287 of the 526 beds are open to children under the age of 12. Furthermore, only 30 of the beds are specifically designated for females, while 232 beds are restricted to male occupants.

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[25] Virginia Department of Social Services, *Child Caring Institutions*, *available at:* http://www.dss.state.va.us/facility/childcareinst.html.

[26] Virginia Department of Social Services, *Children's Residential Facility Directory*, June 2001.

[27] Virginia Department of Social Services, *Child Caring Institutions*.

[28] 8 VAC 20-80-64(C).

[29] 8 VAC 20-80-62.

[30] *Interdepartmental Regulation of Children's Residential Facilities Licensed Facility Directory*, May 2001; *see also* Virginia Department of Education, *Commonwealth of Virginia Private Special Education Residential Schools Directory*, January 2001, *available at*: http://www.pen.k12.va.us/VDOE/Instruction/Sped/privres.pdf.

[31] See sources cited *supra* note 22. Information regarding the capacity for the Grafton School, Richmond Region was obtained directly from the facility on December 14, 2001.

Table 3

Department of Education Residential Facilities*

Name	Capacity	Region**
Timber Ridge School	90	4
Grafton School -- Millwood	29	4
Grafton School -- Elm Street	32	4
Grafton School -- Berryville	84	4
Grafton School -- Shenandoah	8	4
Oakland School	66	6
New Dominion School -- Girls	22	6
New Dominion School -- Boys	72	6
Little Keswick School	30	6
Discovery School of Virginia	40	6
Grafton School -- Richmond	53	10

*This category of facilities does not include the special education programs offered within CORE-licensed facilities as part of a comprehensive treatment package.

It is important to note that this category of facilities does not include the special education programs that are offered within CORE-licensed facilities as part of a comprehensive treatment package. The list also does not incorporate the Virginia Schools for the Deaf and Blind, as they do not serve children with serious emotional disturbance.[32]

Private Day Schools

DOE also provides private day school services for children with special education needs. The facilities are intended to provide a more intensive, structured educational experience while allowing the child to remain in the community.

There are 1,903 private day school slots available in Virginia for children with special education needs. These facilities are geographically distributed throughout the state.[33] However, it should be noted that Northern Virginia has the greatest capacity to serve this population. This region contains 11 facilities that can accommodate up to 855 students. A listing of these facilities is provided as Appendix J.

3. GAPS IN SERVICE

In the first year of the study, a survey was distributed that asked service providers to identify the most frequent barriers that, when present, prevent children and youth from receiving a recommended service. One of the most commonly cited reasons was "service not available" (29%). This result prompted the Commission staff to investigate the gaps in service that currently exist in the system of care in Virginia. Information collected from the Advisory Group, focus groups, and independent research identified a growing need for the services described below.

Facilities for Juveniles with Aggressive Behaviors

Focus group participants frequently reported difficulty in locating residential services for juveniles with mental health treatment needs who exhibit aggressive or difficult to manage behaviors. A number of factors can contribute to a facility's reluctance to

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[32] These are located in Staunton and Hampton, Virginia, and report capacities of 200 and 120, respectively.

[33] Virginia Department of Education, *Private Special Education Day Schools Directory*, February 2001.

accept these juveniles. These may include concern for the juvenile's safety, other residents, and treatment staff, as well as the difficulty in recruiting staff who are willinc to work with this troubled population.

Crisis Stabilization Centers

Focus group participants and members of the Advisory Group also identified the need for short-term crisis stabilization centers throughout Virginia. Juveniles may require services in such a center when placement outside the juvenile's home is needed temporarily. Crisis stabilization centers typically offer a level of services that falls within the continuum of care between the restrictive, treatment-intensive environments provided by psychiatric hospitals, and the less-restrictive settings offered by therapeutic foster care families.

Stabilization centers of this type would prevent hospitalization and allow the youth to remain in the community. Currently, when there are no other placements available for emergency cases, a psychiatric bed is typically purchased for the juvenile. Although it is recognized that this is a more expensive and restrictive placement, alternatives are not readily available. Of additional concern is the fact that many of these placements occur in facilities that are a great distance from the community. This increases the costs of travel for transitional staff and makes incorporation of the family into treatment programs extremely difficult.

Sex Offender Treatment Facilities

Sex offender treatment services are especially difficult to obtain throughout the Commonwealth. Only two residential facilities operate in Virginia that specialize i juvenile sex offender treatment, and both of those are located in the Tidewater area.[34]

The gap in sex offender services may be attributed to several factors. First, many facilities do not accept sex offenders. Even when the sex offending behavior is in a juvenile's history and other treatment needs are the primary reason for the placement, many facilities will not accept the juvenile. When they do accept them, they often do not have experienced staff to provide the necessary treatment. Moreover, the construction of new facilities to serve this population can elicit the "not in my back yard" response from local residents, and raises issues of security and logistics such as combining youth of varying age groups and room sharing.

Less restrictive residential placements that assist in transitioning juvenile sex offenders back into the community and community services, including evaluation services, relapse prevention and counseling are also not readily available statewide.

Transitional Facilities

Virginia also has a shortage of transitional residential facilities such as group homes and independent living programs, which have been cited as key components in a wraparound system of care.[35] These facilities are necessary to provide the continuity of

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[34] These include the Genesis Treatment Agency and the Pines Residential Treatment Center.

[35] Beth Stroul and Robert Friedman, *A System of Care for Children and Youth with Severe Emotional Disturbances*, CAASP Technical Assistance Center, Center for Child Health and Mental Health Policy, Georgetown University Chilo Development Center, June 1994.

service that has proven beneficial to child outcomes. Service providers across Virginia have specifically noted that alternatives are not available for children who "age out" of their current placement. This issue is not unique to Virginia, and other states are currently exploring solutions as well.[36]

Facilities for Children with Multiple Disabilities

It is also difficult to find residential facilities that will accept children and adolescents who have multiple disabilities, including a dual diagnosis of serious emotional disturbance with mental retardation, hearing impairment or substance abuse. In order to receive treatment services, these children and adolescents seek help from residential facilities outside of Virginia.

4. OUT-OF-STATE PLACEMENTS

The Commission staff obtained information from DSS regarding the number and location of out-of-state placements reported through the Interstate Compact Commission. However, the Advisory Group expressed concern that these numbers were not fully reflective of the actual placements made in 2001. In an effort to gain a more accurate perspective of the number and needs of children currently placed in out-of-state facilities, the Commission conducted a survey of Community Policy and Management (CPMT) chairs throughout the Commonwealth. This survey requested information regarding the numbers, locations, and reasons for placements of children outside of Virginia.

The surveys were distributed in September 2001. Of the 116 surveys that were sent out, 72 were completed and returned.

The localities that responded reported a total of 74 out-of-state placements for fiscal year 2001, with these children reported to be placed in a total of 15 different states. Table 4 shows states receiving Virginia placements.

Table 4

FY 2001 Out-of-State Placements

States Receiving Virginia Placements	No. Children
South Carolina	10
Florida	5
Massachusetts	5
Maryland	4
Texas	3
Other	47
Total Out-of-State Placements	**74**

Source: Virginia Commission on Youth Analysis and Graphic of CPMT Chair Survey, September 2001

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[36] Bazelon Center for Mental Health Law, Making Sense of Medicaid for Children with Serious Emotional Disturbance, September 1999.

Twenty-five respondents[37] reported that the factor which contributed most significantly to a child's being placed in an out-of-state facility was "no appropriate placement in VA" (25). The second most frequent response marked was the "Other" category (6). Those who marked "Other" included in their description comments such as "positive feedback from other localities," "rejected by VA facilities," "young sexual offenders, low IQs," and "lower cost."

The reasons that were most frequently cited as contributing to the need for out-of-state placement were "sex offender/sexually aggressive" (15), "aggressive/out-of-control/violent" (12), and "other" (12).[38] Those who indicated "Other" most commonly described children with mental retardation, borderline intellectual functioning, extreme learning disabilities, or dual diagnosis of mental illness with mental retardation. Respondents also frequently cited factors such as autism and other psychiatric disorders.

It is also important to note that ten localities reported that they generally attempt more than five placements prior to placing a child out-of-state. One locality reported that they had tried 40 placements for one specific child prior to placing him in an out-of-state facility.

The survey also asked that CPMT chairs identify the factor that they felt, if remedied, would reduce the number of out-of-state placements most significantly. 36% of the CPMT Chairs responding ranked having facilities for mentally retarded children with dual diagnoses as the single factor that could most significantly reduce out-of-state placements.

Table 5

Factors Most Likely to Reduce Out-of-state Placements as identified by CPMT Chairs

Factor Cited	Rank	CPMT Chair Responses
Facilities for MR children with dual diagnoses	1	36 %
Sex offender treatment	2	16 %
Facilities for behaviorally aggressive/violent children	2	16 %
Facilities that serve autistic children	3	12 %
More state mental health facilities/beds	3	12 %
Greater number of facilities in Southwestern VA	4	8 %
Total Responses 50		

Source: Virginia Commission on Youth Analysis and Graphic of CPMT Chair Survey, September 2001

These responses mirror the gaps in services identified by the focus groups held throughout the state.

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[37] The total number of responses varies by question. The only constant is the total number of out-of-state placements (74).

[38] Categories are not mutually exclusive.

5. AVAILABILITY OF COMMUNITY-BASED TREATMENT SERVICES

Many of the mental health treatment needs of children and adolescents can be managed in non-residential, community settings.[39] In recent years, there has been a strong initiative to shift available resources from residential placements to the development and maintenance of community-based programs. However, there are indications that this expectation has not been fully realized.

When determining the capacity of community-based services one cannot rely on the number of licensed beds since, in theory, the provision of community-based services is not limited by the bricks and mortar of its facility but instead is based on demand. For purposes of this report, the availability of community-based services is instead based upon the utilization data reported by Community Services Boards (CSBs).

The DMHMRSAS FY2000 Utilization report shows that all 40 CSBs provided emergency and case management services as required by law.[40] All 40 also provided outpatient services to at least one or more children ages 0-17. However, this data also reveals that gaps exist in the continuum of care for many communities.

Range of Services Offered
FY 2000

Of the 40 Virginia CSBs

30 provided intensive in-home services,
11 provided therapeutic day treatment,
3 provided early intervention,
2 provided highly intensive services,
2 provided intensive services,
1 provided family support, and
0 provided prevention services

Each of these services is an element in a coordinated system of care. Where coordinated systems of care have been implemented and evaluations conducted, reductions have typically been found in rates of re-institutionalization after discharge from residential settings and out-of-state placements of children and other individual outcomes such as child behavior and parental satisfaction with services are improved.[41] As in any coordinated system, if one component is weak or missing, pressure and stress are felt by the other components and in some cases their efforts are ineffective. However, factors such as the number of service providers practicing in a community and the amount of funding available may currently be limiting many communities' ability to provide a complete and effective array of services.

There are several components of a coordinated system of care that have been identified as gaps in service in Virginia. Service providers have specifically cited a need

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[39] Center for Mental Health Services, *Annual Report to Congress on the Evaluation of the Comprehensive Community Mental Health Services for Children and Their Families Program*, Substance Abuse and Mental Health Services Administration, 1997.

[40] Virginia Department of Mental Health, Mental Retardation, and Substance Abuse Services, *CSB Mental Health Services Utilization Data*, August 2001.

[41] U.S. Department of Health and Human Services, *Mental Health: A Report of the Surgeon General*, 1999.

for greater availability of elements such as transition services for children aging into the adult system, therapeutic day treatment services for children and youth, and family support services such as respite care. Each of these services is discussed in greater detail below.

Transition Services

Service coordination and continuity of services have been documented as important factors in improved outcomes for SED children. The Center for Mental Health Services reported that breaks in service for greater than 30 days have been correlated with decreased improvement in child behavior and clinical outcomes.[42] Moreover, the National Educational Service included continuity of support in the transition to adult living and services as one of the seven best practices in programs for youth.[43] While case management is a mandated component of mental health services offered by CSBs (as funding is available), focus groups specifically identified transition services as that part of case management in which there is a gap. Service providers reported that older youth making the transition to adult services frequently find that there is less funding available for services as an adult, and there are different eligibility criteria for adult and children's services. They also encounter waiting lists to access services with few services available to help ease the transition.

Therapeutic Day Treatment Services

Therapeutic day treatment services combine psychotherapeutic treatments with educational and mental health services to groups of children in non-residential settings.[44] These services may include evaluation, individual, group and family counseling, medication education and management, and opportunities to learn and use daily living skills and enhance social and interpersonal skills. This type of treatment is typically provided in clusters of two or more continuous hours per day.

In Virginia, there was an 18% reduction in utilization of therapeutic day treatment by CSBs from 1999-2000.[45] This reduction is related to the lack of available funding for this service, rather than a lack of desire to provide it. Although the 2001 numbers are not available, CSB representatives report that the lack of availability continues to be a problem for the child and youth population.

Family Support Services

Family support services provide assistance to families who provide care at home for children with mental disabilities.[46] This assistance is intended to allow family members to have greater control over their own lives and the life of the child with the disability. These services may include respite care, adaptive equipment, personal care, supplies and equipment, behavior management, minor home adaptation or modification, day care, financial assistance, and other extraordinary care. DMHMRSAS has recommended that the support provided under these auspices should be "flexible and

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[42] Center for Mental Health Services.

[43] Nicole Deschenes and Hewitt B. Clark, *Seven Best Practices in Transition Programs for Youth*, in *Reaching Today's Youth: The Community Circle of Caring Journal*, National Educational Service, 1999.

[44] *Comprehensive State Plan: 2000-2006.*

[45] *CSB Mental Health Services Utilization Data.*

[46] Ibid.

individualized to meet the unique needs of the family and the individual with the disability."[47]

The 1999 Surgeon General's Report on Mental Health states that family support services have been found to increase families' knowledge and utilization of services, provide them with the skills needed to interact with the system, increase parental understanding and communication with their children, and make parents feel more positive about themselves.[48] Respite care has been cited as particularly beneficial to families with seriously emotionally disturbed children.[49] The service provides planned time off for caregivers, and can be delivered in the child's home or in the respite provider's home or facility.[50] It is an inclusive term and can include hourly or weekend care and even summer camps. Previous studies have found that respite care is most often utilized by families with fewer social supports, younger children, and children with a greater number of functional impairments.[51]

The availability of respite care in Virginia is limited due to the existence of several factors. First, because the infrastructure of a wraparound system of care is still in the process of being established, not all of the necessary components have been put into place in many communities. Because the importance of respite care to child outcomes has only recently been recognized, it was not considered a priority in early efforts. The establishment of this service is further complicated due to the lack of a consistent revenue source to support it. Because funding levels are limited, the implementation of supplemental services of this nature is often deferred so that communities can provide more children with intensive mental health treatment.

Communities across the nation are also reporting difficulties in recruiting sufficient numbers of service providers to provide mental health services such as respite care.[52] These difficulties have been attributed to state-level policies regarding liability and licensing.[53] Unless these issues are resolved, it is unlikely that there will be a substantial increase in the provision of respite services.

B. MENTAL HEALTH PROFESSIONAL AND TEACHER SHORTAGE

The regional shortage of qualified professionals creates a significant barrier to the service availability for children and youth with serious emotional disturbance. This issue is particularly problematic in rural areas, both in Virginia and across the United States.[54] Parallel discussions of the allocation of additional funds for the purchase of services and the employment of more mental health professionals will be ineffective if there are not enough qualified persons to fill the existing and new positions.

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[47] Ibid at cvii.

[48] U.S. Department of Health and Human Services, *Mental Health: A Report of the Surgeon General*, 1999.

[49] Ibid.

[50] Hays-Smith.

[51] Roger Boothroyd, *Understanding Respite Care Use By Families of Children Receiving Short-Term, In-Home Psychiatric Emergency Services*, Journal of Child & Family Studies 7, September 1998.

[52] Center for Mental Health Services.

[53] Ibid.

[54] Bushy, et al, Mental Health and Substance Abuse: Challenges in Providing Services to Rural Clients, Treatment Improvement Exchange, 1996.

1. MENTAL HEALTH PROFESSIONALS

The shortage of qualified mental health professionals has been identified in communities nationwide. In response to this problem, the federal government has established a designation for Mental Health Professional Shortage Areas (MHPSAs). This designation identifies regions that are significantly underserved, based on a ratio of qualified mental health service providers to the total population of the community.[55] As shown in Exhibit A, shortages tend to exist primarily in the Southside, Southwest, Northern Neck, and Peninsula regions of Virginia. These areas tend to be some of the most rural in the state, replicating nationwide results that report the greatest shortages in less populated regions across the U.S.

Once these communities are identified, the National Health Services Corps and other organizations provide local agencies with additional supports and resources in an effort to enhance the recruitment of qualified professionals. The professionals included in this designation are psychiatrists, clinical psychologists, social workers, psychiatric nurse specialists, and marriage and family therapists.[56]

To date, 50 Virginia localities have received the designation, as depicted in Exhibit A.

Of particular concern is the shortage of general psychiatrists in Virginia communities. DMHMRSAS reported in its Comprehensive State Plan for 2000-2006 that "psychiatric coverage varies widely across Virginia localities and the public services system continues to have an ongoing need for staff in the core discipline of psychiatry." [57] DMHMRSAS reports that enhanced psychiatric coverage would help ensure fewer hospitalizations, improve the level of functioning of individuals with disabling mental illnesses, lower the costs of treatment, improve levels of client satisfaction, and improve the quality of services.[58]

In order to recruit greater numbers of psychiatrists and other mental health professionals to regions that suffer from these shortages, state and federal agencies have established incentives for those who choose to practice in these underserved regions. Virginia is no exception; there are four existing programs in the Commonwealth that provide financial assistance to physicians in return for a commitment to serve in an underserved area or a state or local government facility.

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[55] For specific criteria, see Bureau of Primary Health Care, Health Resources and Services Administration, *Criteria for Designation of Areas Having Shortages of Mental Health Professionals*, U.S. Health and Human Services Administration, *available at:* http://bphc.hrsa.gov/dsd/default.htm.

[56] Ibid.

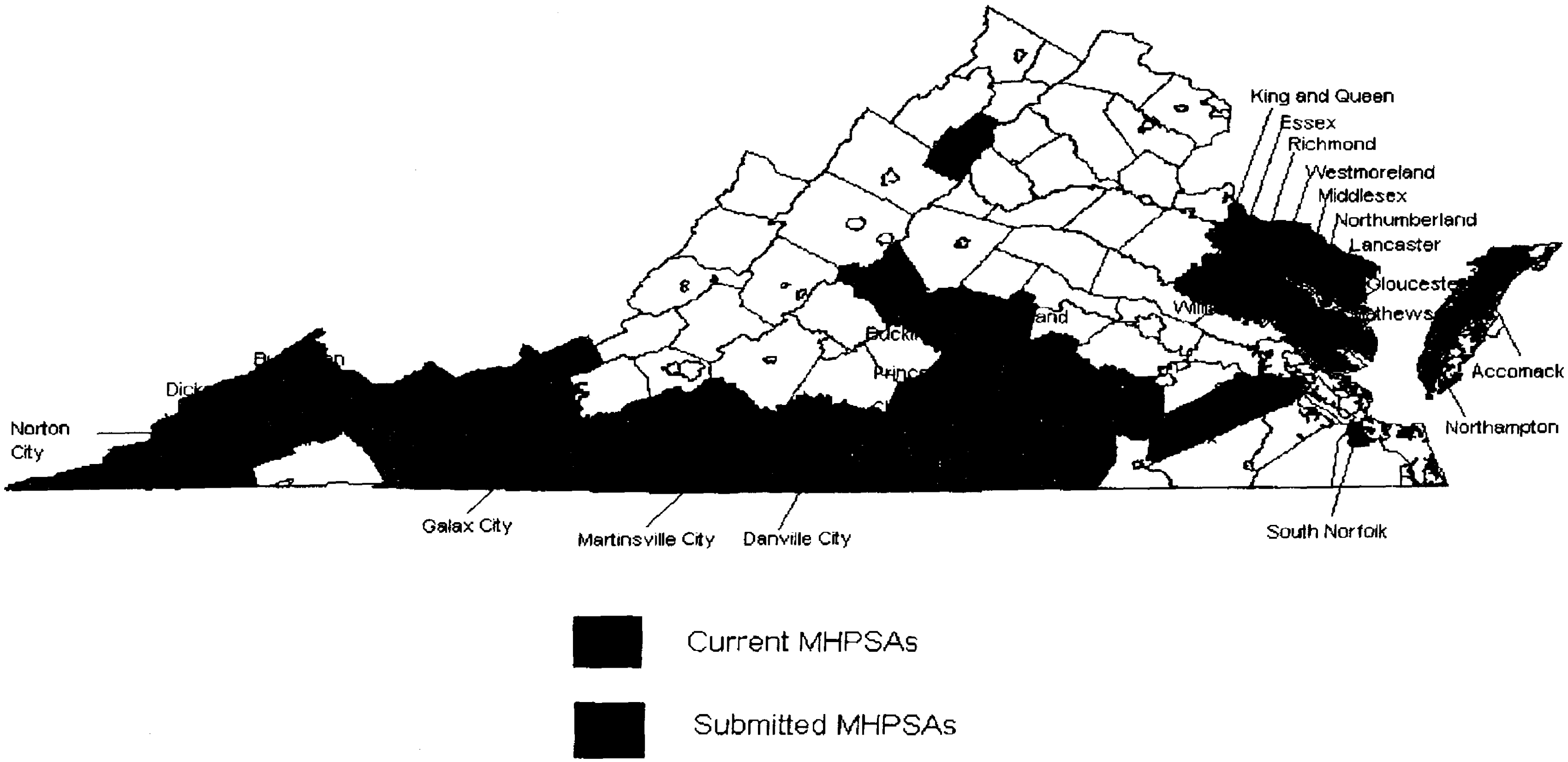
[57] *Comprehensive State Plan: 2000-2006.*

[58] Ibid.

Exhibit A

Effective 4/20/2001

Virginia Health Professional Shortage Areas
Mental HPSAs



These initiatives include:

- the National Health Service Corps (NHSC) Loan Repayment Program;
- the National Health Service Corps (NHSC)Virginia Loan Repayment Program;
- the Virginia Loan Repayment Program; and
- and the Gilmore Fellows Program.

The state and federal loan repayment programs offer $25,000 per year in payment toward a participant's qualified loans for a minimum two-year commitment. This compensation is offered in addition to the salary and benefit package offered by the agency in which the participant is placed. Participants may extend these contracts on an annual basis, and if they choose to do so the program will pay the lesser of $35,000 or the balance of loans outstanding at the start of the service year. The money is taxable; however, the federal NHSC program offers an additional 39% of that amount to compensate for income taxes. The federal/state NHSC program and the Virginia Loan Repayment program do not include this additional compensation.

National Health Service Corps (NHSC) Loan Repayment Program

The National Health Service Corps (NHSC) Loan Repayment program is a federal initiative that offers scholarships and loan repayments to physicians in return for medical service in federally designated shortage areas. Physicians are placed in geographic locations across the U.S. based strictly on need: regions are ranked, and a professional can be sent to any area of the country based on the current level of necessity. Federal agencies often work with state offices to help place professionals within Virginia.

The National Health Service Corps (NHSC) Virginia Loan Repayment Program

The program also exists in the form of a federal/state partnership. Physicians participating in this joint initiative receive assistance in the form of both federal and state funds. Under the current structure, states receive federal funds in the form of grants, which are contingent upon a 50% match. These funds are then combined and appropriated to participants. Physicians in the program are placed across Virginia in public or nonprofit agencies located within designated shortage areas. It is important to note that under the current grant, only primary care physicians may participate in the program. Requests have been made to the federal granting agency to extend the initiative to psychiatrists, but to date these have been rejected.

The Virginia Loan Repayment Program

The Virginia Loan Repayment Program began as one for primary care physicians through a statewide initiative funded solely by the Commonwealth. Placement must be in a designated shortage area; however, it can be in a federally designated MHPSA or in a Virginia Medically Underserved Area (VMUA). Since July 2000, the program has been extended (through Budget Language) to psychiatrists and, as of this reporting period, there was one psychiatrist participating.

Because interest in the program by physicians consistently exceeds the funding available, an expansion of the initiative would be beneficial. Doctors who participate in this program now receive $10,000 per year in loan repayment for one year of service, in addition to a salary. Funding for salaries has generally been the responsibility of the

Exhibit B

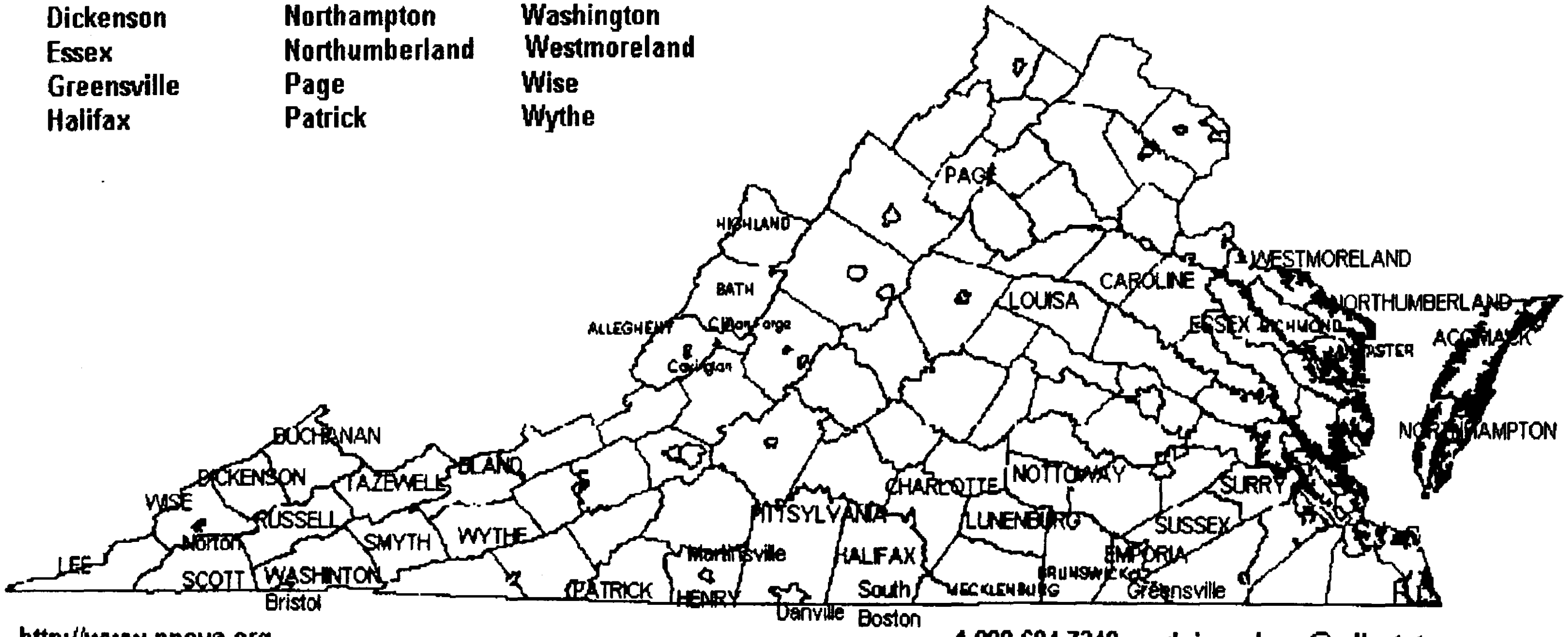
Virginia Medically Underserved Areas

Counties

Accomack
Alleghany
Bath
Bland
Brunswick
Buchanan
Caroline
Charlotte
Dickenson
Essex
Greensville
Halifax
Henry
Highland
Lancaster
Lee
Louisa
Lunenburg
Mecklenburg
Nottoway
Northampton
Northumberland
Page
Patrick
Pittsylvania
Richmond
Russell
Scott
Smyth
Surry
Sussex
Tazewell
Washington
Westmoreland
Wise
Wythe

Cities

Bristol
Clifton Forge
Covington
Danville
Emporia
Martinsville
Norton



http://www.ppova.org 1-800-694-7349 dnierenberg@vdh.state.va.us local CSBs. This has proven problematic, however, as it is difficult for many local CSBs to absorb the cost of a staff psychiatrist. In response, the Department of Health is exploring creative arrangements, such as combining private practice with community work, so that the full load of the salary does not rest solely on the CSB.

The Gilmore Fellows Program

The Gilmore Fellows Program is the fourth initiative that exists in Virginia to combat the shortage of mental health providers. A total of $500,000 was allocated in each year of the 2000-2002 biennium for the recruitment and retention of psychiatrists in medically underserved areas. This program offers psychiatry residents a stipend in exchange for service on a one-year to one-year basis. These residents are recruited from the four psychiatry residency programs in Virginia: Virginia Commonwealth University Medical College of Virginia, the University of Virginia-Charlottesville, the University of Virginia-Roanoke, and Eastern Virginia Medical School. Each of these programs has a faculty mentor, appointed by the department chairman, who may nominate up to three residents to participate in the program. These residents are then given approval by the Psychiatric Underserved Areas Steering Committee (PUAC), which is comprised of representatives from the Virginia Inspector General's Office, the DMHMRSAS, and the Virginia Department of Health.

The program encourages psychiatry residents to spend time in an underserved area in order to familiarize themselves with the population and to provide the community with access to the psychiatric services. The highest priority of the program is placement within a Community Services Board (CSB). The faculty mentor promotes this process by creating an environment within the training program that fosters community practice and provides outreach to the local community services board staff. The program also seeks to ensure that the student-mentor relationship extends beyond training, in order to reduce the sense of professional isolation that many new providers face when working in an underserved community.

One of the limitations of this program is that it does not fund salaries; however, it has been integrated with medical school debt repayment programs that may be attractive to newly trained psychiatrists. The program has been in existence for two years, and the first five participants will exit in July 2002.

2. TEACHER SHORTAGES

The shortage of qualified teachers has been recognized as a significant national problem affecting the quality of education in America.[59] Teacher shortages are most severe in high-poverty schools, and have been found to be particularly acute in specific fields such as math, science, special education, bilingual education, and foreign languages.[60] Virginia, too, has felt the impacts of the shortage of qualified teachers. The

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[59] *The Current State of Teaching in America: Five Barriers to Increasing Student Achievement*, in *A Talented, Dedicated, and Well-Prepared Teacher in Every Classroom: Information Kit*, U.S. Department of Education, September 1999.

[60] Ibid.

Virginia Department of Education reports that acute teacher shortages continue to exist in special education, science (physics/earth science), and mathematics.[61]

The shortage of special education teachers has been noted to be particularly problematic, both in Virginia and nationwide. A 1993-1994 report by the U.S. Department of Education found that more than 56% of high poverty schools and 49% of low-poverty schools had vacancies in special education that they were finding particularly difficult to fill.[62] In Virginia, the eight special education endorsement areas combine to account for 1,193 (16%) of the full-time positions that were either unfilled or filled with unendorsed personnel. [63]

More specifically, teachers for emotionally disturbed children accounted for 83 (4.8%) of the positions that were unfilled or unendorsed.[64] Of additional concern is the fact that this demand for teachers for the emotionally disturbed appears to be on the rise. The Virginia Department of Education (DOE) reports that there was a 79% increase in the number of students with emotional disturbance from 1988 to 1998, resulting in a 34% increase in the number of qualified teachers still needed to provide educational services for these children.[65]

The steady increase in the number of students with emotional disturbance has had a profound and complex impact on the quality of educational services received by SED children. The Virginia DOE reports that in the 1998-1999 school year, it cost an average of $9,303 more per child, in addition to general education costs, to provide special education services to children with emotional disturbance.[66] Particularly affected are private, special education schools. Due to financial limitations, many are now unable to provide competitive compensation for teachers of emotionally disturbed students. This makes retention of qualified teachers more difficult and, as a result, many private special education schools are being forced to hire teachers who are only conditionally or provisionally licensed. These reports are supported by recent statistics, which found that 20% of teachers of students with emotional disturbance in Virginia are not fully qualified.[67] Moreover, these circumstances are compounded for psychiatric hospital-connected day and residential programs, which operate on a year-round basis and find it difficult to attract and keep qualified teachers. The shortage of qualified personnel results in less than adequate educational services for these children.

The Virginia DOE has attempted to combat this shortage with methods similar to those utilized in the health care industry. They have established the Virginia Teaching Scholarship Loan Program (VTSLP) to provide an incentive to students who want to teach in one of Virginia's critical shortage fields. These fields include special education, chemistry, physics, earth science, mathematics, technology education, and foreign languages. Eligible students apply to receive a scholarship-loan of up to $3,720. When the student completes his/her teacher preparation program from a Virginia college or

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[61] *Report on Supply and Demand of Instructional Personnel in Virginia: 1999-2000*, Virginia Department of Education, November 2000.

[62] National Center for Education Statistics, *America's Teachers: Profile of a Profession, 1993-1994*, (1997).

[63] *Report on Supply and Demand of Instructional Personnel in Virginia: 1999-2000.*

[64] Ibid.

[65] Special Education Demographics, Virginia Department of Education, 1999.

[66] Ibid.

[67] Ibid.

university, the scholarship-loan is completely forgiven if the student teaches four semesters in the public schools of Virginia in a critical shortage field. If the student does not fulfill this obligation, he/she must repay the funds. Since 1996, 135 scholarship-loans have been awarded in the field of special education.

3. IMPACTS ON QUALITY OF SERVICE

The shortage of qualified professionals has been found not only to impact the availability of services, but also the quality of the treatment received by children with serious emotional disturbance. The effectiveness of treatment is directly impacted by the way that professionals are recruited, prepared, licensed, and supported. In order to improve child outcomes, Virginia must identify and alleviate those factors that would limit the ability of communities to provide the most effective treatment programs available.

Credentials

The quality of service for children and youth with SED may be dramatically impacted by the credentials of the providers operating in the region. Many areas in which there are shortages of qualified professionals may turn to providers with less education and experience, and this can have a significant affect on child outcomes.[68]

Cultural Challenges

The quality of services may also be impacted by geographic and cultural challenges. Several cultural barriers may deter racial and ethnic minorities from seeking treatment, such as mistrust and fear of treatment, racism and discrimination, and differences in language and communication.[69] Because the diagnosis and treatment of mental disorders is strongly dependent on verbal communication and trust between the patient and service provider, any barrier to this rapport can have a detrimental impact on patient outcomes.[70]

The Center for Mental Health Studies reports that cultural diversity appears to be a nationwide problem, as few regions across the nation have achieved appropriate minority representation among the providers serving on their system-level interagency structures.[71] In fact, the American Psychological Association reported in 1997 that only 13% of all health service psychologists in the U.S. were minorities, while approximately 26% of the population consists of members of a minority group.[72] In order to address this deficit more adequately, the federal government has established grant and scholarship programs with particular emphasis in recruiting minority service providers for shortage areas. One such program is the federal Health Careers Opportunity Program sponsored by the Health Resources and Services Administration (HRSA).[73] This program supports recruitment of young rural minorities to the health professions, as part of a long-term strategy to assure local health care for communities that lack

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[68] *Rural Mental Health: Familiar Problems in a Changing World*, Rural Health News 4, Spring 1998.

[69] *Culture, Race, and Ethnicity: A Supplement to Mental Health: A Report of the Surgeon General*, U.S. Department of Health and Human Services, 1999.

[70] Ibid.

[71] Center for Mental Health Services.

[72] *Training for Psychologists and Mental Health Professionals: SAMHSA Reorganization*, American Psychological Association Public Policy Office, August 2000.

[73] *HHS Programs to Protect and Enhance Rural Mental Health*, Department of Health and Human Services, HHS Fact Sheet, July 25, 2001.

practitioners. This program provides grant funding for public and private nonprofit schools and training programs that provide students from disadvantaged backgrounds with opportunities to develop the skills necessary to become health professionals.

Stretching of Resources

Furthermore, quality of service may be affected by the stretching of human resources. Where mental health and substance abuse services are limited, the existing resources must be extended to meet demand. Providers in these regions have been found to assume multiple roles in order to function in a variety of situations.[74] For example, a counselor in a mental health clinic may need to perform the role of case manager, grant writer, crisis worker, administrator, public relations person, and therapist. This can have a significant impact on the overall quality of care, and may create burnout that results in low staff retention rates. Consequently, increased staffing is necessary to ensure that providers are not stretched beyond their abilities.

The shortage of qualified service providers in Virginia has significant implications for the quality and availability of services for children and youth with emotional disturbance. This issue must be effectively addressed in order to ensure that the mental health needs of these children and youth are recognized and treated in an efficient and preventative manner. However, it must be noted that much of the potential for growth in this area is dependent upon the availability of greater financial resources. Additional funding is necessary to recruit, educate, and properly train larger numbers of quality mental health service providers.

C. COMPREHENSIVE SERVICES ACT FOR AT-RISK YOUTH AND FAMILIES

The funding of services for children and adolescents is central to any discussion of the availability or provision of services for children with serious emotional disturbance (SED). In Virginia, the Comprehensive Services Act (CSA) serves as the core funding mechanism for the majority of these services, and consequently lies at the center of any funding analysis. Information collected in the first year of the study identified that a lack of funds for the child or the service were the two most frequently cited reasons why services were recommended but not received. Throughout the second year of the study, the issue of funding continued to generate much discussion among service providers. Regardless of how the issue was approached, the path consistently led back to the CSA and distinctions between categorizations of mandated and non-mandated.

1. BRIEF HISTORY OF THE COMPREHENSIVE SERVICES ACT FOR AT-RISK YOUTH AND FAMILIES[75]

The Virginia General Assembly passed the Comprehensive Services Act in 1992 after two years of study and planning by the Council on Community Services for Youth and Families. This Council was formed after the Virginia Department of Planning and Budget's 1990 study of Children's Residential Services revealed that although children and families have multiple needs, the children are defined and services limited by the

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[74] Rural Mental Health.

[75] A listing of documents and reports some of which provide a more in-depth review of the history of the CSA can be found in Appendix E.

system and agency they enter - juvenile justice, education, etc.[76] Additional problems identified

> were a fragmented service delivery system which fostered duplication in the provision of treatment services and a funding structure which created local incentives to arrange for counseling and related services in the most restrictive and expensive settings.[77]

Three ways in which the General Assembly set out to correct these problems through the CSA included:

1) the pooling of resources from the multiple funding streams;
2) the use of collaborative arrangements by local agencies serving at-risk youth "to deliver non-duplicative services in the least restrictive settings possible"; and
3) the establishment of program leadership by a council of state officials rather than a single agency with program oversight to local officials.[78]

2. CSA SERVICE FEE DIRECTORY

As indicated on the CSA website "Welcome to the Service Fee Directory" section,

> The Service Fee Directory provides information to assist localities and providers of services regarding the availability of services and fees for those services. Private and public providers of services, including those outside of Virginia, list information describing their programs, locations and maximum fees.[79]

The responsibility for supplying and maintaining information contained in the directory lies with the providers. Inclusion in the directory does not constitute endorsement by the Office of Comprehensive Services, nor does it confirm that the providers are properly licensed, certified or insured.

Authority for the Directory can be found in Virginia Code §2.2-5214 (Michie, 2001). When the CSA was implemented, the prior practice of rate negotiation and rate setting by the state ceased. Instead, the Directory was established so that providers' services and fees could be visible to all and localities could use this directory to select a provider. One of the theoretical goals behind the creation of the Directory was to, by publishing fees, increase competition among providers, thereby driving down fees charged for services. This goal has not been recognized because it is a "seller's" not a "buyer's" market. The demand for certain services, particularly some types of residential services, exceeds the supply. Providers find little need to reduce their fees when they are frequently at or near capacity. In fact, it was asserted that it can even work in the opposite direction, alerting some providers as to how much others are able to successfully charge for their services.

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[76] The Council on Community Services for Youth & Families, *Improving Care for Troubled & "At Risk" Youth & Their Families*, November 1991.

[77] Virginia Joint Legislative Audit and Review Commission, *Review of the Comprehensive Services Act*, Senate Document 26, 1998.

[78] Ibid.

[79] Comprehensive Services Act for At-Risk Youth and Families Website, Welcome to the CSA Service Fee Directory, http://www.csa.state.va.us, December 6, 2001.

It is also important to note that the fees listed in the directory are the *maximum* fees that the provider may charge.[80] Negotiations between providers and localities do exist. As in any free market, purchasing power driven by volume can decrease a localities cost for services. While this works to the benefit of larger localities, however, smaller, rural localities are unable to compete on this basis. This phenomenon occurs most frequently for services that are available on a regional rather than a local basis in which larger localities are competing with smaller ones for the best rate.

For this reason, smaller, rural localities have concerns about a return to state rate setting in which, at least for local services, they could pay much more since the rate could be based on the rates appropriate in large, urban areas. Furthermore, localities, already feeling the impact of increased administrative responsibilities associated with the CSA, find that the negotiation of fees and contracts with providers draws on the already limited resources of localities due to its time-consuming and heavily administrative nature.

During the course of this study, it became apparent that the CSA Service Fee Directory is not widely used. Two primary reasons seem are that 1) local Family Assessment and Planning Team (FAPT) members are aware of the services offered by providers in their locality; and 2) the information contained in the Directory is inaccurate. Related to the first reason, in the event a known provider cannot meet a child's needs, the person working to find a placement will contact colleagues in other localities seeking their recommendation for potential placement. The benefit behind such action is that not all providers are of the same quality or are not appropriate for every child or situation. This type of information cannot be gained from consulting the Directory.

The second reason, inaccuracy of the information, became evident when Commission staff attempted to use the data contained in the directory to gather information on the capacity of residential services for children. Using data from the Directory, a report was created for each of the focus group regions. When this information was presented to focus group members, a number of flaws were identified. One prominent flaw was related to the service codes that identify what types of services the provider offers. Payment for services through the CSA can only be made to providers who are listed in the Directory[81] and have indicated that they provide the service for which payment is requested. Providers appear to indicate the provision of services they do not routinely provide to ensure payment in the event they do provide the service, thereby inflating the apparent availability of a service in that region.

3. CATEGORIZATION AS MANDATED OR NON-MANDATED

Eligibility of a child to access CSA funds is determined by the factors contained in §2.2-5212 of the Virginia Code (2001). There are three primary factors, any one of which enables a child to access CSA funds. The factors include the following:

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[80] Ibid.

[81] As of October 31, 2001, the State Executive Council, upon the advice of counsel, adopted the position that reimbursement from the state pool of funds is not restricted to vendors with rates and services listed in the Service Fee Directory (SFD).

1) the child "requires services or resources that are beyond normal agency services or routine collaborative processes across agencies, and requires coordinated services by at least two agencies;"[82]
2) the child requires placement in a private special education program; or
3) the child is in foster care.

Once a child is determined to be eligible for CSA funds, a more subtle yet crucial distinction is made. The child is determined to be either mandated or non-mandated. The general rule is that children in foster care, children at-risk of being placed in a foster home (foster care prevention services) or special education students eligible for private tuition assistance are mandated to receive services. The children who are non-mandated generally include juvenile offenders or children referred by the mental health system (local CSB). This distinction is critical because this mandate carries with it a requirement for *sum sufficient funding* for the services needed by a mandated child. "

The education and foster care funding streams placed in the pool have sum sufficient language attached to them in federal law and policy and/or the Virginia Code. This means that state and local governments are required, by law, to appropriate sufficient funds to serve these populations."[83]

The cost to provide services through the CSA is divided between state General Fund dollars and local monies. The percentage match required of each locality varies and is based on its actual total 1997 program expenditures. Since 1994 the cost to provide services to mandated children has more than doubled, costing the state and localities $94.5 million in 1994 and increasing to $194.7 million during the year 2000.[84] Given this significant increase over six years and the commitment of funds necessary to meet the needs of mandated children on a sum sufficient basis, a number of localities (44 during program year 2000) do not serve non-mandated youth.

Although the number of mandated youth and amount of money spent on them has increased, the amount spent on non-mandated youth has decreased. Since 1994 state and local money spent on non-mandated children has shifted slightly downward from 10 million to $9.96 million in 2000.[85] As a percentage of the total CSA expenditures, the total amount spent on non-mandated is only 4.9%, down from 9.6% in 1994. Chart 4 depicts the trend in CSA expenditures from 1994 to 2000.

In addition to the rising costs associated with meeting the needs of mandated youth, the fixed nature of the percentage of the appropriation protected for non-mandated youth has contributed to localities' failure to support services for non-mandated youth. This percentage, which is fixed at the same level it was when it began, was established to encourage localities to provide services to non-mandated youth by protecting some of their CSA allocation for this purpose.

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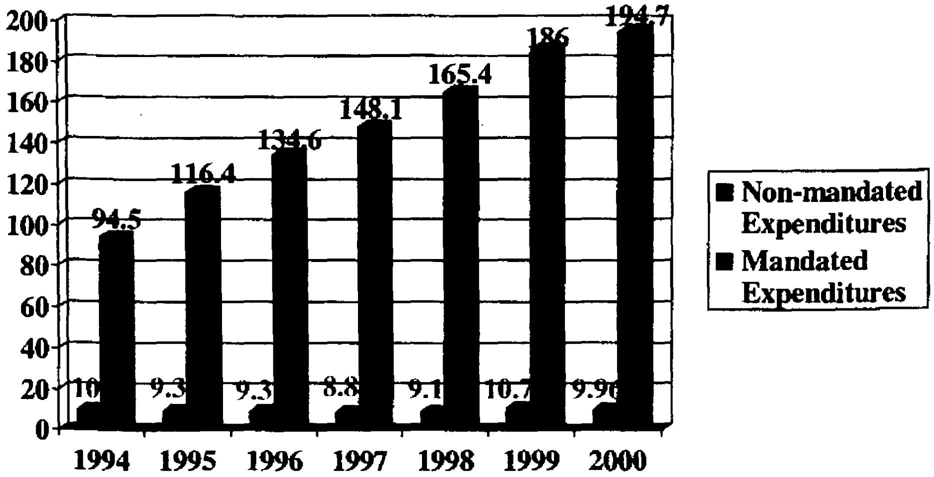
[82] Virginia Code Ann. § 2.2- 5212 (Michie 2001)
[83] Comprehensive Services Act for At-Risk Youth and Families website, Frequently Asked Questions.
[84] Comprehensive Services Act for At-Risk Youth and Families Website, Statistics.
[85] Ibid.

Chart 4

Virginia CSA Expenditures
1994-2000



Source: Virginia Commission on Youth Analysis and Graphic of CPMT Chair Survey, September 2001

The State determines each locality's "protection level" by setting aside 12% of the year's State and local CSA appropriation and then allocating this amount among localities using shares from the growth allocation formula. When the CSA State pool of funds was created in FY 1993, the non-mandated funding streams represented 12% of the total. These funds are "protected" because localities do not have to expend them before requesting supplemental funds to cover mandated services.[86]

Despite the decrease in spending on non-mandated children, it is unlikely that the number of non-mandated youth or the severity of their needs has decreased at the same rate, while the cost to provide services for mandated youth has more than doubled. The distinction created between these two categories by the requirements of federal or state law is seen by many service providers as artificial and indifferent to the children's needs for services.

The Joint Legislative Audit and Review Commission (JLARC) provided a thorough examination of the distinction and characteristics of mandated and non-mandated youth in its 1998 study of the Comprehensive Services Act.[87] JLARC found that "[i]n most cases, the emotional and behavioral problems of children who are considered "non-mandated" are similar, and in some cases, greater than those of children for whom services are "mandated." A thorough evaluation of the CSA was not contemplated nor conducted pursuant to HJR 119; however, JLARC's assessment of the CSA still rings true today.

The lack of money to support services for non-mandated children and youth can be extremely frustrating for the parents and professional trying to help the child and family. Delays in the provision of services to children can result in more severe emotional and

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[86] Virginia Joint Legislative Audit and Review Commission.
[87] Ibid.

behavioral problems for children.[88] A saying frequently made among service providers is "pay now or pay later," meaning that it likely will cost less to address a less severe problem now than to address a more severe problem later. Less expensive community-based services are the first choice to assist children with mental health treatment needs. However, as the problems become more severe, it is likely that more intensive services, including expensive residential placements, will be necessary to meet children's needs.

The costs involved go beyond the financial burden shared by families, localities and the state. The emotional costs to the family also can be significant.[89] Caring for a child with severe emotional disturbance can exacerbate existing problems or create new ones for the child's parents and siblings. Marital relationships, the development of and parental relationships with the child's siblings, job performance and financial circumstances can all suffer. Left untreated, children with severe emotional disturbance will most certainly manifest problems in many areas of their own life, such as school and the community, including the juvenile justice system.[90]

Professionals and judges may, out of a desire to help the child and parents, use less desirable means in order to secure mental health services for the child. These means may include 1) legal actions against school systems; 2) relinquishment of custody through foster care; or 3) entry into the juvenile justice system. These actions can result in increased numbers of non-mandated children receiving services. However, the question is at what cost? A parent's relinquishment of custody to the state for placement in the foster care system is an extremely painful event for the parent, child and other family members. Parents are then deprived of the authority to make medical, educational and other important decisions about their child's life.[91] The unnecessary introduction of a child into the juvenile justice system can also have negative consequences for the child and family. The irony of a child's involvement with the juvenile justice system is that unless the child has committed several offenses or a severe offense and is committed to the state for care at a state juvenile correctional center, the services available to him/her may be limited because the child is likely to be considered non-mandated.

Another complicating factor that can limit a child's access to mental health services while in detention or a state juvenile correctional facility is Medicaid's federal restriction that prevents coverage for a child who is institutionalized and in this case incarcerated. This is especially problematic for children who are placed in detention who need to continue taking medication or who need hospitalization. The Medicaid benefits available to them prior to their detainment are suspended placing the responsibility of the cost to provide the services fully on the locality.

This distinction and limited funding may also restrict services to mandated youths. There exists a misconception that if a child is mandated, he/she can receive any service. Instead, the child is mandated to receive any service that is necessary and

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[88] Stroul, B.A. & Friedman, R.M. (1986). A System of Care for Children and Youth with Severe Emotional Disturbance. (Revised edition, June 1994). Washington, DC: Georgetown University Child Development Center, CASSP Technical Assistance Center.
[89] Staying Together: Preventing Custody Relinquishment for Children's Access to Mental Health Services, Bazelon Center for Mental Health Law and the Federation of Families for Children's Mental Health, November 1999.
[90] Stroul & Friedman.
[91] Staying Together.

related to the status upon which he/she was found to be mandated. For example, a child who is mandated because of special education needs, unless that service is necessary to meet the educational needs of the child, the service is not considered mandated.

D. UTILIZATION OF MEDICAID AND FAMIS

1. MEDICAID

Medicaid serves as a significant source of funding for children and youth's mental health services in Virginia. In 1995, Medicaid-eligible children and youth accounted for 36.7% of all of the hospital discharges of non-newborn children in the Commonwealth.[92] Medicaid also serves as a considerable resource for hospital admissions related to child and adolescent mental health. In 1995, 35.9% of all behavior disorder discharges, 21.8% of discharges for depression, and 27.6% of discharges for manic-depressive disorder were paid for using Medicaid funds.[93] Consequently, the eligibility requirements and services offered under the state Medicaid plan have a significant impact on children's access to mental health services in Virginia.

The general requirements for Medicaid eligibility are determined at the federal level, by the Health Care Financing Administration (HCFA). Each state adopts, with HCFA's approval, a state plan that details the Medicaid services that will be available in that state. Generally, adults are entitled to the basic mental health services that are contained in the state plan, including intensive outpatient treatment, 24-hour inpatient services, and ambulatory services such as clinics and physician services.[94] However, under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) mandate, child beneficiaries are entitled to any federally authorized Medicaid service.[95] This entitles children to all additional option services that are offered by the state.[96] In Virginia, the services supported by Medicaid that address child and youth mental health include intensive in-home services, therapeutic day treatment for children and adolescents, psychosocial rehabilitation, crisis intervention, intensive community treatment, crisis stabilization, mental health support, case management for children at risk of or diagnosed with serious emotional disturbance, mental health clinic option services (provided in state funded mental health clinics), and treatment foster care management.[97]

Medicaid benefits also have been extended in recent years to include coverage of residential treatment for children and adolescents under the age of 21.[98] However, in order to receive this funding, an independent team must provide a certification of need for the child. In addition, as with all Medicaid-funded treatments, the services must be medically necessary, and preauthorization is required.

While Medicaid appears to be a growing source of funding for child mental health services, its resources may not be fully utilized in Virginia. Several studies conducted in the Commonwealth have cited the need for an increased use of Medicaid funding as a

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[92] Virginia Department of Health, *Child and Adolescent Hospitalizations in Virginia*, 1995.
[93] Ibid.
[94] 42 C.F.R. 440 (A) (2001); 12 VAC 30-50-10 (2001).
[95] 42 C.F.R. 411 (B) (2001); 12 VAC 30-50-130 (2001).
[96] Ibid. Further discussion of the EPSDT is contained in the Early Intervention section of this report.
[97] Ibid.
[98] Virginia Code Ann. 32.1-325, *amended by* 17:1 VA. R. 64, effective January 1, 2001.

necessary enhancement to the current level of resources for child mental health services.[99] These studies have identified restrictive Medicaid criteria, in addition to limited state funding, as significant factors affecting statewide service accessibility.

Studies also have recommended that state officials pursue the use of Medicaid funds to offset the costs of the CSA.[100] An analysis by JLARC of the CSA noted that approximately 68% of the children served by the CSA are Medicaid-eligible.[101] The study recognized that many of these children are receiving CSA services through a combination of state and local funds, for which the state could receive 50% reimbursement through federal funds. Further analysis concluded that such an effort could generate an estimated $41 million in CSA savings.[102]

The JLARC study provided several recommendations to increase the use of federal Medicaid funds, including a recommendation that the Department of Medical Assistance Services (DMAS) be required to amend its state plan to include Medicaid payment for residential care and therapeutic foster care. It was also suggested that the State Executive Council and DMAS together pursue the use of Medicaid funds for assessment and case management functions.

The realization of an increased use of Medicaid funds has been slow, for which there are several reasons. JLARC reported that localities might be reluctant to pursue federal funding because of the administrative and program changes that are tied to the use of these resources.[103] In 2000, the Department of Planning and Budget (DPB) reiterated this point, reporting that "[n]ominal incentives currently exist for localities to utilize Medicaid eligible providers," since the "cost savings come with some administrative complexity."[104] Similarly, some providers are reluctant to participate in Medicaid due to the administrative burden and perceived low reimbursement rates. In addition, ideological principles may be preventing the maximized use of federal resources.

Moreover, the decision to use Medicaid funds may be impacted by the increased fiscal responsibilities that are required of states under Medicaid guidelines. For example, if the use of Medicaid were maximized in the method proposed by the JLARC study, state and local CSA funding sources would be responsible for an additional balance of $1.6 million in order to provide the required federal match.[105]

A report by the Bazelon Center for Mental Health Law also identified barriers to adequate utilization of Medicaid funds that exist at the national level.[106] The report states that several of the overarching principles and guidelines of Medicaid preclude adequate utilization for child mental health services; for example, the focus of treatment under Medicaid is on the "patient" child, and not on the family and the environment. Consequently, many family support services, particularly those that round out a

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[99] Joint Legislative Audit and Review Commission.
[100] Ibid.
[101] Ibid.
[102] Ibid.
[103] Ibid
[104] Virginia Department of Planning and Budget, *A Review of the Budget for the Comprehensive Services Act for At-Risk Youth and Families*, September 2000.
[105] Joint Legislative Audit and Review Commission.
[106] Bazelon Center for Mental Health Law, *Making Sense of Medicaid for Children with Serious Emotional Disturbance*, 1999.

wraparound approach, remain unfunded. In addition, there are several child-specific services that have been explicitly excluded from Medicaid funding, such as educational, vocational, and recreational programs.

The need for further analysis of Medicaid utilization in the Commonwealth has been recognized at the legislative level. SJR 441, passed during the 2001 Session, directed JLARC to conduct an evaluation of the development, management, utilization, and funding of health and mental health services provided through DMAS. The resolution calls for a comparison of Virginia's provision of Medicaid-funded health and mental health services, such as child health, long-term care services and waivers, and mental health services, with programs in other states. The final report is to be submitted to the Governor and the 2003 Session of the General Assembly. This report may shed greater light on the availability of services for children and adolescents with SED-OH.

2. FAMILY ACCESS TO MEDICAL INSURANCE SECURITY (FAMIS)

The FAMIS program, launched in August 2001, is an extension of the Virginia Children's Medical Security Insurance Program (CMSIP), which was established in October 1998. FAMIS is designed to meet the needs of the population of working families who do not have health insurance for their children and who make too much money to qualify for Medicaid.

The fundamental principle of the original CMSIP program was the provision of supplemental insurance to working families.[107] During the 2000 General Assembly Session, new legislation was introduced to change the name of CMSIP to FAMIS and reform Virginia's child health program. The goal of the legislation was to move away from the social welfare stigma of the CMSIP program by designing the program to be more like private health insurance. The FAMIS program extended eligibility to children in families with a gross income at 200% or below of the Federal Poverty Level (FPL).[108] The application process and eligibility criteria have also been simplified under FAMIS, and new guidelines have eliminated the need for several verification documents. Consequently, an interested parent may now apply by simply calling a toll free line or returning an application with evidence of income.

FAMIS is structured as a health care delivery system, and utilizes commercial insurance programs and other entities authorized by DMAS for medical treatment. As of the fall of 2001, FAMIS contains subsidies for the health insurance premiums of eligible children with access to employer-sponsored insurance, enabling entire families to benefit from the existing policy. Those children without access to employer-sponsored insurance are instead covered directly under the state-administered plan through private insurers, health care providers, or HMOs.

In October 2001, the Department of Medical Assistance Services implemented the cost-sharing phase of FAMIS. Families enrolled in FAMIS pay premiums based on their income and the number of children and youth they have enrolled in the program. The monthly fee is $15 per month for each child enrolled, and the highest fee any family

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[107] Division of Policy and Research, *Quarterly Report on the Status of the Virginia Children's Medical Security Insurance Program: April 1, 2001 – June 30, 2001*, July 1, 2001.

[108] Information regarding the FAMIS program can be accessed at http://www.famis.org., last *visited* December 13, 2001.

pays is $45 per month, which covers three or more children. A small co-pay is required for medical visits and prescriptions, that is based on family size and income: families with incomes below 150% FPL typically pay $2, while families with incomes above 150% FPL pay $5. Co-payments for families with incomes under 150% FPL are capped at $180/calendar year. Those families with an income above 150% FPL have their premiums capped at $540 and their co-payments capped at $350/calendar year.

The benefit package provided by FAMIS also includes coverage for certain mental health services. Recipients are entitled to outpatient services, allowing for up to 50 medically necessary visits with licensed mental health professional during each benefit period. Enrollees also may receive inpatient services, with 30 days per benefit period provided for inpatient hospital care and partial day services. Inpatient service coverage may also include room, meals, and general nursing services, as well as prescribed drugs and emergency room services leading directly to admission. Also included in both inpatient and outpatient coverage are diagnostic services and mental health services such as detoxification, individual psychotherapy, group psychotherapy, psychological testing, counseling with family members to assist in the patient's treatment, electroconvulsive therapy, and limited case management services.[109]

As of October 26, 2001, there were 35,696 enrollees in the FAMIS program.[110] However, there are several thousand children in Virginia who are eligible for Medicaid or FAMIS but are not currently enrolled in the two programs.[111] As a result, program efforts have focused on outreach initiatives designed to provide information to all eligible families. DMAS has launched an extensive marketing campaign that includes posters, brochures, bus placards, and television, radio, and newspaper advertisements. In order to support these efforts, a logo was finalized and brochures, posters, and flyers have been created.

DMAS has hired five FAMIS Community Outreach Educators to coordinate promotional efforts.[112] The positions are located throughout the Commonwealth, in the Central, Western, Eastern, Northern, and Piedmont regions. The primary responsibility of these educators is to organize local initiatives to assist families in enrolling their children into the FAMIS or Medicaid programs. In pursuit of this goal, the educators have conducted community training workshops and informational meetings throughout the state in an effort to ensure that families are informed of the changes and the benefits that are currently being implemented.

Also, DMAS has conducted activities in collaboration with community-based organizations and public-private partnerships. There are two relationships in particular that proven greatly beneficial to the promotion of outreach efforts. A partnership with the group SignUpNow has allowed DMAS to conduct statewide FAMIS Outreach Training

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[109] Public comment submitted to the Commission in response to this study's findings and recommendations included concerns that FAMIS will not cover some community-based services that were covered under CMSIP. Specifically, there was concern about the absence of coverage for case management, intensive in-home services and crisis intervention services.

[110] *Available at* http://www.famis.org/English/Reports/Enrollment10-26-01.htm., *last updated* October 26, 2001.

[111] Controversy exists as to the exact number of children who are eligible. The Virginia Hospital and Healthcare Association, the Joint Commission on Healthcare and state agency administrators have all presented different numbers. Virginia has not conducted an official study to determine the exact numbers.

[112] *Available at* http://www.famis.org/English/Reports/OutreachEducator.doc., *last visited* December 13, 2001,

Workshops for community representatives. These sessions are intended to provide local community leaders with greater knowledge of the program, so that they may recruit families and facilitate enrollment. In addition, DMAS and the Virginia Health Care Foundation have partnered to support the Project Connect Outreach statewide grant program, which creates sites that enable one-on-one enrollment facilitation to families and allow for outreach that is modified to meet each community's specific needs.

DMAS also continues to establish new relationships in order to enhance the existing network of community-based organizations that assist in outreach efforts. Local agencies and private entities have provided extensive assistance in community and statewide efforts to expand the initiative to reach uninsured families. These additional resources will enable the program to reach more children, and consequently should help to improve statewide prevention and treatment efforts in both primary care and mental health.

E. EARLY INTERVENTION

A review of mental health early intervention services within the context of this study may at first glance appear to be superfluous. However, to focus only on the current needs of these children would be to ignore the opportunities we have to address their needs early before their impairment becomes severe. Meeting the mental health treatment needs of children early can reduce the fiscal and psycho-social costs to the children, their families and our communities.

Early intervention services can be defined as those "intended to improve functioning or change behavior in those people identified as beginning to experience problems, symptoms, or behaviors which without intervention are likely to result in the need for treatment."[113]

Services are based on models of prevention and early intervention from the field of public health and are designed to

1. promote the emotional well-being of children who are perceived to be at risk of adverse developmental outcomes,
2. increase the skills of parents and other caregivers, and
3. intervene early where emerging needs have been identified.[114]

Examples of these services include: family training, counseling and home visits, health and medical services, nutrition services, special instruction and transportation services. Whatever the appropriate services are found to be, professional literature on this topic identifies the eight characteristics that early intervention services should possess.

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[113] *Comprehensive State Plan 2000-2006.*

[114] Simpson, J., Jivanjee, P., Koroloff, N., Doerfler, A., and Garcia, M. (2001). *Systems of Care: Promising Practices in Children's Mental Health, 2001 Series, Volume III.* Washington, D.C.: Center for Effective Collaboration and Practice, American Institutes for Research.

Characteristics of Early Intervention Services

- family centered,
- individualized,
- comprehensive,
- community-based,
- coordinated,
- based on a high level of family participation,
- focused on developmental needs, and
- built on strengths and resilience.[115]

Early intervention programs generate savings to government in at least four ways: increased tax revenues (from improved employment of the parent(s) and later the child), decreased welfare outlays, reduced expenditures for education, health and other services, and lower criminal justice system costs.[116] The Center for Mental Health Services within the Substance Abuse and Mental Health Services Administration of the U.S. Department of Health and Human Services found in their evaluation of systems of care that "six to eleven year old children made significantly more progress" from intake to one year than other age groups.[117] These findings support the theory that the system of care model might have its greatest impact at the earliest ages. Additional research has shown that early intervention efforts can reduce the costs of future criminal activity. Programs such as home visits, parent training, specialized preschools, and graduation incentives have been found to significantly reduce long-term costs related to crime and victimization.[118] Research also indicates that health care utilization is higher for children with psychosocial problems, suggesting that the costs of timely and appropriate mental health care for young children may be offset by decreased general health care costs.[119]

Although research has demonstrated the savings and benefits of early intervention efforts, the commitment of resources to early intervention programs is complicated by the delay in anticipated savings that will come only after considerable time. Governments, even in times of abundance, are faced with limited resources and seemingly endless needs. Unfortunately, early intervention programs are unable to produce the immediate results that justify their existence or the savings that seem to be so necessary to justify their expense.

The number and severity of competing populations and their needs deter the dedication of resources to early intervention or prevention efforts. Children and youth who are experiencing severe impairment, who are unable to remain in their homes, or who are either real or perceived threats to community safety will undoubtedly attract attention. Parents, having exhausted all financial and emotional resources in attempts

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[115] Ibid.

[116] Karoly, L., Greenwood P., Everingham, S., Jattoube, Kilburn, M., Rydell, C.,Sanders, M., and Chiesa, J., *Investing in Our Children: What We Know and Don't Know About the Costs and Benefits of Early Childhood Interventions*, Rand Institute, 1998.

[117] *Annual Report to Congress on the Evaluation of the Comprehensive Community Mental Health Services for Children and Their Families Program* (1998). Atlanta, GA: Macro International Inc.

[118] Karoly, et al.

[119] Bernal, et al, *Economic Implications of Undetected Mental Health Issues in the Pediatric Population*, in A System of Care for Children's Mental Health, Florida Mental Health Institute, 1998.

to help their child, will demand help.[120] Significant resources of time and money are needed to address the children's needs. Professionals working with these children and youth dedicate much of their time to "putting out fires", leaving little time to intervene early and address the needs of children who are at-risk.

Although not all children and youth with serious emotional disturbance will become criminal offenders, law enforcement and the courts likely are familiar with these children. The Virginia Department of Juvenile Justice reports that in 1998, over half of the White youth and almost 40% of Black youth who leave the Reception and Diagnostic Center have a designated mental health treatment need. Likewise, in a survey of Court Service Units conducted by staff of the Joint Study Committee on Treatment Options for Offenders who have Mental Illness or Substance Abuse Disorders (SJR 440), approximately 50% of the respondents (18 of 34) estimated that 26% to 50% of their caseload requires mental health services, with an additional 17% (6 of 34) estimating that over 50% of their caseload requires mental health services.

Virginia has recognized the importance of early intervention as evidenced by its support of numerous programs and services.[121] In the development of what was to become the CSA, the Council on Community Services for Youth and Families stated that one of the objectives of the proposed service delivery system should be to "identify and intervene early with young children and their families who are at risk of developing emotional or behavior problems or both due to environmental, physical or psychological stress.[122] This same language became a part of the Act and is codified in Virginia Code §2.2-5200 (2001). Also, included in the powers and duties of the State Executive Council for Comprehensive Services for At-Risk Youth and Families is the responsibility to "[o]versee coordination of early intervention programs to promote comprehensive, coordinated service delivery, local interagency program management, and co-location of programs and services in communities."[123]

With the enactment of the CSA, a trust fund was established to create incentive for developing innovative services with at least 25% of the funds to be used for early intervention services. The Council on Community Services for Youth and Families originally proposed that the Fund receive incremental increases to 40% by the year 2000;[124] however, these increases were not realized. In fact the language regarding the 25% dedication of funds to early intervention was stricken from the Appropriations Act, Chapter 464 in April 1998. Use of these Trust Fund monies is now limited to the localities listed.

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[120] Parents and families out of a desire to help the child may turn to less desirable means to obtain treatment for their child. Reluctantly, parents may relinquish custody of the child for placement in foster care, or turn to the criminal justice system.

[121] Virginia Commission on Youth, *Report of the Commission on Youth to Study Barriers to the Development of Locally Designed Community-Based System of Early Intervention Services*, Senate Document 27, 1995.

[122] Council on Community Services for Youth and Families, *Improving Care for Troubled & "At Risk" Youth & Their Families: Restructuring Service Delivery & Funding*. A Report to the Governor and General Assembly of Virginia. 1991.

[123] Virginia Code Ann. §2.2-2648 (Michie 2001)

[124] Council on Community Services for Youth and Families.

Arlington	Martinsville/Henry/Patrick
Accomack/Northhampton	Petersburg
Bristol/Washington County	Portmouth
Charlottesville/Albemarle County	Rockbridge
Clarke/Frederick/Winchester	Smyth County
Culpeper County	PD 16 (Fredericksburg, Caroline/ Stafford/King George/Spotsylvania

DMHMRSAS in their Comprehensive State Plan for 2000-2006 identifies children and youth at risk of serious emotional disturbance as a priority population.[125] However, early intervention is given little mention in the plan and is notably absent from the list of system values and priorities. This lack of emphasis is further demonstrated by FY '98 utilization data, which reveal that only 1,274 CSB consumers were served with early intervention services related to mental health.[126] This reflects only .01% of the unduplicated, total number of consumers (119,438) who received mental health services.

Early and Periodic Screening, Diagnostic and Treatment Program

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program, passed in 1967 as Public Law 90-248, is part of the federal Medicaid program. It entitles Medicaid eligible children, younger than 21 years, to a comprehensive package of preventive health care and medically necessary diagnosis and treatment, pertaining to both physical and mental health.[127] Under the EPSDT, states are mandated to

> *screen eligible children, diagnose any conditions found through a screen and then furnish appropriate medically necessary treatment to 'correct or ameliorate defects and physical and mental illness and condition discovered by the screening services'.*[128]

Despite the opportunities provided by this program, implementation has been challenging. Problems that have arisen include, but are not limited to confusion about a child's entitlement, accessing effective health screens, and definitions of available services.[129]

Any child eligible for Medicaid is or should be a participant of the EPSDT program. It is an entitlement under Medicaid and is not a special service in which the child must be enrolled. Not only does Medicaid eligibility entitle the child to EPSDT services, a 1989 law broadened this mandate so that children have a broader entitlement than adults who qualify for Medicaid.[130] Under Medicaid, some services are mandatory but others are included in the state's plan and provided at the option of the state. However, under the EPSDT a state must "make available to children all services listed in the federal

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[125] *Comprehensive State Plan 2000-2006.*

[126] Ibid. It should be noted that it is possible that more children are receiving mental health early intervention services but that they are being categorized as something other than "early intervention services" when they are coded into the system by local Community Services Boards.

[127] 42 C.F.R. 411 (B) (2001); 12 VAC 30-50-130 (2001).

[128] Bazelon Center for Mental Health Law.

[129] Ibid.

[130] Omnibus Budget Reconciliation Act of 1989, Act of Dec. 19, 1989, P.L. 101-239.

Medicaid law 'whether or not such services are covered under the state plan' as long as they are determined to be medically necessary."[131]

The broadening of this mandate has proven problematic in some states especially if the services are not in the state's plan and the state relies on federal definitions of these services. The federal definitions are general and states are left with the discretion to further define the services and provide clarification. Some states have chosen not to further define the services, making it difficult for families and providers to know to what services their child is entitled.[132]

> Thus, although children in all states have the same entitlement to a full array of medically necessary services, the degree to which the state clearly defines those services and sets standards for providers to furnish them can have a major impact on the availability of a particular service for a child.[133]

In addition to interpretations of this broad mandate, the rate of participation of children in EPSDT screenings has not met expectations and the number of children who receive screenings has been low. "In 1990, the Health Care Financing Administration established a participant rate goal of 80%, to be achieved by fiscal year 1995."[134] However in FY 1998, nationally only 67% of the children expected to be screened were actually screened.[135] In Virginia during FY 1998, only 50% of the expected number children were screened.[136]

Generally, pediatricians conduct the screenings as a part of a child's regular physical check-up. "Since pediatricians often do not identify mental health problems and few states have screening tools designed to identify mental health issues, many children fall through the cracks."[137] The Bazelon Center has reported that, nationwide, many Medicaid-eligible children are not receiving necessary services because adequate mental health assessments have not been conducted.[138] In Virginia, the EPSDT program does not include a formal mental health screening, although any health professional can refer the patient for those services.

Another project supporting the efforts of the EPSDT program is the Bright Futures project. Bright Futures was initiated in 1990 and guided by the Health Resources and Services Administration's Maternal and Child Health Bureau, with additional program support from the Health Care Financing Administration's Medicaid Bureau. This initiative developed comprehensive health supervision guidelines with the collaboration of four interdisciplinary panels of experts in infant, child, and adolescent health. These guidelines were reviewed by nearly 1,000 health professionals, educators, and child health advocates throughout the United States. As a result, *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents* was published in 1994. A

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[131] Bazelon Center for Mental Health Law.
[132] Ibid.
[133] Ibid
[134] Olson, K., Perkins, J., Pate, T. (1998). *Children's Health Under Medicaid: A National Review of Early Periodic Screening, Diagnosis and Treatment.* National Health Law Program. http://www.healthlaw.org/pubs/child1998healthxsum.html.
[135] Annual EPSDT Participation Report for All States, FY 1998. Virginia Department of Medical Assistance Services.
[136] EPSDT Annual Comparison, 1997-2000. Virginia Department of Medical Assistance Services.
[137] Bazelon Center for Mental Health Law.
[138] Ibid.

recent revision (2000) has been completed to incorporate current scientific knowledge in health practice.

In addition to the published guidelines, *Building Bright Futures* was launched in 1995 to implement the Bright Futures guidelines by issuing practical tools and materials and providing technical assistance and training. In Fall 2001, *Bright Futures in Practice: Mental Health* was published. *Bright Futures* will be used to

- Inform primary care pediatric health professionals about the essentials of mental health promotion, including monitoring psychosocial development; promoting mental health; preventing and identifying early emotional, behavioral, or substance abuse problems and disorders; providing anticipatory guidance and counseling; and providing appropriate referral and follow-up;

- Identify the support that infants, children, and adolescents need for good mental health; and

- Develop and implement mental health promotion programs and policies.[139]

Bright Futures will also introduce innovative concepts. The philosophy underpinning the effort includes the belief that mental health promotion is

- A health partnership-- a longitudinal process that promotes partnership and a shared agenda among health professionals, the child, and the family;
- Holistic and contextual-- focuses on improving social, developmental, health, and mental health outcomes; views the child in the context of the family and community; and
- Collaborative-- part of a seamless system that includes community-based mental health, health, education, recreation, and human services.[140]

While mental health has long been a part of Bright Futures, a curriculum and training specific to mental health has not been available. The Virginia DMAS, together with the Virginia Department of Health, has been moving toward the adoption of the Bright Futures guidelines and use of the *Bright Futures in Practice: Mental Health* curriculum.

Training using this curriculum is scheduled to begin in Virginia in the Spring of 2002. Several groups have been targeted to receive the training including provider-relations staff of health maintenance organizations (HMOs), physicians through continuing education programs, physician billing staff, and school nurses. Mental health professionals have not been targeted in this initial training phase. Instead primary care physicians - pediatricians and family practitioners - have been targeted, since these physicians are most likely to see the child and in the position to conduct an EPSDT screening. Implementation of the concepts within the curriculum will not be marketed as a Medicaid program. Instead, physicians will be encouraged to apply the concepts across the board to all patients.

The HJR 119 Advisory Group upon hearing the presentation of information on the *Bright Futures in Practice: Mental Health* curriculum recommended and encouraged

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[139] http://www.brightfutures.org/mentalhealth/index.html. November 8, 2001.
[140] Ibid.

the training of mental health professionals, including school counselors and school workers, on the EPSDT and its use to screen for mental health issues. These professionals often have the benefit of daily interaction with these children and opportunities to identify children for screening who otherwise may not come to the attention of physicians. As mentioned previously, this early detection of mental health issues could greatly improve child outcomes.

F. DATA COLLECTION, EVALUATION AND INFORMATION SHARING

Each year the Commonwealth of Virginia and its localities, through the CSA, spend millions of dollars to purchase services to address the emotional and behavioral problems of children and youth in Virginia.[141] In addition to money spent through CSA funding, Medicaid and other federal funds are accessed. However, despite the significant sums of money spent on these services each year, the state possesses little information on the quality or effectiveness of care received by these children and youth.

It has long been recognized as essential that policy makers and those responsible for appropriations have complete and accurate data on which to base their decisions. In one of the first reports that led to the current CSA system, the Mental Health Association in Virginia in its report *The Invisible Children's Project*, recommended the establishment of an interagency data tracking system with which data and costs regarding an individual child could be tracked, unduplicated across agencies. In the November 1991 report, *Improving Care for Troubled & "At-Risk" Youth & their Families*, the Council on Community Services for Youth and Families set forth the plan for what is now known as the Comprehensive Services Act for At-Risk Youth and Families. The report contained recommendations for evaluating the effectiveness of services, analyzing the costs and providing management reports to decision-makers at both the state and local levels. Again in 1992, the Department of Planning and Budget in the *Study of Prevention and Early Intervention Services in Virginia* recommended that program evaluation services be purchased, as this information would be critical to informed decision-making. Similar recommendations for data collection and the use of the data for evaluation purposes continued throughout the 1990's.

Virginia is not bereft of data and agencies do maintain records regarding programs and services provided or funded by them. However, these systems are limited to information specific to the agency's clients and services. Not only are there systemic barriers to interagency sharing and analysis of data, but barriers also can exist within the same agency and their local or regional offices. Databases may collect different elements or systems are not compatible for integration. The multiple systems used by localities, including the various software packages used to report CSA data, are also problematic.

Although DMHMRSAS has developed a data collection system called POMS (Performance and Outcome Measurement System), data contained in that system will only address services provided through the CSBs or state hospitals.[142] Likewise, the DSS tracks information on foster care children through the OASIS System. At some point, children may be in both systems. However, because these systems are not

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[141] In FY 2000, over $200 million of state and local dollars were spent through the CSA.

[142] For additional information regarding POMS, *see Comprehensive State Plan: 2000-2006.*

integrated, one cannot obtain comprehensive data on the services provided to them. Even if each system is accessed, because of different data elements, it is difficult to compare across agencies.

As explained in earlier sections of this report, the CSA system was organized to allow for an interagency, collaborative approach to the provision of services to at-risk youths and their families.[143] Since children and youth, referred by various agencies, are provided services through one comprehensive system, there is tremendous opportunity to establish an integrated data collection system. In recognition of this opportunity, several efforts have been made to address this need. However, despite this recognition and numerous calls for coordinated, statewide data collection and evaluations of individual outcomes, little progress has been made.

In September 1999, the State Management Team of the CSA produced a report on *CSA Uniform Data Collection Standards and Outcome Measures* in which it summarized efforts within the CSA to address data collection and evaluation. The following were reported:

- In 1996 the SEC formed the utilization management steering committee to oversee a feasibility study in response to concerns about the overall increase in costs and out-of-home placements.
- After conducting a feasibility study, the Commonwealth Institute for Child and Family Studies recommended support of a comprehensive system of utilization management processes in their 1996 report *Applying Utilization Management Principles to the CSA: A Feasibility Study, December 1996.*
- The State Executive Council in 1997 endorsed the Utilization Management Implementation Process for Services and the Child and Adolescent Functional Assessment Scale (CAFAS). Also developed were decision support guidelines that localities could use a framework to provide cost-efficient services for children and families.
- In 1997 the Virginia General Assembly added the requirement, through budget language, that all Community Policy and Management Teams (CPMTs) incorporate utilization review of residential placements using CSA funds in order to be considered for supplemental funding.
- In its 1998 report on the Comprehensive Services Act (Senate Document 26), the Joint Legislative Audit and Review Commission (JLARC) recommended that the State Executive Council form a workgroup to identify the data needs and system requirements for a system of performance standards for the CSA.
- In response to the JLARC report, the SEC formed a data collection standards work group that developed a list of data elements to assist in local decision-making. In the second phase of their work, the workgroup developed three basic performance standards, all looking at the proportion of children with particular characteristics.
- In 1999, HB 2075 was enacted giving the State Executive Council oversight of uniform data standards and outcome measures.
- Also in 1999, the Office of Comprehensive Services commissioned the study *Initial Assessment of the CSA Utilization Management Initiative.* Among the findings it was noted that the lack of an individual child-level data system continues to prevent a comprehensive analysis of CSA and its expenditure trends and outcomes. Also noted

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[143] Virginia Code Ann. § 2.2-5200 (Michie 2001).

was a lack of sufficient data systems, at both local and state levels, which is an impediment to effective application of utilization management strategies within the CSA.

- This report concluded by saying that the development of an accurate and timely comprehensive data system in CSA to support the local decision making process is critical.

Throughout the SEC's examination of possibilities to address the need for a data collection system and outcome measures, a primary barrier to achieving the desired results was the incompatible data systems and the cost to ameliorate them. Additionally, there were concerns about Y2K and the resources already dedicated to resolving those concerns. Tracking and understanding the use of services delivered within systems of care has been cited as a prerequisite to understanding the impact on outcomes. A comprehensive computerized management information system (MIS) is critical to understanding the use of individual services, combinations of services, and their costs.[144]

When presented with the work group's recommendations for data elements and performance measures, the SEC deferred action on the group's recommendations until such time as the staff of state agency information systems departments could come together to further discuss the data needs of state and local CSA components. While SEC members recognized the need to move forward with this project, concern was expressed relative to the need for an appropriate data system to gather and analyze CSA relevant information without imposing unnecessary administrative burdens on state or local entities.

To address these concerns, in October of 1998, the SEC considered appointing a work group to assess current data collection capabilities of systems presently utilized by state member agencies and to evaluate the abilities of such systems to assist the CSA at the state and local levels. The work group was to be comprised of MIS Directors from the five state agencies as well as a member of the Office of Comprehensive Services (OCS) and State Management Team (SMT). However, because of the workloads of MIS departments related to Y2K, the project did not move forward.

In early 1999, prompted by the new statutory language giving the SEC responsibility for the development, implementation and collection of uniform data collection standards and the development of outcome measures, the SEC again looked at this issue. SEC discussion indicated that it believed the need for a reliable and non-duplicative data system was most significant. It was suggested, but not acted upon, that a reasonable approach would be to cost out the scope of the project, prepare a list of the positives and barriers to a project of this magnitude, and assemble a list of viable options. Once again, concern was expressed relative to the time demands of Y2K preparation.

The issue of uniformity among localities and their systems resurfaced again in December 1999 when the sub-committee studying the Use of State Facilities for Services under the CSA (SJR 478) recommended selection and implementation of a uniform data system for use by local CPMTs, DJJ and appropriate state agencies. Purchase of hardware in smaller localities was noted as an issue. Discussions following

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[144] Center for Mental Health Services, *Annual Report to Congress on the Evaluation of the Comprehensive Community Mental Health Services for Children and Their Families Program,* 1998.

this recommendation focused on localities that had already purchased hardware and certain software (i.e., how they would be reimbursed or converted to another system), sharing of information, how much the state would contribute toward the new system etc.) However, the focus of sub-committee then returned to the potential use of underutilized DMHMRSAS property for provision of services to CSA children.

In the Summer of 2000, the SEC again discussed the matter and advances in data technology such as the data warehousing and statistical methods. Concerns that such a project would be a significant request of all member agencies, that confidentiality would be an issue and that the current amount of data is sufficient (although integration may be an issue) prevented further implementation.

1. UTILIZATION MANAGEMENT

Virginia's current efforts to evaluate the services and care provided to children lie primarily with utilization management. The utilization management process is generally employed to evaluate the efficiency and appropriateness of the services. Utilization management is defined by the Office of Comprehensive Services as "a set of techniques used by, or on behalf of purchasers of health and human services to manage the provision and cost of services by influencing client care and decision making through systematic data driven processes."[145] In 1997, the General Assembly added budget language requiring that all CPMTs incorporate utilization review of residential placements utilizing CSA funds in order to be considered for supplemental funding.[146] The legislative language requires only the use of the utilization process for residential placements, although it may be used for other services funded through the CSA.

The Commonwealth Institute for Child and Family Studies, after conducting a feasibility study, designed the current utilization management process. Guidelines and processes were developed to "provide a template for determining which *level of need* [emphasis added], services and placement might be the most suitable for a child and family with specific characteristics." All localities are required to complete utilization management on each individual child. However, with the exception of composite data that are reflected on the Office of Comprehensive Services website, data on an individual child are not collected. The composite data include elements such as demographics, referral source, expenditures and number of children served through the Family Assessment and Planning Team (FAPT) process.

2. OUTCOME EVALUATION

Another type of evaluation is outcome evaluation, which can measure the quality of care in terms of the client's response to the mental health care received. However, obtaining reliable and valid outcome data on an individual is more complex than simply conducting a pre- and post-test to assess if the individual's condition improved. There are many variables that can affect a person's response to treatment that must be considered.

Through legislation, the SEC was given the responsibility to "[o]versee the development, implementation, and collection of uniform data collection standards, and

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[145] http://www.csa.state.va.us/html/urguidelines.htm, November 13, 2001.
[146] Utilization Management Manual, http://www.csa.state.va.us/pdf/ummanual.pdf, November 13, 2001.

the development of outcome measures; including, but not limited to, expenditures, number of youth served in specific CSA activities, length of stay for residents in CORE licensed residential facilities, and proportion of youth placed in treatment settings suggested by a uniform assessment instrument for CSA-funded services."[147]

The difficulty in obtaining meaningful outcome data is the need to access and analyze data that goes beyond length of stay and utilization of particular placements and looks at improvements in the child's condition or behavior. The collection of this information is complicated by the lack of integrated data systems, concerns about confidentiality, agreements on definitions and indicators of improvement, and the commitment of resources to complete such a project.

The result of not having outcome evaluation data can be the over-utilization of certain types of services and the underutilization of others. Complicating this is the fact that some categories can include a variety of services. For example, in-home services can include a one-on-one aide, individual child and family counseling, and the provision of life and parenting skills. However, there is little information regarding the effectiveness of these services. Although the Office of Comprehensive Services has developed a utilization management process through which the appropriate *level* of service for the child can be determined, within this particular level of service, there can be several treatment and placement options. Empirical data on the effectiveness of Virginia's services are largely nonexistent. Determination of the most appropriate service within that level is frequently determined by availability of that service, access to funds for the service and one's opinion and experience with it.

Therefore, in order to assist communities and human service providers deal most effectively with these children, these professionals and communities need information on treatment modalities and practices recognized as effective for the treatment of children with mental health treatment needs, symptoms and disorders. Their large caseloads leave little time for the perusal of professional and academic literature. Although empirical, outcome data from Virginia are few, if existent at all, there are reliable data from national studies that can provide guidance to those making treatment decisions.

VIII. Findings and Recommendations

A. CAPACITY

Child and Adolescent Acute Psychiatric Beds

Findings

There are 23 hospitals in Virginia that operate adolescent acute psychiatric beds, including two state facilities. These facilities report that there are 461 beds available to adolescents. However, this number is misleading because not all hospitals reserve beds for adolescent use. Some hospitals "swing" their beds to serve any age group, including children and adults. While these hospitals can serve children and adolescents, only one or two adolescents may be admitted in a year. The result is fewer acute psychiatric beds for adolescents than is officially reported.

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[147] Virginia Code Ann. § 2.2-2648 (Michie 2001).

Clinicians' accounts of difficulties in finding available beds in acute care facilities and documentation of a five-day period in which attempts by the Commonwealth Center for Children and Adolescents to assist in the placement of 35 children in any psychiatric hospital facility failed is additional evidence of this inadequacy.

Recommendation 1

Direct the Department of Mental Health, Mental Retardation and Substance Abuse Services to identify and create opportunities for public-private partnerships and the incentives necessary to establish and maintain an adequate supply of acute care psychiatric beds for children and adolescents, while acknowledging the Commonwealth's responsibility to serve this population.

Findings

Obtaining and then maintaining an accurate count of the number of acute psychiatric adolescent beds is very difficult. Simply accessing Department of Mental Health, Mental Retardation and Substance Abuse licensure data does not provide an accurate picture because it contains the number of beds licensed for the facility and not the number of beds that are actually staffed to receive patients. Furthermore, the licensure data does not specify how many of the licensed beds are for children and adolescents. The number of pediatric psychiatric beds, licensed and staffed, is not contained in any one known database.

Contributing to the difficulty in documenting the number of beds is the reliance on Certificates of Need (CON) (which authorize a certain number of inpatient, acute care beds) to ascertain the supply of acute care beds. The number of beds licensed under the CON remains the official record, while hospitals may be using these beds for residential treatment or another purpose. The licensure of residential treatment beds does not require a CON; instead they are licensed through CORE requirements. A facility may change, without notice, the use of their beds from acute care to residential.

Recommendation 2

Direct Virginia Health Information to provide the number of licensed and staffed acute care psychiatric beds and residential treatment beds for children and adolescents in public and private facilities, as well as the actual demand for these beds, to the General Assembly by December 1, 2002.

Residential Treatment

Findings

Residential services can be difficult to find in Virginia for juveniles with mental health treatment needs who exhibit aggressive or difficult to manage behaviors. A number of factors can contribute to their reluctance to accept these juveniles, including: concern for the safety of the juvenile, other residents and treatment staff; and difficulty in hiring staff willing to work with this difficult population.

There is a need for residential, short-term crisis stabilization centers. A juvenile may be placed in such a center when placement outside the juvenile's home is needed but at a level in between those offered by hospitalization and therapeutic foster care or other less intensive environments. These facilities would prevent hospitalization and allow the youth to remain in the community. Currently, when there are no other *placements available for emergency cases, a psychiatric bed is typically purchased for the juvenile. Although it is recognized that this is a more expensive and restrictive placement, alternatives are not readily available. Many of these placements occur in facilities that are a great distance from the community, increasing the costs of travel for transitional staff and making incorporation of the family into treatment programs extremely difficult.*

Sex offender treatment services are extremely difficult to obtain throughout the Commonwealth. Only two residential facilities operate in Virginia that specialize in sex offender treatment and those are in the Tidewater area. Less restrictive residential placements that assist in transitioning sex offenders back into the community are badly needed. Community services for sex offenders include evaluation services, relapse prevention and counseling; however, they are not readily available statewide.

Also difficult to find are residential facilities that will accept children and adolescents who have multiple disabilities including a dual diagnosis of serious emotional disturbance with mental retardation, hearing impairment or substance abuse. In order to receive treatment services, these children and adolescents often must be sent to residential facilities outside of Virginia.

Recommendation 3

Direct the Department of Mental Health, Mental Retardation and Substance Abuse Services and the Department of Juvenile Justice, where appropriate, to identify and create opportunities for public-private partnerships and the necessary incentives to establish and maintain an adequate supply of residential beds for the treatment of juveniles with mental health treatment needs, including those who are mentally retarded, aggressive, or sex offenders and those juveniles who need short-term crisis stabilization short of psychiatric hospitalization.

Community-based Treatment Services

Findings

Many of the mental health treatment needs of children and adolescents can be managed in non-residential, community settings. As the number of residential placements decreased, there was an expectation that resources would be shifted to support the development and maintenance of community based programs. The Department of Mental Health, Mental Retardation and Substance Abuse Services' FY 2000 Utilization Report shows that all 40 Community Services Boards (CSBs) provided emergency and case management services as required by law. All 40 also provided outpatient services to at least one or more children ages 0-17. However for other services, the following were reported: Of the 40 CSBs, only

- *30 provided intensive in-home services,*
- *11 provided therapeutic day treatment,*
- *3 provided early intervention,*
- *2 provided highly intensive services,*
- *2 provided intensive services,*
- *1 provided family support, and*
- *0 provided prevention services.*

Each of these services is an element in a coordinated system of care. Where coordinated systems of care have been implemented and evaluations conducted, it has been found that they typically reduce

- *rates of re-institutionalization after discharge from residential settings, and*
- *out-of-state placements of children, and improve other individual outcomes such as child behavior and parental satisfaction with services.*

All of these outcomes could result in a reduction of the fiscal and human costs associated with the limited system currently in place. As in any coordinated system, if one component is weak or missing, pressure and stress are felt by the other components and in some cases their efforts are ineffective.

Recommendation 4

Amend Virginia Code §37.1-194 (Purpose; services to be provided), which specifies the CORE services and other services that may be available through a Community Services Board (CSB), to specify that the services available will be provided to adults, children and adolescents rather than to "persons" as it is currently written.

Recommendation 5

Support and endorse the concept of KOKAH[148] or other similar models in which an array of community-based services is emphasized. Support the continuation of existing funding levels for the KOKAH model implemented by Blue Ridge Community Services.

Recommendation 6

Amend and continue in the current biennium budget and in the 2002-2004 budget the current biennium language (323 K) that requires "the Department of Mental Health, Mental Retardation and Substance Abuse Services, *the Department of Juvenile Justice*[149] and the Department of Medical Assistance Services, in cooperation with the Office of Comprehensive Services, Community Services Boards, and Court Service Units" to "develop an integrated policy and plan, including the necessary legislation and budget amendments, to provide and improve access by children, *including juvenile offenders*[150], to mental health, substance abuse and mental retardation services..." Require the Departments to report on the plan to the Senate Committee on Finance and House Committee on Appropriations by June 30, 2002.

C. MENTAL HEALTH PROFESSIONAL AND TEACHER SHORTAGE

Findings

Allocation of money for the purchase of services and the employment of additional mental health professionals is insignificant if there are not enough qualified persons to fill existing and new positions. Fifty Virginia localities have been designated as Mental Health Professional Shortage Areas. There are three programs available to Virginia psychiatrists seeking financial assistance in return for a commitment to serve in an underserved area or a state or local government facility. The three

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[148] Keep Our Kids At Home (KOKAH)

[149] Amendment proposed by the Commission on Youth

[150] Ibid.

programs are the Virginia Physicians Loan Repayment Program, the National Health Service Corp (NHSC) - Virginia Loan Repayment Program, and the Gilmore Fellows Program.

Recommendation 7

Direct the Virginia Department of Health (VDH) to expand the Virginia Physicians Loan Repayment Program to include more psychiatrists, including child psychiatrists, and appropriate additional funds to support such an expansion, including support for VDH staff to administer the program.

Recommendation 8

Appropriate $50,000 for and direct the Virginia Department of Health to pursue the expansion of the National Health Service Corp (NHSC) - Virginia Loan Repayment Program to include mental health professionals (as defined by the NHSC). Financial support should include support for VDH staff to administer the program.

Recommendation 9

Direct the Virginia Department of (VDH) to expand the Virginia Physicians Loan Repayment Program to include other types of mental health professionals beyond psychiatrists, including doctoral clinical psychologist, clinical social worker, or psychiatric nurse specialist. The Virginia Department of Health Professions should also ensure that $1 be set aside from the state license fees of each of the participants in order to provide continued financial support for the program. Financial support should include support for VDH staff to administer the program.

Recommendation 10

Request that the Virginia Department of Health explore the expanded use of telepsychiatry for underserved areas.

Findings

The 2000-2002 biennium budget includes $500,000 each year for the recruitment and retention of psychiatrists in medically underserved areas.

Recommendation 11

Continue the current funding level for recruitment and retention of psychiatrists under the Gilmore Fellows Program (2000 Budget Item 323G), in which psychiatry residents are paid a stipend to work in under served areas with a portion designated for the recruitment and retention of child psychiatrists.

Findings

There is a shortage of fully qualified teachers for children with emotional disturbance. There was a 79% increase in the number of students with emotional disturbance from 1988 to 1998. In the same period, there was a 34% increase in the number of qualified teachers still needed for these children. Many private, special education schools use teachers who are conditionally or provisionally licensed and often cannot provide competitive compensation. Retention of qualified teachers for students with emotional disturbance is problematic for psychiatric hospital connected day and residential programs since they operate year-round.

Recommendation 12

Direct the Virginia Department of Education (DOE) to expand the Virginia Teaching Scholarship Loan Program to enable more teachers seeking an emotional disturbance endorsement to receive funding. Financial support should include support for DOE staff to administer the program.

D. COMPREHENSIVE SERVICES ACT

Service Fee Directory

Findings

The CSA Service Fee Directory was established so that providers' services and fees could be visible to all and localities could use this directory to select a provider. The directory is not widely used by localities to select a provider. Instead, the directory is primarily used to ensure that a provider is eligible to receive CSA funds.[151] *Responsibility for updating information in the directory is with the providers. This study found that the directory contains inaccurate information. Members of FAPTs use personal knowledge of and experience with providers when making placement decisions. As an alternative to the statewide directory, some localities have developed their own local directories.*

One of the theoretical goals behind the creation of the Directory was that the publication of fees would increase competition among providers thereby driving down fees charged for services. The negotiation of fees and contracts draws on already limited resources due to its time-consuming and heavily administrative nature. Additional resources, including staff and funding to support the staff, are needed to effectively negotiate contracts. The size of a locality and the number of children needing services also directly affects a locality's ability to realistically negotiate fees.

Recommendation 13

Request the State Executive Council to improve the information available in and revise the system through which provider information is placed in the Directory, including the procedures by which the information is updated and verified, and make information about this process available to the public by July 1, 2002.

Mandated versus Non-mandated

Findings

As a result of data collection in 2000, the Commission on Youth found that of the seriously emotionally disturbed children on whom information was collected, 32.7% reported "no funds for the child" and 31.7%[152] *reported "no funds for service" as the specific case factors for why services were recommended but not received. It is likely that the children were considered non-mandated under the CSA and other local funds were not available.*

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[151] As of October 31, 2001, the State Executive Council, upon the advise of counsel, adopted the position that reimbursement from the state pool of funds is not restricted to vendors with rates and services listed in the Service Fee Directory (SFD).

[152] Percentages shown are not mutually exclusive.

Out of a desire to help a child, parents, professionals and judges may use less desirable means in order to secure mental health services for the child, including: legal actions against school systems and relinquishment of custody through foster care. As reported by the Joint Legislative Audit and Review Commission (JLARC) in its 1998 review of the Comprehensive Services Act (CSA) "many localities are containing costs under CSA by refusing to serve children who are not 'mandated' under current law." JLARC further noted that

> *In most cases, however, the emotional and behavioral problems of children who are considered 'non-mandated' are similar, and in some cases, greater than those of children for whom services are 'mandated'...; and in terms of criminal behavior, a higher proportion of non-mandated youth posed greater risks.*

Once a juvenile is within the juvenile justice system, many communities lack sufficient capacity to treat juvenile offenders with mental health treatment needs while in local detention homes and when they are released from a state juvenile correctional center or a local detention home. The Department of Juvenile Justice reports that juveniles may be kept in secure detention while waiting for needed services, such as substance abuse treatment or mental health counseling.

Although the number of mandated youth has grown and the amount of money spent on mandated youth has more than doubled since its inception in 1994, the amount of money spent for non-mandated youth has decreased. Given the significant increase in mandated youth, it is unlikely that the number of non-mandated youth or their service needs have decreased. However, the cap on the state appropriation for non-mandated youth has remained unchanged since the Act's inception.

The level of resources committed to non-mandated youth exemplified by the Commonwealth can also be seen in the number of localities who spend little or no money on non-mandated youth: During FY 2000, 46 of the 132 localities (35%) spent zero dollars on non-mandated youth, and 19 of the 132 (14%) spent less than $5,000 on non-mandated youth. Furthermore, it is unlikely that the amount spent on non-mandated youth is indicative of the number of non-mandated youth present in those communities.

Recommendation 14

Request that the Department of Juvenile Justice provide information to localities on opportunities for using Virginia Juvenile Community Crime Control Act (VJCCCA) funds that address mental health treatment services, including the provision of intensive individual and family treatment, and structured day treatment and structured residential programs as authorized in Virginia Code §16.1-309.3.

Recommendation 15

Request that the Department of Juvenile Justice, the Department of Mental Health, Mental Retardation and Substance Abuse Services, and the Department of Criminal Justice Services examine opportunities to leverage non-general fund sources of funding to meet the need for mental health and substance abuse

assessment and treatment services of juveniles, including those within local detention homes.

Recommendation 16
Direct the Joint Legislative Audit and Review Commission to conduct a study that identifies viable incentives that encourage localities to enhance or maintain levels of funding for non-mandated children.

Recommendation 17
Support the current level of funding that was appropriated for non-mandated children and adolescents in the 2000-2002 biennium through Budget Item 325B.

E. MEDICAID AND FAMIS

Medicaid

Findings

In the Department of Planning and Budget's (DPB) September 2000 Review of the Budget for the Comprehensive Services Act for At-Risk Youth and Families it was noted that the use of Medicaid should be maximized to realize general fund savings for state and local governments.

Pursuant to SJR 441, (2001, Saslaw) JLARC is to conduct an evaluation of the development, management, utilization, and funding of health and mental health services provided through the Department of Medical Assistance Services (DMAS). It is to include a comparison with other states of Virginia's provision of Medicaid-funded health and mental health services, such as child health, long-term care services and waivers, and mental health services. JLARC's report will be submitted to the Governor and the 2003 Session of the General Assembly.

Recommendation 18
The Commission on Youth shall monitor the Joint Legislative Audit and Review Commission's study of the Department of Medical Assistance Services, and request that particular attention be given to Virginia's Medicaid provisions related to mental health services for children and adolescents.

FAMIS (Family Access to Medical Insurance Security)

Findings

On August 1, 2001, the Commonwealth of Virginia transitioned from the CMSIP (Children's Medical Security Insurance Plan) to the FAMIS Program. The FAMIS Program uses the Key Advantage Plan, available to state employees, as the benchmark for covered services. Also available to participants in FAMIS are enhanced services such as continued well-child care from ages 6 through 18 and physical therapy, occupational therapy, speech language pathology, and skilled nursing services for special education students. Eligible children covered under employer plans can receive supplemental benefits as needed to be equivalent to those available through the comprehensive health care benefits package under FAMIS. FAMIS covers children up to 200% of the Federal Poverty Level. As of October 26, 2001, there were 35,696 children in Virginia enrolled in FAMIS out of the estimated 65,000 eligible for participation.

Recommendation 19

Direct the Department of Medical Assistance Services' to continue outreach efforts to enroll a greater number of children eligible for participation in Medicaid or FAMIS (Family Access to Medical Insurance Security) and report annually to the Commission on Youth by December 1.

E. EARLY INTERVENTION

Findings

Early intervention services are intended to improve functioning or change behavior in those people identified as beginning to experience problems, symptoms, or behaviors, which, without intervention, are likely to result in the need for treatment. Early intervention appears to have its greatest impact at the earliest ages. Early intervention efforts can reduce the social costs of future criminal activity. Programs such as home visits, parent training, specialized preschools, and graduation incentives have been found to significantly reduce long-term costs related to crime and victimization. Research also indicates that health care utilization is higher for children with psychosocial problems. This suggests that the costs of timely and appropriate mental health care for young children may be offset by decreased general health care costs.

Virginia has recognized the importance of early intervention, including in the Comprehensive Services Act since one of the fundamental precepts behind it was the importance of early identification and treatment of children in order to enhance the likelihood of positive outcomes. However, Virginia's failure to support early intervention for mental health services is indicated by the finding that, in FY 98, only 1,274 CSB consumers were served with early intervention services related to mental health, reflecting only .01% of the unduplicated, total number of consumers (119,438) who received mental health services.

The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) has not been fully utilized to conduct mental health screenings and to provide the services necessary to treat an identified condition. The Department of Medical Assistance Services is taking steps to emphasize and promote the use of EPSDT for the identification and treatment of mental health treatment needs through the implementation of Bright Futures. Information and training related to the EPSDT for physicians and mental health providers is planned.

Recommendation 20

Request that the Department of Medical Assistance Services continue their efforts to provide information to physicians and mental health providers about the comprehensive picture of services available through the Early and Periodic Screening, Diagnosis and Treatment (EPSDT). The Department of Medical Assistance Services shall inform the Commission on Youth of its progress prior to the 2003 Session of the General Assembly.

Recommendation 21

Request the Department of Medical Assistance Services, together with the Virginia Department of Education, to provide information and training, including

information on available services, to school nurses, school counselors and school social workers. The Department of Medical Assistance Services shall inform the Commission on Youth of its progress prior to the 2003 Session of the General Assembly.

Recommendation 22

Request the Department of Medical Assistance Services to encourage physicians to make referrals to mental health providers, when appropriate, so that a full assessment of the child's mental health treatment needs can be made. The Department of Medical Assistance Services shall inform the Commission on Youth of its progress prior to the 2003 Session of the General Assembly.

F. DATA COLLECTION, EVALUATION AND INFORMATION SHARING

Findings

The Commonwealth and its localities spend a substantial amount of money each year to provide mental health and substance abuse treatment services to children and adolescents. However, information on the effectiveness of services is not available.

The Office of Comprehensive Services has developed a utilization management process through which the appropriate level of service for the child can be determined. However, within this particular level of service, there can be several treatment and placement options. Local human service professionals would appreciate assistance to determine the most appropriate treatment and/or provider given the problems and disorders of the child, thereby improving outcomes. As the Joint Legislative Audit and Review Commission in its Review of the Comprehensive Services Act, Senate Document 26 (1998) identified, linking program and participant outcomes could provide "a meaningful tool to assess whether providers are producing the type of results required given the nature of the children they receive."

Recommendation 23

Direct the Virginia Commission on Youth to coordinate the collection and dissemination of empirically-based information that would identify the treatment modalities and practices recognized as effective for the treatment of children, including juvenile offenders, with mental health treatment needs, symptoms and disorders. An Advisory Committee comprised of state and local representatives from the Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services, Virginia Department of Social Services, Virginia Department of Medical Assistance Services, Virginia Department of Juvenile Justice, Virginia Department of Education, Virginia Department of Health, Virginia Office of Comprehensive Services, private providers and parent representatives should assist in and guide this effort.

Upon completion, client specific information on the types of services utilized for certain conditions and behaviors in Virginia should be collected. This information should be shared with entities involved in efforts to develop a policy and plan for children's improved access to mental health services as required under current biennium language (Item 323 K).

The results of the study shall be used to plan future services and resources within the Commonwealth for children with serious emotional disturbance or at risk of serious emotional disturbance; to identify effective models that could be replicated; and to identify effective means to transfer technology regarding effective programs, such as education, training and program development to public and private providers.

IX. Acknowledgments

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Virginia Hospital and Healthcare Association

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House Joint Resolution 119

Offered January 21, 2000

Directing the Virginia Commission on Youth to study children and youth with serious emotional disturbance requiring out-of-home placement.

Patrons-- Rhodes, Cantor, Christian, Darner, Hall, Hamilton, Jackson, Jones, J.C., McDonnell, Purkey and Watts; Senators: Forbes, Howell, Miller, Y.B. and Puller

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Referred to Committee on Rules

WHEREAS, at least one in five children and adolescents may have a diagnosable mental, emotional, or behavioral problem that can lead to school failure, alcohol or other drug use, violence, or suicide; and

WHEREAS, in June 1999, the Department of Mental Health, Mental Retardation and Substance Abuse Services estimated that approximately 90,000 children and adolescents had serious emotional disturbance and approximately 55,000 had serious emotional disturbance with extreme impairment; and

WHEREAS, in 1998, 17.4 percent of juveniles committed to Department of Juvenile Justice facilities had prior psychiatric hospitalizations; and 57 percent of the females and 47 percent of the males entering juvenile correctional centers had a designated mental health need; and

WHEREAS, the Comprehensive Services Act (CSA), Virginia's statewide system of services for troubled and at-risk youth and their families, is not meeting the needs of all children with serious emotional disturbance, particularly those children whose services are not mandated by the CSA and who fall outside of the foster care and special education systems; and

WHEREAS, there is a total of 64 beds available for the impatient hospitalization of children and adolescents in state mental health facilities in the Commonwealth, a reduction of 108 beds since 1992; and

WHEREAS, in 1998, the Joint Legislative Audit and Review Commission determined that there were 217 children at acute or severe and recent risk who were in need of services, including out-of-home care for treatment of serious emotional disturbance, whose services were not mandated under the Comprehensive Services Act nor funded through other sources; and

WHEREAS, in 1999, the Virginia Supreme Court determined that there were 3,595 children with severe or acute and recent risk in need of services, including out-of-home care for treatment of serious emotional disturbance, whose services were not mandated under the Comprehensive Services Act nor funded through other sources; and

WHEREAS, local governments are concerned about the high cost of treating children with serious emotional disturbance, and defining and quantifying the population will have significant implications for service delivery; and

WHEREAS, any recommendation for reform to the system of care must be based on accurate, quantifiable data; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Commission on Youth be directed to study children and youth with serious emotional disturbance requiring out-of-home placement. The Commission shall develop and implement a methodology for accurately determining the number of children with serious emotional disturbance in need of out-of-home placement. Such methodology shall include, but not be limited to, the following: (i) a description of the population; (ii) a description of state and local services available in the Commonwealth; (iii) an analysis of funding sources; and (iv) an assessment of unmet needs.

During the second year of the study, the Commission shall assess the service capacity for children and youth with serious emotional disturbance in need of out-of-home placement, with the goal of suggesting reform to increase the system's effectiveness and efficiency.

RESOLVED FURTHER, That an advisory group be established to assist the Commission and to provide oversight and direction in the process. The advisory group shall be comprised of 19 members as follows: one representative from the State Executive Council for the Comprehensive Services Act; one representative from the Office of Comprehensive Services; two representatives from local Community Policy and Management Teams; two representatives from the Virginia Association of Community Services Boards, one of whom shall be a member of the Child and Family Services Council; one representative of the League of Social Services Directors; one representative from the Virginia Mental Health Planning Council; two representatives from the Virginia Municipal League; two representatives from the Virginia Association of Counties; one representative from the Virginia Mental Health Association; one representative from the Virginia Coalition of Private Provider Associations; one representative from a private psychiatric hospital; and the designees of the Commissioner of the Department of Mental Health, Mental Retardation and Substance Abuse Services, the Commissioner of the Department of Social Services, the Director of the Department of Juvenile Justice, and the Superintendent of Public Instruction.

All agencies of the Commonwealth shall provide assistance to the Commission for this study, upon request.

The Commission shall submit an interim report to the Governor and the 2001 Session of the General Assembly and shall submit its final findings and recommendations to the Governor and the 2002 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

Appendix B

Advisory Group
Second Year Study

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[1] Joined the Advisory Group for second year study effort

VIRGINIA COMMISSION ON YOUTH

Survey of Children and Youth With Serious Emotional Disturbance In Need Of Out-Of-Home Care

Pursuant to HJR 119, the Commission on Youth is conducting a study of youth with **Serious Emotional Disturbance who** need of out-of-home care. The Commission is charged with defining this population and determining an accurate estimate of the number of children in Virginia who require these services. The following survey was developed to help the Commission on Youth track this population. The information you provide will be used to determine service and funding needs.

Please review the attached instructions and complete one survey for each child in your facility and/or on your caseload at this time who meets the criteria specified in the instructions. For the child, this means a DSM diagnosis and or two or more of the listed characteristics, and for the caregiver this means at least one of the listed characteristics. Return all surveys in the postage-paid envelope provided. If you misplace these envelopes, you may send your responses to: John Nezlek, College of William & Mary, Department of Psychology, PO Box 8795, Williamsburg, VA 23187-8795. Additional surveys and envelopes can also be obtained from John Nezlek. Call 757.221.3881 or email jbnezl@wm.edu.

SECTION 1: DEMOGRAPHICS

1. Client ID Number: (last 4 digits of social security number)____________________
2. City/County of Residence: ____
3. Agency: ____
4. Contact Person: ____
5. Telephone Number: ____
6. Client's date of birth: __________________
7. What is the client's race/ethnicity?

   ☐ Caucasian ☐ African-American ☐ Asian ☐ Hispanic ☐ Other (specify)__________________

8. What is the client's sex?

   ☐ Female ☐ Male

9. What is the household income of the client's caregivers?

   ☐ Under $20,000 ☐ $21,000-40,000 ☐ Over $40,000 ☐ Do not know

SECTION 2: Child Characteristics

10. Does the client have a current DSM IV diagnosis?

☐ Yes ☐ No ☐ Don't Know

If no or don't know, proceed to question 10.

11. What are the diagnoses? *(Please specify)*

☐ Axis I ____________________ ☐ Axis II ____________________

☐ Other______________________________

12. In the last 12 months, has the client: *(Circle all that apply)*

A. attempted suicide one or more times, or had a specific plan for committing suicide one or more times?
B. been hospitalized in a public or private psychiatric facility?
C. receiving special education services for children with emotional disturbance (with an IEP), or is scheduled for an IEP to determine eligibility for a special education program for children with emotional disturbance?
D. been found eligible and is receiving special education services for a disability other than emotional disturbance?
E. routinely missed two or more days of school per month as a direct result of symptoms associated with his/her mental illness (i.e., do not include absence due to physical illness).
F. demonstrated a drop in school performance/productivity to the point that there is a risk of failing at least half the courses?
G. exhibited behavior that was so disruptive/aggressive that client presents threat to the safety of others in the home or in the community?
H. had persistent problems or difficulties relating to peers that result in few, if any, positive peer relationships?
I. had at least one family / caregiver relationship characterized by constant conflict that is disruptive to the family / caregiver environment?
J. required intervention by at least two different agencies?

13. Have problems in personality development and social functioning lasted at least one year?

☐ Yes ☐ No

14. Are problems expected to last at least one year without services?

☐ Yes ☐ No

SECTION 3: Family Characteristics

15. Do any of the following describe the client's primary familial environment (Adult/s with primary responsibility for the client's care)? *(Circle all that apply)*

A. Sociofamilial setting is potentially dangerous to the client
B. Client is at risk because of lack of resources required to meet client's needs/demands

C. Family has exhausted emotional and/or economic resources and is unable to care for the child

D. Gross impairment in caregiver's judgement or functioning (may be related to psychosis, substance abuse, severe personality disorder, mental retardation, etc.)

E. Caregiver is hostile, rejecting, or does not want client to return to home

F. Client is subjected to sexual abuse in the home

G. Client is subjected to physical / emotional abuse or neglect in the home.

H. Caregiver "kicks" client out of the home without trying to make other living arrangements.

I. Client currently removed from the home due to sexual, physical or emotional abuse or neglect

J. Failure of caregiver to provide an environment safe from possible abuse to a client previously abused or traumatized

K. Severe or frequent domestic violence takes place in the home

L. Caregiver is openly involved in unlawful behavior

M. Caregiver contributes to or approves of client's involvement in potentially unlawful behavior

N. Caregiver does not take an active role in supervision of child

SECTION 4: Service Plan

16. Based on the service plan for this client, please check out-of-home services that were recommended and received within the last six months and services that were recommended but not received in the last six months. For services that were recommended but not received, please describe how responsible system and case factors were for why this service was not received. Use the following scale to make these ratings: 1 = not all responsible and 5 = very/highly responsible. Please be specific in identifying "Other" out-of-home services that may have been recommended for this client.

SYSTEM FACTORS

Placement provides safety for child
Lack of recommended services
Agencies unable to work effectively together
Limited community tolerance
Funds not available for this service or this child
Community support to maintain child at home
Placement necessary for public safety
Court ordered service

CASE FACTORS

Placement / treatment ineffective
Child unwilling to cooperate
Family unwilling to cooperate
Caregiver lacks necessary resources
Family preference
Child not eligible
Facility unable to design appropriate treatment plan

Service/Treatment/Placement	*Services Recommended and Received*	*Services Recommended but **NOT** Received*	*To what extent were **system factors** responsible for why this service was not received?*	*To what extent were **case factors** responsible for why this service was not received?*
Psychiatric Hospitalization	☐	☐	1 2 3 4 5	1 2 3 4 5
Residential Treatment	☐	☐	1 2 3 4 5	1 2 3 4 5
Residential School - Special Education	☐	☐	1 2 3 4 5	1 2 3 4 5
Group Home	☐	☐	1 2 3 4 5	1 2 3 4 5
Therapeutic Foster Care	☐	☐	1 2 3 4 5	1 2 3 4 5
Other (Specify)____________________	☐	☐	1 2 3 4 5	1 2 3 4 5

17. Thinking about all the services for this client that were recommended but not received, what factors were responsible for why recommended services were not received? *(Circle all that apply)*

System Factors:

A. Placement provides safety for child
B. Lack of recommended services
C. Agencies unable to work effectively together
D. Limitation of community tolerance towards children with serious emotional disturbances
E. Funds not available for this service
F. Funds not available for this child
G. Strong community support to maintain child at home/in community
H. Placement necessary for public safety
I. Legal requirements / Court order
J. Other____________________________________

Case Factors:

A. Placement / treatment ineffective
B. Child's unwillingness to cooperate with services/treatment
C. Family's unwillingness to cooperate
D. Caregiver lacks necessary resources
E. Family preference for/against particular placement or treatment
F. Child does not meet eligibility criteria
G. Facility unable to design treatment plan to meet child's needs
H. Other____________________________________

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Appendix E

Synopses of Twenty Documents Related to Study

1. *Investing in Virginia's Future: A Continuum of Care for Our Adolescents at Risk. An Interagency Conference*; May 11-13, 1988, Virginia Beach, Virginia; Conference Proceedings; Published through the Child and Adolescent Service System Program Grant, Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services.

Beth A. Stroul, M.Ed., keynote speaker:

- The Report of the Joint Commission of the Mental Health of Children (1969) and the1978 President's Commission on Mental Health found that millions of children and youth were not receiving needed health services.
- Jane Knitzer, in her 1982 book Unclaimed Children, reported that there are about 3 million severely emotionally disturbed youth in the U.S. and that 2/3 of these children do not receive the services they need. She also made the assertion that 40-60% of the children placed in hospitals are hospitalized primarily because there are no alternatives.
- The Office of Technology Assessment of the U.S. Congress in January 1987 reported that despite the tragic nature of children's mental health problems and an increased knowledge of how to prevent and treat these problems, the care available to children does not reflect this knowledge.
- Presentation of a "System of Care" for seriously emotionally disturbed youth.
  - Core Values: Child-centered and Community-based
  - Principles: 1) Comprehensive array of services; 2) Least restrictive setting; 3) Family Orientation; 4) Service Integration; 5) Case Management; and 6) Smooth Transitions.
  - Dimensions of Service: 1) Mental Health Services; 2) Social Services; 3) Educational Services; 4) Health Services; 5) Vocational Services; 6) Recreational Services; and 7) Operational Services.

Recurring issues throughout the conference:

- Shared responsibility within the system for these children
- Cooperation among state and private agencies
- The need for a continuum of care in providing services to children
- The need for aftercare but the lack of funding for aftercare service (the children return from a residential setting to the same or worsened situation at home which created/exacerbated the crisis in the first place)
- The need for an interagency pool system

Commonalties of the Model Programs Highlighted:

- Community-based system of care for SED youth
- Wide range of services demonstrating a continuum of care in or near the child's home or home community.
- Parental involvement, when appropriate, in the child's treatment
- Interagency collaboration with linkages to the private sector
- Integration of mental health, education, juvenile justice and social service environments.
- Access to range of services from any point in the system

Interagency Funding:

- Consortium of Child Mental Health
  - Funding of last resort
  - Impetus for it began in spring of 1987 with the Mrs. Baliles' "First Lady's Forum on Child Mental Health" where the need for joint ownership and planning for SED children was discussed.

  - The result of the Forum was a memorandum of agreement by the Secretariats and department heads and an interagency budget initiative for the 1988-90 biennium. The agreement created an Interagency Funds Pool to help localities meet the needs of SED children and criteria for eligibility for funding.

Regional work sessions:

- Common problems identified include:
  - Inadequate funding
  - Inadequate resources (services)
  - Need to improve service delivery (including training for staff)
  - Need for community cooperation and collaboration
  - Need for state guidance and coordination
  - Need for a comprehensive continuum of services
  - Need for early intervention to prevent more serious problems
  - Need for flexibility in funding sources and streams to meet the child's needs
  - Lack of available foster home placements
  - Lack of client/family involvement
  - Lack of community-based programs
  - Lack of transitional services

2. The Council on Community Services for Youth & Families, *Improving Care for Troubled & "At Risk" Youth & Their Families*, November 1991.

Introduction:

- This report essentially sets forth the plan for what is now known as the Comprehensive Services Act for At Risk Youth and Families.
- This report included the following:
  - Preliminary findings from the evaluation of the demonstration projects
  - A long-range plan for phasing in community–based nonresidential services across the Commonwealth
  - An interagency plan for redirecting current funds and identifying new revenue sources for funding community-based services, including consideration of Medicaid; and
  - Any proposed legislation necessary for implementation.

Findings:

- As a result of the demonstration projects, there was greater cooperation and fewer turf issues among agencies, particularly those that historically had not been full participants. Also, there was also more involvement of private providers in the process
- Two common characteristics were established in the five community interagency structure:
  - All five had an administrative or agency directors group that monitors grant activities and conducts long-range planning, which improved communication and sharing of resources across agencies.
  - Communities have consolidated their existing multidisciplinary interagency assessment teams resulting in more cases being staffed and providing greater flexibility and more service options.

A long-range plan for phasing in community–based nonresidential services across the Commonwealth:

- Characteristics of the Proposed System:
  - Earlier identification and intervention
  - More flexible funds
  - More community control and flexibility
  - More funds managed at local level
  - More options to serve youth and families:
    a) Tailored services to meet strengths and needs of youth and family
    b) Family support and community services balanced with secure and intensive treatment placements
    c) More family involvement in service decisions
  - Expanded costs to invest in proposed system

- Local governments would consolidate the multiple interagency teams into one structure.
- Local governments would appoint a collaborative team at the policy and management level that has the authority to make decisions on interagency funding and policy issues.
- This team would establish one or more family assessment and planning teams who would assess the strengths and needs of the troubled youth and families and identify and arrange for the provision of services.
- Several state-level interagency teams would be consolidated into one structure to better coordinate program and fiscal policies, support community efforts and reduce the duplication and fragmentation of state requirements across agencies.

<u>An interagency plan for redirecting current funds and identifying new revenue sources for funding community-based services, including consideration of Medicaid:</u>

- Existing funding structure at the time of the report:
    - 16 funding streams across four agencies
    - The required local match varies from 0% to 50% (one ranges up to 80% based on community's ability to pay).
    - Localities have no financial interest in 46% of the total dollars they spend leaving little incentive to consider cost-effectiveness.
    - Costs for services depend on which agency is paying.
    - The distribution of current resources across the state is based on historical expenditure patterns of accessing certain funding streams and does not necessarily reflect a community's need, nor its ability to pay.
- <u>Recommended structure</u>
    - Create a state pool in which nine funds are consolidated from which public or private services across four child-serving agencies can be purchased.
    - Authority and accountability for spending the funds would be at a community level.
    - Communities would be required to match the allocation of state pool funds based on their ability to pay, with local shares capped at 45%.
    - Under this plan all localities would receive additional or the same amount of state dolls with no locality receiving a reduction in state funds. Proposed formula was considered revenue neutral to local governments.
    - Recognizes the need to fund foster care and special education services at sum sufficient levels.
    - Establishes a trust fund in which at least 25% of the funds must be used for early intervention services and would increase incrementally to 40% by the year 2000. These funds would be used to develop:
        - a) Early intervention services for young children at risk
        - b) Community services for troubled youth who can appropriately and effectively be served in the home and/or community.
        - c) Grants would be available to communities at 100% state funding for at least two years in order to develop, stabilize and evaluate the services at which time the community would assume the local mach required under the state pool funding formula.
    - Potential Revenue Sources: 1) Medicaid reimbursement; 2) pending federal legislation and funding; 3) private foundation funding. An interagency plan for redirecting current funds and identifying new revenue sources for funding community-based services, including consideration of Medicaid.
    - Training and technical assistance would be provided at the state and community level to support the new system.
    - The Commonwealth would institute methods for evaluating the effectiveness of services, analyzing the costs, and providing management reports to decision-makers at both the state and community level.

3. Mental Health Association in Virginia, *The Invisible Children's Project*, July 1989.

Introduction:

- Recognized "that many seriously emotionally disturbed children, or children at risk of developing emotional disturbance, are not receiving the services they need and are being placed out-of-their homes and communities and out-of-state to receive mental health services."
- "A full range of community-based services is necessary to keep these children with their families and in their home communities."
- This project collected data on children and adolescents placed in out-of-home placements between July 1, 1987 and June 30, 1988 from each of the then four child-serving agencies – the Department of Corrections, Education, Mental Health, Mental Retardation and Substance Abuse Services, and Social Services.

Findings:

- National Statistics:
  - Twelve percent of America's 63 million children and adolescents experience mental health problems; five percent of these children experience severe and persistent mental health problems.
  - Approximately three million of America's children and adolescents are seriously emotionally disturbed.
  - Demographics indicate that 30% of monies for mental health services should be allocated for children; instead, children's services receive only about 10% of mental health resources.
  - Only one of three children in need of mental health services actually receives those services.
- If appropriate treatment options are not available in the community, the child may be sent away from home to residential treatment, sometimes out-of-state.
- Recent (to the 1989 report) reports in Virginia by DSS and DMHMRSAS suggest that Virginia is effectively treating only a small portion of these children, adolescents, and their families.
- Applying national prevalence rated to Virginia, this report suggested that approximately 74,500 youth are estimated to be SED.
- "While a residential placement may be able to address the child's needs within the context of its program, successfully transitioning the child back to his home and community too often proves to be difficult, if not impossible."
- "It is easier for them [service providers] to demand change from the child rather than to implement changes in the environment/systems that produced, or added to, the child's difficulties."
- This study collected data on the number of "invisible children" in Virginia. For purposes of the study "invisible children" were characterized by:
  - A defined mental health problem that can be diagnosed under DSM III-R; **and/or**
  - Problems in personality development and social functioning which have been exhibited over at least one year's time; **and**
  - Problems which are significantly disabling based upon the social functioning of most children; **and**
  - Service needs that require significant intervention by more than one agency; **and**
  - The child must reside in:
    - An out-of-state facility; or
    - A correctional learning facility; or
    - A state or private psychiatric hospital; or
    - A 24-hour private residential facility; or
    - An approved foster care setting; or
    - A mental health group home; or
    - A correctional group home; or
    - A public residential school; or
    - A facility where distance causes a disconnectedness from family/community resources.
- The study adopted the following guiding principles:
  - Treatment and care should be through a comprehensive array of services that is community-based and family-focused.
  - There should be collaboration in all planning, funding, and implementation strategies.

- Early identification and intervention
- Use of a case manager for each child.
- Recognition of the special needs of families with children with multiple impairments.
- The needs of the child and family should dictate the types and mix of services provided with families as full participants in service planning and delivery.
- There should be effective advocacy and protection of rights of emotionally disturbed children.
- Services for children and their families should be available throughout the state to avoid the need for institutional care because of lack of services.
- Emotionally disturbed children should receive services within the least restrictive, most normalizing environment that is clinically appropriate.
- Services should be provided without regard to race, religion, etc. and sensitive to cultural differences.

Data Collection on the Number of "Invisible Children"

- Data is presented by four state agencies and is not uniform, but rather reflects the funding of differing types of residential or hospital placements.
- Because each agency tracks the children differently, the data is not an unduplicated count of children.

Recommendations:

- "Redirect or develop flexible policies for existing funding streams so that these funds can be used to serve children in their homes and/or communities. Funding for which a child is eligible should follow the child into less restrictive alternatives."
- "Develop new funding initiatives for community-based services."
- "Establish an interagency data tracking system with which data and costs regarding an individual child could be tracked, unduplicated, across agencies."
- "The joint board liaison committee should undertake a review of the Code of Virginia to make recommendations to each of the child serving agencies with regard to policies and administrative functions that would encourage "gatekeeping", joint service planning for individual children, joint agency budget planning for children's services, and resolution of issues such as confidentiality and 'which agency is responsible to do what'."

4. Virginia Department of Planning and Budget, *A Study of Children's Residential Services*, June 1990.

Introduction:

The General Assembly mandated the Department of Planning and Budget (DPB) to conduct a study of children's residential services as item 461 of the 1989 Appropriation Act. The four agencies included in the study were the Department of Mental Health, Mental Retardation, and Substance Abuse Services, the Department of Social Services, the Department of Corrections, and the Department of Education.

Major objectives of the study:

- Document and evaluate the current delivery of residential services
- Identify changes in funding, administration, and service delivery which would provide incentives for the development and use of alternatives to residential care and promote agency collaboration

Terms defined:

- "Residential care" -- out-of-home care in a group or institutional setting longer than thirty days for children with emotional or behavioral problems.
    - Short term placements of less than 30 days were excluded on the assumption that they were for the primary purposes of detention, evaluation, or crisis stabilization, rather than residential care.
    - The definition excluded placements in parent-model situations such as family foster care, therapeutic foster care, and family-oriented group homes.
- "Funding streams" -- federal or state funds used to either operate residential programs or purchase services for individual children from public or private residential care providers.

Findings:

- State funds paid for all or part of the residential care through 14 funding streams across the four agencies.

Children in Residential Care:

- DPB compiled an interagency database by merging 14 files containing demographic, placement, and cost information. From this they determined:
    - There were actually 4,993 children in residential care in FY 88. This number is an unduplicated count derived from an interagency data base of 14,000 child entries.
    - Children in residential care averaged 2 placements during FY 88 – This number is underreported because DPB generally did not include those where the length of stay was less than 30 days
    - More than 80% of the children included in a survey of local agencies had received residential or other services from two or more child-serving agencies.
    - In FY 88, 6% of the children in residential care (303 children) were placed outside of the Commonwealth.

Expenditures for Residential Care:

- The Commonwealth spent a total of $93.6 million in federal, state, local, and other funds for the children in residential care during FY 88.
    - $52.4 million (74%) were for governmental residential programs
    - $18 million were for residential services purchased for individual children.
- Expenditures per child averaged $19,000 annually, although a significant number of children were in care for less than the full year.
- The study found that state funds allocated to children's residential services during FY 88 and 89 were substantial and increased sharply, and significant increases in the state share of costs of residential care could be expected to continue through the 1990-1992 biennium.

Service Delivery:

- The study team conducted extensive interviews with state and local agency staff, judges, providers, advocates, and parents. These revealed the following:
- There was widespread consensus that, although residential care is sometimes the most appropriate and effective method of service delivery, selection of the residential option should be carefully weighed because the removal of the child from home for treatment makes reintegration into the family and community more difficult.
- Part of the demand for children's residential services reflects the limited funding available for nonresidential programs.
- Categorical funding and limits placed on the use of funds sometimes result in children being inappropriately labeled to enable them to receive treatment.
- Certain local agencies lacked effective procedures for screening the appropriateness of placement decisions and most local agencies were unable to effectively monitor the continued appropriateness of residential placements.

Funding and Administration:

- The current funding structure and administration of children's residential services do not allow for adequate planning, budgeting, and program evaluation.
- The methods by which the Commonwealth funds residential services for children do not provide sufficient incentive for localities to consider cost-effectiveness in their placement decisions and may inadvertently provide incentive for use of residential services before less costly alternatives.
- Where localities are required to contribute a fixed share of the costs of residential services, differences in the ability of localities to provide required matching funds limit access to these services by children from poorer localities.

Recommendations:

- The study concludes that the current service delivery system for children with emotional and behavioral problems and their families requires significant change in order to be consistent with the

Commonwealth's policy goals of family preservation, individualized services in the least restrictive setting consistent with child welfare and public safety needs, and community ownership of children.

- The Commonwealth should track expenditures of children in residential care to control costs, project expenditures, and provide a base to evaluate program effectiveness. The four agencies, in consultation with DPB and the Office of the Attorney General, should develop an interagency tracking and reporting system to compile demographic, placement, and cost information on children in residential care.
- The Departments of Youth Services and Social Services should consolidate funds that purchase residential services and allocate these to localities through a single funding stream in each department.
- To encourage the use of community services and increase equity in access to services, the Commonwealth should incorporate the following principles in funding:
  - Local sharing in the cost of residential placements
  - Higher levels of state support for therapeutic foster care and other nonresidential alternatives
  - State funding of children's services which uses "ability to pay" as one factor in determining local cost share
- Other potential sources for funding children's services should be explored, including federal IV-B and IV-E funds, federal education funds, Medicaid Title XIX, and Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services for medicaid eligible children.
- The Commonwealth should expand alternative community-based programs for children and their families.
- DMHMRSAS should assign children at imminent risk of residential placement by the other agencies as a priority for community mental health services.
- State monies saved from increased use of alternative services or from changes in methods of funding residential care should be redirected to develop community based services for children in or at risk of out-of-home placement and their families.

The four state agencies should develop a process to review the appropriateness and effectiveness of selected residential placements.

5. The Council on Community Services for Youth & Families, *Comprehensive Community Service Model for Troubled Children and Their Families in Virginia*, November 1990.

Introduction:

- This report lays the foundation for the development of the Comprehensive Services Act for at Risk Youth and Families.
- Provides a model for developing local systems of service and care for children at risk of becoming, or currently are emotionally disturbed, behaviorally disordered, and abused and neglected, and their families.
- This report includes the following:
  - A *comprehensive service model* to define the most effective alternative for providing services to at risk youth (graphic display and narrative).
  - A list of *core values for the system of care.*
  - A list of *guiding principles for the system of care.*
  - A list of *service components* and their individual definitions and role within the service model.

Findings:

Current data indicates that troubled children generally have multiple problems and have therefore been found in the care of a variety of child-serving agencies. This report resolves that services should be organized in a functional rather than in an agency based manner. All troubled children, whether emotionally disturbed, behaviorally disordered, or abused and neglected, have many common service needs. The model proposes integrated and comprehensive services for all disturbed youth.

Comprehensive Service Model

- Based on the premise that troubled children and their families are best served by a system of care that is comprehensive, coordinated, and responsive to needs.

- Each child's service program has to be tailored to his/her individual needs rather than attempting to fit the child into a prestructured program.
- Stresses comprehensive care in conjunction with early recognition and preventative care.
- Adopts the premise that available resources and funding should be pooled.
  - By combining resources from various agencies, funding can be utilized to support individually tailored service plans for each child and family.
  - Troubled children generally come into contact with a variety of child-serving agencies.
  - All troubled children, whether emotionally disturbed, behaviorally disordered, or abused and neglected, have many common service needs.
- Communities are diverse and faced with needs and problems with varying levels and types of resources available for troubled youth. Therefore localities should be able to choose from an array of *core services* to meet the local needs of youth and their families.

Core Values of Care

- Children and families of the Commonwealth of Virginia should be recognized as the most important entities of the Commonwealth.
- The system of care should be child centered and family focused.
- The child should always be served within the context of the family, which should be the primary point of intervention in the development of the service model.
- A system of care should enable the child's development as an effective citizen.
- The system of care should be community based and community owned to the maximum extent possible to maintain a continuum of service options.
  - This system of care should make use of all public, private, local regional, state, and federal resources available.

Guiding Principles for the System of Care:

Emotionally disturbed, behaviorally disturbed, and abused and neglected children should

- Have access to a comprehensive array of services.
- Receive individualized services guided by an individualized service plan.
- Receive services within the least restrictive, most normative environment appropriate.
- Be treated with the full involvement of their families in planning, delivery and evaluation of services.
- Receive services that are integrated and inter-disciplinary to assure collaborative case management.
- Be provided with case management so that they can move through the system of services in accordance with their changing needs.
- Be identified and treated early in order to enhance the likelihood of positive outcomes.
- Be ensured smooth transitions to the adult service system as the reach maturity.

6. Commonwealth of Virginia Department of Mental Health, Mental Retardation, and Substance Abuse Services, *Virginia Child and Adolescent Service System Program (CASSP) Demonstration Project*, August 1992.

Major Goals and Approach:

- Identify and empower constituencies of advocates, parents, families, consumers, and providers to promote and guide state level system development for children and adolescents.
  *Experience with parents and child advocates to date has revealed that the stigma of mental illness, and the personal stress of raising a seriously emotionally disturbed child are barriers to parents' involvement in support groups and advocacy efforts.
- Promote interagency coordination in the planning, funding and delivery of services to seriously emotionally disturbed children and adolescents.
- Develop a responsive service system for seriously emotionally disturbed children and adolescents, which include those services necessary to effectively meet the complex needs of this population.
- Provide training to community services boards and Local Interagency Service projects to ensure that community-based service development and implementation are guided by state-of-the-art knowledge.

Accomplishments:

- A variety of needs assessment and planning activities were undertaken during the CASSP project.
    - 1987, *The First Lady's Forum on Child Mental Health*
    - 1989, *The Invisible Children Project*
    - 1989, *The Mental Health Plan 1990-1992*
    - 1989, *Child and Adolescent Psychiatric Hospital Units Staffing Study*
    - 1990, *Study of Children's Residential Services*
    - 1991, *The Council on Community Services for Youth and Families*
    - 1991, *The Mental Health Plan 1992-1994 and implementation Progress Report*
    - 1992, *Needs Assessment for the Interagency Trust Fund*
- Several legislative, regulatory, policy and budgetary changes which support movement toward community based care have been accomplished in Virginia over the period of the CASSP grant.
    - Minor's Treatment Laws

      Laws have been developed over the past two years to govern the inpatient hospitalization of children in public and private sector facilities. The laws altered admission processes for children by developing specific admission criteria. Voluntary admissions of minors to state psychiatric facilities increased to 45% of total admissions.
    - CSB Budgets and Planning

      For the first time in Virginia, specific guidance was given by DMHMRSAS to community service boards on priorities for child and adolescent services. This was the first step in the Department's move toward having a foundation of specific services available across Virginia for seriously emotionally disturbed youth.
    - State Board Policy

      The State Board of the DMHMRSAS adopted a policy to specifically target seriously emotionally disturbed youth and their families. This policy made a clear statement to the state as a whole about the Department's priorities for services and serves as a guideline for all new Department initiatives.
    - Community Medicaid Initiative

      New changes added coverage for: case management, in-home crisis and long-term interventions, day treatment and education programs, and summer therapeutic programs.

7. Commonwealth Institute for Child and Family Studies, *The Council on Community Services for Youth and Families Demonstration Projects: Technical Report on Evaluation*, October 1992.

Introduction:

In 1990, the Governor and General Assembly appropriated more than $2 million to establish youth and family projects in order to demonstrate how to improve services and control costs. Under the direction of the three Cabinet Secretaries of Health and Human Resources, Education, and Public Safety, the Council on Community Services for Youth and Families redirected and pooled existing funds to supplement the initial interagency appropriation. They also awarded $3.4 million to five communities to establish and conduct demonstration projects during the 1990-92 biennium. The sites selected were Lynchburg/Bedford, Richmond, Roanoke, Norfolk, and the Rappahannock area. The Commonwealth Institute for Child and Family Studies was awarded a contract to evaluate the demonstration projects.

Findings:

- Although specific outcomes were difficult to assess in the short time frame available for the evaluation, some changes were apparent in the follow-up data on youths and families.
    - Youths in the demonstration projects were significantly less likely to be placed in a residential setting following their identification for demonstration project services.
    - Youths in the demonstration projects were significantly more likely to have received advocacy, case management, financial assistance, in-home services, and transportation services.
- Interviews were conducted with approximately 50 local personnel on two separate occasions, and survey responses were obtained from over 450 respondents in the five demonstration sites.

- Localities reported that interagency assessment teams were central to their projects; in all cases, the teams had been expanded either in number or in frequency which they met.
- Representatives from all localities expressed the opinion that the demonstration project resulted in a more positive and enthusiastic approach to the work of interagency teams.
- The availability of more resources, and particularly the availability of a greater number of local service alternatives, was stressed as one of the major positive outcomes already felt by local personnel.
- These changes were seen as improvements in interagency functioning, but many respondents also expressed concern that the increased staff time required to devote to community assessment teams and the staffing of cases presented a considerable drain on already limited staff time.

- Personnel at the five localities were asked about their perceptions of interagency communications and collaboration. Their perceptions of change were assessed in three areas:
  (1) Overall perceptions of the local service system
    - An improvement in the local service system was perceived by the personnel in two localities; worsening in another; and no change in the other two.
  (2) Opinions regarding the relationships among agencies
    - A worsening of interagency collaboration was perceived by the personnel in all five localities.
  (3) Perceptions of the service system along specific dimensions (e.g., goals, leadership, coordination, and interdisciplinary function)
    -A minor but statistically insignificant improvement was perceived across the five localities in terms of their perception of change in specific aspects of the service system. However, statistically significant improvements were noted by personnel in two localities.
- The perceptions of consumers who responded to a satisfaction questionnaire were consistently positive. They indicate that:
  - They would recommend the services they received to friends in similar need.
  - They would seek the same services again if the needs arose.
  - The services they received helped them deal more effectively with their problems.
- Available data suggested that, on average, the use of residential care changed very little.

8. Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services, *Comprehensive Services for At-Risk Youth and Families: Demonstration Projects FY 93 Evaluation Report*, February 1994.

Introduction:
This report contains information from the evaluation of the implementation and impact of the five demonstration projects. These projects were designed as a means for improving services and controlling costs by expanding community-based services delivered through an interagency collaboration approach. The five demonstration project sites were:

- RADCO Planning District, comprised of the city of Fredericksburg and the counties of Caroline, King George, Spotsylvania, and Stafford;
- Cities of Lynchburg and Bedford, and Bedford County;
- City of Norfolk;
- City of Richmond; and
- City of Roanoke.

The funding of the demonstration projects resulted in the development of new services and the expansion of existing services. New services developed included:

- Intensive Probation Services
- Therapeutic Respite Care
- Parent and Student Aide Programs
- Day Treatment Programs
- After School Programs
- Therapeutic Summer Programs
- Pre-school Prevention Program
- Transition Classroom

Findings:

1. Who are the youth and families being served by the demonstration projects?

The typical youth might be:

- Black or white male, 11.9 years old
- Experiencing a number of problems including aggressive behavior, defiance, oppositional behavior, concentration problems, lying, and hyperactivity.
- Failed at least one grade in school.
- Placed out of the home at least once within the 12 months preceding intake.
- Impoverished (38% live in households with incomes of less than $10,000)
- Have parents who are divorced (28%), separated (11%) or widowed or single (24%).

2. What evidence is there of increased identification and intervention with younger children at risk of developing emotional and behavioral problems?
    - There has been a documented increase in each locality in the number and types of services.
3. How have the communities' capacities for providing community-based alternatives to residential services changed through the demonstration projects?
    - There has been a notable increase in the number and types of services available to meet the needs of families with serious emotional and behavioral disturbances.
    - Increases occurred across all categories of service.
    - The trend toward the development of new and more specialized services appeared to have continued into the second year of the demonstration projects.
    - However, even with the increase in number and scope of services, the number of gaps in services has not decreased due to increase in demand.
        - Reported gaps increased from 74 in November 1992 to 84 in July 1993.
        - Reasons for continued existence of gaps include: (1) a continuing lack of resources, especially funds and staff; and (2) the continued presence of barriers to the receipt of services, particularly in the area of insurance requirements and private provider admissions criteria.
4. How have local child serving agencies cooperated and collaborated in the planning and provision of services to youth with serious emotional and behavioral problems?
    - Staff across all five agencies collaborated with each other at the local level in new and more specialized ways from Nov. 1992 to June 1993.
    - More time and staff have been devoted to interagency meetings than during first year of project implementation.
    - Overall, staff reported a high degree of satisfaction with the level and intensity of interagency collaboration efforts, although concerned about the time and energy required to make this approach work.
5. How satisfied are the youth, families and service providers with the services being received through the project?
    - Families report a highly positive perception of the extent to which the services they have received have met their needs.
    - There was an increase in the number of families reporting being very satisfied with their child's progress overall.
    - There was a decline in the degree of difficulty experiences by families trying to access services.
    - Service providers indicated satisfaction with demonstration projects.
6. To what extent has the use of residential services changed as indicated by the number of youth placed out of the home and the expenditures for these services?
    - It is premature to make conclusive statements about the role of demonstration projects in controlling residential placements and costs.
    - Statewide data available on youth residential placements and their associated costs are limited with regard to their level of detail and their comparability across state agencies.
7. To what extent have the youth served changed as the result of services received through the demonstration projects?
    - Projects appear to have a positive impact.
    - "There is ample evidence that a child-centered, family focused, community-based approach to service troubled youth is a notable improvement over more traditional methods."

9. Community Services Board Planning Committee, *The Impact of the Downsizing of Virginia's State Psychiatric Hospitals for Children Without Increased Community Care Options*, December 1994.

Introduction:
This study sets forth the impact of the downsizing of Virginia's public psychiatric hospitals without an increase in community care options. Some facts that define the problem include:

- In 1996, actual and planned reductions in public psychiatric hospital beds for children and adolescents reduced beds from 172 to 120.
- The savings from the reductions were not reinvested into community services for children with serious emotional and behavior problems and their families.
- "Admissions to state psychiatric hospitals for children have increased on average 11% per year since 1982."
- The average length of stay for children has dropped from 143 days in 1987 to 31 days in 1994. CSBs work with hospital staff to plan for the discharge of children back to their communities, and have responded to the responsibility for the ongoing treatment needed by these troubled children and their families in several ways.
- "[T]he complexity of the issues presented by children and adolescents with severe emotional and behavior problems has increased over the years."
- "While the Comprehensive Services Act has met the needs of many troubled youth and their families, many more troubled children seen by Community Services Boards are not in the "mandated" population which is the priority for services under the Comprehensive Services Act."
- Fifty-three percent (53%) of CSBs reported waiting lists for services longer than one month.
- "Because of this delay in services, interventions with children in our communities often come only after the child's behavior has reached emergency levels...These late interventions mean that longer and often more costly types of care must be provided."
- Despite maximizing services with existing services, increased interagency collaboration, shifting of staff internally into children's services and increased available reimbursements from Medicaid, services available are not meeting service demand.

Recommendations:

- Each CSB should have or be able to purchase a flexible array of eight basic services, which can keep children out of expensive hospital and residential care. To avoid duplication of services, these services should be offered in conjunction with other community agencies. The eight services include the following: intensive mental health community intervention staff; alternative treatment and education programs; parent and school aides; care coordinators; specialized outpatient treatment staff; respite care; therapeutic individual homes; funding to purchase psychiatric hospital care.
- The majority of Community Services Boards have only two or three of these basic services. No CSB has the full eight basic services required or the capacity necessary to meet public demand for mental health services. (*But see,* The Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services, *Keeping Our Kids At Home (KOKAH) Project: A Study of the Feasibility, Efficacy, and Cost-Effectiveness of Expanding the Project Statewide*, September 1999, in which it is reported that a 1998 survey (*source unknown*) of the CSBs menu of community-based services for children with serious emotional disturbance revealed that over 50% of all CSBs are providing five or more of these foundation services.)
- To provide these services, the estimated increased funds required to provide a basic array of child mental health services in all 40 CSB areas, capable of serving 2% to 2.5% of the child population each year is $47,830,600. Also provided were options for funding.

10. Research and Evaluation Center of the Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services, *Comprehensive Services Act Implementation Assessment – Fiscal Year 1994*, April 1995.

Introduction:
This is a report on the implementation of the CSA during its initial year of operation – July 1, 1993 through June 30, 1994. Data was collected and findings reviewed in relation to seven implementation issues: Youths served, expenditure of state pool funds, local administrative costs, team functioning/interagency collaboration, family participation, public-private partnership and goal achievement.

Youths Served:
The report notes that the information received is limited in its reliability and depth. The data were collected by hand with many opportunities for misinterpretation of term by local staff and errors in recording and calculations at all levels. Automated data management system is available but used by only 35% of the localities.

- About 8,000 youths served through CSA pooled funds during first year.
- Majority (around 60%) were white, male and between the ages of 13 and 17.
- Most (91%) were "mandated" – entitled to services through federal or state mandates.
- Of all CSA youth served who were *mandated*, 57% were in private, residential care (includes foster care children).
- About 66% of *all* youth served through CSA pooled funds were placed outside their homes (includes foster care children).
- About 83% of all youth received services provided by the private sector.

Recommendation:

- Improve information available to decision makers through the development of a CSA management information system.

Expenditure of State Pool Funds:

- Total spent on CSA services in FY 94 - $103,251,744. Of this amount 61% came from state allocations and the remaining 39% was provided by local governments.
- Of the total amount expended 11% was supplemental (the initial allocation was insufficient to meet the service needs of the mandated population).
- The finding reinforced conventional knowledge that privately provided out-of-home care is the most expensive type of service for troubled youths. *This type of service was provided for 57% of the mandated CSA youth in FY 94, yet it consumed 76% of the total pooled funds spent on the mandated population.*
- Non-residential, public services averaged $2,342 per mandated child, per year. These services are typically community-based and operated by local government agencies.
- *One of the unresolved issues related to CSA funding mechanisms included the "continuation of the long-standing problem of inadequate funding for non-mandated youth."*

At the August 18, 1994 meeting of the State Management Team (SMT) a focus group was conducted. A top priority among the critical issues was to address the struggle between the mandated and non-mandated children. More specifically:

- "[T]he adequacy of funding for non-mandated youth continues to be a major concern. A problem exists in the very use of the terms 'mandated' and 'non-mandated.' The distinction is artificial, for the actual needs among the two groups are often identical."
- "[T]he juvenile justice population has been long underserved. This group has not advocates. Now that '286' funds are no longer available, judges in particular are frustrated with the lack of alternatives for the youth they see. Today's court cases often present more serious and more complex child and family circumstances than wee encountered in past years. These situations may require costly remedies, yet services for mandated youth are given higher priority."
- "[T]he availability of children's services is directly affected by the degree to which local funds are allocated for these services. Children who are non-mandated are especially vulnerable because under CSA regulations, services for this population are more likely to require 'new'

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- local funding than services for mandated children (286 funds required no local match). In attempts to conserve limited funds, decisions by local governments may have detrimental effects on certain at-risk youth and their families.
- "***Some SMT members suggested that this problem may be resolved by 100% state funding of services to severely emotionally and behaviorally disturbed youth and their families."*** [emphasis added] At a minimum, there should be a funding mechanism that does not in effect penalize localities which choose to serve their non-mandated youth....The SMT, it was suggested, should strive to develop means by which all eligible children would experience equal access to services."
- "The issue of differing philosophies for dealing with youthful offenders was raised. There is a debate at both the local and state levels which can be characterized as 'punishment vs. treatment'. This debate is relevant for the CSA because placements in juvenile correctional centers are fully funded by the state, while alternative, community-based services require local funds. Even though for some youthful offenders community-based services are less costly and more effective, these youth may be placed in state correctional centers in order to preserve local funds."
- SMT members acknowledged that there will never be enough state funds for all needed service for at-risk youth and families and that other sources of funding must be pursued, including family contributions and medicaid.

<u>Recommendations</u>:

- Provide incentives and/or assistance to localities to develop community-based services which foster family preservation and cost savings.
- Identify and correct financial disincentives which may encourage localities to utilize our-of-home placements, instead of community-based services.
- *Explore potential mechanisms by which non-mandated youth could have adequate access to CSA services, and project attendant costs to the state and localities.*
- As recommended by the CSA Forecasting Task Force, request the Department of Planning and Budget to re-establish the technical forecasting group to project the future demand for CSA services and their associated costs.

<u>Local Administrative Costs</u>:

- There was a general sense among local agency staff that the CSA is a financial burden for localities.
- Localities were allocated state funds, but the $5,000 received by most localities was viewed as unrealistically low

<u>Recommendations</u>:

- Continue state financial assistance to localities for CSA administration.
- Create or find ways to reduce the local administrative burden.

<u>Team Functioning/Interagency Collaboration</u>:

- Findings were generally positive and point to an enhancement of interagency collaboration through the CSA team process.

<u>Recommendations</u>: (four recommendations were made, the most relevant is listed below)

- Identify specific problems CSA teams may encounter with local courts and aggressively seek solutions.

<u>Family Participation</u>:

- Overall findings were positive.
- Parent representatives had positively contributed to the process.
- The majority of parents of the youth served attended the FAPT teams, participated in the meetings and adequately represented the views of the youth's family.

<u>Recommendation</u>:

- Continue to monitor the capacity of FAPT's to engage parents of troubled youths in service planning and implementation.

Public-Private Partnership:

- Of the 53 chairpersons who indicated having knowledge of private provider *rates*, 28 (53%) perceived an increase in fees since the beginning of the CSA.
- A majority of all survey respondents saw no increase in private *services* during the first year of the CSA.

Recommendations:

- Establish more formal private-public partnerships to lay the groundwork and provide incentives for developing a full array of children's services which are consistent with the intentions of the CSA.
- Request the Department of Planning and Budget to repeat its study of private provider fees, now that the CSA has been operational for one and one-half years. The study will determine whether rates have changed, the degree of the change, and the relationship between rate changes and the CSA.

Goal Achievement:

- The goal receiving the most recognition of progress was interagency collaboration.
- Receiving considerable acknowledgement of progress was the goal of incorporating families into the service planning processes of the CSA.
- Some or moderate progress toward achievement was acknowledged for the following three goals:
    - Provide communities flexibility in the use of funds;
    - Provide services in the least restrictive environment; and
    - Improve the quality of services to troubled youths and their families.
- It was felt that the least amount of progress was achieved in public-private partnerships and early identification of and intervention with at-risk young children

Recommendations:

- Publicly recognize local CSA participants for their accomplishments in making the CSA a reality during its first year of operation.
- To enable the CSA to meet its goal of early intervention, request the SEC to assume responsibility for the coordination of prevention/early intervention activities within the framework of the CSA.
- Incorporate "restrictiveness of placement" into future CSA evaluation efforts.
- Determine the appropriate time to publicize the CSA nationally, so that Virginia's experience may assist other states initiating similar efforts.

Local administration of the CSA, *funding of the "non-mandated" population* and strengthening public-private partnerships are some of the areas which require further attention.

11. State Management Team, *Non-Mandated Youth: History and Potential Fiscal Approaches*, July 1995.

Introduction:

The purpose of the paper is to provide a history of Comprehensive Services Act (CSA) funding with respect to non-mandated youth, and to provide a brief analysis of the various approaches that have been proposed to resolve the problems localities are experiencing in serving non-mandated youth. •The paper was not intended to endorse any particular approach.

Background:

- Four of the nine funding streams merged for the purposes of creating the CSA State Pool of Funds had previously provided services for non-mandated youth. These accounted for 12% of the total pool. These streams were:
    - DYFS "286" funds
    - DYFS "239" funds
    - State Interagency Consortium on Child Mental Health
    - State Hospital Private Bed Purchase funds

- To ensure that the sum sufficiency requirements for special education and foster care services did not prevent funds from being spent on non-mandated youth, the State Executive Council created a protection level policy. This allowed localities to protect a portion of their allocation for youth in the juvenile justice system. This protection system provides localities with the opportunity to apply for supplemental funds in the event that youth requiring foster care or special education services became known to the locality after they had created their allocation plan. Decision making regarding the use of the protection level and the expenditure of funds rests with the locality.
- In FY 1994, the first year of the CSA, localities could protect an amount up to their actual 286 and 239 expenditures in 1993. In FY 1995 this protection level was increased in an effort to expand the services provided to non-mandated youth. The protection level was expanded to apply to those localities that did not have youths served under "286" funds prior to CSA. The protection level statewide was approximately 12% of the total pool, reflecting the proportion of non-mandated youths in the original pool.

Findings:
- FY 95 year-to-date figures reveal that the expenditures in a sizeable number of localities will not equal their protection level. This indicates that a large number of localities are not using the protection provided by the SEC to assure that some non-mandated youth in their locality receive services.
- A comparison of FY 94 and 95 expenditures to date for non-mandated youth indicates a decreasing reliance on residential services and on private services. This suggests that community efforts to build their capacity to provide alternatives to residential services and to private services is beginning to be realized.
- The approaches used by the SEC to assure that localities have funds available to serve non-mandated youth have had mixed success. Although expenditures for non-mandated youth exceed the amount spent in FY 92, the base year for the CSA, the proportion of funds spent on these youth have decreased statewide.
- Analysis has revealed two distinct spending patterns exhibited by localities:
  - "Want More" – localities that spend (or nearly spend) their protection level, and want more funds to serve youth
  - "Don't Spend" – localities that have not accessed or have minimally accessed their protection level
- Any approach to resolve the funding issues must address both types of spending patterns in order to create improvements on a statewide basis.

Approaches:
For both "wants more" and "don't spend":
- Broaden access to supplemental funds – Access for non-mandated youth would be based on obligation of 100% of the protection level. To mitigate the impact of increasing access to supplemental funds, the cap on local match rate would be removed for supplemental funds for mandated and non-mandated youth. Those localties with actual local match rates higher than 45% would be required to use their actual match rate.
  - This approach would move the CSA toward decategorization of youth, at the level of requesting supplemental funds.
  - However, this may add to the cost of the pool, and exacerbates the debate regarding the allocation formula and the local match level.
- Expand utilization of the trust fund for non-mandated youth – Three potential approaches have been discussed: 1. change the criteria for the trust fund to focus solely on non-mandated youth 2. change the trust fund match rate or "step down" for community services grants 3. increase the available funds.
  - This would increase services for non-mandated youth.
  - However, this is a limited source of funds, and only a limited number of youth would be impacted based on the small amount of funds available.
- Allow CPMTs to use VJCCA funds as local match for youth who are before the juvenile court.
  - This would increase the pool for juveniles before the court, and would maximize 2 fundings streams that, for some localities, have relatively small funds available.
  - However, this may violate the intent and administration requirements of the VJCCA, and unless there is a requirement that local services cannot be reduced, this may result in a

reduction of services. In addition, the use of the 2 state funding streams to match each other moves away from state-local partnership for services.

- Allow CPMTs to use CSA funds for match for non-CSA grants – Grants could be federal, state, or local government or private, with a match requirement that would not preclude the use of pool funds.
  - This increases the pool without additional pressure on state pool of funds.
  - However, this may increase administrative requirements and decrease the state's ability to manage the pool efficiently.
- Decategorize CSA through block granting CSA funds to locality, without pool requirements – Supplemental funds and the reimbursement process would be eliminated. (e.g. sum sufficiency requirements would be removed) Federal mandates would not be impacted. Unexpended funds would stay in the locality at the year-end for use with this population.
  - This would achieve decategorization and would increase local flexibility and control. Furthermore, no additonal state funds would be needed beyond the initial allocation, as the sum sufficient mandate would be removed.
  - However, the increased financial burden for localities as a result of removing the sum sufficiency requirement on the state is likely to create a situation in which localities are unable to meet needs.
- Require a local match for services provided in state facilities
  - This would reduce the utilization of state funds for facilities and would increase local responsibility. It would also encourage state-local partnership in serving youth.
  - However, this would be perceived as an unfunded mandate on localities, and the approach implies that local government has responsibility for committing youths in state facilities. Furthermore, it violates the assumption that the state is responsible for the cost of commitment in state facilities.
- Re-create the "286" and "239" funding streams by removing the Dept of Youth and Family Services as a participating agency in CSA.
  - This would allow the amount of services provided to DYFS youth to be controlled by DYFS allocations and decisions, and therefore these youth would not be impacted by decisions made in the community regarding allocation of CSA funds.
  - This would undermine the intent of the CSA by singling out one group of youth with characteristics that are similar to children served by other agencies. In addition, local ownership for youth and control of services for youth in their community would be decreased, and duplication of services may occur due to lack of inter-disciplinary team decision-making.

Approaches for "wants more":

- Reallocate protection levels – State would distribute protection levels not used/wanted in certain localities to those who want a higher protection level, or any CPMT not wanting their entire protection level could "sell" a portion of it to another CPMT.
  - This increases the protection level and allows for access to supplemental funds for non-mandated youth in some localities.
  - However, it also encourages some localities' practice of not serving or under-serving non-mandated youth.
- Increase the pool at a rate greater than that required to adjust for inflation and the increasing population of youth requiring services.
  - This would increase the amount of funds available.
  - However, it is likely that there are state funds available for this, and this additional funding may not change the service to non-mandated youth in many localities.
- Mandate the non-mandated population
  - More youth would receive services.
  - However, it would be difficult to create a comparable category without federal entitlement. In addition, without some standard of eligibility that can be used with some uniformity in all localities the access of pool funds could be enormous. Furthermore, it is unlikely that additional state funds are available to meet the demand of this population, and it is possible that localities would be left paying 100% of the bill if the state pool is drained before a locality claims reimbursement for a youth without a federal entitlement.

Approaches for "don't spend":

- Lower the local match rate if the locality has used 100% of the protection level for non-mandated youth.
    - This provides an incentive for localities to spend their protection level.
    - However, the administrative burden on localities to determine when and how the protection level is "used" may not be worth the potential benefit. In addition, there is a potential for increasing access of state pool dollars and creating a deficit.
- Increase the match rate for mandated youth if the locality has not used 100% of its protection level for non-mandated youth.
    - This once again provides an incentive for localities to spend their protection level.
    - However, localities may perceive this as an under-funded state mandate on localities. Furthermore, this increases state control over local decision-making, contrary to the intention of the CSA. It also may produce creative efforts to get around the consequences

12. Secretary of Health and Human Resources, Secretary of Public Safety, and the Secretary of Education, *Evaluation of the Comprehensive Services Act*, House Document 50, 1995.

Introduction:

- Purpose of the report is to study and evaluate the effectiveness and efficiency of and the adequacy of state funding for the CSA
- Report is based on the experiences of VA's counties and cities during the 1st year of implementation (July 1, 1993 through June 30, 1994)
- Three major objectives of the report:
    1. Provide preliminary data on local administrative costs of implementing the CSA during FY 1994.
    2. Provide preliminary data on the adequacy of CSA pooled service funds for FY 1994.
    3. Examine the interrelatedness of various planning processes for services to mandated children.

Findings:

- Localities agree on one major point: implementing the CSA is costly in terms of staff time, administrative support, and actual expenses
- Most localities believe that the Act is meeting its goals of stronger interagency collaboration and family participation.
- A major concern expressed at all levels and across the state is that non-mandated youth do not receive the services they need.
    - State Management Team feels that the distinction between the mandated and non-mandated youth is artificial, and that the actual needs among the two groups are often identical.
    - Some members of the SMT feel that the juvenile justice population is long under-served, and given the more complex child and family circumstances being encountered in past years in court cases, the group may require more costly remedies. However, the youth are competing for funds with other youth who are given higher priority due to their "mandated" status.
    - The availability of children's services is directly affected by the degree to which local funds are allocated to these services. Non-mandated children are especially vulnerable because under CSA regulations, services for this population are more likely to require local funding than services for mandated children. Decisions by local governments to conserve limited funds may have detrimental effects on this limited type of at-risk youth and their families.
    - There should be a funding mechanism that does not in effect penalize localities that choose to serve their non-mandated youth. Currently there are definitely financial incentives for serving some categories of youth and disincentives for serving others. The SMT should strive to develop means by which all eligible children would experience equal access to services.
    - Other sources of funding must be aggressively pursued. Medicaid is seen as a relatively untapped resource for revenue.
    - Greater community flexibility should be allowed in the use of CSA funds. Currently, communities are not allowed to divert funds earmarked for mandated children to services for non-mandated children.
    - One community report indicated that "prevention of foster care" has become the "catchall" due to the distinction made between mandated and non-mandated children.

13. Joint Legislative Audit and Review Commission, *Review of the Comprehensive Services Act*, Senate Document 26, 1998.

Findings:

- Despite the emphasis the statute places on serving children with serious emotional and behavioral problems, almost half of the at-risk children who received treatment services through CSA in FY 1995 either had no risk or no recent history of risk for serious behaviors such as those which pose a danger to themselves or others. While the majority of these represent local attempts to provide early intervention services, others may indicate a misuse of the CSA.
- In a number of localities CSA staff either misclassified some children, or manipulated the system to establish eligibility for youths under the "mandated" service provisions of the statute.
    - To circumvent those aspects of the program eligibility criteria that are regarded as too restrictive, CSA staff admit that they manipulate the system and establish eligibility for children who do not meet the requirements of certain provisions of the statute.
    - In some other localities that have provided funding only for children who are "mandated" by state statute, CSA staff are misclassifying "non-mandated" children to ensure that they will receive services.
- In terms of the placement of children in treatment programs, approximately 70 percent of the children who are approved for services were initially provided treatment in a community-based setting. Most of the remaining children received treatment in residential group homes. However, when these placement decisions were examined based on the risk of the child, in about half the cases the treatment setting could not be justified.
- More than 70 percent of the parents and grandparents of children who received services through CSA indicate that the program has helped to stabilize their child's behavior in the community, at home, or at school.
- State officials should be encouraged to pursue the use of Medicaid funds to offset some of the cost of CSA to both the state and localities. This effort could generate an estimated $41 million in CSA savings ($25.9 million – State; $15.4 million – local)

Recommendations:

- The General Assembly may wish to require that the State Executive Council develop a mandatory uniform assessment process to be used by all localities which identifies the appropriate level of care for the various levels of risk. This can help to ensure that CSA participants will be served in the least restrictive environment.
- The General Assembly may wish to amend Section 2.1-755 of the Code of Virginia to require all cases for which treatment services (not foster care maintenance) are requested to appear before a local multi-agency team prior to the development of the service plan. Cases for which service plans are developed outside of this process should not be eligible for CSA funding.
- The General Assembly may wish to require the Department of Medical Assistance Services to amend its state plan to include Medicaid payment for residential care and therapeutic foster care. The State Executive Council should work with the Department of Medical Assistance Services on the use of Medicaid funds for assessment and case management functions.

Overview of the CSA:

- Multiple funding streams were consolidated into one pool of funds
- The CSA was organized on principles of local service coordination among agencies, greater local flexibility to design treatment plans, and a more extensive use of community based services.
- Using this pool of funds, the human service agencies in the localities are now required to form a multi-agency team to plan and implement a coordinated assistance plan for those children whose treatment needs are beyond the capacity of any one agency.
- One of the basic purposes of the program is to stabilize the child through the provision of services in the *least restrictive environment*, preferably the child's home or community.

- CSA eligibility criteria:

  Staff must determine whether a child referred to CSA has a qualifying behavior or emotional problem that either:

  a. persisted over a significant period of time or are of such a critical nature that intervention is warranted OR
  b. is significantly disabling and is present in several community settings AND
  c. requires services or resources that are unavailable or inaccessible, or that are beyond the normal agency services, or require coordinated interventions by at least two agencies
  d. places the child in an imminent risk of entering residential care and require services or resources that are beyond normal agency services or routine collaborative processes across agencies
- Mandated youth are youth who would have been served by one of the categorical funds because of existing service mandates; includes special education students eligible for private tuition assistance, those in foster homes, or those who are at risk of being placed in foster-home placement. *This group has priority over other youth when localities make plans to spend CSA funds.* Because of the "sum sufficient" requirement for mandated populations, the state and local fiscal implications for service to this group are significant.
- Non-mandated youth are primarily juvenile offenders and children with mental health problems; not covered by sum-sufficient language and are only served at the discretion of individual localities
- The most frequently funded CSA service in FY 1996 was foster care (43 %)
- Total CSA expenditures have risen more than 62% in the program's first three years of operation.

<u>Participants served through the act</u>:

- Most beneficiaries are mandated recipients who come from highly dysfunctional families
  - 9 out of 10 youths served entered the program as a mandated case
- Most of the participants are in the13 to 17 year old age group
- More than 40% of the sample displayed symptoms of conduct disorder – this was especially prevalent in the non-mandated group (65%)
- Risk profile for CSA participants was examined through the Childhood Severity of Psychiatric Illness (CSPI); incorporates three dimensions:
  - Nature and severity of child's symptoms of psychopathology
  - Risks identified for children
  - Capacity of caregivers to manage the child in the community
- Half of the children entering CSA had two lowest levels of risk for serious behavior: no risk or a history of risk; may demonstrate that CSA program may have drifted from its intended focus
- A higher proportion of the non-mandated youth posed greater risks for criminal behavior
- Proportion of mismatched services is high; the use of a multi-agency team improves the likelihood that a child with recent or acute risks received the services needed.

<u>Local implementation and monitoring of the act</u>:

- Achieving savings in the aggregate cost of the program will be difficult without limiting the extent to which children with needs are served.
- Many localities are containing costs by refusing to serve children who are not mandated under current law – however, the emotional and behavioral problems of non-mandated children are similar, if not greater, than those of mandated children; More than 1/3 of all localities continue to spend no CSA money on at-risk children who are considered non-mandated; another 24% spent less than ¼ of their money for non-mandated children.
- Savings therefore are not being achieved based on a rational policy that differentiates between the needs of children.
- Nonmandated kids less likely to receive treatment, and if they do, less money is spent on them than the mandated kids

  <u>Recommendation:</u> The General Assembly may wish to amend the Code of VA to require that non-mandated cases, where children have displayed acute or recent risk, be afforded sum sufficient funding. In order to access sum sufficient funding for these cases, local CSA multi-agency teams should be required to make these risk determinations through a uniform

assessment process. This recommendation is contingent on the General Assembly's approval of Medicaid as an alternative funding source for CSA.

Use of Medicaid funding:

- There are Medicaid-eligible children who are receiving CSA services through a combination of state and local funds for which the state could receive reimbursement through federal funds (68% are Medicaid eligible).
- Localities have been reluctant to use the funds because of the administrative and program changes that go along with the use of federal dollars (stringent federal requirements); may be seen as contrary to the original intent of CSA, which was to provide flexibility to localities in design of their programs.
- Another key issue is the feasibility and fiscal implications of expanding Medicaid's Early Periodic Screening and Diagnostic Testing program to include residential services; assessment of costs the state would incur from non-CSA children who might be eligible for expanded services and the fiscal considerations for state and local budgets.
- State and local CSA funding sources would have to pick up a balance of $1.6 million – 94 non-CSA court children that may access residential care under EPSDT
- Bottom line: an estimated $40 million in state and local savings could be achieved
- A better alternative for VA is to build community based alternatives to state facility care, and to maximize the use of alternative funding such as Medicaid to pay for services

14. The Office of the Executive Secretary, Supreme Court of Virginia under the direction of the Comprehensive Services Act State Executive Council, *A Study of Services for Children Who Are Not Included in the Mandated Populations of the Comprehensive Services Act for At-Risk Youth and Families*, December 1998.

Introduction:

"This study reports on the effort undertaken during 1998 to estimate the number and costs of treatment for non-mandated children who would meet acute and severe risk criteria but who do not currently receive services under the CSA. The projections included in this document address three specific estimates: 1) The number of children meeting the acute and severe risk criteria; 2) The type of services these children would need; and 3) The costs of providing these services."

Data Collection:

- A survey was sent to court service units, CSBs, and CPMTs.
- Survey contained three data categories: 1) Eight risk behaviors and whether that behavior had been displayed within 3 days, the last month or ever; 2) The respondent's evaluation regarding the most appropriate type/level of treatment service for the child; and 3) The final disposition of the case or a notation if a disposition had not been rendered.

Findings:

- The total number of children assessed to be at acute or severe levels of risk is 20,661.
  - The report notes that a significant proportion of the children seen through court service units (53.3%) or community service boards (69.3%) were assessed as having displayed no risk behaviors.
- In all risk categories, the most frequently recommended treatment options are wraparound services (45.5%) and intensive in-home services (16.9%).
- Two cost estimates to provide services to these children were made.
  - Empirical Model Estimate - $120,779,235 of which the state share is $76,694,815, with the average locality share at $44,084,420.
  - Theoretical Model Estimate - $305,530,851 of which the state share is estimated at $194,012,090. Local costs would average $111,518,761.

- "Other potential sources of funding for children who are assessed at acute and severe levels of risk but not currently mandated for service through the Comprehensive Services Act were not a focus in this study...There are a number of ways that local government and service providers go about procuring services for children. Indeed, some non-mandated children may be receiving such services already." These include:
  - Services through the "Virginia Juvenile Community Crime Control Act (VJCCCA), which provides funding for community-based intervention services for children/youth involved with the juvenile justice system";
  - "Children in locally-operated programs such as detention, outreach detention, group homes and community services boards."
  - "Children whose primary risk factors are aggressive or threatening behaviors and who come to the attention of the juvenile justice system would likely be managed through juvenile court sanction and supervision."
  - "Community Service Boards may provide services to children based on several funding strategies available to local communities. Options may include fee-for service, Medicaid-funded mental health services, and special local or state-funded initiatives."
  - Non-mandated children may receive services through CSA. Approximately 1,705 children were served during the 1998 fiscal year, at a cost of roughly $9.5 million. (*But see* Virginia Department of Planning and Budget, *A Review of the Budget for the Comprehensive Services Act for At-Risk Youth and Families*, September 2000 in which 1,451 non-mandated children were cited as being served in FY 1998.)
  - "Children may receive services through private insurance, although indications are that such funding is often exhausted before the need for services ends or covers only a limited range of the services needed."
  - The Children's Medical Security Insurance Plan (CMSIP).
  - Effective January 1, 2000, Medicaid funds will support residential treatment services for children meeting specific eligibility criteria.

- Service capacity was not addressed by this study.

Recommendations:
- Further study needs to be done.
- "Further inquiry could comprehensively distinguish existing services and funding source and, most importantly, identify gaps in these areas."
- Examination of these issues should be undertaken by the Secretaries of Education, Health and Human Resources, and Public Safety. "A broad-based policy review is required, not unlike the original effort that resulted in the development of legislation and policy for the CSA."

15. Department of Education and the Disability Commission, *Educational Needs of Emotionally Disturbed Students with Visual and Hearing Impairments*, Senate Document 20, January 1999.

Introduction: This report was conducted in response to SJR 193, requesting the Department of Education and the Disability Commission to study the educational needs of emotionally disturbed students with visual and hearing impairments. Specifically, the resolution called for the study to:
  - Determine the number of students with emotional disturbances who have visual/hearing impairments,
  - Identify and review the educational programs available for such students in Virginia,
  - Determine the need for instructional staff and the qualifications required to teach such students,
  - Evaluate the educational needs of such students over the next five, ten, and fifteen years,
  - Recommend the changes and alternatives necessary to ensure the availability of quality special education programs for these students.
- For the purposes of the study, emotionally disturbed students included those hearing or visually impaired students who have been formally classified as such by their school divisions following an evaluation from school psychologists or other trained personnel. The study also included those students who have demonstrated consistent behavior disorders in school but have not been classified

as emotionally disturbed, because their physical disability prevented the use of standard testing protocols. The services that provide support for emotional development and behavior disorder are included on Individualized Education Plans required for all special education students.

Findings:

- The Commonwealth of Virginia does not operate state programs for emotionally disturbed blind or deaf children.
- Local school divisions and communities frequently have difficulty providing the services that adequately serve students with these combinations of disabilities, and thereby rely on residential services.
- Students with severe hearing problems or deafness who are emotionally disturbed require services that aid in closing the gap that exists between the students' use of American Sign Language as a way of communicating and the hearing and speaking ability of the students' parents, teachers, and counselors.
- Most school psychologists, counselors, and social workers, the providers of guidance and counseling services, are not fluent in sign language, making it difficult for them to work with deaf children.
- The hiring of an interpreter for use in a counseling session is effective only if the interpreter is available when counseling is needed.
- The Department of Education (DOE) reported that in 1996-97, 83 percent (220 of 226) of the interpreters working in local divisions failed to meet the DOE's requirements for interpreters. This is problematic because an individual who has minimal, but lowly developed, interpretation skills may be assigned to interpret in a course that requires highly developed skills due to the nature of the course material and the vocabulary (middle and secondary courses). It can also be problematic because they may be asked to interpret during the developmental years that reading and language skills are acquired (early grades). In either case, the student may not receive enough quality interpretation to acquire the content and skills needed to successfully learn the Standards of Learning.
- Services for students who are blind and emotionally disturbed are not needed. Treatment via oral communication can be effective in addressing their emotional needs.
- At the time of the study there were five regional programs in Virginia for mental health services for deaf, hard-of-hearing, and deaf-blind children. Providers had an estimated ratio of one staff person to 6,781 children and adults with disabilities.
- There are presently no residential services in Virginia for the student who is deaf and has an emotional disturbance or behavioral disorder.
- The Virginia School for the Deaf and Blind in Staunton (VSDB-S) returns from 3 to 6 students to their home communities annually. A survey of school divisions suggests a demand for residential and day treatment services for 77 students statewide. Students for whom these services are unavailable are either served with a patchwork of community-based services, which have been judged ineffective in meeting students needs according to a local school division survey, or they are served in out-of-state residential facilities. The cost of these out-of-state facilities exceeds $157,000 per student per year, and is borne by the student's local school division.
- The study also examined programs for deaf students with emotional disturbance in other states to identify state of the art programming, likely outcomes of such programs, staffing patterns, and funding issues. Two programs were examined closely:
    - The Pennsylvania School for the Deaf
    - The Learning Center for Deaf Children in Massachusetts

Recommendations:

- The study recommended that the Massachusetts program be used as a model for implementation in Virginia, and that it should be adopted at the Virginia School for the Deaf and the Blind at Staunton.
- Creation of a program on the campus of the residential school for the deaf and blind places the program within an existing deaf community and among educators and residential specialists who have experience working with deaf students. This placement prevents the common isolation that deaf persons frequently experience in their schools and communities.
- The program should be developed for in-state purposes, with an approximate caseload of 10 students each year and low teacher-student and dorm staff-student ratios. The children should be grouped by age ranges of 6 though 12 and 12 through 18. The program should operate 7 days a week, as compared to the current VSDB-S programs which operate 5 days a week.

- This program would be a residential initiative, separate from the current program, and placement at the facility would enable students to step-down to a less restrictive treatment setting and to interact with other students who are deaf.
- The program could either focus on managing student behavior or providing therapeutic programs. While therapeutic programs are generally believed to be more effective, they are also more costly.
- The per student costs were estimated at $93,000/year based upon the enrollment of 10 students.
- The study recommended that the tuition be a shared state-local responsibility. Additional funding sources mentioned included the CSA, the State Department of Medical Assistance Services, and Medicaid.

16. Hays-Smith, Melissa, *Continuum of Care for Children and Adolescents: A Presentation to HJR 225 by the Child and Family Services Task Force of the VACSB*, August 4, 1999.

Introduction:
This is a presentation regarding the continuum of community services needed by children and their families in VA, based on nationally recognized ideas that describe a complete system of care.
  - Without a complete system of care, the existing components are compromised in their availability and effectiveness.

Services discussed:
1. Family support services
    - More recognized in mental retardation field.
    - Necessary for all children with serious emotional disorders and/or chemical dependence.
    - Includes community services such as Parenting Classes and Support Groups
2. Crisis Intervention Services
    - Needed for children in psychiatric crisis and demonstrating self-injurious behavior.
    - Includes specialized assessments and knowledge of community resources to provide intensive, short-term counseling and case management to children and families.
3. Case Management
    - This service has been a frustration to providers in the state for many years because of the lack of the ways to deliver it properly.
    - Need for it was highlighted by implementation of the CSA.
    - Only case management designed to work with seriously mentally ill or mentally retarded is Medicaid reimbursable.
    - Two types addressed:
        a) Targeted – non-intensive, follow-along case management; involves assessment, monitoring, education, advocacy, and service linkages.
        b) Family-focused – delivered intensely to a load of 5 – 15 families, working with the family as a unit.
4. Outpatient Services
    - Access to this service needs to be greater and available in more non-mental health settings, such as schools or school-based health clinics.
    - Includes psychiatric services and medication management specialized for children, as well as individual, group, and family psychotherapy.
    - Not readily available across the state.
5. Intensive Community-Based Treatment
    - Wide range of services with different focuses that take place in different settings.
    - Require flexibility in delivery and are not reimbursable by Medicaid.
    - Include: In home therapy, intensive in-home services, therapeutic day treatment, therapeutic preschool, intensive outpatient services.
    - Therapeutic day treatment is an important tool – less restrictive alternative to hospitalization or residential treatment and can be used to provide a transition from or back to the community; particularly successful in natural settings such as schools, after school programs, and community centers or park programs.

6. Specialized Vocational Programs
    - Often not available to adolescents with special needs because behavior problems can eliminate training opportunities.
    - Can be center-based or can involve the presence of support staff in community jobs.
    - Would be classified as non-mandated services under the CSA, which does not insure funding.
7. Community-Based Residential Services
    - These are over-relied upon due to the absence of other components of the system of care.
    - This setting is not a normal setting for social and emotional growth and is not the place for children to spend large periods in their development.
    - Necessary component of the complete continuum of care.
    - Communities have difficulty funding this service, particularly when use is inconsistent and high.
    - The CSA can fund some of them through fees, but resources are not available to establish and maintain residential services beyond what costs are covered by fees.
    - Includes: crisis stabilization units, substance abuse residential treatment, therapeutic foster care, community group homes, and programs for independent living skills.

17. The Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services, *Keeping Our Kids At Home (KOKAH) Project: A Study of the Feasibility, Efficacy, and Cost-Effectiveness of Expanding the Project Statewide*, September 1999.

Introduction:

This is an assessment of the "KOKAH (Keeping Our Kids at Home) project to determine the impact of the program in reducing community and institutional costs of care and examine the feasibility, efficacy, and cost-effectiveness of expanding the program statewide. The goal of KOKAH is to reduce Blue Ridge Community Services (BRCS) utilization of child and adolescent state inpatient facilities." The project does this primarily through the purchase of local inpatient and hospital-based day treatment.

Findings:

- "The KOKAH project has reduced BRCS state facility bed days used from 2,459 in FY95 to 1,096 in FY99" – a reduction of 55%.
- In comparison to other CSBs, BRCS has the eighth highest utilization of state child and adolescent impatient facilities.
- "The cost of care is lowest for children and adolescents diverted to community-based services."
- "Thirty-five CSBs are within a 50-mile radius of a private psychiatric hospital that serves children and/or adolescents. There appears to be moderate community-based service capacity upon which to develop additional hospital diversion pilots."
- "Over 55% of CSBs provide five or more foundation community-based services to children and adolescents. The extent of child-specific diversion and step-down services is unknown. There appears to be moderate community-based service capacity upon which to develop additional hospital diversion pilots."

Recommendations:

- A pilot of a modified KOKAH project should be implemented in each of the Health Planning Regions of the State.
- "The KOKAH model should be modified to include less reliance on local inpatient hospitalization, a broader array of community-based diversion and step-down services, and standards for hospital utilization rates."
- "A grant of flexible dollars should be awarded to each pilot site to purchase and/or implement an array of services, with an emphasis on community-based services and including purchase of local inpatient treatment."
- "The development of standardized risk assessment and clinical guidelines to support decision-making regarding the use of local private facilities and state inpatient facilities is also recommended."

18. Child and Family Services Council, *Virginia's Continuing Policy to Take Away State Psychiatric Hospitals for Children Without Increasing Community Service Options*, November 1999.

Introduction:
This is a position paper in which the Council discusses the need for VA to collaborate with community services boards and advocacy groups to plan comprehensively and provide the necessary funds so that community systems of care can be actualized immediately.

Argument:

- VA relies heavily on the use of state facilities, and there is little in the way of child specific funding.
- Many communities across the state depend on state facilities operated by DMHMRSAS in order to meet the needs of children and adolescents.
- There is a *de facto* policy to decrease state hospital resources for children without providing alternatives to state hospitalization in the community.
- VA has begun to dismantle state mental health facilities for children and adolescents
    - The adolescent unit at Central State Hospital was closed, reducing the number of state mental health beds available to adolescents by 30.
    - There is now only a total of 64 inpatient beds to serve statewide:
        1. All children requiring inpatient psychiatric care who don't have Medicaid or third party insurance;
        2. All who have exhausted their insurance coverage but still require inpatient care;
        3. Those with behavior problems so severe that private providers refuse to serve them; and
        4. All in the Dep't of Juvenile Justice who require psychiatric care.
    - Dejarnette is the only state mental health facility serving children younger than 13 years. All adolescents from the Dep't of Juvenile Justice are now also treated at the Dejarnette Center, which is not a secure forensic facility. This means that serious felons are across the hall from 5 year olds.

Recommendations:

- Sufficient funding for community service development has been shown to reduce the number of hospitalizations of children, who could benefit from less restrictive, although very intensive, services.
- A solution would be to transfer state funds to develop services close to communities across the state. Resources available to communities to develop inpatient psychiatric services right in the community, is a solution where there are private providers who are willing to serve diverse ages, dually diagnosed children and behaviorally aggressive children.
- The money the state is saving from downsizing institutional care should be made available to communities to provide follow up care.
- VA must begin to plan services for children and adolescents, and should include in its comprehensive planning families, advocates, community service providers (public and private) and the DMHMRSAS.

19. Report of the Joint Subcommittee to Evaluate the Future Delivery of Publicly Funded Mental Health, Mental Retardation and Substance Abuse Services, *Report to the Governor and the General Assembly of Virginia*, House Document 101, 2000.

- The 1998 session of the GA directed the joint subcommittee to examine the "impact of a carve-out of Medicaid-financed mental health, mental retardation, and substance abuse services from any managed care contracts negotiated with health maintenance organizations and the feasibility of contracting out the administration of all Medicaid-covered mental health, mental retardation, and substance abuse services to DMHMRSAS."
- Virginia's State Plan includes:
    - Required services: outpatient services, including psychiatric services and psychological testing if provided by a medical doctor; inpatient services in a general hospital; and inpatient psychiatric hospital services for individuals under 21 years of age as part of the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program.

  - Optional services: inpatient services provided to persons with mental retardation in an intermediate care facility; mental hospital services for persons 65 and over; outpatient services, including psychiatric services and psychological testing when provided by a licensed clinical psychologist or mental health clinic; mental health and mental retardation community rehabilitation services; and mental retardation home-based and community-based waiver services. [covers substance abuse treatment only for pregnant and postpartum women – partial hospitalization and residential services and only one occurrence during a lifetime -- and for children if treatment is part of their EPSDT plan]
  - "Carve-out" treatments from the Medicaid Medallion II managed care program (pay on a fee-for-service basis and are not included in the capitation rates paid to HMO contractors): rehabilitation services (day treatment/partial hospitalization, psychosocial rehabilitation, crisis intervention, intensive community treatment, crisis stabilization and mental health support), targeted mental health and MR case management, residential and day support substance abuse treatment for pregnant and postpartum women and intensive in-home and therapeutic day treatment for children and adolescent services in the EPSDT program [private providers may deliver these services, but initial access is through the CSB]
- VA has adopted a more restrictive Medicaid income eligibility criteria than most states; less than 70% of people who live in poverty eligible for Medicaid [VA ranks 43 among the states on this measure]
- A VACSB survey indicated that 40 to 55% of clinically eligible persons who are seriously mentally ill do not qualify for Medicaid – for many the income threshold is too low to qualify; moreover, even if qualified, recipients face a disincentive to work because they risk losing their eligibility
- DMAS reported that not all community services are available statewide, and lack of statewide access places VA out of compliance with Health Care Financing Administration requirements; Examples:
  - Only 3 CSB's offer day treatment/partial hospitalization for mentally ill
  - 10 offer day treatment for children and adolescents
  - 2 provide residential substance abuse treatment for pregnant women
  - 3 offer crisis supervision or stablization for people with MR
- In response, CSBs say that restrictive Medicaid criteria and limited funding have affected statewide service accessibility – because of complex funding and administrative structure, CSBs must decide whether to provide services and how much Medicaid match they can afford without jeopardizing services to Medicaid ineligible consumers.
- VA Eligibility:
  - VA applies more restrictive income and resource criteria to Medicaid eligibility for people with disabilities
  - One of 11 states to adopt "209(b) of the Social Security Amendment of 1972" which allows states to use eligibility criteria that were in place before the Supplemental Security Income (SSI) was established
  - Under this option VA is required to allow SSI recipients with incomes in excess of the eligibility criteria to "spend down" their income to a level the would qualify them for Medicaid.
  - The VA program must also allow SSI recipients to exclude the value of his home or contiguous property; however, VA restricts the value of contiguous property that can be excluded to $5000.
- Children's Services
  - DMAS presented data that showed:
    - Only 10 CSB's provide day treatment
    - 3 provide partial hospitalization
    - 2 provide crisis stablization
    - 5 provide intensive community treatment
  - VA's EPSDT program does not include a formal mental health screening, although any health professional can refer for services
  - Report by the Bazelon Center indicates that many Medicaid-eligible children are going without the care they need because adequate assessments of their mental health have not been made.
  - Child and Family Services Task Force of VACSB reported that the full continuum of care necessary for the successful treatment of children and adolescents is not available because of rigid Medicaid definitions or inflexible service delivery requirements.
  - Recommendation #14(e) – CSB's to function as care coordinators, and as the single point of entry into the services system. Care coordination is the central service function of CSBs in a managed system of care, and it would be provided exclusively by the CSBs and behavioral health

authorities. The HJR 240 joint subcommittee recommended that CSBs and behavioral health authorities be local care coordinators and not the primary or only providers of services.

  - Current needs:
    - "There is a dire lack of case management, either targeted or family-focused intensive, for children and their families as some feel has been highlighted by the implementation of the Comprehensive Services Act."
    - Access to outpatient services
    - Intensive community-based treatment
    - Specialized vocational programs
    - Community-based residential
  - There is a perception that consensus, unanimity, and agreement on definitions is lacking among the public and the private sector regarding children's services.
  - The joint subcommittee noted that on occasion, block grants have been given for services, and some CSBs have chosen not to use those funds for children's services, instead using those funds for other programs or populations.
- Performance and Outcomes Measurement System (POMS)
  - Prior to this study DMHMRSAS had launched an initiative to develop, test, refine, and implement a system for measuring provider performance and consumer outcomes.
  - Separate sets of performance and outcomes measures and data have been developed for each of five program areas:
    - Adult mental health
    - Child mental health
    - State hospital
    - Substance abuse
    - Substance abuse prevention
    - Mental retardation measures still under development
  - Measures are designed to reflect different priorities and the unique characteristics of the population
  - Address such issues as access to services, quality and appropriateness of services, human rights, consumer and family involvement, consumer satisfaction, and consumer outcomes.
  - Statewide implementation is to begin July 1, 2001 and be completed October 1, 2001.
- Comprehensive Services Act
  - It is anticipated that at least portions of some public facilities will be available for alternative uses as patients are discharged.
  - Admissions to mental health facilities have declined steadily over the years, down from 9,880 in 1984 to a projected 3,685 in 2000. (62.7% reduction in adult admissions, 3.9% annual average rate of reduction)
  - These facilities have a total of 427 buildings, of which 131 are currently occupied (46 are scheduled for demolition pending availability of capital outlay funding and 36 buildings have been declared surplus)
  - SJR 478 (1999) was passed requesting this joint subcommittee to establish a special task force to examine whether the buildings could be converted to use for the provision of services to at-risk youth and families under the CSA.
  - Recommendation #32 – That the Chair of the CSA State Executive Council, supported by OCS, shall examine the potential for use of the underutilized state property under the control of the DMHMRSAS to determine whether the use of this property, leased to vendors, would reduce the cost of services in the provision under the CSA. Every attempt should be made to locate these treatment facilities, if deemed feasible, in an appropriate geographic distribution across the state that allows all children and families to have reasonable access to services.

20. Virginia Department of Planning and Budget, *A Review of the Budget for the Comprehensive Services Act for At-Risk Youth and Families,* September 2000.

Introduction:

- "The purpose of this study is to examine the expenditures and funding levels of the Comprehensive Services Act and make recommendations to establish the appropriate funding levels...This document will also seek ways to add fiscal prudence and stabilize the program.
- Study provides an excellent background of CSA including its history, organizational structure, the process, and populations served.

Findings and Recommendations:

- "Overall expenditure growth for the agency has remained relatively constant. However, expectations of savings from non-general fund sources have not been met. This has created a need for additional general Fund resources."
- A number of findings and recommendations were made related to the fiscal administration of the CSA, including expansion of Title IV-E funding and maximum utilization of Medicaid. Additional issues included technical assistance to localities, the Utilization Management process, provider rates, and parental co-pays and child support collections.
- Two additional sources of funding to address the needs of children within the CSA population were addressed. The Community Crime Control Act ($29.5 million each year) is distributed to localities to address the needs of the Juvenile Justice population. The Children's Mental Health Initiative funding ($4.25 million each year) was added during the 2000 General Assembly as an attempt to address the needs of the non-mandated population of CSA. In addition to serving non-mandated youth, these funds may have a positive effect on curbing growth within CSA.
- This study also notes that in addition to this study, "various state agencies, consultants, General Assembly, local governments, and other have completed at least 12 other studies. Many of which have similar recommendations and conclusions."

HJR 119
COMMISSION ON YOUTH FOCUS GROUPS

MINUTES

Bristol - May 16, 2001
Charlottesville - June 13, 2001
Prince Edward - June 14, 2001
Norfolk - June 20, 2001
Fairfax - June 22, 2001

BRISTOL

In Attendance:
Patty Bowers, Special Education, Bristol County Schools
Lisa McCoy, Special Education, Washington County Schools
Tammy Francisco, Washington County Dept. of Social Services
Doug Meade, Washington County Dept. of Social Services
Bob Gose, Bristol Dept. of Social Services
Randy Blevins, 28th Court Service Unit
Allen Anderson, Prevention & Children's Services, Highlands Community Services Board
Andi Carter, Family Preservation Services
Lisa May, Highlands CSA
Commission Staff: Georgia Smith, Kristi Wright

I. Introduction by Kristi Wright
II. Overview of findings of previous studies on SED children's services and the CSA
III. General discussion of these findings:

A. CSA Service Fee Directory

1. ***The general sentiment was that the information contained in the CSA Service Fee Directory database is inaccurate and is infrequently accessed by local agencies.***
    a) Providers use experience and contacts with coworkers and other agencies to determine the appropriate placements.
    b) It was reported that local providers need to know specifically what they are looking for in order to successfully use the CSA database. Participants felt that general searches on the database are not particularly helpful. Typically, agencies download the most frequently used information from the database and make their own easily accessible lists.
    c) It was also asserted that the information is not updated with enough frequency, and the rates listed are not necessarily correct.
    d) Suggestions for improvements include:
        i. The characteristics of the database be refined to make it easier to use.
        ii. The creation of positions for people who serve as experts in case placement.

e) In the CSA Service Fee Directory data runs for Region 1, which includes Bristol and Washington County, the following inaccuracies were noted:
   i. Name changes have occurred in many of the facilities.
   ii. The actual programs offered are different than those listed.
   iii. The capacities of the facilities are unclear and may be inaccurate. Capacity was cited as a misleading measure of how many children can be served. It was asserted that, while capacity may serve as a fair measure of available residential services, community-based agencies serve populations that are more fluid, with "capacity" contingent on the availability of funding.
   iv. There are some home-based services provided in the area, yet none are listed in the Service Fee Directory. Participants indicated that there are local private agencies in Southwest Virginia that provide these types of services, and that these agencies are currently managing at least 64 cases of this type.
   v. Addington Hall may have closed.
   vi. The District 28 Family Group Home program is now closed, and the location is currently occupied by the Crime Control Detention Alternatives Program. This new program provides services for children appearing before the court. The Virginia Department of Juvenile Justice can provide additional information regarding these services.
   vii. Highland CSB is listed twice. It was suggested that this could be because there are different rates and capacities for younger and older children.
   viii. The Soma Life Treatment Center was unknown to the participants.
   ix. Donald Podock is not currently available as treatment provider.
   x. There are services provided in the region that are outside of the realm of CSA funding, and therefore are not listed in the database.

f) *"ED, SU" Chart Analysis:*
   i. It was suggested that the data be broken down by CSB coverage area. The CSBs are the safety net, and have the responsibility for serving the population.
   ii. It might be more useful to list the name of the service category rather than the number code used in the database when creating the chart.

2. ***There were concerns with the "fee for service" method that is currently employed by the Commonwealth:***
   a) "Fee for service" may not be the most effective way to contract with service providers. It was suggested that the State explore other options.
   b) The negotiating of fees is not done in practice. The primary difficulty relates to the attempts of smaller, rural areas to compete with the larger, metropolitan areas. These metropolitan areas can supply larger numbers of kids, and there is little incentive for the facilities to negotiate with small localities.
   c) There is no guarantee of the volume of work that will exist, and this makes "fee for service" methods difficult in practice.

3. ***Suggestions of other databases that could be useful:***
   The "294" program funded by the General Assembly created a database of services that may be useful for the purposes of the HJR 119 study.

B. Gaps in Services

1. *Residential programs* – The lack of residential facilities that provide psychiatric intervention beyond that available in a group home was identified as a significant gap. In many cases, there is a need for residential stabilization that cannot be provided by outpatient community treatment efforts.

2. *The rural nature of Southwest Virginia makes service provision difficult*
   a) Current treatment facilities are too far away, and therefore the families cannot be tied into the treatment programs. A residential facility should be centrally located in Region 1; the necessary capacity would be about 20 beds.
   b) The group expressed frustration with the length of time that it takes to get approved access to resources outside of the state. This region's proximity to North Carolina, Tennessee, and Kentucky makes this particularly frustrating.
   c) There are also cultural issues – children from rural areas placed in metropolitan treatment centers have difficulty adjusting to this cultural change.
   d) *Barriers*:
      - There have been plans to address this need which would have allowed private providers to utilize space within a public facility. However, these plans were stalled in the political arena.
      - There has been a statewide reduction in residential treatment programs, and this has significantly affected service availability.

3. ***Sexual offender programs***– Programs to serve this population are needed. In addition, behavior patterns of this type are starting at earlier ages, and there is a need for facilities that serve these younger offenders.

4. ***More funding for non-mandated kids*** – Most are getting funding by being funneled through "foster care prevention."

5. ***More substance abuse residential treatment***
   a) Many of those kids also have emotional disturbance problems.
   b) To access substance abuse treatment, children from Region 1 are sent to a facility in Winchester.

6. ***Need for stronger public/private relationships***
   a) Participants believed that there is lack of understanding and cooperation between public and private service providers. Some participants expressed the belief that many public agencies feel that private providers place too much emphasis on profit.
   b) It was suggested that this unwillingness to cooperate with private providers may be attributed to the fact that there are fewer private providers in rural localities, and this creates a distrust that results in a love-hate relationship.
   c) Participants indicated that private providers were not invited to participate on FAPT teams.
   d) One of the factors that is believed to be considered by private providers when deciding to provide service in a particular region is the receptiveness of the community.
   e) It was asserted that at the State level the focus is on local/private partnerships, and that this emphasis should instead be placed on statewide/private relationships.
   f) Some participants felt that, while the State has recognized the significance of the issue, it has failed to follow-up with the necessary policy changes that would foster improved relationships.

7. ***Issues of parental accountability***
   a) There was a general consensus that the community needs to educate and involve parents in order to make treatment effective.
   b) Participants expressed the concern that parents are often resistant to change and unwilling to become involved in treatment efforts.
   c) It was suggested that communities make parents accountable if they do not follow-up properly, or provide incentives to parental involvement and cooperation.

d) Participants felt that Bristol and Washington County have been most successful in their efforts to include parents in treatment efforts.

8. ***Termination of parental rights cases on Circuit Ct. and Ct. of Appeals dockets*** – Participants indicated that the dockets at Juvenile & Domestic Relations courts have improved, but appeals are still a source of delay in disposition and implementation of treatment for troubled youths.

9. ***Need for Independent Living Services*** –This gap in service affects the 18 to 21-year age group. A group home may be used as an alternative, but it does not provide the same opportunities and services as an independent living setting.

10. ***Private insurance***
    a) While there is a need to look more to private insurance as a source of funding, limitations within the coverage offered by private insurance companies were identified as a barrier to the provision of mental health services to youths in the region. Inpatient treatment often may be the only mental health coverage available.
    b) Challenging the determinations of insurance companies requires a certain level of sophistication, making it difficult for some parents to do so.

11. ***Need for foster care homes in the region***
    a) The participants expressed concern regarding the lack of therapeutic and regular foster care placements in the area.
    b) Compensation for the provision of these services was highlighted. Because therapeutic placements are paid more, families opt to provide this service. A therapeutic placement may be the only alternative even though only regular foster care was needed.
    c) The belief that "typical" foster care kids are rare was also discussed. Because of the availability of foster care prevention services, foster care is necessary only in the more serious cases, and as a result therapeutic placements are on the rise.

12. ***Funding for wraparound services***
    a) *Early intervention and prevention services* -- Anger management, social skills, mentoring, and parenting programs are needed.
        - There was general consensus that localities are only serving children once they are in serious need, and therefore they are only addressing issues once they have become serious and expensive to treat.
        - It was suggested that the definition of SED does not allow for early intervention in very young kids. Many young kids are not able to meet the SED criteria under the CSA, and therefore remain at risk and without services.
        - However, the group felt that DSM IV diagnoses are also problematic. They label young children with a diagnosis they carry for life.
    b) *Aftercare services*
        - The participants indicated that residential facilities provide aftercare programs that are accessible for local kids, but fail to provide options for children who live great distances away.
        - The group agreed that the more rural areas throughout the region are struggling to provide aftercare/wraparound services.
        - It was asserted that these services are not readily available due to lack of funding.
        - The group also felt that there is subtle resistance to the provision of local services and the wraparound concept. It was suggested that this could be attributed to the

fact that agencies believe that they get more for their money using residential treatment services.

C. CSA Issues

1. *Funding*:

a) Participants expressed concern regarding current Medicaid regulations that restrict access to "child-placing" agencies. They indicated that several agencies that serve youth populations in the region are not "child-placing agencies," and cannot access Medicaid funds.

b) There was a general concern that the amounts received by localities for mandated children have not increased over the last 8 years, and are based on a one-year determination of need. This determination was made in 1993 and has not been recently updated.

c) Participants also discussed the fact that several counties will not provide a local match for non-mandated kids.

d) The group also felt that the historical practices of larger localities are affecting CSA appropriations to less-populated regions. Original funding allocations were based on prior expenditures. Localities that kept residential costs down were allocated less money.

e) The group expressed little hope that funding for CSA would increase. Since CSA was originally seen as saving money, but has instead cost more money, the group did not believe that more money will be available for non-mandated kids.

f) The group felt that by allowing private access to Medicaid, the government has improved the availability of services. However, many felt that this happened because the federal government initiated the process, rather than the State. There was a general consensus that there often is a lack of meaningful state action in the area of youth services. As an example of this inaction, participants cited the fact that the State is just beginning to receive reimbursement for Title IV-E funds. They indicated that other states have been accessing this money for several years.

2. *Proposed Solutions*:

a) Private providers do not have access to Title IV-E money, and if they did this would drive down the costs (federal issue).

b) There is a need to explore all resources (insurance, federal funding) to the fullest extent.

c) The General Assembly should abolish the distinction between mandated and non-mandated children. They should just be considered "community" children.

3. *Implementation of CSA*

a) Participants felt that there is a growing need for state assistance in finding the proper placements for children. Many expressed the belief that because rural areas do not have the same CSA capabilities as larger, more populated areas, they should be provided with more state assistance.

b) There was a general feeling that the requirements of the Act are paperwork intensive, and require extensive administration efforts.

c) The group was also troubled by the fact that there is currently no accountability to the state regarding the implementation of the requirements of the Act.

d) Residential facilities would also benefit from technical assistance in CSA procedures and requirements.

e) The group was also troubled by the fact that every locality gets the same amount of administration money, regardless of needs.

f) There was a general concern that some counties in rural regions do not have CSA coordinators. One of the difficulties cited was the unwillingness of local officials to provide a match to the state amount appropriated to hire people for these positions.
g) The group also discussed the fact that the huge workload assumed by the coordinator creates a high turnover rate.
h) Another problem cited was the fact that certain communities have poor relationships with the CSBs, and this creates greater difficulties in determining and meeting treatment needs.

CHARLOTTESVILLE

In Attendance: Martha Carroll, 16th District Court Service Unit; Buz Cox, Charlottesville Department of Social Services, Gretchen Ellis, CSA Coordinator; Jim Herndon, Parent; Daniel Key, People Places of Charlottesville; Kevin Kirst, Albemarle County Schools Special Education Services; Cheryl Lewis, Albemarle County Department of Social Services; Bill Lieb, Community Attention; Linda Peacock, Assistant City Manager for Charlottesville; John Pezzoli, Region Ten Community Services Board.
Commission Staff: Georgia Smith, Kristi Wright

Kristi Wright welcomed the attendees and invited the participants to introduce themselves. She then described the purpose of the study and referenced the findings detailed in the HJR 119 Interim Report.

Ms. Wright then reviewed the summary of findings from previous studies regarding youths with serious emotional disturbance and the Comprehensive Services Act. The group addressed the fact that many of these studies have identified related gaps in services and have provided similar recommendations.

Participants discussed the unique structure of the youth services provided in the Charlottesville/Albemarle community. Members of the group indicated that youth services in the localities of Charlottesville and Albemarle are coordinated under a larger entity, the Commission on Children and Families. This commission was created through the merging of the local CPMT and the Charlottesville/Albemarle Commission on Children and Youth (CACY Commission), and currently incorporates all of the relevant local programs for youth, including those falling under the auspices of the Department of Juvenile Justice and the VJCCCA. Members of the group stated that they felt that this unique coordination of services has been very successful, and has greatly increased the efficiency of the system and provided tangible benefits to youths in the region.

The group addressed the utility of the CSA Service Fee Directory. Members indicated that the database is infrequently used by practitioners in the Charlottesville area for child placement purposes. This was attributed to the fact that the process of matching a child's needs to specific treatment facilities requires a level of individualized knowledge and judgment that cannot be duplicated through the search of a database. Rather, service providers generally use their personal knowledge or inquire with colleagues when determining the proper placements for youths. Furthermore, the members expressed the belief that use of the CSA Service Fee directory was historically difficult and as a result people devised other methods for obtaining the information.

Group members also targeted the accuracy (outdated information) of the directory as a reason for its infrequent use. They also indicated that the information regarding services provided by particular facilities was sometimes misleading (i.e. overstatement of services provided) and made child placement more difficult. Members stated that a search of the directory was typically only conducted to ensure that a chosen provider was listed or to locate facilities in unfamiliar regions for an emergency placement.

The group then analyzed the service providers that were listed for the Charlottesville region in the CSA Service Fee Directory and the DMHMRSAS database. They indicated that many of the services listed were infrequently used by local agencies. Again they emphasized that child placements are primarily made on a case-by-case basis, following consideration of factors such as the proximity of the service provider to the community, the service area, reputation, and quality of the provider, and the specific needs of the child.

Gretchen Ellis informed the group during this discussion that the local CSA office is currently in the process of renegotiating contracts and updating their records on local providers, including documentation of the providers' current rates. She indicated that surveys have been sent out to service providers in the area requesting updated information.

The members also identified gaps in services that have been recognized by local service providers. Ms. Wright initially directed the group's attention to Figure 10 of the Interim Report, and asked whether any of the barriers identified in this figure were particularly relevant to the Charlottesville/Albemarle region. The group reported that one of the most notable gaps in the region is a lack of sufficient interim placements for youths. Participants specifically cited a need for services targeted toward youths who require a placement that falls between therapeutic foster care and restrictive residential programs such as a psychiatric hospital.

Participants also reported that if a suitable match for a child is not immediately available, he/she is sometimes placed in a more restrictive setting than is necessary for treatment purposes. Group homes were proposed as a remedy to this situation, but participants indicated the limited availability of beds and the existence of waiting lists at these homes generally prevented their use for emergency placements.

The group discussed the availability of foster care placements in the region. Participants indicated that the problem encountered with foster care placements was not in the availability of homes, but in the identification of a suitable match for specific children. The group also reported that there is a much greater demand for therapeutic foster care homes than for regular foster care placements due to the severity of the children's mental health needs.

Participants also addressed the problem of waiting lists at local treatment facilities. Group members indicated that the typical number of children on a waiting list for local facilities was 5 to 6. However, the general sentiment was that the size of local waiting lists is likely not representative of the number of children in need of services. If a placement at a particular facility is not available, the child may have to be placed in a less appropriate facility, or given the reality of the waiting list, no referral is made.

The group members also reported that when there are no other placements available for emergency cases, a psychiatric bed is typically purchased for the child. Although it is recognized that this is a more expensive and restrictive placement, alternatives are not readily available. Many of these placements occur in facilities that are a great distance from the community, and this increases the costs of travel for transitional staff and makes incorporation of the family into treatment programs extremely difficult.

The group discussed the lack of inpatient substance abuse treatment programs in the region. Members indicated that a sufficient number of outpatient programs exist in the area, but that children requiring inpatient treatment are sent to Richmond or Harrisonburg. The group reported that placements are primarily based on whether substance abuse is the primary diagnosis for the child.

There was also a discussion of the adequacy of funding for non-mandated children in the region. The general sentiment was that the distinction between mandated and non-mandated children, while problematic, typically did not prevent local youths from receiving services. The provision of services while a child is in foster care may be one way these children receive mandated services. This was recognized as problematic because it requires parents to relinquish custody of their children in order for them to receive treatment.

The group also addressed the funds for non-mandated children available through the Non-mandated Initiative Fund of the DMHMRSAS. They indicated that when this money was first set aside, spending was sluggish because the rules were complex and burdensome. However, they reported that once the regulations were revised and simplified, the region made use of their share of the funds set-aside for non-mandated children.

The group also identified other funding issues that impede effective treatment for some youths. Members stated that parents often are unaware of the different funding options available for services. The group also expressed frustration with the fact that private insurance coverage typically ends before treatment programs are completed, hindering more successful outcomes. Once their insurance coverage ends, these children may enter the state system and receive funds through the CSA.

Another gap in service cited by members was the lack of adequate assessment services. They stated that youths might not receive a thorough evaluation of needs during the initial encounter with public agencies. A thorough assessment would be helpful in making decisions on treatment needs and an appropriate placement. A longer period of time is needed to conduct the assessment. However, a suitable, local placement is frequently not available where a thorough assessment can be conducted in cases of emergency placement.

Also related to emergency placements, a need was expressed for a local facility that can handle the safety and security needs of certain children while a full assessment is completed. The absence of such a placement may result in an expensive, out-of-community, treatment-oriented, initial placement, which may or may not be indicated upon the completion of the assessment.

Long-term outcome evaluation was identified as necessary to determine whether local agencies are providing effective treatment for youths. Members stated that this type of assessment has been prevented in the past by the lack of human and financial resources in local agencies. Gretchen Ellis indicated that the local CSA office was in the process of initiating a long-term study of treatment outcomes for services in the region.

Also identified was a lack of day treatment programs in the region. Members stated that for some children, the only unsuccessful part of a treatment plan is the school setting. However, due to the lack of day treatment programs, the child must be removed from the family and be served in a residential setting in a different community.

In addition, the group felt that there is a lack of transitional services for youths being released from residential placements back into the community. The members stated that there is a need for more step-down programs, especially for children who have experienced long-term residential placements.

Participants cited a lack of services for youths once they reach the age of 18 who need to transition to the adult mental health system. Members indicated that these youths appear to "drop off a cliff" once they reach adulthood due to the fact that limited follow-up support is available in the community.

The group then discussed the capacities of local outpatient treatment programs. The general sentiment was that the needs of the community with respect to outpatient treatment are currently being met. However, members felt that the region has a need for a larger inpatient treatment facility.

Other problem areas cited by members were the lack of sex offender treatment (some private providers do evaluations) services and the shortage of dentists in the area who will accept Medicaid.

The group discussed community-based gaps that may undermine successful youth treatment programs. Members felt that there is a growing need for community-based family support services and early case management.

Participants addressed potential barriers to services in the region. Staffing difficulties were the first issue to be discussed. Participants felt that an expansion of services would be difficult due to the lack of availability of qualified service providers in the area. In addition to the lack of availability, these are difficult jobs and recruitment for them can be hard. During this discussion, it was reported that Department of Juvenile Justice employees have experienced staffing difficulties due to the long delays encountered in receiving requisite background checks from the FBI.

Group members also cited the lack of a reliable, sufficient funding source as a barrier to the expansion of services. Due to large start-up costs and without a reliable funding stream, it is felt that private or public providers will not invest in a new residential facility. In addition to start-up costs, a provider will consider if there will be enough clients to make it worthwhile. While the group indicated an increasing need for the construction of a new residential facility in the region, it was speculated that an initiative of this type is likely to encounter substantial resistance in the political arena since current policy leans toward a decrease in the cost of residential placements, and any additional expenditures related to this service are unlikely to be approved. In addition, the group cited the "Not in My Back Yard" mentality as a potential barrier to the construction of a local residential facility.

PRINCE EDWARD

In Attendance: Amanda Bailey, Prince Edward County Court Service Unit; Beth Cook, Crossroads Community Services Board; Diann Inge, Private Counseling Practice; Alice McCormick, Prince Edward County Public Schools; Roma Morris, Prince Edward County Social Services; Jonathan Pickett, County Planner; Sheri Wise, Family Preservation Services
Commission Staff: Georgia Smith, Kristi Wright

Kristi Wright welcomed the attendees and invited members to introduce themselves. Following the introductions, Ms. Wright provided an explanation of the purpose and scope of the current study. She then initiated a discussion of the findings of previous research regarding youths with severe emotional disturbance, as well as those studies evaluating the CSA.

The group discussed the utility of the CSA Service Fee directory for local service providers. Participants expressed little familiarity with the directory and reported that the database was infrequently used by local agencies. They stated that placements were typically based on personal knowledge and/or contact with colleagues in other regions. When use of a database was necessary, the group indicated that a system operated by the Department of Education was more frequently used to match children to services. Also discussed was the intent that the directory would increase competition among service providers, thereby driving down costs. The participants expressed the belief that competition and negotiation for services was generally not an option for their local agencies.

Members discussed the accuracy of the Commission produced, regional reports that list service providers in the CSA Service Fee Directory and the DMHMRSAS database. The group indicated that several private agencies in the area were not listed in either database. In addition, members indicated that many of the facilities that are most frequently used for placements of local children were not listed. The reasons cited for the absence of these facilities were their location outside of the region, in areas such as Petersburg and Richmond, and their listing under corporate headquarters, which are located in a different region.

The group addressed gaps in services that have been encountered by local agencies. Members indicated that there is a shortage of qualified service providers in the area, and this has periodically created difficulties in the expansion of outpatient services to meet increasing treatment needs. The members attributed the shortage of qualified providers in the region to the difficulty for rural localities to compete with the salaries and benefits offered by agencies in larger metropolitan areas.

Members also indicated that there is a serious shortage of foster care placements in the region. The group reported that there are essentially no therapeutic foster care homes available for seriously troubled youth, and that even the number of traditional foster care homes is limited with most foster homes serving more than one county. Group members expressed the belief that this shortage may be attributed to the substantial needs of the children being placed, as well as the limited compensation that is provided to families for their services. The group also cited the class structure of the region as a contributing factor, as there is a noticeable absence of middle class families, who are typically the most interested in foster care placements. Although there is a foster care placement coordinator, this person serves seven counties.

The group stated that there is a shortage of residential treatment facilities in the region. Members reported that the closest residential facilities are located in Lynchburg and Goochland, and this makes transportation, transitional services, and family involvement much more difficult. The general sentiment was that a residential facility should be constructed locally to serve youths in the region.

A lack of sex offender treatment programs was also identified as a notable gap in service. Members indicated that Poplar Springs Hospital in Petersburg is the closest facility providing sex offender evaluation and treatment. This has proven problematic in the past because offenders released from correctional centers cannot receive the aftercare required for parole in the community, and they have to be sent to state-funded halfway houses located in Staunton.

Members also cited a shortage of inpatient substance abuse treatment services. Youths from the region are currently sent to Popular Springs Hospital for inpatient treatment. However, it was thought that this program is now restricted primarily to detoxification.

Participants felt that a greater number of step-down programs should be offered in the region. The general sentiment was that if there were more local services available, many of the more expensive residential placements could be prevented. The suggestion was made that an alternative school for troubled youths should be constructed in the area using CSA funds. The Presbyterian Home in Lynchburg was cited as an example of an effective transitional program that could be used as a model for future programs. Youths at this facility attend a community school during the day but return to the facility in the evening.

There was also a discussion of general transitional services in the region. Participants indicated that while interim counseling is provided for youths upon leaving a residential placement and returning to the community, the transition would be more effective if a follow-up provider could meet with the child prior to his/her release from the facility. However, this practice is currently unavailable due to funding guidelines, which restrict the child from receiving two types of intensive services during the same period of time. Transportation costs associated with meeting with the child at the facility are also problematic since the residential facilities are not close.

Other gaps in service identified by participants were the absence of youth-adult transitional services and independent living programs. Members indicated that youths turning 18 are left little, if any, transition assistance. The DePaul program in Lynchburg was recently found but it is often full and very expensive. The belief was expressed that these youths have an increased potential to end up in the adult criminal justice system, and therefore a consideration of their transitional needs should be made at an earlier stage.

The group also discussed the fact that there is a lack of adequate respite care in the area. Participants suggested that funding for respite care for troubled families should be obtained through the CSA using the category of "foster care prevention." The lack of respite care was also cited as particularly problematic because it was felt that the number of available foster care families could be increased if this service was offered as part of the program.

An additional concern raised by the group was the limited availability of CSB services. Members reported that there is currently a two-month waiting list for both youths and adults seeking an appointment.

The group also expressed concern with the decreasing capacity of state hospitals for youth placements. Many felt that the lack of available state beds was creating serious difficulty in providing treatment for youths in the area.

Participants then began to address the barriers to services that have frequently been encountered in the region. The first issue cited by group members was the difficulty in obtaining transportation for youths to and from treatment services. Members indicated that because many of the treatment programs were located a great distance from the community, the cost and availability of transportation is a substantial barrier to treatment. Participants reported that the typical cost for transportation services is $85 per child, per day. It was noted that the cost is often absorbed by the school system, and that this agency frequently struggles due to the limited availability of vehicles and staff to meet transportation needs. Participants were further discouraged by the fact that CSA funding does not extend to transportation expenses. In addition, they expressed frustration with the fact that families frequently do not use the transportation services provided by Medicaid.

The group also addressed the difficulties encountered with the Medicaid process. They stated that many providers in the area do not accept Medicaid clients due to the excessive amounts of paperwork and the increased accountability often associated with the program. This issue was cited as especially problematic because the children who receive Medicaid benefits are often the children with the greatest need for local services.

Members also discussed the difficulties encountered due to the security and behavioral problems exhibited by many of the youth served. Some participants expressed the belief that high-security placements, while often necessary, create warehouses for troubled youth rather than providing successful treatment outcomes. The group also indicated that they have encountered difficulties keeping youths in less secure residential placements due to behavior problems. Residential facilities can request a one-on-one staff/youth ratio for extremely difficult youths. If requested and the child is mandated, a one-on-one aid is then required. This type of placement drives up the costs of services for those children.

The group also discussed the recent trend in the severity of youth problems at earlier ages. While most clients were adolescents, they are seeing some as young as six years old. Some members suggested in-utero substance abuse as a factor driving this pattern.

Participants then addressed the lack of family cooperation encountered by local service providers. Members indicated that while counseling and early intervention services are available in the region, families rarely make use of them and often resist cooperation with treatment plans unless facing legal consequences. The existence of a rural underclass, with low educational levels, high rates of poverty and a mistrust of the "system," was noted as contributing to this problem.

Members also reported that family issues have a substantial impact on transitional services and aftercare for youths leaving residential facilities and returning to the community. The general sentiment was that because youths are typically being returned to the same environment in which many of the problems originated, the progress made with the child during residential treatment is often undermined, regardless of local follow-up efforts.

The group then discussed ways in which the family members could be persuaded to increase their participation in treatment efforts. Members suggested that greater participation could be achieved if daycare, food, and transportation services were provided for families who choose to participate in counseling and aftercare programs. However, the group also recognized the fact that this solution may be unavailable due to funding limitations.

Participants then addressed the evaluation of treatment outcomes in the region. They stated that outcome evaluations are not typically conducted by local public agencies, but that providers in the area learn through experience and informal channels which facilities are most effective for specific services. Sheri Wise also reported that Family Preservation Services is currently conducting outcome evaluations in conjunction with the University of Virginia.

The group then discussed the regional availability of funding for non-mandated youths under the CSA. Participants indicated that the current funding level for Prince Edward is $16,000/year for non-mandated children, and that this typically serves about two youths annually. However, members expressed the belief that inadequate funding for non-mandated children was not a serious issue due to the fact that the majority of the youths served in the region are mandated. They explained that youths likely to be classified as non-mandated can be provided with services through the court using VJCCCA funds. When VJCCCA funds are unavailable, the next avenue that is generally explored is the CHINS classification, which allows the child to receive mentoring and in-home counseling services. Participants stated that it is only if these treatment options fail that a child is referred to the FAPT team.

NORFOLK

In Attendance: Steven Blair, Office on Youth; Eleanor Bradshaw, Norfolk Interagency Consortium; Maxine Brown, Norfolk Interagency Consortium; Barbara Craig, Norfolk Department of Human Services; Breck Daughtrey, Norfolk City Council; Kevin Moran, 4th District Court Service Unit; Robert Neuville, Private Provider; Tina Parcell, Lutheran Family Services; Gloria Simpson, Department of Education.
Commission Staff: Georgia Smith, Kristi Wright

Kristi Wright welcomed the attendees and invited members to introduce themselves. Following the introductions, Ms. Wright provided an explanation of the purpose and scope of the current study. She then initiated a discussion of the findings of previous research regarding youths with severe emotional disturbance, as well as those studies evaluating the CSA.

The group discussed the overall effectiveness of the CSA and the utility of the Service Fee directory for local service providers. During this discussion, the participants expressed the belief that competition and negotiation for services was generally not an option for local agencies. Some members also indicated that the CSA operates at different levels of efficiency in different localities, making determinations of its overall efficacy difficult.

NORFOLK (cont.)

Participants reported that the CSA Service Fee Directory is infrequently used by local agencies. They explained that the FAPT teams are knowledgeable of the available services in the region and the suitability of these facilities for specific child placements. Consequently, the database is generally only used to determine a particular provider's eligibility for funding. Members indicated that the database would be more useful if providers were required to update their listings periodically.

The local CSA Coordinator in Norfolk currently maintains relationships with local service providers and obtains updated information regarding rates and capacities. Members indicated that it is likely that this type of list is maintained in all localities, and suggested the CSA directory be essentially eliminated, and that a provider list be maintained at a local level and sent electronically to the state on an annual basis.

Members then addressed the scope of the current study. Some participants expressed concern that the definition of SED used for the purposes of this study is too broad and includes most, if not all, the children they serve.

The group then commenced a discussion of the youth services available in the Norfolk area. Overall, group members felt that the region provides adequate wraparound and residential services, and also has established a sufficient monitoring process for residential placements to ensure that children are properly matched.

Participants also discussed the effectiveness of local assessment centers, which are designed to provide early intervention services to youths. Members indicated that these centers receive referrals primarily from local school systems, and are staffed by representatives from the Department of Social Services, the Department of Education, the Community Services Board, and the Court Service Unit. They felt that these centers have been very effective in their early intervention efforts due to the strong level of coordination between community agencies.

The group then addressed gaps in services that have been encountered by local agencies. They reported that one of the most serious gaps in the region is a lack of sufficient interim placements for youths. Participants specifically cited a need for services for younger children who require a placement that falls between therapeutic foster care and acute psychiatric treatment. They indicated that since the introduction of managed health care, psychiatric facilities no longer provide temporary stabilization services. Consequently, under the current system, these children are placed in either unnecessarily restrictive psychiatric facilities or with other service providers where the child will require constant supervision.

Concerns were raised over the decreased capacity of state hospital placements for children and adolescents. It was also noted that the savings from reductions in the number of hospitalizations should be earmarked for other services for children.

Participants cited the need for more short-term transitional living facilities for children released from correctional centers. They reported that the region currently makes use of halfway houses and local group homes. However, it was reported that the capacities for these facilities are limited and placements are frequently unavailable. Of particular concern is the lack of transitional services in relation to the sex offender population. Members stated that intensive, home-based independent living services are currently provided for these types of offenders. However, because prior victims are often members of the offender's household, out-of-home placement is frequently necessary. The availability of transitional services for this population is limited, however, as foster care is typically not feasible and group homes often will not accept sex offenders.

Members stated that the construction of a group home specifically for transitional sex offenders was previously proposed as a solution to this problem. Issues of funding and the "Not in My Back Yard" sentiment presented barriers to its construction. Also problematic are internal facility issues such as client safety and risks of re-offending.

The group then cited a need for services designed to provide a transition for youths entering the adult system. Members reported that waiting lists exist for local CSBs, and this prevents many youths from directly transitioning from youth-based to adult-based programs. Also discussed was the fact that while the availability of these programs should be enhanced, localities cannot ensure that all youths take advantage of these services. Upon reaching the age of 18, youths gain the ability to refuse treatment and become emancipated from the system.

The lack of jobs and job training for SED youths was also cited as a local gap in service. It was reported that there is a shortage of jobs in the community that are suited to the abilities and potential of many of the SED children for whom services are provided. Training for and positions available may not provide adequate challenge to allow these youths to work at their highest potential.

Participants discussed the availability of substance abuse evaluation and treatment in the community. They reported that adequate screening and outpatient treatment is typically available through the court system, which conducts initial assessments for all offenders. In addition, a Certified Substance Abuse Counselor has been assigned to each of the CSU's by the Department of Juvenile Justice, and they are authorized to contract out for treatment services using SABRE funds. However, group members indicated there are not enough financial resources available to provide treatment for all of the youths involved in the court system that demonstrate substance abuse problems.

Furthermore, participants reported that there is a shortage of available resources for substance abuse treatment outside of the court system. They indicated that the money available for this type of treatment typically targets specific populations, such as youths with the dual diagnoses of HIV and substance abuse. Participants felt that this limited availability of community funding may force parents and their children to become involved in the court system in order to allow their children to gain access to substance abuse services.

The group also cited substantial difficulties in placing youths in therapeutic foster care once they reach the age of 12. They have encountered problems due to a shortage in the number of therapeutic foster care placements available for this age group. In addition, issues arise due to the stigma that is often associated with foster care for older children. Members explained that many teenage youths feel that being placed in foster care is an indication that no one loves or cares about them, and they therefore would rather become involved in the court system and be labeled a delinquent than receive a foster care placement.

The need for treatment facilities that address the needs of children with dual diagnoses was identified. Participants specifically cited a need for a state facility that treats youths who demonstrate symptoms of mental retardation or neurological disorders in conjunction with mental health problems. Children from the region with these types of disorders are currently placed in out-of-state facilities at a substantially increased expense to the Commonwealth.

The group then addressed the barriers to service that have been identified in the region. Initially the group discussed the difficulties that the school system has encountered in providing educational services to children with long-term emotional or mental disturbances. It was reported that the educators are faced with the difficult task of constantly adapting education plans for students who require frequent hospitalization.

The lack of communication between service providers and families was also cited as a potential barrier to treatment. It was reported that providers need to coordinate efforts to incorporate treatment goals and education into the family environment.

The group also reported that the availability of services in the region has been impacted by a lack of funding. Members emphasized the fact that the system of treatment cannot be effectively driven by costs, and that there is no cheap way to serve the needs of seriously emotionally disturbed children. The belief was expressed that if services are not provided early, it will result in increased costs to the government and society in the future. The group also discussed the recent trend in the severity of youth problems at earlier ages, and the increased demands on funding and services that have occurred as a result.

Participants discussed the increasing financial burden on localities in the provision of youth services as well as the general shifting of costs to the localities. They felt that the costs for residential placements cannot be shouldered entirely by the localities, especially with restrictions on the raising of revenues and inequities of the current tax structure.

It was also reported that with the implementation of the CSA, there was a decrease in the coverage by HMOs and insurance carriers of mental health services, further limiting the resources available to local agencies. Members also expressed frustration with the failure of the CSA to provide compensation for administrative time and related costs.

Generally, members reported that the level of interagency cooperation exercised in the region serves as an effective counterbalance for the lack of funding resources. However, some members expressed concern regarding the efficiency of interagency efforts to create a cooperative, therapeutic treatment environment in the provision of services.

The group addressed the available funding for non-mandated children in the region. Participants indicated that foster care prevention and non-custodial foster care were typical placements for non-mandated children. They emphasized the effectiveness of these types of placements, as they provide successful alternatives that allow for children to remain either in the home or connected to family members. The group also expressed the belief that non-custodial placements are very successful in the region due to the level of agency cooperation.

FAIRFAX

In Attendance: Jamie Bacigalupi, Parent Representative to the FAPT; Paul Edwards, Department of Education; Kathy Froyd, Department of Family Services; John J. Harold, Fairfax-Falls Church Community Services Board; Leslie Kelley, Graydon Manor; Sandy Kniaz, Parent Member of FAPT team; Gail Ledford, CSA Manager; Jamie McCarron, District 19 Court Services Unit; Ron McDevitt, Department of Administration for Human Services, Fairfax County; Sally Sibley, Private Provider, Member of CPMT; John Todd, Department of Education.
Commission Staff: Georgia Smith, Kristi Wright

Kristi Wright welcomed the attendees and invited members to introduce themselves. Following the introductions, Ms. Wright provided an explanation of the purpose and scope of the current study.

The group discussed the overall effectiveness of the CSA and the utility of the Service Fee directory for local service providers. Participants reported that the CSA Service Fee Directory is generally only used to determine the eligibility of a particular provider to receive funding under the CSA. They indicated that Fairfax utilizes its own contracting process with service providers and maintains a list of available facilities in the region. Consequently, there is little need to use the Service Fee Directory for placement purposes.

Some members expressed the belief that it is necessary for the state to maintain a central list of service providers, and felt that the utility of the database would be increased if providers were required to update their listings periodically. The group reported that the fees and capacities provided by the database are often outdated.

Related to the use of the directory as a means to encourage competition, it was reported that when comparisons of providers and their fees are made, it is possible that one is not comparing apples and apples. The service and fee listed may not include the same items or associated costs that another provider includes in the listed cost. They also indicated that the structure of the database calls for agencies to be over-inclusive in listing the services provided, making the entries seem misleading. They explained that because providers cannot be paid for services not listed in the database, providers might stretch their lists to include all possible treatments, however remote. The issue was also raised that it may be difficult for some providers to frequently update their information due to lack of Internet access.

Some participants suggested that the level of provider participation would be enhanced if use of the Service Fee Directory was no longer tied to funding, and was instead utilized as a marketing tool to enhance visibility throughout the state. However, other members expressed the concern that if the database were no longer tied to funding, providers would stop using it altogether.

Participants addressed the utility of the DMHMRSAS' database for staff to identify local services and capacities for the purposes of the current study. Members expressed concern that many types of services were not listed, including day schools. This was recognized, and it was noted that this and other missing information had been requested from additional sources.

Ms. Wright initiated a discussion of the findings of previous research on youths with severe emotional disturbance and the efficacy of the CSA. Group members reported that many of the issues identified in prior studies are still of significant concern today.

The group addressed gaps in services that have been encountered by local agencies. They first identified the need for more community services aimed at keeping children with mental retardation in the community. There are an adequate number of services available to support children with mental retardation in the community, but more children could remain in the community if there were additional state funds to pay for the services. Medicaid is another source of funding to pay for these services, but it is difficult to access.

Specifically, participants cited the need for facilities that provide long-term residential placements for children with mental retardation who can be maintained in the school system, but who cannot remain in the home. Members indicated that because most of these children are Medicaid and waiver eligible, it is possible that a local group home could be established and a residential placement obtained. However, the concern was expressed that once these children reach adulthood, the locality would lose the CSA match in funding. The locality then would be forced to provide the match, and because the waiver is life long, the local cost is unpredictable. Members also reported that there is a need for transitional services for youths entering adulthood that would provide a link to adult mental health services.

A need for increased services for young children (ages three to nine years) who are at risk was addressed. Group members reported that children are now displaying serious emotional and behavioral problems at younger ages, and there are few services available to meet those needs.

The group reported that sex offender placements are extremely difficult to obtain throughout the Commonwealth. They indicated that there are 2 facilities located in the Tidewater area of Virginia. Only one of these facilities is used; the quality of care is felt to be inadequate at the second facility. While members felt that this facility generally is able to meet the demands of the county, a notable portion of the region's sex offenders are reported to have been placed in out-of-state facilities. Participants also stated that quality of service is of particular concern for this population, and therefore local agencies have exerted a great deal of effort to evaluate local facilities and ensure the effectiveness of treatment methods.

Members cited a lack of step-down facilities for sex offenders. They indicated that the transition of sex offenders back into the community was extremely difficult due to the lack of interim placements. They also felt that the implementation of innovative, specialized treatment programs for this population is currently impeded by the lack of available funding.

The group addressed the strength of prevention and early intervention efforts in the region. Participants reported that although sufficient agency initiative exists to expand local programs, action is limited due to insufficient resources. Members specifically expressed an interest in placing more mental health staff in the local elementary schools, but felt that current funding and staffing levels will not support this type of project. The group also discussed Charlottesville's participation in the Promoting Safe and Stable Families initiative, which is coordinated under an AFSA federal grant. Some members expressed the desire for a program of this type to be implemented statewide.

The need for temporary crisis care facilities in the region was also identified. Members reported that there are multiple populations of youths with crisis needs that are not being effectively met, and that local agencies are struggling to place these youths in available services. This need is currently being addressed locally, as the county has entered the planning stages for the construction of a local crisis care center. This center is expected to provide16 beds for youth in need of early crisis intervention.

With recent changes in truancy laws and the resulting increase in truancy cases referred to the Court Services Unit, there are not enough probation workers to handle the increase. It also was noted that mental health issues are prevalent but the children often are non-mandated which results in fewer opportunities for services. Because truancy is a status offense and status offenders cannot be placed in juvenile detention centers, the less-secure shelter home is consequently crowded with youths with mental health needs.

Members cited the need for increased funding for facilities that serve dual diagnosis populations. They specifically discussed the lack of available resources for children facing concurrent issues of substance abuse, sexual victimization, and mental illness. Participants reported that a local facility serves this population, but it is under-utilized due to limited funding resources.

Participants stated that they have encountered difficulties in finding placements for mentally ill youth that exhibit violent behaviors. They felt that the problem has been exacerbated by the state's elimination of a substantial portion of the available psychiatric beds. They also expressed concern with the quality of care provided in the local psychiatric facilities, and reported that an increasing number of aggressive, mentally ill youths from the region are being placed out-of-state. The impact of early termination of services due to limited insurance coverage was also addressed, with the belief expressed that the resulting short-term placements were generally unsuccessful. They also cited difficulties in placing members of this population due to the legal requirement that youth over the age of14 consent to hospitalization.

Group members discussed the difficulties encountered in obtaining placements for children with severe medical problems. They stated that services for members of this population are generally provided out-of-state and are often extremely expensive.

FAIRFAX (cont.)

Several barriers to service in the region were discussed. The issue considered to have the greatest impact is the inadequacy of CSA funding for non-mandated children. Members reported that the non-mandated funds allocated to Fairfax for FY 2002 have already been obligated. They expressed frustration with the fact that the state portion of non-mandated funding has not been increased since the CSA was enacted, while the demand for these services has increased dramatically. They felt that if funding were ensured for the non-mandated youth who are not currently receiving services, the local facilities would be able to meet the needs effectively. Participants also expressed the belief that other localities continue to underutilize the funds because they are unable to provide the local match required.

The services provided for outpatient sex offender treatment by the local Court Service Unit for non-mandated children were also noted. The Fairfax CSU is a local entity. It contracts outside of the CSA and uses local funds to pay for these services from private mental health providers. While members stated that this independent funding source has increased the available services for the population, a waiting list still exists. These local services are tried first, but if the child is still on the waiting list, the child may have to be committed to state facilities due to the lack of resources within the community.

Participants discussed the use of non-custodial foster care placements. They indicated that local agencies have explored the option, but have not increased their utilization of the service. They explained that some of the reluctance might be attributed to the fact that the families involved must attend court hearings every six months, just as they would for a traditional foster care placement. In addition, there are many state and federal requirements and it can be difficult for an agency to fully comply, increasing the potential for violations during an audit.

The group addressed the impact that the mandated distinction has made on local relationships. Members reported that because school and foster care agencies are the default source for mandated funding, these agencies are placed under pressure by families to find placements, services and funding for children who are not mandated under CSA. Participants reported that in the past this has created tension and hindered agency collaboration.

Members explained the initial under-utilization of DMHMRSAS' non-mandated funds across the Commonwealth. The failure to spend the total allocations during the first year was attributed to the process that was initially required for expenditures under this fund. It was reported that the funds were, in reality, only available to localities from November through May of the first fiscal year, and that this severely inhibited the ability to meet the needs in the community.

Participants also discussed prior legislation that would have allowed localities to expand expenditures for non-mandated services based on specific client characteristics. While this legislation was unsuccessful, local agencies expressed their support for an initiative of this type.

The group cited the need for a mechanism under CSA to provide start-up funds for new facilities. Some members expressed the belief that the availability of services would be improved if these funds were available, as new facilities typically encounter cash flow problems during the initial 45 to 60 days of operation.

Group members identified several difficulties encountered with Medicaid guidelines. They reported that the statewide rate structure for home-based services is low reducing the number of private agencies willing to participate. Participants also reported that some local facilities cannot meet the strict state requirements established for Medicaid. Specifically, they felt that it was inappropriate for therapeutic foster care and residential facilities to face the same stringent guidelines that apply to acute psychiatric facilities. The group also discussed issues such as the inadequacy of the administrative assistance received from the corporate administrator in West Virginia, and the efficiency of the Florida and Delaware Medicaid systems.

Members also expressed concern with the fact that parents are often affected by the collective shortcomings of Medicaid and the CSA. They reported that families are placed in a desperate position when short-term Medicaid funding runs out for a child's treatment and there is no available non-mandated funding for the continuation of services.

Group members concluded by expressing their belief that the CSA has been successful in getting local agencies to collaborate and share responsibility for the children of the community.

Survey of Community Policy and Management Team (CPMT) Chairs

Survey on Children Placed in Out-Of-State Facilities

Part I — Descriptive Information

1. Your name ______________________________
2. Title ______________________________
3. Agency ______________________________
4. Contact Information (Address, Phone, E-mail address): ______________________________

____

____

____

5. Locality that your CSA team serves: ______________________________
6. Total number of children (ages 0 to 22) served by your CSA team during FY 2001: __________

Part II — Use of Out-of-State Facilities

7. Please indicate the number of children ages 0 to 22 from your locality that were placed in out-of-state facilities during FY 2001: __________

8. Please list the states in which those placements were made (Use postal abbreviations, e.g. PA, FL):

____

____

9. What factors contributed most significantly to these children being placed in an out-of-state facility?
(Check all that apply):

- ☐ No appropriate placement in Virginia
- ☐ Proximity to family members
- ☐ All appropriate facilities in Virginia were full
- ☐ Other (Please explain) ______________________________

10. If on question 9, you checked "no appropriate placement in Virginia," which of the following were reasons contributing to the need for the out-of-state placements? (Check all that apply):

- ☐ Aggressive / Out of control / Violent
- ☐ Hearing impaired / Deaf
- ☐ Sex offender / Sexually aggressive
- ☐ Vision impaired / Blind
- ☐ Substance abuse
- ☐ Autistic
- ☐ Victim of sexual abuse
- ☐ Attachment disorder
- ☐ Victim of physical abuse
- ☐ Other psychiatric disorder

☐ Other (Please explain)

____

11. On average, how many in-state placements are attempted before placing a child in an out-of state facility?__________

12. In your opinion, what is the most pressing treatment need that, if met, could prevent some out-of-state placements?

Please return before Monday, October 1, 2001. Please *FAX* it to the Virginia Commission on Youth at (804) 371-0574 OR mail it to *Virginia Commission on Youth, General Assembly Building, Suite 517B, Richmond, VA 23219.*

Localities Included in HJR 119 Regions

Defined by Virginia Commission on Youth for purposes of study

1. *Southwestern*
   Lee, Wise, Dickenson, Buchanan, Scott, Tazewell, Russell, Bland, Smyth, Wythe, Grayson, Carroll, Washington (Grundy, Abingdon, Marion, Bristol, Lebanon, Wise)

2. *Roanoke*
   Giles, Craig, Botetourt, Roanoke, Montgomery, Pulaski, Floyd, Franklin, Patrick, Henry (Roanoke, Salem, Martinsville, Radford, Christiansburg)

3. *Shenandoah Valley*
   Alleghany, Bath, Highland, Rockingham, Augusta, Rockbridge, Page (Staunton, Lexington, Covington, Harrisonburg)

4. *Winchester*
   Shenandoah, Warren, Clarke, Frederick (Winchester, Front Royal)

5. *Western Southside*
   Bedford, Pittsylvania, Halifax, Campbell (South Boston, Lynchburg, Danville)

6. *Charlottesville*
   Amherst, Nelson, Albemarle, Greene, Madison, Orange, Louisa, Fluvanna, Buckingham (Charlottesville, Palmyra, Dillwyn)

7. *Northern Valley*
   Fauquier, Culpeper, Rappahannock (Warrenton)

8. *Central Southside*
   Appomattox, Charlotte, Nottoway, Lunenburg, Mecklenburg, Prince Edward (Farmville, South Hill)

9. *Eastern Southside*
   Dinwiddie, Brunswick, Greensville, Southampton, Sussex, Surry, Prince George (Colonial Heights, Petersburg, Emporia, Waverly)

10. *Richmond*
    Cumberland, Amelia, Powhatan, Goochland, Henrico, Chesterfield, Hanover, New Kent, Charles City (Richmond, Midlothian, Ashland, Chester)

11. *Tidewater & Eastern Shore*
    James City, York, Isle of Wight, Suffolk, Chesapeake, Virginia Beach, Accomack, Northampton (Hampton, Williamsburg, Portsmouth, Virginia Beach, Norfolk, Newport News, Cape Charles)

12. *Northern Neck*
    Spotsylvania, Stafford, King George, Caroline, Westmoreland, Northumberland, Richmond, Lancaster, Essex, Middlesex, Mathews, King William, Gloucester (Fredericksburg, Saluda, Bowling Green, Montross, Warsaw)

13. *Northern Virginia*
    Prince William, Fairfax, Arlington, Loudoun (Vienna, Springfield, Manassas, Falls Church, Annandale)

Appendix I

Listing of Child Caring Institutions

Child-caring institutions are residential facilities that provide 24-hour care to children placed by their parents or guardians. The children, who range in age from birth through seventeen, require residential care, guidance and supervision until they are able to return to their parents or guardians. Child-caring institutions may keep children in care for several years. There are six licensed child-caring institutions in Virginia. Child-caring Institutions were granted the authority by the 1987 General Assembly to remain licensed under the Minimum Standards for Licensed Child-Caring Institutions, 22 VAC 40-100-10 et seq. if they do not accept public funds. Facilities accepting public funds must be licensed under the Standards for Interdepartmental Regulation of Children's Residential Facilities.

Listing of Child Caring Institutions as Reported by the Virginia Department of Social Services

Miller Home of Lynchburg
Patrick Henry Boys' and Girls' Plantation
Patrick Henry Boys' Home of Halifax
Patrick Henry Girls' Home
Patrick Henry Girls' Home of Bedford
Union Mission Children's Home

Listing of Child Caring Institutions as Reported in the Licensed Facility Directory

Alpha House
Alpha House II
Arcadia Leadership Academy, Inc.
Boys Home
Brookfield
Charity House of Youth & Family
Charles Dermid Children's Home
Children's Home of Virginia Baptist
Elk Hill Farm
Harvest Child Care Ministries
Harvest Child Care Ministries-2
Henry and William Evans Home
Independent Living and Support
Independent Living Program
Jackson Feild – Eleventh House
Janie Hammit Children's Home
Joy Ranch, Inc.
Mount Rogers Shelter Home
New Hope Supervised Living
New Hope Supervised Living II
Oliver Hill House
P.O.P's House
Paula House of Youth & Family
Presbyterian Children's Home
Presbyterian Home
Rainbow Christian Services
Rosey Grier Youth Shelter
Safehaven
Saint Joseph's Villa
Seton House for Boys
Seton House for Girls
Somerville Youth Home
Stars/Gemini House
Stars/Orion House
Tekoa II
Tekoa III
Tekoa, Inc.
This Way House
United Methodist Family Services
Victory Boys Home
Victory House – Positive Pathways
Virginia Baptist Children's Home
Virginia Home for Boys
W.O.O.D.S. at Camp on Craig
Youth Emergency Shelter
Youth First Living Center-Ida House
Youth First/Ella House
Youth First/Georgia House
Youth for Tomorrow – New Life

PRIVATE SPECIAL EDUCATION DAY SCHOOLS

DIRECTORY

SCHOOL	DISABILITY CATEGORY(IES)
ACCOTINK ACADEMY Ms. Julia Warden Education Director 8519 Tuttle Road Springfield, VA 22152 (703) 451-8041 (703) 569-5365 (fax)	Emotional Disturbance Mental Retardation Specific Learning Disability *Maximum Capacity:* 194 *Grades:* *Ungraded* *Ages:* *5 – 22*
ACCOTINK ACADEMY ALTERNATIVE LEARNING CENTER Angela Schwartz Education Director 6228 Rolling Road Suites D, E & F Springfield, VA 22152 (703) 644-9072	Emotional Disturbance Mental Retardation Specific Learning Disability *Maximum Capacity:* 50 *Grades:* *7 – 12* *Ages:* *12 - 22*
ACHIEVEMENT CENTER (THE) Ms. Barbara A. Whitwell Director P.O. Box 12368 615 North Jefferson Street Roanoke, VA 24025 (540) 982-0128 (540) 982-3629 (fax)	Specific Learning Disability *Maximum Capacity:* 90 *Grades:* *Ungraded* *Ages:* *5 – 13*
BERMUDA RUN EDUCATIONAL CENTER Ms. Jeanne Knieriemen Director 3803 Ruffin Road Hopewell, VA 23860 (804) 458-4182 (804) 541-0985 (fax)	Emotional Disturbance Other Health Impairment *(ADHD)* *Maximum Capacity:* 36 *Grades:* *K – 12* *Ages:* *5 – 21*

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SCHOOL	DISABILITY CATEGORY(IES)
CHARTERHOUSE SCHOOL Mr. Ed Dawson Education Director 3900 West Broad Street Richmond, VA 23230 (804) 353-4461, ext. 1269 (804) 353-3061 (fax)	Emotional Disturbance Specific Learning Disability *Maximum Capacity: 42* *Grades: 7 – 12* *Ages: 11 – 17*
CHESAPEAKE BAY ACADEMY Ms. Mary Ann Dukas Director 715 Baker Road Virginia Beach, VA 23462 (757) 497-6200 (757) 497-6304 (fax)	Other Health Impairment *(ADHD)* Specific Learning Disability *Maximum Capacity: 126* *Grades: K - 12* *Ages: 5 - 21*
COLUMBIA ACADEMY Ms. Stella Quinn Director 2244 Executive Drive Hampton, VA 23666 (757) 827-3111 (757) 827-3128 (fax)	Emotional Disturbance Mental Retardation Specific Learning Disability *Maximum Capacity: 35* *Grades: K – 12* *Ages: 7 – 21*
COMMONWEALTH ACADEMY Dr. Melanie Kerber Director 3431 Carlin Springs Road Falls Church, VA 22401-2802 (703) 931-8018 (703) 931-8093 (fax)	Other Health Impairment *(ADHD)* Specific Learning Disability *Maximum Capacity: 50* *Grades: 6 – 12* *Ages: 12 – 18*
CRAWFORD DAY SCHOOL Ms. Millie Davis Principal 825 Crawford Parkway Portsmouth, VA 23704 (757) 391-6675 (757) 391-6651(fax)	Emotional Disturbance Hearing Impairment Mental Retardation Specific Learning Disability Speech / Language Impairment *Maximum Capacity: 70* *Grades: K – 12* *Ages: 4 – 21*

SCHOOL	DISABILITY CATEGORY(IES)
DIFFERENT DRUM Mr. Steve Brown Director 4451 Brookfield Corporate Drive Suite 201 Chantilly, VA 22021 (703) 802-2866 (703) 802-2196 (fax)	Emotional Disturbance Specific Learning Disability *Maximum Capacity:* 25 *Grades:* 9 – 12 *Ages:* 14 – 21
DOMINION SCHOOL (THE) Ms. Debra K. Pell Director 5410 Port Royal Road Springfield, VA 22151-2301 (703) 321-9091 (703) 321-9017 (fax)	Emotional Disturbance Specific Learning Disability *Maximum Capacity:* 25 *Grades:* 9 – 12 *Ages:* 14 – 21
EAST END ACADEMY Ms. Ruby Gilliam Director 610 31st Street Newport News, VA 23607 (757) 247-0039 (757) 247-0158 (fax)	Emotional Disturbance Mental Retardation Specific Learning Disability *Maximum Capacity:* 60 *Grades:* 1 – 12 *Ages:* 7 – 20
EDUCATIONAL DEVELOPMENT CENTER Ms. Etna G. Carr Executive Director P.O. Box 25517 Richmond, VA 23260 (804) 228-2600 (804) 228-1606 (fax)	Emotional Disturbance Multiple Disabilities Other Health Impairment(s) *Maximum Capacity:* 125 *Grades:* K – 12 *Ages:* 5 – 22
ELK HILL – HARAMBEE Mr. Ron Spears Director of Community Base Services P.O. Box 99 Goochland, VA 23063 (804) 457-4866 (804) 457-2830 (fax)	Emotional Disturbance Specific Learning Disability *Maximum Capacity:* 50 *Grades:* 6 – 12 *Ages:* 11 – 17

SCHOOL	DISABILITY CATEGORY(IES)
ELK HILL FARM – VARINA Ms. Heather Marchessault Principal 8151 Warriner Road Richmond, VA 23231 (804) 795-7392 (804) 795-1983 (fax)	Emotional Disturbance Specific Learning Disability *Maximum Capacity:* 60 *Grades:* 5 – 12 *Ages:* 11 – 18
FOUNDATION SCHOOL OF ALEXANDRIA (THE) Ms. Denese Lombardi Director 25 South Quaker Lane Alexandria, VA 22314 (703) 212-2090 (703) 212-0465 (fax) Email: dlombardi@fs-dms.org	Emotional Disturbance *Maximum Capacity:* 80 *Grades:* 6 – 12 *Ages:* 12 – 21
GRAYDON MANOR Mr. Russ W. Nelson, Director 152 Enterprise Street Sterling, VA 20164 (703) 430-0176 (703) 430-0651 Email: rwnelson53@aol.com	Emotional Disturbance Mental Retardation Specific Learning Disability *Maximum Capacity:* 30 *Grades:* 6 – 12 *Ages:* 11 – 18
KELLAR SCHOOL (THE) Ms. Judith Lemke Education Director 10396 Democracy Lane Fairfax, VA 22030 (703) 218-8500 (703) 359-0463 (fax)	Emotional Disturbance *Maximum Capacity:* 56 *Grades:* 4 – 12 *Ages:* 9 – 22
LAFAYETTE SCHOOL Ms. Elizabeth Irwin Administrator 3020 Fontaine Avenue Extended Charlottesville, VA 22901 (804) 971-8636 (804) 977-8529 (fax) Email: lafayette@netscape.net	Emotional Disturbance *Maximum Capacity:* 25 *Grades:* 3 – 12 *Ages:* 7 – 18

SCHOOL	DISABILITY CATEGORY(IES)
LEARY SCHOOL Mr. Eugene F. Meale Director 6349 Lincolnia Road Alexandria, VA 22312 (703) 941-8150 (703) 941-4237 Email: learyschool@bellatlantic.net	Emotional Disturbance Specific Learning Disability Mental Retardation *Maximum Capacity: 135* *Grades: 1 – 12* *Ages: 6 – 21*
MATTHEW'S CENTER FOR VISUAL LEARNING Ms. Laurie Heilman President 10535 Knollwood Drive Manassas, VA 20111 (703) 369-3476 (703) 369-2976 (fax) Email: WWW.matthewscenter.org	Autism Mental Retardation Speech / Language Impairment *Maximum Capacity: 12* *Grades: Ungraded* *Ages: 3 – 14*
METROPOLITAN DAY SCHOOL Mr. Purcell C. Branch, Jr. Director 2824 North Avenue Richmond, VA 23222 (804) 321-2777 (804) 321-6029 (fax) Email: www.metropolitandayschool.com	Emotional Disturbance Specific Learning Disability *Maximum Capacity: 70* *Grades: K – 12* *Ages: 5 – 18*
MINNICK EDUCATION CENTER Mr. Anthony M. Walker Coordinator P.O. Box 905 Kime Lane Salem, VA 24153 (540) 389-8646 (540) 389-7623 (fax) Email: minnick@lfsva.org	Emotional Disturbance Other Health Impairment(s) *Maximum Capacity: 60* *Grades: K – 12* *Ages: 5 – 17*
MINNICK EDUCATION CENTER - RADFORD Mr. Gary W. Wilburn Director Route 11 West 7516 Lee Highway Radford, VA 24141 (540) 731-4094 (fax) Email:	Emotional Disturbance Other Health Impairment(s) *Maximum Capacity 30* *Grades: K – 12* *Ages: 5 – 17*

SCHOOL	DISABILITY CATEGORY(IES)
MINNICK EDUCATION CENTER WYTHEVILLE Gary W. Wilburn Director 425 Grayson Road Wytheville, VA 24382 (540) 228-8088 (540) 228-9087 (fax) Email:	Emotional Disturbance Other Health Impairment(s) *Maximum Capacity:* *30* *Grades:* *K – 12* *Ages:* *5 – 17*
MORRISON SCHOOL Dr. Sharon Morrison Director 139 Terrace Drive Bristol, VA 24201 (540) 669-2823 Email: sch.vizz@aol.com	Specific Learning Disability *Maximum Capacity:* *50* *Grades:* *1 – 12* *Ages:* *6 – 18*
NEW COMMUNITY (THE) Ms. Julia Ann Greenwood Headmistress 4211 Hermitage Road Richmond, VA 23224 (804) 266-2494 (804) 264-3281(fax)	Specific Learning Disability *Maximum Capacity:* *82* *Grades:* *6 – 12* *Ages:* *12 – 18*
NEW VISTAS SCHOOL Ms. Lucy G. Ross Director 520 Eldon Street Lynchburg, VA 24501 (804) 747-1003 (804) 747-1116 (fax)	Emotional Disturbance Other Health Impairment(s) Specific Learning Disability Traumatic Brain Injury *Maximum Capacity:* *52* *Grades:* *1 – 12* *Ages:* *6 – 18*
NORTHSTAR ACADEMY Mrs. Candace David Director 8055 Shrader Road Richmond, VA 23229 (804) 747-1003 (804) 747-1116 (fax)	Other Health Impairment(s) Specific Learning Disability *Maximum Capacity:* *56* *Grades:* *1 – 10* *Ages:* *6 – 17*

SCHOOL	DISABILITY CATEGORY(IES)
OAK VALLEY CENTER, INC. Dr. Jaren Van Den Heuvel Administrator 3953 Pender Drive, Suite 106 Fairfax, VA 22030 (703) 591-1146 (703) 591-1148 (fax) Email: oakval@kscais.com	Emotional Disturbance Specific Learning Disability *Maximum Capacity:* 60 *Grades:* 2 – 12 *Ages:* 7 – 21
OAKWOOD SCHOOL / CHILDREN'S ACHIEVEMENT CENTER Mr. Robert C. McIntyre Director 7210 Braddock Road Annandale, VA 22003 (703) 941-5788 (703) 941-4186 (fax) Email: oakmc@cs.com	English as a Second Language Specific Learning Disability *Maximum Capacity:* 110 *Grades:* 1 – 9 *Ages:* 6 – 14
PALADIN ACADEMY Ms. Rita Taylor Director 3753 Centerview Drive Chantilly, VA 20151 (703) 397-0520 (703) 397-0522 Email: rntl@erols.com	Specific Learning Disability Other Health Impairment(s) *Maximum Capacity:* 110 *Grades:* 1 – 9 *Ages:* 6 – 14
PHILLIPS SCHOOL FOR COMPTEMPORARY EDCUATION Dr. Sally Sibley Administrative Director 7010 Braddock Road Annandale, VA 22003 (703) 941-8810 (703) 658-2378 (fax) Email: sce97@erols.com	Autism Emotional Disturbance Mental Retardation Multiple Disabilities Specific Learning Disability *Maximum Capacity:* 130 *Grades:* Ungraded *Ages:* 6 – 21
POPLAR SPRINGS ACADEMY Mr. Brenden Folmer Director 350 Poplar Drive Petersburg, VA 23805 (804) 748-7490 ext. # 287 (804) 861-5625 (fax) Email: poplarsprings@aol.com	Emotional Disturbance Other Health Impairment(s) Specific Learning Disability *Maximum Capacity:* 20 *Grades:* 5 – 12 *Ages:* 11 – 17

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SCHOOL	DISABILITY CATEGORY(IES)
PYGMALION SCHOOL Ms. Carol Guzewiz Director 1104 North Augusta Street Staunton, VA (540) 886-2777	Emotional Disturbance Mental Retardation Specific Learning Disability *Maximum Capacity: 20* *Grades: K – 12* *Ages: 6 – 18*
RIVERMONT SCHOOL – CHASE CITY Ms. Elizabeth Allen Coordinator 121 East 2nd Street Chase City, VA 23924 (804) 372-3303 (804) 372-3199 (fax) Email: liz.allen@centrahealth.com	Emotional Disturbance Mental Retardation Other Health Impairment(s) Specific Learning Disability Traumatic Brain Injury *Maximum Capacity: 30* *Grades: K – 12* *Ages: 6 – 17*
RIVERMONT SCHOOL – CHATHAM Ms. Beth Ackerman Coordinator 101 Climax Elementary Circle Chatham, VA 24531 (804) 432-0335 (804) 432-0548 (fax) Email: beth.ackerman@centrahealth.com	Emotional Disturbance Mental Retardation Other Health Impairment(s) Specific Learning Disability Traumatic Brain Injury *Maximum Capacity: 30* *Grades: K – 12* *Ages: 6 – 17*
RIVERMONT SCHOOL – LYNCHBURG Mr. Jim Gallagher Coordinator 3024 Forest Hills Circle Lynchburg, VA 24501 (804) 947-4697 (804) 947-4082 (fax) Email: lloydtannenbaum@centrahealth.com	Emotional Disturbance Mental Retardation Other Health Impairment(s) Specific Learning Disability Traumatic Brain Injury *Maximum Capacity: 30* *Grades: K – 12* *Ages: 6 – 19*
RIVERMONT SCHOOL – ROANOKE Ms. Jennifer Younger Coordinator 3743 Challenger Avenue Roanoke, VA 20412 (540) 977-3400 (540) 977-5298 (fax) Email: jennifer.younger@centrahealth.com	Emotional Disturbance Mental Retardation Other Health Impairment(s) Specific Learning Disability Traumatic Brain Injury *Maximum Capacity: 40* *Grades: K – 12* *Ages: 5 – 21*

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SCHOOL	DISABILITY CATEGORY(IES)
RIVERSIDE SCHOOL, INC. Ms. Julie Wingfield Director 2110 McRae Road P.O. Box 3533 Richmond, VA 23235 (804) 320-3465 (804) 320-6146 (fax) Email: riverside@cstone.net	Specific Learning Disability *Maximum Capacity: 51* *Grades: 1 – 8* *Ages: 6 – 14*
ROANOKE MONTESSORI SCHOOL Ms. Novella Thompson Director 3379 Colonial Avenue, S. W. Roanoke, VA 24018 (540) 989-3739 (540) 989-3035 (fax)	Specific Learning Disability *Maximum Capacity: 90* *Grades: Pre K – 4* *Ages: 2 ½ - 10*
SAINT COLETTA SCHOOL Ms. Sharon B. Raimo Executive Director 207 South Peyton Street Alexandria, VA 22314 (703) 683-3686 (703) 683-9888 (fax) Email: sraimo@stcoletta.org	Autism Mental Retardation *Maximum Capacity: 150* *Grades: Ungraded* *Ages: 5 – 22*
SETON CENTERS Ms. Mary K. Doherty Executive Director 115 Hillwood Avenue Falls Church, VA 22046 (703) 533-7670 (703) 533-7678 (fax) Email: stnctr@erols.com	Specific Learning Disability *Maximum Capacity: 120* *Grades: 1 – 12* *Ages: 6 – 18*

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SCHOOL	DISABILITY CATEGORY(IES)
SHENANDOAH AUTISM CENTER Ms. Wanda Taliaferro Executive Director 371 Linden Drive Staunton, VA 24401 (540) 213-0309	Autism *Maximum Capacity:* 10 *Grades:* *Ungraded* *Ages:* 2 – 18
SNOWDEN ACADEMY Ms. Nancy Van Valkenberg Director 1200 Sam Perry Boulevard Fredericksburg, VA 22401 (540) 372-3900 (540) 372-3918 (fax) Email: nvanvalk@medicorpihn.com	Developmentally Delayed Emotional Disturbance Mental Retardation Other Health Impairment(s) Specific Learning Disability *Maximum Capacity:* 30 *Grades:* K- 12 *Ages:* 6 – 22
SOMERVILLE EDUCATION SERVICES Kathleen FitzSimmons Chief Administrator 11127 Marsh Road Bealton, VA 22712 (540) 788-4610 (540) 788-4621 (fax)	Seriously Emotionally Disturbed Specific Learning Disability *Maximum Capacity:* 8 *Grades:* 6 – 12 *Ages:* 11 - 18
STAR CENTER (THE) Ms. Andrea Canova Director P.O. Box 801 Fredericksburg, VA 22404 (540) 372-6710 (540) 373-1791 (Fax) Email: acanova@eri-va.com	Emotional Disturbance Specific Learning Disability *Maximum Capacity:* 30 *Grades:* 7 – 12 *Ages:* 12 – 21
VIRGINIA INSTITUTE OF AUTISM Ms. Erika Drescher Administrator 517 Park Street Charlottesville, VA 22902 (804) 923-8252 (804) 923-8566 (fax) Email: via@cstone.net	Autism Developmentally Delayed *Maximum Capacity:* 12 *Grades:* *Preschool – Elementary* *Ages:* 2 – 12

SCHOOL	DISABILITY CATEGORY(IES)
WHITE OAK SCHOOL Ms. Nancy J. Martin Administrator 7180 US Highway # 29N Blairs, VA 24527 (804) 836-6472 (804) 836-6473 (804) 836-8293 (fax) Email: whiteoak@gamewood.net	Developmentally Delayed Emotional Disturbance Mental Retardation Multi – Handicapped Other Health Impairment(s) Specific Learning Disability Traumatic Brain Injury *Maximum Capacity:* 40 *Grades:* K – 12 *Ages:* 5 – 22
WHITE OAK SCHOOL MARTINSVILLE BRANCH Ms. Janet Martinez Program Manager P.O. Box 836 Fieldale, VA 24089 (540) 634-0350(51) (540) 634-1453 (fax) Email: whiteoak@kimbanet.com	Developmentally Delayed Emotional Disturbance Mental Retardation Multi – Handicapped Other Health Impairment(s) Specific Learning Disability Traumatic Brain Injury *Maximum Capacity:* 40 *Grades:* K – 12 *Ages:* 5 – 22
WOODSIDE ACADEMY Ms. Annikken Vittorini Director 17579 Warwick Boulevard Newport News, VA 23603 (757) 888-0400 1-800-697-0999 ext. # 265 (757) 888-2167 (fax)	Emotional Disturbance *Maximum Capacity:* 55 *Grades:* Ungraded *Ages:* 10 – 17