An Integrated Policy and Plan to Provide and Improve Access to Mental Health, Mental Retardation and Substance Abuse Services for Children, Adolescents and Their Families (Budget Item 330-F, 2004 Appropriations Act) July 1, 2003 -- June 30, 2004

To the Governor and Chairman of The House Appropriations and Senate Finance Committees of the General Assembly

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EXECUTIVE SUMMARY

Background

In June 2003, the Department of Mental Health, Mental Retardation and Substance Abuse Services submitted a report of *A Policy and Plan to Provide and Improve Access to Mental Health and Substance Abuse Services to Children, Adolescents and Their Families* to the Chairman of the Senate Finance and House of Appropriations Committees. This report satisfied the legislative intent of the budget language contained in 329-G and the report delineates the recommendations to improve access to mental health, mental retardation and substance abuse services for children and their families. The report includes eight recommendations to address unmet service needs, funding, infrastructure and system issues as well as recommendations for improvement including analysis of the Comprehensive Services Act (CSA) and recommendations related to systems improvement to address unmet need in rural communities.

This report identifies the status of the eight recommendations made in June 2003 and recommendations for next state fiscal year. The budget language for 2004 is included in budget item 330-F from the 2004 General Assembly Session. The current budget language:

> "The Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS), the Department of Medical Assistance Services (DMAS), and the Department of Juvenile Justice Services (DJJ), in cooperation with the Office of Comprehensive Services (OCS), Community Services Boards (CSBs), Courts Service Units (CSUs) and representatives from community policy and management teams representing various regions of the Commonwealth, shall develop an integrated policy and plan, including the necessary legislation and budget amendments, to provide and improve access by children, including juvenile offenders, to mental health, substance abuse, and mental retardation services. The plan shall identify the services needed by children, the costs and sources of the funding for the services, the strengths and weaknesses of the current services delivery system and administrative structure, and recommendations for the improvement. The plan shall examine funding restrictions of the Comprehensive Services Act which impede rural localities from developing local programs for children who are often referred to private and residential treatment facilities for services and make recommendations regarding how rural localities can improve prevention, intervention, and treatment for high-risk children and families, with the goal of broadening treatment options and improving quality and costs effectiveness. The Department of Mental Health, Mental Retardation, and Substance Abuse Services shall report the plan to the Chairmen of the Senate Finance and House Appropriations Committees by June 30th of each year".

Recognizing the current budgetary situation, the recommendations contained within this report are designed to lay the groundwork for future action and to promote awareness of the need for continued support of children's issues by legislators and key policy and decision makers. This report details DMHMRSAS activities for 2003-2004

related to the 329-G recommendations to provide and improve access by children and their families to mental health, mental retardation and substance abuse services and includes recommendations and work plan activities for the 2004-2005 fiscal year.

Implementation Plan for the Recommendations

Workgroup members were committed to ensuring broad support for moving forward in the direction of improving access to services for children and their families across disabilities and approved activities for implementing the final recommendations contained in the 2003 report. The workgroup endorsed the goal of moving from a concept to actuality the service needs of children and adolescents with mental health, mental retardation and substance abuse issues and their families would be met.

The workgroup recommended appointing an advisory group to the Department's Office of Child and Family Services and that the Office develop a work plan consistent with the recommendations of the 2003 report. They suggested the advisory group be in place no later than the first quarter of State Fiscal Year 2004 and implementation activities begin in the second quarter of State Fiscal Year 2004 and continue forward as appropriate.

For the development of the 2004 Report, the Department organized a steering committee comprised of existing 329-G work group members to review and develop plans for the 330-F budget item report. Membership of the 329-G work group included child-serving state agencies such as the DMHMRSAS, the Department of Juvenile Justice (DJJ), the Department of Social Services (DSS), the Department of Criminal Justice Services (DCJS), the Department of Education (DOE), the Commission on Youth (COY), and the Virginia Supreme Court. This group also included representation from Voices for Virginia's Children, local community service boards, community policy and management teams, family assessment and planning teams, and a parent representative.

The steering committee held two meetings to address the recommendations for the 330-F, the Policy and Plan to Provide and Improve Services to Children with Mental Health, Mental Retardation and Substance Abuse Services. Two meetings were held in the fourth quarter of the 2003 fiscal year, May 25, 2005 and June 17, 2004, respectively to review the status of the actions of the Department since the last report and to suggest strategies for developing recommendations for the next plan.

A variety of strategic planning activities have been initiated by the Department to develop and recommend strategic directions for restructuring the system of care for redirecting existing system resources and aligning the system of care with the vision of a community based system of care. The Child and Adolescent Special Populations Workgroup of the Department's Restructuring Advisory Committee convened by the Commissioner included a majority of the representatives of the former 329-G workgroup. This group met from August 2003 to August 2004. This group was asked to develop sets of short-term and long-term recommendations on how mental health, mental retardation and substance abuse services for your and their families might be strengthened. The Child and Adolescent Special Populations Workgroup recommendations include developing and promoting a vision of integrated child and family services statewide,

integration of services across disciplines, development of new services, primary prevention and early intervention, statewide cross training across disciplines, etc. The Child and Adolescent Special Population Workgroup endorsed the work of the 329-G workgroup and the steering committee, in turn proposed including many of the recommendations of the Child and Adolescent Special Population Workgroup into planning and implementation activities in accordance with the 330-F budget item.

In addition, the Steering committee determined that the report for FY 2004 should include the actions related to the 2003 report and an update on the eight recommendations and where appropriate, continuation of essential recommendations from the report, a summary of child-related projects of the Department, and the identification of new initiatives and funding recommendations. For a complete listing of participants of the 329-G workgroup, steering committee and the Child and Adolescents Workgroup representatives, please see **Appendix A.**

Recommendations and Status of Recommendations
(For more detailed status information the full report).

Recommendation 1

DMHMRSAS should initiate a budget request to fund an integrated continuum of mental health, mental retardation and substance abuse services for children, adolescents and their families. The budget initiative shall give consideration to the varying geographic needs in Virginia, filling identified gaps, addressing co-occurring disorders and the needs of special populations such as children with early development needs, juvenile offenders, and adolescents in need of transitional services into the adult services system.

Recommendation 2

The DMHMRSAS should initiate a budget request to build an infrastructure of children and adolescents and their families at the community services boards with a determined number of dedicated integrated case managers and mental health clinicians for community service boards/behavioral health authorities.

Recommendation 4A

The DMHMRSAS, in conjunction with Community Services Boards and Behavioral Health Authorities, should request a dedicated pool of flexible funds to be used specifically for program start-up and program development, allocated in a manner that maximizes flexibility in program design and promotes achieving specific outcomes for children, adolescents and their families with mental health, mental retardation and substance abuse needs.

Status of recommendation 1, 2 and 4A: Recommendations 1, 2, and 4A addressed budget requests to be submitted by the Department to the General Assembly for funding. These three recommendations are addressed together. The Department initially developed four budget proposals to increase capacity for children and adolescents in the community.

The intent of the budget request was to provide funding for specialized populations, case managers, and for acquiring and promoting training for child psychiatrists in the state.

The outcome of the Governor's biennium proposed budget included $2,000,000, to provide mental health services to children and adolescents by addressing the services needs and building capacity in the community. These funds were ultimately approved by the 2004-2006 biennium budget passed by the 2004 General Assembly. The intent of this appropriation is to finance non-mandated Comprehensive Services Act services (CSA) to build community capacity for the behavioral health needs for children's services. Funds will be allocated to local community services boards.

Recommendation 3

The DMHMRSAS should continue to explore existing resources within state and federal funds to provide statewide training on mental health, mental retardation and substance abuse services and in integrated case management as related to the recommended continuum of mental health, mental retardation and substance abuse services for children, adolescents and their families. All agencies within the Secretariats of Education, Health and Human Resources and Public Safety shall cooperate in the planning and funding of the training.

Status of Recommendation 3: In October 20003, a work group of select state staff of the Department of Mental Health, Mental Department of Health, Department of Social Services and Department of Education, and the Virginia Institute of Social Services Training (VISSTA) at Virginia Commonwealth University were organized to review the Bright Futures materials and to develop a curriculum for the training and education of staff across agencies. Georgetown University, National Technical Assistance Center for Children Mental Health provided technical assistance staff to this work group to assist in developing a Virginia-specific curriculum. The curriculum will be adopted by the Department and used statewide for training case managers and other entry-level staff who work with children.

Recommendation 4B

The DMHMRSAS, in conjunction with Community Service Boards and Behavioral Health Authorities, should establish a cooperative agreement with a state university to evaluate the efficiency of such programs based on terms established by the DMHMRSAS.

Status of Recommendation 4B: No action has been taken on this recommendation. In conjunction with Community Services Boards and Behavioral Health Authorities, meetings will be planned to implement this recommendation in 2005.

Recommendation 5

DMHMRSAS should continue to support the integrated Office of Child and Family Services in the Division of Community Support Services. This Office shall provide

leadership for child and family issues on a statewide basis through coordination of services delivery and integration of disability service systems, with the goal of improving access to mental health, mental retardation and substance abuse services for children, adolescents and families in Virginia.

Status of Recommendation 5: This was a significant recommendation of the 2003 report that the Department has successfully implemented. The Department's Office of Child and Family Services was established April 2004. This office provides leadership and direction in developing a seamless system of care that integrates services across disciplines. This involves partnering with stakeholders working to improve services for children, developing policies that promote children and family services, addressing gaps in existing services, developing new services using evidence based practices and expanding existing evidenced based models, increasing family involvement on committees, councils, task forces, addressing children's issues, and increasing family involvement on committees, council, task forces addressing children's issues and increasing funding for children services increasing funding for children services**.**

Recommendation 6

The Office of Child and Family Services, DMHMRSAS should organize and support a state advisory committee composed of families of children with mental health, mental retardation and substance abuse services, children's services representatives of state agencies representing a system of care, representatives of services program organizations, private providers and advocacy organizations.

Status of recommendation 6: Currently, several groups are involved in children's services including but not limited to the 330-F workgroup, the Child and Adolescent Special Populations Workgroup, the Child and Adolescent Task Force and other parents who may or may not have affiliation with any of these groups. Consistent with the recommendations of the 329-G workgroup to form a statewide advisory group and to involve and build links to parents, the Department will establish an advisory group that is responsible for promoting services for children and to support activities that improve services to children. Representatives from groups representative of children's interests will be invited to participate on this advisory group.

Recommendation 7

DMHMRSAS should seek ways to build and link the network of parents of children and adolescents with mental health, mental retardation and substance abuse service needs.

Status of Recommendation 7: No action was taken on this recommendation during fiscal year 2003. Currently the Department has several contracts with organizations to provide family support services to parents of children with mental health and mental retardation disabilities. During 2004, the Department plans to assess existing resources available to parent organizations to determine how best to build and link the network of families with children who require or receive mental health, mental retardation and substance abuse services.

Recommendation 8

DMHMRSAS should create, publish and fund an interactive website to be used as a resource for children, adolescents and families to enable improved access to mental health, mental retardation and substance abuse services, providers, educational resources and supports.

Status of Recommendation 8: The Department expects to continue publishing relevant information about mental health, mental retardation and substance abuse services and links to educational resources and supports for families and providers on its web site. Additional activities planned for 2004-2005 include strengthening partnerships with universities to explore training for child and adolescent service providers, professional development for clinicians trained in child and adolescent mental health, and to explore developing interactive, web based curriculum to meet the training needs of diverse regions statewide.

A Policy and Plan to Provide and Improve Access to Mental Health, Mental Retardation and Substance Abuse Services for Children, Adolescents and Their Families

INTRODUCTION

This *2003-2004 Report on the Integrated Policy and Plan to Provide and Improve Access to Mental Health, Mental Retardation and Substance Abuse Services for Children and Adolescents* provides a progress report on the *DMHMRSAS Report on the Integrated Policy and Plan to Provide and Improve Access to Mental Health, Mental Retardation and Substance Abuse Services for Children and Adolescents* submitted in 2002, and additional information on the progress toward the development of the "329-G Policy and Plan" and recommendations. The information contained in this report will detail the activities, issues, findings, and background of the proposed recommendations of the 329-G Planning Group and associated workgroups for the FY 2003-2004 State Fiscal Year.

Since the implementation of the Comprehensive Services Act in 1993, children's issues have been studied and researched extensively from a variety of perspectives in Virginia, and recommendations have been made to the General Assembly related to improving services for children in many of the resulting research studies and documents. Many of these reports were reviewed and referenced during the development of House Document 23, *Final Report of the Commission On Youth: Youth with Emotional Disturbance Requiring Out-of-Home Treatment.* For your information and review, listed in **Appendix B** are the 20 reports in House Document 23 (HD 23) by reference, with the major outcomes and issues highlighted.

Themes and issues in the documents referenced for HD 23 were consistent with those themes and issues that were brought into discussions during the 329-G Planning Group and workgroup meetings. Some selected main themes related to Budget Item 329-G were:

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

Since September of 2000 (and the printing of House Document 23), there have been additional related studies completed, with recommendations that the 329-G Planning Group and workgroups found helpful in developing the recommendations in this report. Those most recent studies are listed below.

YEAR

2002	*Studying Treatment Options for Offenders Who Have Mental Illness or Substance Abuse Disorders* (HJR142/SJ97 Final Report: Senate Document 25, 2002 General Assembly Session) Joint Commission on Behavioral Healthcare, Virginia Crime Commission and the Virginia Commission on Youth
2002	*A Plan for Improving Services and Containing Costs in the Treatment and Care of Children Under the Comprehensive Services Act for At-Risk Youth and Families*, Secretary of Health and Human Resources

The depth and breadth of research and information gathering over the past years related to CSA and children's issues in general provided a solid foundation on which 329-G activities could take place. These studies and reports provided a wealth of information on historical developments, geographic and population need, costs of implementation of services and systemic considerations relevant to the 329-G Policy and Plan.

WORKPLAN DEVELOPMENT AND ACTIVITIES TO DATE

329-G Planning Group

In order to "provide and improve" access to children services, the Department needed to know what access issues existed in Virginia, and develop recommendations that would address these access issues comprehensively. To accomplish this goal, the 329-G Planning Group wanted to gain consensus by initially exploring what an "ideal" system of mental health, mental retardation and substance abuse services for children, adolescents and their families would entail.

A major product of the meeting was the group's identification of the "characteristics of integrated system for children". The 329-G Planning Group then prioritized areas to work on during the next year. Those areas identified as priority were (highest priority items listed first):

- Restructuring/Rebuilding the system
- Funding issues
- Service needs
- Gaining buy-in from others
- Advocacy for mental health issues
- Education of legislators and others on the need
- Child and family involvement

Following this meeting, the DMHMRSAS created a crosswalk of the characteristics of an integrated system for children and families, by the identified focus areas.

National attention is directed toward school-readiness and children's well-being and research supports early identification and intervention enhances the likelihood of positive outcomes for children with emotional disturbances. Virginia is on the threshold of a turning point to address the services needs of our children. The State Executive Council of the Comprehensive Services Act has endorsed a new position for the Office of Comprehensive Services to provide leadership for the programmatic needs of CSA and seeking to hire staff to provide clinical program leadership of the program. CSA has initiated data collection to document the multiple mental health diagnoses of the 16,000 children they serve. The Commission on Youth developed a Collection of Evidence Based Practices of Effective Treatment Modalities for Children and Adolescents. The Department's Child and Adolescent Workgroup identified recommendations to restructure mental health, mental retardation and substance abuse services to improve the behavioral health system of care for children and their families.

The *2004 Report on the Integrated Policy and Plan to Provide and Improve Access to Mental Health, Mental Retardation and Substance Abuse Services for Children and Adolescents* includes a review and status report of the 2003 recommendations, the activities of the Department to develop and recommend strategic directions for restructuring the system of care and proposed recommendations for State Fiscal Year 2005-2006.

Process

The 2003 *Policy and Plan to Provide and Improve Access to Mental Health, Mental Retardation and Substance Abuse Services* recommended that the 329-G planning group assume an advisory role to the Department on children's issues. The 2003 329-G work group included child-serving state agencies such as the DMHMRSAS, the Department of Juvenile Justice (DJJ), the Department of Social Services (DSS), the Department of Criminal Justice Services (DCJS), the Department of Education (DOE), the Commission on Youth (COY), and the Virginia Supreme Court. This group also included representation from Voices for Virginia's Children, local community service boards, community policy and management teams, family assessment and planning teams, and a parent representative. For a complete listing of participants of the steering committee and the Child and Adolescents Workgroup representatives, please see **(Appendix C)**.

The Department convened a steering committee comprised of the 2003 329-G work group members to review and develop plans for the 330-F budget item. The steering committee held two meetings to address the recommendations for 330-F, *The Policy and Plan to Improve Access to Mental Health, Mental* Retardation *and Substance Abuse Services*. Meetings were held on May 25 and June 17, 2004 respectively to review and discuss the status of the actions of the Department on the 2003 recommendations and to suggest strategies for the development of recommendations for the next plan. The steering committee proposed the recommendations of the Child and Adolescent Special Population Workgroup of the Department's Restructuring and Reinvestment Committee is included in this report. The Child and Adolescent Special Population workgroup included a majority of the representatives of the former 329-G workgroup and the Child

and Adolescent Special Population Workgroup supported and endorsed the work of the FY 2003 329-G work group.

In addition, the Steering committee determined that the report for FY 2004 include a status report of the actions related to the 2003 recommendations and continuation of essential recommendations, a summary of child-related projects, identification of new initiatives of the Department and funding recommendations.

Full Report of the Status of 2003 Recommendations:
(For the reporting period July 1, 2003 through June 30, 2004

Recommendation 1

DMHMRSAS should initiate a budget request to fund an integrated continuum of mental health, mental retardation and substance abuse services for children, adolescents and their families. The budget initiative shall give consideration to the varying geographic needs in Virginia, filling identified gaps, addressing co-occurring disorders and the needs of special populations such as children with early development needs, young juvenile sex offenders, and adolescents in need of transitional services into the adult services system.

Recommendation 2

The DMHMRSAS should initiate a budget request to fund a determined number of dedicated integrated case managers for children and families all community service boards/behavioral health authorities.

Recommendation 4A

A. The DMHMRSAS, in conjunction with Community Service Boards and Behavioral Health Authorities, should request a dedicated pool of flexible funds to be used specifically for program start-ups and program development, allocated in a manner that maximizes flexibility in program design and promotes achieving specific outcomes for children, adolescents and their families with mental health, mental retardation and substance abuse needs.

Recommendations 1, 2 and 4A addressed budget proposals request to be submitted by the Department to the General Assembly for funding. These recommendations are addressed together. The Department initially developed four budget proposals to increase capacity for services for children and adolescents in the community. The intent was to provide funding for specialized populations, case managers, and for acquiring and promoting training for child psychiatrists in the State. (These budget proposals are consistent with recommendations from the Child and Adolescent Special Population Workgroup.)

The first proposal would provide specialized services to children and adolescents to improve their functioning at home, in school and in the community. Total funding for this budget item included $9.15 million. These funds targeted specialized services to populations including: children and adolescents with or at risk of serious emotional or behavior problems, children and adolescent offenders with mental illness and/or substance abuse involved in the criminal justice system, youth with co-occurring mental illness and mental retardation and at-risk of hospitalization or who are hospitalized in state facilities, youth age 14-21 requiring transition services and supports from special education to adult living. Local community services boards would provide services and funding could be used for startup for new program development or building capacity. Funding could also be used as match for state, federal or private grants. In addition, salary and fringe benefits for one FTE staff position was included for Central Office to coordinate program development, provide technical assistance, and to monitor program implementation.

The second budget recommendation was for funding of case managers at local community services boards. The intent is a single case manager for ensuring individualized services and supports, cross-agency care coordination, linkages to community supports and resources. The funding would ensure capacity building for children's services and ensure access to necessary mental health, mental retardation and substance abuse services.

The third proposal involved funding for board-eligible or certified psychiatrists to provide psychiatric assessments, evaluations and treatment to children and adolescents with severe mental health or behavioral problems. The psychiatrists would be available at all 40 community services boards. The availability of psychiatric services would permit seriously emotionally disturbed children and adolescents to remain in their homes and communities, rather than placed out-of-home or out-of-community settings for treatment. The budget recommendation included $ 8.0 million based on 40 psychiatrists at $200,000 each including salary and fringe benefits.

The third proposal would increase the number of board-certified child psychiatrists and doctoral psychologists specializing in serving children in Virginia. Through this initiative, child psychiatry fellows and doctoral interns in clinical psychiatry and psychology will be established at the Commonwealth Center for Children and Adolescents and the Southwestern Virginia Mental Health Institute. This proposal will ultimately increase the number of board or certified child psychiatrists in Virginia. The proposal will establish and support child psychiatry fellows and doctoral interns in clinical psychiatry and psychology at the Commonwealth Center for Children and the Southwestern Virginia Mental Health Institute. This proposal will broaden the training experiences of psychiatrists and psychologists to include direct experiences with children and adolescents having mental illnesses served with public funds. This proposal will strengthen relationships among state facilities and universities with psychiatry and clinical psychology programs.

The Governor's biennium proposed budget included $2,000,000, which merged recommendations 1 and 2 to provide mental health services to children and adolescents by

addressing the services needs and building capacity in the community. These funds were ultimately approved by the 2004-2006 biennium budget passed by the 2004 General Assembly. The intent of this appropriation is to finance non-mandated Comprehensive Services Act services (CSA) to build community capacity for children's services. Funds will be allocated to local community services boards.

Recommendation 3

The DMHMRSAS should explore existing resources within state and federal funds to provide statewide training on mental health, mental retardation and substance abuse services and in integrated case management as related to the recommended continuum of mental health, mental retardation and substance abuse services for children, adolescents and their families. All agencies within the Secretariats of Education, Health and Human Resources and Public Safety shall cooperate in the planning and funding of the training.

In the October 2003, Department staff consulted with the National Technical Assistance Center for Children's Mental Health at Georgetown University Center for Child and Human Development about models of successful evidence-based practices and evaluation and assessment state-of the art tools for assessments of the mental health needs of children. The Georgetown Technical Assistance Center identified a well known national initiative entitled *Bright Futures.* The curriculum and training materials of this initiative promote health and well being of infants, children and adolescents. A set of materials that includes, A Mental Health Practice Guide and Mental Health Tool Kit contain child development and mental health information for the emotional-social stages of child development from birth to adolescence. These materials are geared toward educators and health professionals, including non-clinical behavior health professions and community services work, and promote partnerships between health professionals, families and members of the community.

In October, a work group of select state staff of the Department of Mental Health, Mental Department of Health, Department of Social Services and Department of Education, and the Virginia Institute of Social Services Training (VISSTA) at Virginia Commonwealth University were organized to review the Bright Futures materials and to develop a curriculum for the training and education of staff across agencies. Georgetown University, National Technical Assistance Center for Children's Mental Health provided technical assistance staff to this work group to assist in developing a Virginia-specific curriculum. The work group completed the curriculum by June 2004 and planned three pilots of the curriculum with school nurses, substance abuse case managers, and case managers from Social Services and Community Services Boards in the July and August 2004. State staff identified and used existing resources to develop and provide training to about 90 participants from schools; community services boards, and social services agencies. Workgroup members from the Department of Mental Health, Mental Retardation and Substance Abuse Services, Social Services and Health were trainers for the curriculum. DMHMRSAS and Health Department staff served as trainers for all three pilots.

A special training was planned for social services workers and case managers at community services boards in August 2004. Participants received Bright *Futures* materials, which included the Mental Health Guide and Mental Health Took Kit. Participants also received a listing of Child Development Clinics, Community Services Boards, Health Departments and Social Services Agencies.

All three pilots were evaluated using evaluation forms and feedback gathered at the end of the training. Responses gathered from participants point to the *Bright Futures* materials were very helpful in providing assessment instruments and materials to understand the developmental and mental health needs of children and adolescents. About eighty-five staff has been trained on the curriculum. Georgetown University in the process of evaluating first two pilots for the substance abuse and school nurses using feedback from the training sessions and written evaluations of participants. The Department anticipates that the Georgetown University evaluation results will be available in the fall. The workgroup plans to meet this fall to assess the evaluations and make further recommendation on how to integrate this training into existing cross agency training. This activity is consistent with recommendations from the several committees working on children's issues. The curriculum will be adopted by the Department and used statewide for training case managers and other entry-level staff who work with children.

The 330-F work group members, through active participation on various other state-level workgroups, expressed growing concern about the lack of mental health services for children and identifying strategies to address the developmental and mental health needs of children and adolescents. The work group identified the need for development of a training curriculum to emphasize the early identification of children with mental health concerns. The curriculum would be used to training child-serving staff of all agencies.

The 330-F workgroup identified other state-level work groups that are addressing the child development and the mental health needs of children and adolescents: They are:

- The Child Welfare Advisory Committee of the Department of Social Services. In July 2003 the Administration on Children and Families of the U. S Department of Health and Human Services conducted a review of Virginia's Department of Social Services Office of Child and Family Services. As a result of this federal review, the Child Welfare Advisory Committee was tasked with developing Virginia's Performance Improvement Plan (PIP).
- The Child and Adolescent Special Population Workgroup of the Department's Restructuring and Reinvestment Committee. The Child and Adolescent Special Population workgroup has been involved in strategic planning activities around restructuring the Department's system of care.
- The Safe Families in Recovery Work Group, a work group looking how to provide mental health and substance abuse services to families who abuse or neglect children or families who are before the courts.

- The Virginia Advisory Committee of Juvenile Justice, a work group of the Virginia Department of Criminal Justice Services responsible for recommending needs and priorities for the development and improvement of the juvenile justice systems and for advising the Governor on matters related to the Juvenile Justice and Delinquency Prevention Act (JJDP). This advisory committee makes recommendations to the Criminal Justice Services Boards on two federal JJDP grants.
- The Safe Families in Recovery Work Group, a work group looking how to provide mental health and substance abuse services to families who abuse or neglect children or families who are before the courts.
- The Virginia Advisory Committee of Juvenile Justice, a work group of the Virginia Department of Criminal Justice Services responsible for recommending needs and priorities for the development and improvement of the juvenile justice systems. And for advising the Governor on matters related to the Juvenile Justice and Delinquency Prevention Act (JJDP). This advisory committee makes recommendations to the Criminal Justice Services Boards on two federal JJDP grants.

The Department successfully received a $500,000 grant from the Department of Criminal Justice Services to provide mental health services in five juvenile Detention centers in the state utilizing mental health clinicians and case managers in the five detention centers. The grant provides opportunities for collaboration among five community services boards and five detention centers, providing assessments, case management, crisis intervention, outpatient interventions including psychiatric consultation, limited medications, and interventions. The five community services boards and detention centers are:

Community Services Board	Detention Center
Chesapeake	Tidewater Detention Home
Crossroads	Piedmont Regional Detention Center
Planning District One	Highlands Juvenile Detention Commission
Richmond Behavioral Health Authority	Richmond Juvenile Detention
Valley Community Services Boards	Shenandoah Valley Juvenile Center

Evaluative tools such as the Massachusetts Youth Screening Instrument ensure appropriate services for the children placed at the detention centers. To date 700 juveniles have been evaluated and served.

Recommendation 4

B. DMHMRSAS, in conjunction with Community Service Boards and Behavioral Health Authorities, should establish a cooperative agreement with a

state university to evaluate the efficiency of such programs based on terms established by the DMHMRSAS.

No action has been taken on this recommendation. In conjunction with Community Services Boards and Behavioral Health Authorities, meetings will be planned to implement this recommendation in 2005.

Recommendation 5

DMHMRSAS should establish an integrated organizational unit that merges existing staff providing child, adolescent and family services into one unit. This organizational unit should report to the Assistant Commissioner of Community Services. The unit should provide leadership for child and family issues on a statewide basis through coordination of services delivery and integration of disability service systems, with the goal of improving access to mental health, mental retardation and substance abuse services for children, adolescents and families in Virginia.

This was a significant recommendation of the 2003 report that the Department has successfully implemented. The Department's Office of Child and Family Services is committed to developing a seamless system of care that integrates services across disciplines, partnering with stakeholders working to improve services for children, developing policies that promote children and family services, addressing gaps in existing services, developing new services using evidence based practices and expanding existing evidenced based models, increasing family involvement on committees, councils, task forces, addressing children's issues, and increasing funding for children services.

Of significance to the successful implementation of an integrated unit within the Department to accomplish the intent of the 329-G legislation for leadership for child and family issues on a statewide basis as well as the coordination and integration of services systems with the goal of improving access to mental health, mental retardation and substance abuse services for children, adolescents and families in Virginia, the infrastructure of the Office of Child and Family Services should be looking for expansion of staff and resources. In 2004, the Department applied for a federal grant in the amount of $750,000 from the U.S. Department of Health and Human Services, Office of Substance Abuse and Mental Health Services Administration, Center of Mental Health Services. The Department expects to hear from the U.S. Department of Health and Human Services about whether or not the Department's application has been approved by September 30, 2004.

Recommendation 6

DMHMRSAS should establish a state advisory committee for child and family services to support activities of the organizational unit in Recommendation 5.

Currently, several groups are involved in children's services including but not limited to the 330-F workgroup, the Child and Adolescent Special Populations Workgroup, the Child and Adolescent Task Force and other parents who may or may not have affiliation with any of these groups. Consistent with the recommendations of the 329-G workgroup to form a statewide advisory group and to involve and build links to parents, the Department intends to establish an advisory group that is responsible for promoting services for children and to support activities that improve services to children. Representatives from groups representative of children's interests will be invited to participate on this advisory group.

Recommendation 7

DMHMRSAS should seek ways to build and link the network of parents of children and adolescents with mental health, mental retardation and substance abuse service needs.

No action was taken on this recommendation during fiscal year 2003. Currently the Department has several contracts with organizations to provide family support services to parents of children with mental health and mental retardation disabilities. During 2004, the Department plans to assess existing resources available to parent organizations to determine how best to build and link the network of families with children who require or receive mental health, mental retardation and substance abuse services.

Recommendation 8

DMHMRSAS should create, publish and fund an interactive website to be used as a resource for children, adolescents and families to enable improved access to mental health, mental retardation and substance abuse services, providers, educational resources and supports.

The Department expects to continue publishing relevant information about mental health, mental retardation and substance abuse services and links to educational resources and supports for families and providers on its web site. Additional activities planned for 2004-2005 include strengthening partnerships with universities to explore training for child and adolescent service providers, professional development for clinicians trained in child and adolescent mental health, and to explore developing interactive, web based curriculum to meet the training needs of diverse regions statewide.

ASSOCIATED ACTIVITIES (SFY2004-2005)

Early Intervention

Virginia has been involved in the federal Part C program since its initiation in 1987. While Virginia provided early intervention services prior to implementation of the federal program, participation in Part C has improved the accessibility and quality of services, increased coordination and collaboration among state and local agencies including development of public-private partnerships, expanded services to an increasing

number of children, and provided rights and safeguards to infants and toddlers with disabilities and their families across the Commonwealth. Virginia went into full implementation in 1992 with the understanding and commitment that funding and services would be a shared responsibility among state agencies serving children and that eligible infants and toddlers with disabilities would receive necessary services. The Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS0, lead agency for Part C early intervention services, receives federal funds from the Office of Special Education Programs for the participation of infants and toddlers with disabilities ages 0-3 and their families in the program.

Studies show that infants and toddlers with disabilities who receive appropriate early intervention services have the best opportunities to reach their maximum potential and be functional members of their community. Further, studies show that a significant amount of learning occurs within the first two years of life and this time period is the most critical for a child's growth and development. Early interventional services for infants and toddlers with disabilities results in a 30% savings in future special education costs. Additional cost savings for taxpayers have been documented in public assistance services and other programs. Early intervention services can prevent secondary disabilities and worsening medical conditions and as a result significant future medical cost savings.

In September 2003 a comprehensive cost study was undertaken to collect data to understand the total cost of Virginia's Early Intervention System and to assist DMHMRSAS in determining systems improvements. The study was intended to answer questions related to total cost of the system, how many children should Virginia be serving, average hourly cost of direct services, the ratio of direct services to all other costs, and cost differences related to personnel types. The Cost Study components included a cost survey, salary survey, revenue survey, time survey and demographic analysis.

It was anticipated that during 2004, the early intervention system would have expenditures exceeding available revenues. Additional Part C funds had been made available to local interagency coordinating councils to ensure availability of funds to encourage and support ongoing provider participation and ensure availability of early intervention services for the increasing number of children being identified. The additional funds helped resolve issues such as waiting lists and the Part C system losing providers in Part C in FY 2001-2002 and prevented similar issues in FY 2002-2003.

To address the Part C budget reduction by making proactive efforts to ensure services for all eligible children and their families over the next year, a workgroup comprised of local council coordinators, public and private Part C providers, parents, CSB MR and Executive Directors, and DMHMRSAS staff was convened in order to help identify possible short-term strategies to address the Part C budget reduction. The recommendations of that workgroup reflected the attitude that Virginia's Part C program would not enter 2004-05 thinking in terms of how long the limited Part C funds will last before they run out; rather, the group focused on what will it take and what needs to happen to make those funds last for the full year. To that end, the workgroup made several recommendations including developing policies related to the level of frequency

and intensity of services and what action should be taken to ensure families have access to necessary services, regionalize services whenever possible, etc.

In August 2003 and completed in 2004, the Department of Mental Health, Mental Retardation, convened a group of stakeholders and DMHMRSAS to examine Virginia's Part C system, identify the system's unique strengths and challenges, and make recommendations about infrastructure changes that will improve Virginia's Part C system. In the course of its work, the task force carefully examined administrative, funding and service delivery issues in Virginia's Part C system. Based on their analysis of all aspects of Virginia's Part C system, research into Part C infrastructure issues in 5 other states, and public comment on the draft of this report, the task force makes the following recommendations:

- The Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) will remain the State Lead Agency for Virginia's Part C system.
- The other state agencies involved in Virginia's Part C system will remain involved in the Early Intervention Interagency Management Team and the VICC. They will provide leadership and guidance to their local counterparts.
- In each of the 40 CSB areas, there will be a Local Lead Agency. The Local Lead Agency may be any public agency, as determined by the local Part C system.
- The LICC will advise and assist the Local Lead Agency in implementing the local Part C early intervention system.
- The local participating agencies/providers will carry out the responsibilities outlined in contracts with the Local Lead Agency and/or in local interagency agreements.
- A comprehensive data system will be developed and implemented to manage and monitor Virginia's Part C system.
- A task force will be established to further research and make recommendations related to possible additional economies of scale and efficiencies.
- DMHMRSAS will continue to work with other participating state agencies to identify possible funding assistance for the Part C system from those agencies and to coordinate interagency support for efforts to increase state funding for Part C in the 2006 budget.

Existing funds are insufficient to ensure that all Part C eligible children and families receive necessary entitled early intervention services. While the number of Part C eligible children has increased, funding levels are actually decreasing because some state and local organizations that voluntarily allocated funds to early intervention services are reducing or eliminating budget allocations to early intervention as they stretch their funding to support other services. Without this funding, Part C eligible children will not receive necessary services.

Overall, the growth in the number of children in need of services has consistently averaged 8%, over the last five years. Needs for early intervention have become increasingly well documented during the last years. Substantial reliable data have been provided through the DMHMRSAS Comprehensive State Plan, the Cost Study, and the reports of several committees comprised of Executive Directors, MR Directors, council

coordinators, providers, and families. Consumer needs, costs, and revenue are well defined. The average cost per child served in early intervention is $4,036. Approximately 1/3 of that cost can be reimbursed though an active level of insurance billing.

In 2004, the General Assembly appropriated $750,000 to DMHMRSAS. These funds are restricted for the provision of Part C early intervention services for unserved and underserved children. In spite of the General Assembly 2004 appropriation, Part C has a deficit of $1.25 million for FY 04-05 and this includes the recent increase of Virginia's Federal Part C allocation, which has not kept pace with needs, and the exhaustion of previously available one-time unexpended Federal funds. To keep pace with the need, projections for 2004-05 include additional funding in the amount of $3.5 million and $5.8 million for fiscal year 2005-06. This amounts to a request for $2,690 per eligible child.

Child and Adolescent Mental Health

The membership of the 329-G Planning Group was represented in many activities this reporting period that were had an impact on the provision and improvement of access by children, adolescents and their families to an integrated system of mental health, mental retardation and substance abuse services. The activities listed below (by disability area) fall within the context and scope of this report as they relate to the overall conceptualization of the need to provide and improve access to mental health, mental retardation and substance abuse services for children, adolescents and their families in Virginia.

<u>Reinvestment and Restructuring: Child and Adolescent Special Population Work Group</u>

In July 2003, the Commissioner organized the five special populations workgroups of the Reinvestment and Restructuring Initiative. The purpose of the special populations workgroups was to address the specific short and long-term needs of forensic, geri-psychiatric, mental retardation, mental retardation/mental illness, child/adolescent, and substance abuse populations.

The Child and Adolescent Workgroup began meeting in August 2003 and met fourteen times between August 2003 and July 2004 to make recommendations related to children with mental health, mental retardation and substance abuse services. The work of the 2003 329-G planning group was an important source for guiding the Child and Adolescent special populations group. Membership in these special populations groups included representation from regional partnerships, advocacy groups, consumers, family members, relevant State agencies, public and private providers and other interested parties.

The Child and Adolescent Workgroup recommended that their committee function be incorporated into the 329-G workgroup to reduce duplication of the two workgroups. This work group had four subcommittees:

Demonstration Funding Work Group

Mental Health and Juvenile Justice
Substance Abuse Work Group
Prevention Work Group
Mental Retardation Group

In general, this workgroup recommended the need to enhance behavioral health services in Virginia. Behavioral health services are defined to include mental health, mental retardation and substance abuse services. The steering committee for 329-G activities endorsed the recommendations of the Child and Adolescent Special Population and suggested that the recommendations be incorporated into the FY 2004 plan. The recommendations of the Child and Adolescent Work group were summarized by the Department and are included in **Appendix D**.

Suicide Prevention Services:

Since State Fiscal Year, the Department has directed five objectives of the Youth Suicide Prevention Plan. Theses objectives are:

Objective 1**:** Training: DMHMRSAS will disseminate successful strategies for suicide intervention programming and DMHMRSAS will develop and coordinate statewide suicide crisis intervention, including the expansion of hotline services, and improve collaboration and related interagency communication.

Objective 2: Coordination of activities with the Department of Health and the Commission on Youth to improve the ability of primary care providers to recognize and treat depression, substance abuse and other mental illnesses associated with suicide risk

Objective 3: Develop and Promote Childhood Depression Awareness Day in May (The National Mental health Awareness Month) with accompanying materials.
Objective 4**:** Identifying resources currently available through the community service boards to support families and loved ones of people who commit suicide or attempt suicide.

Objective 5: Develop resources and information links for DMHMRSAS website.

The Department has consistently maintained its efforts to direct the five goals identified above and allocated funds from the General Assembly for this purpose. The Department has implemented a number of activities to achieve the objectives, for example, collaborative training utilizing joint purchasing of resources as well as providing technical assistance and training to the community services boards and interagency planning and collaboration.

The DMHMRSAS receives an annual allocation of state general funds to support the implementation of youth suicide prevention activities associated with the Youth Suicide Prevention Plan (Senate Document 16, 2001 General Assembly Session). This allocation was reduced in October 2002 with the state budget cuts to from $75,000 to $20,000. DMHMRSAS utilized these funds to support and provide technical assistance on a statewide basis geared toward the goal of reducing youth suicide Training imitative

included train-the-trainer sessions, educational resources and material. A major goal of DMHMRSAS activities is providing an increased awareness of the risk factors associated with youth who may be at-risk for suicide and adolescents at increased risk, for example, youth with substance abuse disorders and/or depression.

The DMHMRSAS is represented on the Virginia Department of Health's (VDH) Interagency Suicide Prevention Advisory Council, a group convened by the VDH that is comprised of key state agencies and stakeholders that serves in an advisory capacity to the Virginia Department of Health (Lead agency for suicide prevention efforts in Virginia). The Department participated with the Department of Health in developing the Lifespan Plan with participation of stakeholders from around the Commonwealth, utilizing research from national and state resources, and guidance and review by an Interagency Committee. This Life Span is due to the Secretaries in the fall of 2004.

Acute Care and Residential Placements

In accordance with §37.1-189.3 of the *Code of Virginia*, the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) is required to report the following information to the Chairmen of the House Appropriations and Senate Finance Committees and the Virginia Commission on Youth on a quarterly basis:

- Total number of licensed and staffed inpatient acute care beds.
- Total number of licensed and staffed residential treatment beds in facilities licensed by DMHMRSAS, excluding group homes.
- Information on children and adolescents for whom admission to acute care facilities or residential treatment facilities was sought but unable to be obtained:
  - Date of birth
  - Date admission was attempted
  - Reason the child or adolescent could not be admitted into the hospital or facility

In the first two quarters of FY2004, there were a total of three cases reported, two children presented with mental retardation/low intelligence. There were no residential cases reported which appears to be consistent with the number of available licensed residential beds with low census. In FY 2003 there were only twelve acute care cases and 29 total residential treatment cases reported. The data provided very little information to develop trends about the problems of acute care and residential placements. Two general conclusions were; the inadequate number of licensed and staffed acute care beds in southwest Virginia and the statewide problem in difficulty in placing aggressive/violent/unmanageable youth in both acute care and residential treatment facilities. This was especially true for youth with moderate to severe mental retardation.

The Department continues to receive low number of reports on the incidence of difficulty in obtaining acute care and residential beds. Communication with representatives of the Community Services Boards and other child and adolescent representatives did show an increase in reporting in FY 2004. The Office of Licensing has noticed an increase of the number of specialized group and residential facilities for

children in Virginia in the past year. The Department projects that the reduction in reports may be due to the increase in specialized group homes and residential beds.

The Child Welfare Advisory Committee

In July 2003 the Administration on Children and Families of the U. S Department of Health and Human Services conducted a review of Virginia's Department of Social Services Office of Child and Family Services. As a result of this federal review, the Child Welfare Advisory Committee was tasked with developing Virginia's Performance Improvement Plan (PIP). The review identified access issues for mental health services for children in the DSS child welfare system.

CSA Activities

The Department is active on the Sate Executive Council, the State and Local Advisory Council, and work groups to improve the ongoing implementation of the Comprehensive Services Act. The work groups are: The Training and Technical Assistance Workgroup, Custody Relinquishment; An Ad Hoc Workgroup of the State and Local Advisory Committee to look at the impact of licensing procedures on the placement of children for the SEC. The Department continues to be a key stakeholder in the development and planning for this legislation.

The Secretary of Health and Human Resources, Office of Comprehensive Services, State Executive Councils and the State and Local Advisory Team continue to identify ways to provide and improve services to children at risk of emotional and behavior problems. Key activities during the past year have been the implementation of a minimum data set, the development of a brochure to increase the role of families in CSA and a review of the licensing regulations that interfere with the placement of children.

DMHMRSAS coordinated quarterly meetings of four Community Service Boards targeted toward the enhancement of local evidence-based practice services program development and implementation

During the 2002 General Assembly, legislation was passed (House Bill 887/Senate Bill 426) which directed DMHMRSAS 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. DMHMRSAS now reports this data on a quarterly basis to the Chairmen of the House Appropriations and Senate Finance Committees and the Virginia Commission on Youth.

Partnership with the Child and Family Task Force of the Virginia Association of Community Services

DMHMRSAS actively participates in four quarterly meetings with the Child and Family Task Force to enhance integrated services for children, adolescents and their

families at the community level. The Department consistently promotes evidence-based practices for program development and implementation during these meetings.

Mental Health and Juvenile Justice:

In July 2003, DMHMRSAS received a grant from the Department of Criminal Justice Services to pilot the provision of mental health services in five juvenile detention centers. The implementation of this grant allows for a partnership between detention centers and the community services board to hire, supervise, and manage the provision mental health services in the detention center. The grant provides for five clinicians and five case managers housed in the detention centers to provide the services and to purchase limited amount of psychiatric consultation for the juveniles. As indicated under recommendation 1, the first year of the pilot has been good with usual grant implementation issues.

The Department of Criminal Justice Services has recommended the continuation of the grant funding for a second year with hopes for continuation for the fourth year. The first and second years of the grants requires a 10% match of federal funds, which has been shared by the Department, community services boards and the detention centers. The first and fourth year will require an increased match of 25% to 50% in state funds. The Department and the local partners will need state funds allocated for this purpose. The Child and Adolescent Workgroup has recommend funding for detention centers to continue and expand this project. The first year resulted in approximately 700 youth who were screened and provided crisis intervention, outpatient and case management services during their stay in detention.

Anecdotal data from this project is beginning to document the need for community mental health professionals in all detention centers as well as the provision of services before and after juveniles are discharged from the detention centers or state juvenile corrections facilities. State funds will be needed to provide for continuity of services before, during and after the juvenile returns to his or her community. The Child and Adolescent workgroup recommends that state funds be made available to community services boards to build capacity to provide continuity of services to juveniles whether or not they are placed in the community or in the detention centers. The minimum services array for these juveniles should include assessments and evaluations, crisis interventions, outpatient services including psychiatric consultation and medication, and case management. Funds to community services boards would promote the best practices services for these youth. Funds provided to detention centers could meet the needs of juveniles while in the detention centers however; the funds cannot be used for continuity of services once the youth is discharged. Community services boards would ensure consistent community clinical interventions regardless of whether the juvenile is in the detention center or community setting.

Child Fatality and Review Team

Section 32.1-283.1 authorizes the development of the State Children Fatality and Review Team, its membership; access to and maintenance of records and the confidential nature of the review process. The purpose of the team is to review violent and unnatural

deaths of children who died in Virginia. The team meets six times a year to complete its work. The Team has been successful in the development of Youth Suicide Prevention Plan, legislation related to child seat belts, safe sleeping arrangement of children, child abuse and neglect and prevention awareness issues. The Team recommends whether deaths are preventable and whether interventions could have prevented deaths. Recommendations from the Team may result in legislation to address improved education and public awareness issues that could prevent unnecessary deaths. The Department is an active participant on the review team.

Advocacy and Parent Activities

As continued from 2003, Voices for Virginia's Children, a statewide, non-profit, non-partisan child advocacy organization, has continued to provide advocacy to improving access to mental health care for children in several ways. Leading the 300plus members, the Virginia Coalition for Children's Mental Health, Voices has served as a liaison and catalyst for organizations and individuals across the state working to improve access to mental health services for children. Bringing the voices and experiences of parents to state level decision makers, Voices works directly with legislators and administration officials to make careful and substantive policy improvements making children a priority.

During the FY 2004, the Department continues to maintain a contract with Parent and Children Coping together to provide training, education and support to families of children with mental health disorders. Parents and Children Coping Together (PACCT) is a statewide organization for families of children with mental, emotional and behavioral disorders operated by parents and family members. During FY 04, PACCT published "Parent Watch", a quarterly newsletter targeted toward an audience of families and providers. PACCT also operates a statewide phone number as a source of information on children's mental health. The numbers (local and toll-free) are on PACCT brochures and stationery, and are distributed on correspondence and during trainings. The support provided by DMHMRSAS also includes mini-grants and technical assistance to new and existing family support groups and networks, providing linkages for families of children with mental, emotional and behavioral disorders.

PACCT also offers parents or caregivers (who care for children with mental, emotional and behavioral disorders) a stipend to encourage their attendance at various training events. The stipend is offered to assist parents and caregivers overcome barriers to their participation in the training program.

DMHMRSAS is assessing how to provide and build a stronger family network in Virginia and will be working with all family organization that provide support and services to families of children with mental health, mental retardation and substance abuse services.

Continuum of Services

The Department continues to promote the need for an array of services to meet the needs of children with mental health, mental retardation and substance abuse conditions.

In addition to the array, services supports are needed to meet the specialized needs of youth. The array should include access to all the services listed by parents to meet the needs of their children.

COMMUNITY SERVICES	OUT-OF-HOME/RESIDENTIAL
Prevention	
Early Intervention/Intervention	Therapeutic Foster Care
Crisis/Emergency	Therapeutic Group Care
Assessment	Therapeutic Camp
Outpatient Treatment	Independent Living
Home-Based Services	Crisis Residential
Day Treatment	Inpatient Hospitalization
Family Support	

The continuum of care array is divided into services that are provided while the child is in the home (or a home-like) environment, and out-of-home services. A child or adolescent may utilize those services within the array that best fits his or her need. The full service array is needed to adequately serve the mental health, mental retardation and substance abuse service needs of children, adolescents and their families.

Specialized and supportive services fall under the categories listed in the recommended continuum of mental health, mental retardation and substance abuse services for children, adolescents and their families. Supportive services such as transportation, advocacy, legal services and self-help groups augment the service array. Additional services, which would be included within the categories of the services above, are designed specifically for special population needs, such as for children with developmental delays, and services for children zero to three years of age. Examples of services that would also support the recommended service array, depending on the need of the child, adolescent and/or family are:

- Assistive technology
- Audiology
- Family training, counseling and home visits
- Health services
- Medical services
- Nursing services
- Nutrition services
- Occupational therapy
- Physical therapy
- Psychological services
- Respite care
- Speech-language pathology
- Vision services

An essential service for all the services in the continuum of care is case management. Effective case management services ensure the child, adolescent and family's easy and efficient navigation of the mental health, mental retardation and substance abuse services system. At each community services board there are different levels and intensities of these services, based on the needs of the community and other variables. A comprehensive needs assessment of what is currently being provided aligned with what is needed by children, adolescents and their families in Virginia will be completed in order to fully address and implement the recommended continuum of

services in an effective manner toward the goal that improved access by children, adolescents and their families to needed services will occur.

The recommendations from the services workgroup to the 329-G Planning Group were as follows:

- Continue to support statewide suicide prevention activities.
- Continue to support intensive "family focused" case management services for pregnant, parenting, and at-risk substance-using women and their families.
- Promote prevention activities, as related to early childhood development issues.
- Look at utilizing a comprehensive, uniform instrument for assessment and data collection across all agencies from time of entry into system.
- Support dissemination of Bright Futures mental health module to health care professionals.
- Increase the number of therapeutic day treatment providers.
- Support the Department's policy on transition services by strengthening interagency participation in transition planning and identifying strategies to support interagency collaboration at the state and local levels.
- Move toward an integrated case management system that integrates all information about children and adolescents with mental health, mental retardation, and substance abuse issues and ensures that interventions are planned and coordinated to meet the multiple needs of the child and those systems serving the child and his/her family.

Substance Abuse Services

In fiscal year 2004, the Office of Substance Abuse Services (OSAS) and the Office of Child and Family Services (OCFS) provided or were involved in the following substance abuse services that addressed the needs of children.

Safe Families in Recovery Project (SFRP): DMHMRSAS, DSS and the Office of the Executive Secretary of the Supreme Court (OES) received a one year technical assistance grant from the National Center for Substance Abuse and Child Welfare (NCSACW) July 2003 to improve outcomes for families affected by substance use involved with the child welfare system and who may also be involved with the dependency courts. The goals of the technical assistance grant were to develop a memorandum of understanding and a 3-5 year interagency strategic plan. The project assembled a 30 plus member interagency Advisory Team that meet throughout the year with a NCSACW consultant to develop a plan. Five regional focus groups (74 participants) were held (Culpeper, Newport News, Charlottesville, Roanoke, and Abingdon) with community stakeholders to obtain additional input. The Office of the Executive Secretary of the Supreme Court (OES), DSS, and DMHMRSAS signed a Memorandum of Understanding in July 2004. The Safe Families in Recovery Project applied for and obtained additional technical assistance from NCSACW through Dec

2004 to develop and disseminate best practice models, guidance materials and templates for adaptation by communities.

Developing and Implementing Women's Substance Abuse Services: two-day meeting and a two- day training for substance abuse directors/managers and supervisory staff held in December 2003. The purpose of these meetings was to review the federal expectations for substance abuse programs which serve pregnant women and women with dependent children. The Substance Abuse Prevention and Treatment Block Grant Women's Set-aside expectations mandate substance abuse prevention and treatment-funded providers (the CSBs) provide case management services and appropriate therapeutic interventions for the children of women served under the Substance Abuse Prevention and Treatment Block Grant.

Additionally, staff reviewed the Adoption and Safe Families Act and its impact on services to children in substance abusing families involved in the DSS child welfare system and participated in training entitled "*Designing a Trauma Informed Service System"* and "*Non-Traditional Parenting Interventions"* conducted by Community Connections National Trauma Center for Trauma Recovery and Empowerment.

Substance Abuse Child and Adolescent Special Populations Workgroup: this workgroup met four times in the Spring of 2003 to develop recommendations related to the service needs of substance exposed infants; children and adolescents affected by parental/or other caretakers substance use as well as treatment needs for children and adolescents that use substances including those who are dual diagnosis.

Bright Futures: Participated in development and provision of children's mental health and well being screening curriculum that included emphasis on children who were substance exposed or affected by caretaker's substance use. Curriculum piloted at the Virginia Summer Institute for Addiction Studies in Williamsburg July 2004 and there were twenty participants who attended the training.

Commonwealth Partnership for Women and Children Affected by Substance Use: in conjunction with the Substance Abuse and Addiction Recovery Alliance (SAARA), staff coordinated four regional consumer conferences/family event activities targeted at the impact of substance use on the family in state fiscal year 2004. The Partnership also began planning for its SFY 2005 training and education activities and elected to coordinate cross trainings between substance abuse and child welfare providers regarding service delivery needs and how to access services.

Technical assistance: staff provided technical assistance to community services boards desiring to develop or enhance services for substance exposed, substance affected and/or substance using children and adolescents. Staff also provided technical assistance to other agencies and workgroups regarding the needs of children and families affected by substance use.

Family Support

During 2004 the Department through the Office of Mental Retardation Services established a workgroup comprised of Family support program staff, fiscal staff, and Mental Retardation Directors to revised outdated guidelines on the Family Support Program. The workgroup reviewed outdated guidelines that were in two separate documents and revised them into one document developing consistency with interpretation and implementation of the statewide family support program. The intent of the revised guidelines is to allow families easy access to family support services that their son/daughter may be eligible to receive. These guidelines provide consistent application and implementation of family support program across the Commonwealth to ensure that assistance is provided to families that served children residing at home with their families. The guidelines clarify the vision of family support, definition and principles of a family support program. Services and supports payable with family support funding are addressed as well as areas that funding is not allowable.

The Family Support Program provides financial assistance for families to provide care for a child with a diagnosis of mental retardation living in the home. The goal of the program is to provide service, and/or supports identified by a family as necessary to maintain their eligible family member in their home. The guidelines have been disseminated to all CSBs.

SFY 2005 RECOMMENDATIONS

The Department should continue to expand and enhance the recommendations in the initial 329-G report to improve the access to services to children and their families. The Department should also address new recommendations identified in the report to improve services to children and their families.

Recommendation 1

DMHMRSAS should resubmit a budget request to fund an integrated continuum of mental health, mental retardation and substance abuse services for children, adolescents and their families based on evidenced base practices. The budget initiative shall give consideration to the varying geographic needs in Virginia, filling identified gaps, addressing co-occurring disorders and the needs of special populations such as children with early development needs, young juvenile sex offenders, and adolescents in need of transitional services into the adult services system.

Recommendation 2

The DMHMRSAS should resubmit a budget request to fund a determined number of dedicated integrated case managers for children and families in all community service boards/behavioral health authorities.

Recommendation 3

The DMHMRSAS should continue to explore existing resources within state and federal funds to provide statewide training on mental health, mental retardation and substance abuse services and integrated case management as related to the recommended continuum of mental health, mental retardation and substance abuse services for children, adolescents and their families. All agencies within the Secretariats of Education, Health and Human Resources and Public Safety shall cooperate in the planning and funding of the training.

Recommendation 4B

The DMHMRSAS, in conjunction with Community Service Boards and Behavioral Health Authorities, should resubmit the request for a dedicated pool of flexible funds to be used specifically for program start-ups and program development, allocated in a manner that maximizes flexibility in program design and promotes achieving specific outcomes for children, adolescents and their families with mental health, mental retardation and substance abuse needs.

Recommendation 5

DMHMRSAS should continue to build the infrastructure of the new office of Child and Family Services to be an integrated organizational unit of the Department. This organizational unit should be involved at all levels seeking state and federal funding and developing policy for children and family services. The Office should provide leadership for child and family issues on a statewide basis through coordination of services delivery and integration of disability service systems, with the goal of improving access to mental health, mental retardation and substance abuse services for children, adolescents and families in Virginia.

Recommendation 6

DMHMRSAS should complete formalizing the state advisory committee for child and family services to support activities of the organizational unit in Recommendation 5. This should including identifying members, establishing by-laws, meeting schedules and setting agendas.

Recommendation 7

DMHMRSAS should seek ways to build and link the network of parents of children and adolescents with mental health, mental retardation and substance abuse service needs through collaborative effort with other child serving agencies and organizations to develop and implement statewide Parent/Family network and Advocacy Program.

Recommendation 8

DMHMRSAS should create, publish and fund an interactive website to be used as a resource for children, adolescents and families to enable improved access to mental health, mental retardation and substance abuse services, providers, educational resources and supports.

Recommendation 9

DMMHMRSAS shall review the policies and procedures of the department to identify gaps and to develop an integrated approach to the provision of services to children, adolescents and their families. This policy should review age criteria and how to promote consistency among all children services agencies in the provision of services to children, adolescents and their families.

Recommendation 10
The Department should provide training and technical assistance on the development of systems of care for children in the Commonwealth to Community Services Boards and other interested parties.

Recommendation 11
The Department should work with Community Services Board to provide cross training to other local human training on children issues.

Recommendation 12
The Department should review all State Board Policies related to prevention, mental health, mental retardation and substance abuse services and make recommendations to improve integrated services for children, adolescents and their families.

Work plan activities for SFY 2004-2005

1.1 By October 31,2004 submit a budget request to fund an integrated continuum of services for children and adolescents and their families.

1.2 By October 31, 2004 submit a budget request for a sufficient number of case managers for community services boards and behavioral health authorities.

1.3 By October 31, 2004, resubmit the request for a dedicated pool of flexible funds to be used specifically for program start-ups and program development, allocated in a manner that maximizes flexibility in program design and promotes achieving specific outcomes for children, adolescents and their families with mental health, mental retardation and substance abuse needs.

1.4 By June 30, 2005 identify funding resources and submit grant applications for funding to support statewide training on mental health, mental retardation and substance abuse services and integrated case management as related to the

recommended continuum of mental health, mental retardation and substance abuse services for children, adolescents and their families.

2. Continue collecting data about research related to evidence-based practices for integrated services systems reviewing other states' information and utilizing technical assistance from national sources.

3. By May 31, 2005, the Department will sponsor a conference on the system of care for children to all community services boards.

4. By June 15, 2005 training and technical assistance should be provided locally or regionally to CSBs on system of care.

5. By June 15, 2005, The Department with collaboration from other parent networks and Federation of Families will have established and organized Family involvement network.

6. By June 15, 2005, the Department's review of polices and procedures impacting children services will be finalized and new ones developed if deemed appropriate.

7. By June 30 2005, the Department will strengthen partnerships with universities and explore training for child and adolescent service providers, professional development for clinicians trained in child and adolescent mental health, and explore developing interactive, web based curriculum to meet the training needs of diverse regions statewide.

8. By June 30, 2005, the Child and Family Services Advisory Committee will be formalized.

9. By June 30, 2005, three (3) human services will be cross-trained on needs of children with mental health, mental retardation and substance abuse disorders.

APPENDIX A

FY 2003 329-G Membership

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APPENDIX B

Recommendation/Content Summary from Appendix E
House Document 23

YEAR	TITLE	PRIMARY AUTHOR	TOPIC ADDRESSED AND/OR RECOMMENDATIONS
1988	Investing in Virginia's Future: A Continuum of Care for our Adolescents at Risk	Interagency Conference Proceedings, DMHMRSAS	A memorandum of agreement by the Secretariats and department heads and in interagency budget initiative for the 1988-1990 Biennium. The agreement created an Interagency Funds Pool to help localities meet the needs of Seriously Emotionally Disturbed (SED) children and criteria for eligibility of funding.
1991	Improving Care for Trouble and At-Risk Youth and 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. This report included: 1) Preliminary findings from the demonstration projects; 2) A long-range plan for phasing in community-based nonresidential services across the Commonwealth; 3) An interagency plan for redirecting current funds and identifying new revenue resources for funding community-based services, including consideration of Medicaid; and 4) Any proposed legislation necessary for implementation.
1989	The Invisible Children's Project	Mental Health Association of Virginia	1) Treatment and care should be through a comprehensive array of services that is community-based and family focused; 2) There should be collaboration in all planning, funding, and implementation strategies; 3) Early identification and intervention 4) Use of a case manager for each child 5) Recognition of the special needs of families of children with multiple disabilities; 6) 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; 7) There should be effective advocacy and protection of rights for emotionally disturbed

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			children; 8) Services for children and their families should be available within the least restrictive, most normalizing environment that is clinically appropriate; and 9) Services should be provided without regard to race, religion, etc. and should be sensitive to cultural differences.
1990	A Study of Children's Residential Services	Virginia Department of Planning and Budget	1) 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 goals of family preservation, individualized services in the least restrictive setting; 2) Expenditures of children in residential care should be tracked, in an effort to control costs and an interagency tracking and reporting system should be developed; 3) Consolidation of funds in social services and juvenile justices systems used for residential placements; 4) Funding of residential placements should be shared by the placing locality; 5) Other sources of funding for children's services needs to be explored; 6) Community-based services for children and their families need to be expanded; 7) DMHMRSAS should prioritize services for those children at imminent risk of residential placement by other agencies; 8) State funds saved from increased usage of community based options should be reinvested in developing increase community-based services capacities; and 9) DSS, DMHMRSAS, DSS and DOE should develop a process to evaluate the appropriateness and effectiveness of selected residential placements.
1990	Community Service Model for Troubled Children and Their Families in Virginia	The Council on Community Services for Youth and Families	Selected findings: 1) Children and their families are best served by a system that is comprehensive, coordinated, and responsive to needs; 2) Each child's service program has to be tailored to his/her individual needs rather

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			than attempting to fit the child into a pre-structured program; 3) Comprehensive care in conjunction with early recognition and preventative care; 4) Available resources and funding should be pooled; 5) Communities are diverse and faced with needs and problems with varying levels and types of resources available to youth; and 6) Localities should be able to choose from an array of core services to meet the local needs of youth and their families.
1992	Virginia Child and Adolescent Service System Program (CASSP) Demonstration Project	DMHMRSAS	Sought to: 1) Identify and empower constituencies of advocates, parents, families, consumers, and providers to promote and guide state level system development for children and adolescents; 2) Promote interagency coordination in the planning, funding and delivery of services to SED children and adolescents; 3) Develop a responsive service system for SED children and adolescents that includes those services necessary to effectively meet their complex needs; and 4) Provide training to community services boards and local interagency service projects to ensure community-based service development and implementation are guided by state-of-the-art knowledge.
1992	The Council on Community Services for Youth and Families Demonstration Projects: Technical Report on Evaluation	Commonwealth Institute for Child and Family Studies	Selected findings of demonstration projects conducted to identify how to improve services and control costs: 1) Youth in demonstration projects were significantly less likely to be placed in a residential setting; 2) Youth in the demonstration projects were significantly more likely to have received advocacy, case management, financial assistance, in-home services, and transportation services; 3) Interagency teams were central to the projects, and in all cases, the teams were expanded either in number of participants or frequency of meetings;

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			4) The availability of more resources and local service alternatives was a major positive outcome expressed by local personnel; 5) Changes in structure were seen as positive, but concern expressed over increased staff time demands attending meetings and staffing of cases; 6) Responses to consumer satisfaction questionnaires were consistently positive; and 7) Data suggested that on average, the use of residential care changed very little.
1994	Comprehensive Services for At-Risk Youth and Families: Demonstration Projects SFY '93 Evaluation Report	DMHMRSAS	New Services Developed: 1) Intensive probation 2) Therapeutic Respite Care 3) Parent and Student Aide Programs 4) Day Treatment Programs 5) After School Programs 6) Therapeutic Summer Programs 7) Pre-school Prevention Programs 8) Transition Classrooms Major Explorations: 1) Who are the youth being served by the Demonstration Projects?; 2) What evidence is there of increased identification and intervention with younger children at risk of developing emotional and behavioral problems?; 3) How have the communities' capacities for providing community-based alternatives to residential services changed through the Demonstration Projects?; 4) How have local child serving agencies cooperated and collaborated in the planning and provision of services to youth with SED and behavioral problems?; 5) How satisfied are the youth, families and service providers with the services being received through the project?; 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 those services?; and 7) To what extent have the youth served changed as the result of services received

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			through the Demonstration Projects?
1994	The Impact of the Downsizing of Virginia's State Psychiatric Hospitals for Children Without Increased Community Care Options	Community Services Board Planning Committee	Selected findings: 1) Each CSB should have or be able to purchase a flexible array of eight basic services; 2) Capacity of the CSBs to provide these eight foundation services needs to be expanded as needed in that locality; and 3) To provide the needed services, the estimated increase in funding needed is $47.830,600.00.
1994/5	Comprehensive Services Act Implementation Assessment	Research and Evaluation Center of the DMHMRSAS	Recommendations: 1) Improve information available to decision makers through the development of a CSA Management Information System; 2) Provide incentives and/or assistance to localities to develop community-based services which foster family preservation and cost savings; 3) Identify and correct financial disincentives which may encourage localities to utilize out-of-home placements, instead of community-based services; 4) Explore potential mechanisms by which non-mandated youth could have adequate access to CSA services, and project costs to the state and localities; 5) As recommended by the CSA Forecasting Task Force, request the Department of Planning and Budget re-establish the technical forecasting group to project the future demand for CSA services and their associated costs; 6) Continue state financial assistance to localities for CSA administration; and 7) Create or find ways to reduce the local administrative burden. 8) Identify specific problems CSA teams may encounter with local courts and aggressively seek solutions; 9) Continue to monitor the capacity of Family Assessment and Planning Teams to engage parents to participate in service planning and implementation; 10) Establish more formal private/public

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			partnerships to lay the groundwork and provide incentives for developing a full array of children's services consistent with the intentions of CSA; 11) Request the DPB repeat its study of private provider fees; 12) Publicly recognize local CSA participants for their accomplishments in making CSA a reality; 13) Request that the State Executive Council (SEC) assume responsibility for the coordination of prevention/early intervention activities within the framework of CSA; 14) Publicize Virginia's experiences with CSA.
1995	Non-Mandated Youth: History and Potential Fiscal Approaches	State Management Team	1) 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; 2) There is a decreasing reliance on residential and private service, suggesting that community efforts to build capacity may be realized; 3) There is mixed success regarding the CSA non-mandated funds; 4) Two distinct types of spending patterns are exhibited by localities: "Want more" and "Don't spend"; 5) Any approach to resolve funding issues must address both types of patterns in order to create improvements on a statewide basis;
1995	Evaluation of the Comprehensive Services Act	Secretary of Health and Human Resources, Secretary of Public Safety, and the Secretary of Education	1) Implementing CSA is costly in terms of staff time, administrative support, and actual expenses; 2) Most localities believe that CSA is meeting its goals of stronger interagency collaboration and family participation; and 3) Non-mandated children do not receive the services they need.
1998	Review of the Comprehensive Services Act	Joint Legislative Audit and Review Commission	1) The General Assembly may wish to require that the SEC develop a mandatory uniform assessment instrument process to be used by all localities that identifies the appropriate level of care for various levels of risk; 2) The General Assembly may wish to require all cases for which treatment services (not

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			foster care maintenance) are requested to appear before a multi-agency team at the locality; 3) 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; and 4) The General Assembly may wish to require that non-mandated cases where children have displayed acute or recent risk by afforded sum-sufficient funding.
1998	A Study of Service for Children Who are Not Included in the Mandated Populations of the Comprehensive Services Act for At-Risk Youth and Families	The Office of the Executive Secretary, Supreme Court of Virginia: Under the direction of the Comprehensive Services Act State Executive Council	1) Further study needs to be done; 2) Further inquiry could comprehensively distinguish existing services and funding source and, most importantly, identify gaps in these areas; and 3) Examination of these issues should be undertaken by of 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.
1999	Educational Needs of Emotionally Disturbed Students with Visual and Hearing Impairments	Department of Education and the Disability Commission	1) Adopt a Massachusetts program for use at the Virginia School for the Deaf and Blind; and 2) Creation of a program on the campus of the residential school so it is in the community and among educators/residential specialists who have experience working with the deaf and blind population.
1999	Continuum of Care for Children and Adolescents	Child and Family Task Force of the Virginia Association of Community Service Boards (VACSB)	Services that, on a nationally recognized idea of a system of care, comprise what is thought of as a "system of care" for children and adolescents: 1) Family Support 2) Crisis Intervention 3) Case Management 4) Outpatient 5) Intensive Community Based Treatment 6) Specialized Vocational Programs; and 7) Community-Based Residential Programs
1999	Keeping Our Kids at Home	DMHMRSAS	1) A model of KOKAH should be implemented in each of the Health Planning Regions of

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	(KOKAH) Project: A Study of the Feasibility, Efficacy, and Cost-Effectiveness of Expanding the Project Statewide		the state; 2) The KOKAH model should be modified to include less reliance on local inpatient hospitalization, a broader array of community-based and step down services, and standards for hospital utilization rates; 3) A grant of flexible dollars should be given to each site, to purchase or implement an array of services, with an emphasis on community-based treatment—including the purchase of local inpatient treatment; and 4) The development of a standardized risk assessment and clinical guidelines to support decision-making regarding the use of local private facilities and state inpatient facilities.
1999	Virginia's Continuing Policy to Take Away State Psychiatric Hospitals for Children Without Increasing Community Service Options	Child and Family Services Council of the Virginia Association of Community Service Boards	1) Sufficient funding for community service development has been shown to reduce the number of hospitalizations of children, who could benefit from less restrictive, but very intensive services; 2) Transfer state funds to develop services close to communities; 3) The funds saved from downsizing institutional care should be made available to the community to provide follow-up care; and 4) Virginia must begin to plan services for children and adolescents, and should include in its comprehensive planning families, advocates, community service providers and the DMHMRSAS.
2000	Report of the Joint Subcommittee to Evaluate the Future Delivery of Publicly Funded Mental Health, Mental Retardation and Substance Abuse Services: A Report to the Governor	House Document 101, 2000 General Assembly Session	A feasibility study examining the impact of a carve-out of Medicaid financed mental health, mental retardation and substance abuse services from any managed care contracts negotiated with HMOs, and of contracting out the administration of all Medicaid-covered mental health, mental retardation, and substance abuse services to DMHMRSAS. 1) CSBs 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

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			health authorities; and 2) The Chair of the State Executive Council, supported by the Office of Comprehensive Services, shall examine the potential for the use of the underutilized state property under the control of the DMHMRSAS to determine if the use of this property, if 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 children and families to have reasonable access to services.

Appendix C

Membership—Child and Adolescent Special Populations Workgroup

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Don Roe Commonwealth	Center for Children and Adolescents

DMHMRSAS Liaison:

Pamela Fitzgerald Cooper	DMHMRSAS

At-large Members:

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Appendix D

Child and Adolescent Special Populations Workgroup Recommendations:

The Workgroup strongly recommends that the state DMHMRSAS adopt the system of care model developed by the Georgetown University's Technical Assistance Center for Children's Mental Health and adopted by SAMHSA. The DMHMRSAS shall lead the statewide promulgation of this system of care model with other state agencies, families, CSBs, and other public and private providers. The workgroup recommends four major funding priorities:

1. Four system of care demonstration projects outlined in Appendix E ($2.5 million)
2. Parent/Youth Involvement Network ($500,000 for the first year – $1 million for second year)
3. Behavioral health services provided by CSBs in detention centers during and after detention stay ($3.5 million)

   [*There is a difference between the recommendations of the Juvenile Justice Subcommittee and the larger workgroup on lead agency for these services*]
4. All resources in Virginia need to be maximized to build the capacity for behavioral health services that includes a comprehensive continuum of prevention, early intervention, and intensive therapeutic services
   a. Increase Medicaid rates for day treatment services to $150 per day
   b. Add substance abuse services to the DMAS State plan and provide funding for treatment services for youth and their families with primary or secondary substance abuse diagnoses ($5 million)
   c. Conduct a rate study to expand community-based services in the state plan to include:
      i. Intensive Case Management Level System in CSBs
      ii. Parenting Education
      iii. Respite services
      iv. Behavioral Aides
   d. Training priorities are:
      i. Systems of Care ($500,000 for 5 regional and 1 state training);
      ii. Fund slots for university training of child psychiatry fellows and child psychology interns with payback provisions ($60,000 per fellow, $26,000 per intern).
   e. Multisystemic Therapy (MST) and Functional Family Therapy (FFT) capacity building ($2.5 million to include training and statewide licensure, and to oversee and fund local MST/FFT services)

Other System of Care Recommendations

1. The DMHMRSAS will recommend to the State Executive Council and the General Assembly possible Code, regulatory changes, and budget initiatives to support the revision and expansion of state and local systems of care.

2. The system of care must include prevention and early intervention services for children and their families with or at risk of mental health, mental retardation, and substance abuse problems.
3. State agencies should continuously blend and braid funding sources to meet the needs of children and adolescents with MH/MR/SA problems and their families.
4. DMHMRSAS will support and expand its Office of Child and Family Services to assure that children's behavioral health services are prioritized and include all service entities related to children and their families.

Additional recommendations related to increased funding

1. Conduct statewide trainings on evidence-based, best practices, and promising treatments for children with behavioral health problems—statewide workshops, seminars, and cross community trainings
2. Cross-state and agency National Systems of Care model training ($200,000 managed by DMHMRSAS with VACSB)

Recommendations not related to funding

1. Encourage partnerships and collaborations among parents, all providers, and other stakeholders of children and their families with behavioral health problems
2. Support the continuation of the Child and Adolescent Special Population Workgroup activities by merging the membership with the group established by Budget Item 330-F of the 2004 Appropriations Act
3. Support systems of care model including: 1) a coordinated, integrated, and individualized treatment plan; 2) families and surrogate families are full participants in all aspects of the planning and delivery of services; and 3) support a unitary (i.e., cross agency) care management/coordination approach even though multiple systems are involved, just as care planning structures need to support the development of one care plan (Pires, 2002)
4. Promote integration of services across MHMRSA disabilities by establishing policies that require services providers to conduct a single comprehensive intake addressing the areas of MHMRSA and developing a unified services plan and record
5. Continue the dissemination of the Commission on Youth's "Collection" of evidence based practices
6. Seek grant funding to enhance child and adolescent behavioral health services by establishing matching fund capacity through private foundations/corporations
7. Strengthen university/community partnerships to enhance child and adolescent behavioral health services
8. Encourage DMAS to "suspend" rather than "terminate" Medicaid benefits while children and adolescents are in a public institution including state hospitals, juvenile detention centers, juvenile correctional facilities, and jails.

Appendix E
Participant list for meetings of the
329-G Steering Committee
May 29, 2004 & June 17, 2004

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