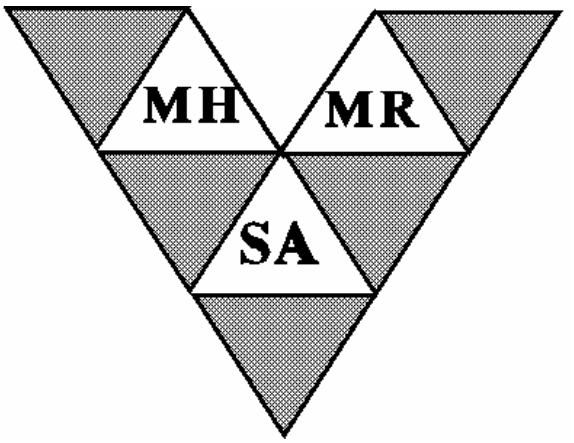
An Integrated Policy and Plan to Provide and Improve Access to Mental Health, Mental Retardation and Substance Abuse Services for Children, Adolescents and Their Families

(Budget Item 330-F, 2004 Appropriations Act)

July 1, 2004- June 30, 2005

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



Presented By
James S. Reinhard, M.D.
Commissioner

Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services

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EXECUTIVE SUMMARY

General Assembly Guidance

Over the past several years, the General Assembly has become aware of significant problems in the child and adolescent mental health, mental retardation, and substance abuse services system in Virginia. As a result, in 2003, the General Assembly adopted Budget Item 329-G, followed by the 2004 adoption of Budget Item 330-F and now named by the workgroup as Child and Family Behavioral Health Policy and Planning Committee.

The current budget language states:

> *"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 (CSU's) 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, mental retardation services and substance abuse 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*".

General Assembly Support

While progress has been made with the system of care initiatives in improving access to services, most notably, the Comprehensive Services Act, the children's service system is still plagued by fragmentation and gaps in services. There is still an over-reliance on residential care, inadequate community services to help parents keep their children at home, and parents forced to move from agency to agency seeking the coordinated package of services their children need. With remarkable consistency, legislative, policy, advisory, and family support groups have called for significant change resulting in better outcomes for children and families. Stable and sufficient funding to implement the system of care concept and to increase community capacity to provide evidence-based practices is a need that has been cited by all stakeholders. The Virginia General Assembly has responded by providing $6.1 million to the Department to provide services to children with behavioral health needs who are considered non-mandated for funding

under the Comprehensive Services Act and for Virginia's very youngest population, funding in the amount of $3.125 million has been provided for early intervention services.

Report Linkage with DMHMRSAS Efforts

In harmony with the recommendations contained in this report, the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) has been engaged in a major restructuring and transformation of its mental health system focused on implementing a vision that includes consumer-and family-driven services that promote resilience in children and the highest possible level of participation in community life including school, work, family and other meaningful relationships. This transformation initiative builds upon the collaboration and coordination process among child serving agencies and expands the focus into a comprehensive, cross-agency effort that includes, Medicaid, juvenile justice, social services, education and the Office of Comprehensive Services. In addition to the transformation initiative, the Department is engaged in an Integrated Strategic Planning Process (ISP) that builds on the transformation of services and focusing on the system of care. Finally, the DMHMRSAS assumed the lead role in preparing Virginia's Mental Health Transformation Grant, forwarded to the Substance Abuse and Mental Health Services Administration (SAMHSA) under Governor Warner's signature in June of this year. Funding decisions are expected in mid-September. The Transformation Initiative, the Integrated Strategic Planning process, and the Transformation Grant share a focus on the system of care model of serving children and their families.

This report provides a framework that Virginia can follow to address its children's behavioral health care crisis. It recommends that the state officially adopt as its goal local and regional development of the national systems of care model. This model proves a continuum of services, from prevention and early intervention services to wraparound services designed to keep children in communities to more intensive levels of behavioral health care. These services are child centered and family driven, and they incorporate evidence based or promising treatment practices

Priority Funding Recommendations for 2006-2007 Biennium

Since the biggest single cause of the children's behavioral crisis is lack of capacity, the report makes many suggestions about needed services and funding. The report recognizes that it is not possible at present to fund all of the unmet behavioral health needs of the children and youth of the Commonwealth; instead, the report prioritizes three funding recommendations for the 2006-2007 biennium.

Recommendation 1**:** Family Support

Build a statewide family support coalition designed to link existing family support organizations and groups such as Association for Retarded Citizens (ARC), Family Voices, Parents and Children Coping Together (PACCT) and other organizations that provide services, supports and advocacy to families who have children with mental health mental retardation, substance abuse, chronic illness, disabilities and other special needs.

Recommendation 2: Training

Expand training and education opportunities for new clinicians where there is an undersupply of specialists (child psychiatrists, child psychologists, etc.) with payback provisions so they can practice in Virginia. Provide ongoing behavioral health care training for existing staff and health care professionals such as pediatricians, family practitioners and primary care physicians. Often primary care physicians are the first professionals to evaluate children with behavioral health disorders.

Recommendation 3: System of Care

Fund evidence based initiatives that will serve as the catalyst for the expansion of systems of care in selected localities. Implementing these specific projects will result in empirically based outcome data that will provide clear/compelling reasons to replicate/expand these initiatives throughout the State.

System Change Without Funding

Within the systems of care framework, the report makes numerous recommendations for change, many of which do not require funding. These include:

Adopting Children's Behavioral Health Services as a Very High Priority. The DMHMRSAS needs to emphasize through policy that children's behavioral health policies, plans, and services are of the highest priority.

Using CSA funding Flexibly and Creatively to Develop Additional Services. The State Executive Council should authorize and encourage communities to use CSA funds more flexible and creatively, including developing pilot projects to serve children with behavioral health needs more effectively at the same or lower cost.

Suspending Rather Than Ending Medicaid Benefits When Youth enter Juvenile Justice Facilities. DMAS should suspend rather than end Medicaid benefits when youth enter detention and prison facilities.

Developing Standards for Case Management: The DMHMRSAS should develop case management standards for Community Service Boards throughout the state.

Coordinating and Leading Children's Behavioral Health Services Planning with other State Agencies. The DMHMRSAS is only one state agency among several including DMAS, DJJ, DSS, DOE, OCS, VDH, and DRS that play a role in the welfare of children in the Commonwealth. DMHMRSAS should coordinate and lead the planning for children with behavioral health needs; and

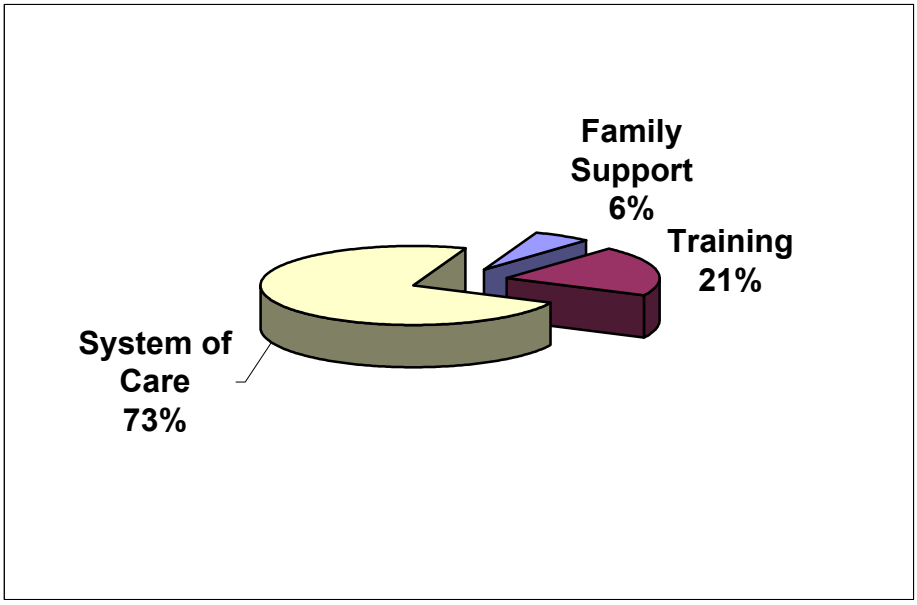
Providing Guidance to Local Offices to Maximize Children's Behavioral Health Funding. The DMHMRSAS should develop guidance document to help local offices maximize third party funding for children's behavioral health services.

Expanding the Membership on the Child and Family Services Behavioral Health Policy and Planning Committee: The State Legislature should add DSS, DOE, VDH, DRS, family organizations, organizations serving youth in the juvenile justice system, and other organizations involved in the provision of children's behavioral health services to the list of agencies and entities comprising the membership of the Child and Family Behavioral Health Policy and Planning Committee in the FY 2007-2008 biennium budget language reauthorizing the Committee.

Making prevention activities a central focus: The Department should make prevention activities a centerpiece of its policies and plans regarding children's behavioral health services. Evidence-based preventions services have been shown not only to reduce child and family suffering due to behavioral health problems, but also to save money. Funding prevention services when children are young will reduce the cost of services to the sate as they age.

Taking initial steps to change the term "case management" to care Coordination: Families of children with behavioral health problems often resent being thought of as "cases" that need "managing, which they experience as dehumanizing. They prefer to have their care coordinated so that all providers who work with them work in concert with each other towards a set of shared goals. Changing the official term to care coordination would recognize the central role families play in the care of their children.

PROJECTED COST FOR FUNDING RECOMMENDATIONS



Costs

Family Support	$ 500,000
Training	$ 1,700,000
System of Care	$ 6,040,000
Total Costs	$ 8,240,000

FULL REPORT

INTRODUCTION

In 2004, the General Assembly issued Budget Item 330-F and directed the Department of Mental Health, Mental Retardation and Substance Abuse Services to continue the committee with the same budget language related to improving access to services for children and their families across disabilities initially addressed in Budget item 329-G. The budget language of Item 329-G and 330-F requires the Department of Mental Health, Mental Retardation, and Services to report the plan to the Chairmen of the Senate Finance and House Appropriations Committees by June 30th of each year. The DMHMRSAS sought and received approval for extensions of this report deadline.

Several recommendations were contained in the 2004 report, including one that supported 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. The 330-F Committee held its first meeting in November 2004, revitalized the membership, elected officers, developed operational guidelines and changed its name to the Child and Family Behavioral Health Policy and Planning Committee. It includes members from across the state and from a variety of state agencies and external organizations. For the first time – in fact, for the first time in any of the committees and workgroups that have written studies and reports on children's behavioral health in Virginia – the Committee included family physicians and a large number of family members as regular participants. The committee met a total of 8 times since its first meeting.

OVERLAP OF THEMES AND RECOMMENDATIONS

A number of key themes and recommendations have emerged through the previous various workgroups on child and adolescent behavioral health care that include:

- Develop a **system of care** for children and adolescents with behavioral health care needs that involve all state and local agencies serving children;
- Establish **service systems that are child-centered, family-driven, community–based, and culturally competent**;
- Build **family support networks**;
- Establish a **child and adolescent office within the DMHMRSAS**;
- Request **funding to build capacity** for consistent services filling identified gaps to include a comprehensive continuum of prevention, early, intervention, and intensive therapeutic services;
- Develop mental health **services for incarcerated youth**;
- **Eliminate funding and service silos** by blending and braiding resources;
- Recommend **Code regulatory changes** to support revision and expansion of state and local systems of care;
- **Promote evidence-based and best practices** in services for children with behavioral health disorders; and
- Conduct **statewide training to build capacity and strengthen system of care values**

CURRENT STATUS - STRENGTHS, ESSENTIAL SERVICE PRINCIPLES, AND PRIMARY CHALLENGES

An assessment of Virginia's current system of care for children and families points to areas of strength, essential principles for building appropriate services, and primary challenges that must be met to fully transform the system of care.
Strengths:

- The Comprehensive Services Act (CSA) system has promoted collaboration/coordination for nearly ten years at the local and state level;
- CSA's values include many of the values of the system of care model;
- Local flexibility in service provision;
- Strong children's behavioral health advocacy and support;
- Parts of a continuum of care are in place;
- Strong universities with the capability to train child mental health, mental retardation, and substance abuse professionals;
- Excellent public inpatient facilities for children and adolescents;
- Recent formation of an Office of Child and Family Services in the state DMHMRSAS and;
- Evidence-based/promising programs are in place in a few areas; and

Essential Foundation Principles:

The Committee concluded that the keys to expanding Virginia's areas of success in serving children with behavioral health needs and their families requires a foundation built upon the following principles:

- All children in need receive appropriate and timely services;
- There must be significant family and youth involvement at all levels of planning, decision-making, and service delivery;
- There must be agency collaboration at state and local levels;
- There must be sufficient and flexible funding for services;
- There must be an adequate amount of services/treatments that are: evidence-based/promising and/or best practices; child-centered; family-driven; culturally competent; strengths-based; and community-based;
- Services must be coordinated and integrated with each other, including behavioral health and health care;
- Services must be individualized and driven by an individualized d service plan;
- Preventive and early intervention services must be a central area of emphasis;
- There must be sufficient funding for research on innovative interventions;
- There must be an adequate supply of qualified professionals; and
- There must be seamless access, equity, and efficacy of services.

Primary Challenges

It is important to note that in addressing behavioral health needs of children and adolescents in Virginia that there are challenges we are facing. Thee following statistics are important factors in improving services in the Commonwealth for children and adolescents:

- 24% of the population of Virginia is under the age of 14;
- 14% of healthcare funds are spent on children: and
- 7% of mental heath expenditures go to children under the age of 18 (Landers, 2001).

Three recent studies, The Child and Adolescent Special Population Workgroup Report, the Custody Relinquishment Committee report and the 329-G 2004 Report as well as several others that have been completed in the past five years, demonstrate that there is much interest in, and awareness of, the significant problems in the children's behavioral health services system in Virginia. Nevertheless, many challenges still exist that must be addressed if we are to transform services for children and their families.

1. **Lack of service capacity.** The greatest cause of the deficits in the children's behavioral health services system in Virginia is the lack of service capacity. The lack of capacity means that not only are services unavailable in many areas but that almost every community in the Commonwealth lacks a continuum of services from the most intensive to the least intensive. Without a continuum of care, there is no continuity of care for children in which children can step down to lower levels of care when they are ready – and, if needed, step up to higher levels of care – that are the least restrictive for them. Thus, children and adolescents are placed in services that are more restrictive than they require due to lack of capacity for placing children in intermediate-level community-based services.

2. **Lack of access to care**. Families in rural areas complain about their inability to obtain needed behavioral health services for their children, but so do families in urban areas. Even the barest minimum of services – individual and family therapies and medication management – are unavailable in many communities, and are insufficiently available even in the larger, more urban communities. Waiting lists of two to six months for outpatient services confront families in crisis, with the result that they do not receive the help they need unless their child is acutely hospitalized for being in imminent danger to themselves or others. However, when their children are discharged from the hospital, the same long waiting lists or absence of services await them.

"*I think one of the situations we're getting into is that everything is locality by locality. What [one county] does is different from what [another county] does."*

-- Parent

3. **Lack of a full continuum of community based care**. Services are fragmented and care coordination is lacking due to shortages of child and adolescent psychiatrists and psychologists, funding with its

accompanying eligibility requirements, and the lack of coordination between primary care physicians responsible for medication management and therapists and counselors. In addition, Virginia's children and adolescents with serious emotional disturbances are at increased risk of out-of-home placements due to the lack of consistent and integrated community-based services. These children often require intensive therapeutic interventions, parental support, medications, and involvement of multiple agencies, short-term inpatient hospitalizations, and long-term residential treatment to address their pervasive problems. Untreated, these children require the most intensive and costly services over their lifespan.

4. **Lack of service integration.** In the absence of appropriate behavioral health services provided by qualified professional staff, other systems are left to cope with troubled children and provide behavioral health care. Often, primary care physicians are the first professionals to evaluate children with behavioral health disorders and they have not been trained to conduct these specialized evaluations. This is a significant problem, because it has been estimated primary care physicians such as pediatricians and family doctors prescribe 80% of psychoactive medication for children.

The second system that is left to deal with children's behavioral health problems is the public schools system. Frequently problems are first recognized at school, but school systems are ill prepared to deal with children with serious emotional disorders. Few schools have school-based mental health services that enable children with psychiatric disorders to learn in school.

When mental health and substance abuse services are not provided or are inadequately provided, the final stop for some youth with psychiatric disorders is the juvenile justice system. In fact, it is estimated that 50-80% of youth involved in the juvenile justice system have mental health and/or substance abuse disorders. Unfortunately, behavioral health services for youth in detention centers are inadequate to meet the needs of the majority of incarcerated adolescents.

5. **Lack of knowledge and information.** Families who seek services for their children – particularly intensive services – often do not know where to find services nor how to go about accessing them. Most communities do not have local behavioral health resource directories, nor has a statewide directory been compiled.

"They need a master list of resources. As soon as a parent finds out your kid has [a problem, they should say,] 'Here's a master list of resources.' Doctors, therapists, anybody dealing with kids, school nurse, pediatrician, counselor's offices, school [should have a copy]. Those are the places that you go first…they are the ones who say something's not right and we need to talk to you."

-- Parent

"It's really hard to find out where to go to get help. There's just not enough information out there about where to go to get help."

-- Parent

6. **<u>Lack of family involvement</u>.** It is essential for transforming Virginia's behavioral health system that there be increased participation of families in the design, administration and delivery of behavioral health services for children and adolescents.

7. **<u>Lack of comprehensive quality standards and minimum competencies</u>.** Virginia has established quality standards only for regulated children's psychiatric inpatient and residential facilities. In the absence of standards for non-facility community-based services, the quality of services can vary greatly. All communities would benefit from minimum quality behavioral health service standards.

8. **<u>Lack of evidence-based treatments</u>.** Evidence-based treatments (EBTs) are treatments, which have been found through repeated research to be effective in treating specific disorders. EBTs reflect state-of-the-art practice in many fields including behavioral health. Use of EBTs does not preclude the use of other treatments, such as those that have been designated as "promising", but they do provide the best-known possible treatment for particular problems at present. Not all behavioral health disorders have EBTs, but for those that do, consideration should be given to using EBTs.

One Family's Story:

When my son was about eight years old, things were noticeably different about his behavior. When the full-blown crisis hit, we were in awe at the lack of answers, help, support, and even direction that was available. As caring, engaged, always-involved parents, we were at a loss as to how to help our child and our family. Being told that we "lacked discipline" and that we "spoiled our child", we were at a loss. We tried all the techniques that were thrown at us. We kept making phone calls and seeking help.

Through a family member who lives out of state but is in the mental health field, we finally were able to get some direction. We had to look out of state! Why? After a much-traveled road of seeking adequate professionals, an almost lost childhood for my son, many sleepless nights and struggles to keep a loving, caring family intact, I still have questions of "How did it get so bad?" and "Does anyone care to help make it right?"

In 2001, my son was diagnosed with Bipolar Disorder. He also has a Learning Disability and Separation Anxiety. In sixth grade, there were many days that he was physically carried from my car into school. I was in IEP meetings almost monthly trying to figure out what would work. Seventh grade was not much better. He was put on half days, arriving at 11:30 AM. An in-home tutor for Math was tried. On the books, 48 days were missed. In addition, many days were spent in the front office or guidance office because he simply could not function in the school environment. About 70 days of education were wasted. In class it was not much better. Do we need to fail at everything before we pay attention to what is actually needed? Our children need us now!

We are still in a struggle. Trying to navigate a system that is so unfriendly with too many questions and never enough answers will never secure our future.

Mother of a child with Bipolar Disorder

FUNDING RECOMMENDATIONS FOR THE 2006-2007 BUDGET

This report outlines a framework for transforming children and adolescents' behavioral health needs and is the product of a year long process that involved stakeholders who came together to study the behavioral health system for children, to examine its strengths and weaknesses, challenges, and opportunities for system change and to make recommendations to the Governor and the General Assembly. Stakeholders from many agencies and organizations, including family physicians and a significant number of parents, met monthly to develop this report, and several subcommittees also met regularly during the year. The Committee's recommendations include:

- Increase family support and involvement in the behavioral health system so that families participate fully and are partners in policy and practice at all levels.
- Expand the capacity of the child and family behavioral health services system to meet the growing need so that wherever families live, they will receive services, have choice and are fully integrated into community living.
- Officially endorse and encourage localities to implement the nationally recognized " System of Care Model" developed by Georgetown University, National Technical Assistance Center for Children's Mental Health.

Recommendation 1: Fund a Family Support Coalition

Virginia needs a statewide family support coalition that will link existing family support organizations, help them coordinate their efforts, and increase their ability to provide support to families in need. The Committee recommends funding such a coalition to perform three critical functions:

- To develop and disseminate children's behavioral health resource information to families across the state;
- To connect families with other families experiencing similar difficulties who can provide support and guidance; and
- To partner with state agencies to develop and submit federal grant applications to increase the state's federal funds and its behavioral health service capacity.

Cost of Recommendation 1: $500,000

Recommendation 2: Fund Training.

Virginia has a shortage of specially trained child and adolescent clinicians, particularly child psychiatrists and psychologists. It also has a shortage of children's behavioral health service providers in rural areas. The Committee recommends:

- Fund four new two-year child psychiatry fellowship slots and four new one-year child psychology internship positions in already existing fellowship and intern programs at state academic medical centers. These positions should

come with payback clauses stating that for each year of funding, the fellow or intern agrees to provide one year of behavioral health services in an underserved area of Virginia.
- Train established behavioral health clinicians, including those who have specialized in adult treatment but are forced to treat children and adolescents because there are no available specially trained child psychiatrists and therapists, in Evidence-Based Treatments for children and adolescents with behavioral health problems.
- Provide child and adolescent behavioral health care training for health care professionals, including pediatricians, family practitioners, and primary care physicians, to help them develop greater understanding of children's behavioral health problems.

Cost of Recommendation 2: $1,700,000

<u>Recommendation 3</u>: Fund Elements of Systems of Care.

- Multi-Systemic Therapy (MST)/Functional Family Therapy (FFT):

  Despite the proven effectiveness of MST and FFT, very few localities in Virginia have been able to offer these services due to the costs associated with start-up and implementation. The recommendation of 329G/330F is to continue the two (2) home-based Demonstration Projects that are currently funded, and expand these Projects to six (6) additional sites. The specific populations that will be served by these Projects include youth with juvenile justice involvement, and/or those with co-occurring mental health, mental retardation, and issues who are at risk for involvement in the juvenile justice system by virtue of their disabilities.

Cost: $4,000,000 for eight sites and outcome evaluations

- Mental Health/Juvenile Detention Center Programs:

  In FY 2006, the number of MH/Detention Center Demonstration Projects will be expanded from 5 to 7. A 50% state/federal match funds the Projects. These Projects provide specialized mental health services to juveniles detained in the targeted local community detention facilities. Outcome data from the currently existing MH/Detention Center Projects has reflected a significant reduction in recidivism among that target population as a result of the specialized services. Therefore, 329G/330F is recommending that the State increase the number of MH/Detention Center Projects by adding four new sites per year until services are available in all 25 Detention Centers in Virginia.

Cost: $240,000 for four additional sites and outcome evaluations for all sites

- School-Based Mental Health Services:

  The third part of this proposal will involve a totally new funding initiative for 20 Mental Health/School-Based Demonstration Projects (four per Region). The Projects will target middle school students who experience educational difficulties as a result of psychiatric and/or substance abuse problems. The Projects will utilize national best-practice service models that effectively reduce behavioral and mental disorder related problems in schools, and improve academic attendance/performance rates. The actual service models developed by the targeted sites, along with the outcome evaluation reports, will be disseminated to other CSBs and school systems throughout the state.

Cost: $1,800,000 for 20 sites and outcome evaluations

Total Cost of Recommendation 3: $6,040,000

Total Cost of Recommendations 1-3: $8,240,000

The priority recommendations made in this report have a total cost of $8,240,000 per year. In a time of competing priorities, this may seem like a large amount however, the Child and Family Behavioral Health Policy and Planning Committee believes it is time to make vulnerable children a high priority in Virginia. The Committee recommends that the State Legislature invest $8.24 million this year as a down payment on the future of Virginia's children.

Policy, Legislative and Administrative Practice Recommendations

While funding recommendations are a priority focus of this report, other recommendations propose policy, legislation and administrative practice changes that support the transformation process include:

Adopting Children's Behavioral Health Services as a Very High Priority. The Department needs to emphasize through policy that children's behavioral health policies, plans, and services are of the highest priority.

Using CSA funding Flexibly and Creatively to Develop Additional Services. The State Executive Council should authorize and encourage communities to use CSA funds more flexible and creatively, including developing pilot projects to serve children with behavioral health needs more effectively at the same or lower cost.

Suspending Rather Than Ending Medicaid Benefits When Youth Enter Juvenile Justice Facilities. DMAS should suspend rather than end Medicaid benefits when youth enter detention and prison facilities.

Developing Standards for Case Management: The DMHMRSAS should develop case management standards for Community Service Boards throughout the state.

Coordinating and Leading Children's Behavioral Health Services Planning with other State Agencies. The Department is only one state agency among several including DMAS, DJJ, DSS, DOE, OCS, VDH, and DRS that play a role in the welfare of children in the Commonwealth. Department should coordinate and lead the planning for children with behavioral health needs; and

Providing Guidance to Local Offices to Maximize Children's Behavioral Health Funding. The Department should develop guidance document to help local offices maximize third parry funding for children's behavioral health services.

Expanding the Membership on the Child and Family Services Behavioral Health Policy and Planning Committee: The State Legislature should add DSS, DOE, VDH, DRS, family organizations, organizations serving youth in the juvenile justice system, and other organizations involved in the provision of children's behavioral health services to the list of agencies and entities comprising the membership of the Child and Family Behavioral Health Policy and Planning Committee in the FY 2007-2008 biennium budget language reauthorizing the Committee.

Making Prevention activities a central focus: The Department should make prevention activities a centerpiece of its policies and plans regarding children's behavioral health Services. Evidence-based prevention services have been shown not only to reduce child and family suffering due to behavioral problems, but also to save money.

Take initial steps to change the term “case management” to care coordination: Families of children with behavioral health problems often resent being thought of as “case” that need “managing” which they experience dehumanizing. They prefer to have their care coordinated, so that all providers who work with them work in concert with each other towards a set of shared goals. Changing the official term to care coordination would recognize central role families play in the care of their children

CONCULSION

DMHMRSAS 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 and procedures that promote children and families 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. DMHMRSAS works with the General Assembly to develop legislation and funding request to promote children's behavioral health services.

The primary providers of public community mental health services for children and families are the 40 community services boards (CSBS) or behavioral health authorities, which are local government entities that vary considerable in per capita funding, geography, services, populations served, political jurisdictions served, and organizational structure. The array of services available to consumers and families is highly variable from one locality to another. Virginia has achieved significant progress in supporting recovery-oriented evidence based practices (EBPs) and the Department is committed to advancing evidence based practices using dissemination and demonstration projects and creating public-private partnerships to guide their implementation.

Although progress continues to be made in improving and accessing behavioral health services, the committee believes much work is still needed to move children and adolescent services ahead in the Commonwealth. The priority recommendations made in this report have a total cost of $8,240,000 per year. In a time of competing priorities, this may seem like a large amount of funding but this would be a down payment on the investment on Virginia's future.

APPENDICES

Appendix A

Child and Family Behavioral Health Policy and Planning Committee (330-F)
Membership List (as of 6/20/05)

NAME	AFFILIATION
Meyer, Brian L., Ph.D. Chair	Virginia Treatment Center for Children/ VCU Medical Center
Gallagher, Fran Vice-Chair	Medical Home Plus/Parent
Arthur, Carolyn	Henrico Area Mental Health & Retardation Services
Batten, Ken	DMHMRSAS
Boise, Joanne S.	Virginia Department of Health
Bryant, Sandy, RNCS, LPC	Central Virginia CSB
Bynum, Joan B.	DSS
Cicatiello, Francine	Parent
Cole, Mary F.	Cumberland CSB
Davidson, Charline	DMHMRSAS
Discenza, Mary Ann	DMHMRSAS
Duval, Jeanette	DMHMRSAS
Fisher, Stacie RN, MS	DMHMRSAS
Frye, Kay	DJJ
Gewanter, Harry, M.D., FAAP, FACR	Medical Home Plus
Hamaker, Leah D.	Virginia Commission on Youth
Hancock, Catherine K., APRN, BC.	DMAS
Kube, Joyce	PACCT/Parent

Child and Family Behavioral Health Policy and Planning Committee (330-F)
Membership List (as of 6/20/05)

Kurgans, Martha	DMHMRSAS
Lovelace, Erica A.	DRS
Lynch, Dean	Deputy Secretary, Health & Human Resources
McCaughey, Kim	DSS
Miller, Marilyn	DJJ
Murdaugh, Ursula	DCJS
Rafferty, Beth	RBHA
Reams, Pat, MD, FAAP, MPH	Physician
Ricks, Shirley G.	DMHMRSAS
Roe, Don, Ph.D.	DMHMRSAS-CCCA
Shue, Barbara P., MSW	DMHMRSAS-CCCA
Smith, Joanne	Virginia Council on Juvenile Detention
Sood, Bela, M.D.	Virginia Treatment Center for Children/ VCU Medical Center
Valentine, Angela	DJJ
Wilburn, Gina	Blue Ridge Behavioral Healthcare
Wright, Kristi S.	Voices for Virginia's Children

Appendix B – 2005 Report Writing Committee

Chair	Brian L. Meyer, Ph.D.
Vice-Chair	Fran Gallagher

Sandy Bryant
Francine Cicatiello
Mary Ann Discenza
Kim McCaughey
Beth Rafferty
Shirley Ricks
Don Roe

Appendix C – Status Report of the 330-F 2004 Recommendations

The following are the recommendations from the 2004 report:

Recommendation 1

DMHMRSAS should resubmit a budget request to fund an integrated continuum of mental health, mental retardation and 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 services and integrated case management as related to the recommended continuum of mental health, mental retardation and 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 4

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 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 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 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 services, providers, educational resources and supports.

Recommendation 9

DMHMRSAS 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's issues.

Recommendation 12

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

Status of recommendations 1, 2 and 4:

No budget requests were submitted for the 2005 session of the biennium.

The General Assembly appropriated $500,000 for services for serious emotionally disturbed children non-mandated by the Comprehensive Services Act (CSA) to build community capacity for the behavioral health needs for children's services.

In addition, $1.0 million was appropriated for two Child and Family demonstration projects for one rural and one urban site. A request for Proposals will be disseminated statewide for the demonstration projects to build community capacity for target populations using criteria of strengthening linkages to system of care and evidence base practice models, building on the resources of existing child and adolescent programs and service patterns.

Fiscal Year 2006 funding considerations include $250,000 to continue to fund five demonstration projects for Detention Centers/CSBs across the state and to use $250,000 remaining funds to expand 3-4 new projects with CSBs and Detention Centers to replicate the models identified above. This will continue to allow over 700 children in detention centers to access needed services.

For Early Intervention, all local lead agencies participating in the Part C program will receive funding in the amount of $2.25 million that will be allocated using a formula that is based on the average three-year child count.

Status of Recommendations 3 and 10**:**

Recently the Department through the Office of Child and Family Services and the Mental Health Planning Council was pleased to sponsor the statewide conference, "Building Systems of Care". This conference, held in Roanoke on March 22nd and 23rd 2005 was an important step in the direction of an integrated system of care for Virginia's children. Representatives of CSBs were in attendance, along with over 200 other participants, including state and local serving agencies and parents.

As a follow-up to this important training event funded in part by the Community Mental Health Services Block Grant each CSB that participated in the System of Care Conference received $2,000 in federal mental health block grant funds. These funds, could be used by the CSB or be combined with the funds received by other CSBs in the region to support further training, technical assistance and other educational resources that would help you implement a local system of care for children.

Status of Recommendation 5:

The Office of Child and Family Services is committed to implementing best practices and evidence-based treatment related to behavioral health and substance use and co-occurring disorders, but does not have sufficient staff to develop, oversee and monitor services in order to correct the variation in quality and access that currently exists statewide. The Office of Child and Family Services submitted two grant proposals to the Office of Mental Health Services Administration of the U.S. Department of Health and Human Services for infrastructure to support and maintain the ongoing development and provision of adolescent behavioral health services and adolescent services throughout the Commonwealth. The grant for supporting and maintaining ongoing adolescent behavioral health services was not funded and the Department is waiting to hear if the grant for adolescent services will be funded. These grants were intended to fund a full

time Adolescent Treatment Coordinator position and Program Specialists within the Office of Child and Family Services and support state processes to assess, facilitate and coordinate ongoing cross system planning of services for adolescent substance use and co-occurring disorders. In addition, the Office has provided 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 services for children, adolescents and families in Virginia.

Status of Recommendation 6:

Currently, several groups are involved in children's services including but not limited to the Child and Family Behavioral Health Policy and Planning Committee, the Child and Adolescent Task Force, MR Council, SA Council, the Mental Heath Planning Council, advocacy groups (ARC, Voices, PACCT, SARA, Mental Heath Alliance) and other parents who may or may not have affiliation with any of these groups. Consistent with the recommendations of the 2004 329-G workgroup to form a statewide advisory group and to involve and build links to parents, the Department established an advisory group that is responsible for promoting services for children and to support activities that improve services to children. The advisory group has 51% parent representation and state agency representatives. The advisory group meets quarterly and held two meetings in 2004.

Status of Recommendation 7:

The Department renewed its contract with Parents and Children Coping Together (PACCT) in 2004-2005. Additionally, efforts are underway to bring together multiple organizations that serve, support and advocate for children with disabilities. A preliminary steering group has met a few times to discuss how parent organizations can come together to speak with one voice on behalf of children building a statewide family coalition. The purpose of the coalition will be to build and link, through a coalition, existing family support organizations and groups such as: Arc of Virginia, Family Voices a program of Medical Home Plus, PACCT, Parent to Parent of VA, etc. that provide services, supports and advocacy to families who have children and youth with mental health, mental retardation, chronic illness, disabilities and other special needs.

A statewide coalition would coordinate and strengthen the work of Virginia's family support organizations, reduce fragmentation and overlap, while preserving each group's uniqueness and mission. The statewide coalition would also benefit Virginia's efforts to share information with families, increase parent knowledge, interest and participation in a variety of state initiatives, and increase our efforts to obtain additional grant funding to support children with special needs and their families.

Status of Recommendation 8:

The recommendation for the Department to create, publish and fund an interactive website to be used as resource for children and families for improving access to mental health, mental retardation and services and to serve as a resource for providers was not acted upon due to the lack of funding to support such an initiative.

Status of Recommendations 9 and 12:

The Department will review the policies and procedures related to child and adolescent services and will request the Child and Family Behavioral Health Policy and Planning Committee to make recommendations to improve integrated services for children and their families and to identify gaps and strategies to promote consistency among all children services agencies.

Status of Recommendation 11:

The recommendation for the Department to work with CSBs to provide cross training to other local human services agencies on children's issues were not initiated in 2004-2005.

Appendix D – Child and Adolescent Special Populations Workgroup Recommendations

Recommendations Involving State Funding

The workgroup recommended four major funding priorities:

1. Four system of care demonstration projects ($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)
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 – Juvenile Justice-Related Recommendations Child and Adolescent Behavioral Services Policy and Planning Committee

In order of priority:

1. Support Recommendation # 7 of the Child and Adolescent Special Populations' Workgroup (Crosswalk Document including 329-G Workgroup Recommendations), which states:

   Encourage DMAS to "suspend" rather than terminate Medicaid benefits while children are in a public institution.

2. Given the success of the pilot program providing mental health services to adolescents in five juvenile detention centers throughout the Commonwealth (reducing hospitalizations, reducing use of room confinement as behavior management tool, reducing use of isolation cells for observation of suicidal residents, and providing needed mental health services to high at-risk population):
   a. Ensure that a position in the Office of Child and Family Services at DMHMRSAS remains funded, with at least fifty percent of time dedicated to this project.
   b. Mandate completion of evaluation of the pilot program and establish programmatic standards.
   c. Expand the program to cover all twenty-four juvenile detention centers throughout the Commonwealth.

3. Support funding recommendations needed to ensure compliance with standards established by DMHMRSAS, DJJ, DOE, and other agencies responsible pursuant to HB 2245 and SB 843, passed by the 2005 General Assembly, requiring coordination and delivery of mental health/ services to juveniles transitioning from Juvenile Correctional Centers or post-dispositional detention programs.

4. Recommend that the Commissioner for DMHMRSAS, Director of DJJ, and Director of DOE conduct a feasibility study for establishing psychiatric treatment programs in existing secure detention facilities.

Appendix F – Relinquishment of Custody Workgroup Draft Recommendations

Recommendations for System Reform

1. Develop the mechanism to coordinate with other affected Secretariats all state level children's services in the Commonwealth. This coordination should include, but not be limited to, the current efforts underway related to the state's Program Improvement Plan (PIP) developed in response to the federal Child and Family Services Review (CFSR) to improve access to mental health services for youth, and the expansion and enhancement of access to child and adolescent mental health services.
2. Examine the State Corporation Commission (SCC), Bureau of Insurance's role in exploring mental health parity for at-risk youth and the inclusion of a full service continuum in private sector insurance. Specifically, explore the use of private insurance funds for home-based, day treatment, and crisis stabilization in order to prevent more expensive hospitalization. Further, consider "hold-harmless" in which funding for hospitalization could be redirected without exceeding existing financial risk.
3. The Department of Social Services shall collaborate with other child serving agencies to develop, by July 1, 2005, a method for tracking the incidence of custody relinquishment for the sole purpose of obtaining behavioral health treatment services.
4. Review and analyze alternative models of child serving systems that reduce or eliminate categorical funding, decrease fragmentation, and support cost containment strategies.
5. Support development of an appropriate, accessible, and outcomes based continuum of behavioral health and treatment services for Virginia youth that includes at a minimum:
    - Assessment and diagnosis
    - Behavioral aide services
    - Case management services
    - Crisis residential services
    - Crisis services
    - Day treatment/partial hospitalization services
    - Early intervention and prevention
    - Family support/education
    - Home-based services
    - Inpatient hospital services
    - Medical management
    - Mental health consultation
    - out patient psychotherapy
    - respite services
    - School-based services
    - Therapeutic foster care, therapeutic group home
    - Residential treatment centers
    - Transportation
    - Wraparound services

Recommendations for Funding Expansion and the Efficient use of Existing Resources

1. Explore differential matches for CSA funding, specifically related to incentives for localities to use CSA non-mandated funds and request necessary policy and **Code** changes that would reduce the local match requirement for localities using their non-mandated CSA allocation.
2. Analyze the financial implications of increasing the CSA targeted non-mandated levels of funding.
3. Review, analyze and develop specific recommendations for development and funding of community based services infrastructure and program start-up.
4. Expand funding for behavioral health services for youth.
5. Explore funding options allowable under the Medicaid and State Children's Health Insurance Programs including those implemented in other states.

Recommendations for Changes in Policy and Code

1. Direct each child serving agency to initiate an immediate review of all policies, procedures and practices and to bring forward specific recommendations for changes that would enhance parental collaboration and involvement, enhance and expand access to appropriate mental health treatment, and reduce the variability in the implementation of services.
2. The Department of Social Services shall, in collaboration with other state and local partners, revise, disseminate and train localities on clearly defined policies and procedures regarding the use of voluntary placement agreements that will encourage the appropriate use of these options. Areas to be addressed include but are not limited to: collection of child support; access to treatment foster care; and non-custodial foster care case management practices.
3. The Department of Social Services shall put forth revisions to the Code of Virginia, Departmental policy, and if necessary, will promulgate emergency regulations to ensure consistency between public and private child welfare agencies in all areas that effect parental access to the full range of placement services as allowed by the Code of Virginia.
4. Encourage prevention, early intervention and the use of least restrictive, community-based services with differential CSA match rates for localities for these services. Specifically, the SEC shall review and analyze a differential match rate on mandated foster care prevention funding used to purchase community-based, non-residential services.
5. Advocate for changes in federal laws, regulations, and funding to reduce or eliminate the need for families to relinquish custody for the sole purpose of accessing behavioral health treatment services. Specifically, the SEC should advocate for passage of the Family Opportunity Act (S. 622, H.R. 1811) and the Keeping Families Together Act (S. 1704 and H.R. 3243).

Recommendations for Service Improvements and Program Development

1. Continue process to review and identify Virginia and national best practices that demonstrate results in improving access to behavioral health treatment and the reduction of custody relinquishment.
2. Direct all agencies represented on the State Executive Council to develop and implement technical assistance and training for localities focusing on the dissemination of best practices in the areas of access to mental health, parent

collaboration, early intervention and development of a system of care model. This can best be achieved by working with the well-established, nationally recognized associations and organizations readily available to state and local jurisdictions.

These resources include:

- National Resource Centers supported by the Children's Bureau of the federal Health and Human Services (available at no cost to Virginia)
- Brazelon Center for Mental Health Law
- Child Welfare League of America
- National Technical Assistance Center for Children's Mental Health at Georgetown University
- SAMSHA Center for Mental Health Services – Systems of Care information
- Federation of Families for Children's Mental Health

3. Direct the Department of Mental Health, Mental Retardation and Services to lead a collaborative effort with other child serving departments, parents, and advocacy organizations to develop and implement a statewide parent/family resource and advocacy program that is coordinated with existing programs and affiliated with the Federation of Families for Children's Mental Health.

Appendix G - Early Intervention (Part C) Recommendations

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 had a deficit of $1.25 million for FY 04-05, which included the 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, the General Assembly appropriated $2.25 million for FY 2004-05 and additional funding in the amount of $2.25 million for fiscal year 2005-06.

In an effort to identify fiscal priorities for the FY 2006-2008 Biennium, the following areas of importance were identified: funding to fully implement entitled services, eliminate waiting lists and comply with federal requirements, ongoing funding for the next two years to fund and maintain a management information data system to comply with federal data reporting requirements, funding associated with the provision of services in natural environments, and funding for workforce development, continued education, and retention to address serious shortages of trained personnel.

With increased funding, the early intervention will increase Child Find to identify potentially eligible children. Currently there are an insufficient number of early intervention personnel, and it is expected that the shortage of trained personnel will increase and this will negatively impact the system's ability to deliver services. Building capacity will require a number of activities including analysis of competing markets and personnel preparation by universities, specifically the curricula and capacities for developing career paths and preparation of early intervention personnel. Additionally, infants and toddlers with disabilities and their families will be affected by these personnel shortages due to the added costs to providers of meeting the federal requirements for providing services in natural environments.

Appendix H –Substance-Exposed Infants Workgroup Recommendations

Pre-natal Screening for substance use

- Integrate and behavioral health screening questions into standardized assessment to be conducted by prenatal care providers on all pregnant and preconception women.
- Train providers to conduct behavioral health screening preconception and throughout pregnancy.
- Develop and promote incentives for Medicaid and insurance reimbursement for providers to complete a behavioral health screening (/mental health/domestic violence)
- Train medical providers to screen for fetal alcohol syndrome (FAS) and alcohol related birth disorders (ARBD) in newborns and children
- Identify mechanisms to ensure implementation of §54.1-2403.1 (prenatal screening for) and §63.2-1509 (physician reporting following delivery of substance-exposed birth)
- Identify treatment resources for medical providers

Increase Awareness

- Media campaign for public and providers regarding risks of perinatal substance use to the infant and where to seek treatment with information regarding treatment resources and contact number

Training

- Provide education and cross training for child welfare, early intervention, mental health, and medical providers regarding the prevalence of perinatal substance use.
- Provide education and cross training for child welfare, early intervention, mental health, and medical providers regarding the prevalence co-occurring disorders amongst women who use during pregnancy.
- Provide education and cross training for child welfare, early intervention, mental health, and medical providers regarding recommended intervention and referral practices.
- Identify existent training opportunities/mediums/marketing efforts into which we can integrate training efforts e.g. Virginia Summer Institute for Addiction Studies (VSIAS), regional perinatal council (RPC) trainings, Virginia Interagency Coordinating Council (VICC), Virginia Institute for Social Service Training Activities (VISSTA), Mid-Atlantic Technology Transfer Center (Mid-ATTC), etc.

Service Coordination

- Identify resources - within CSBs and communities - for substance-exposed infants, pregnant and parenting substance using women & how to access them.
- Explore potential collaborative efforts.
- Integrate concerns into pre-existing workgroups such as the Child and Family Task Force, Commonwealth Partnership, SLAT, etc. Identify appropriate workgroups for substance-exposed infants, youth affected by SA and substance-using youth.
- Support development of family courts.

- Identify available treatment resources for perinatal substance use as well as substance exposed infants. (Involves identifying where these services are provided within each CSB)
- Address linkages between child welfare, early intervention, and school system and services to ensure service coordination and seamless transition as child ages out of certain services and into others from birth through adolescence. Coordinate case management assignment. Provide appropriate cross training as indicated.
- Address linkages between child welfare, early intervention, school system and services to ensure compliance with mandated requirements from such legislation and plans as the Child Abuse Prevention and Treatment Act (CAPTA), the Adoption and Safe Families Act (ASFA), Virginia's Program Improvement Plan (PIP) and the Women's Set-aside of the Prevention and Treatment Block Grant (SAPT BG). Provide appropriate cross training as indicated.
- Identify ways to increase family involvement across systems.

Adolescent Recommendations

Screening

- Identify and promote screening instruments that can be used across disciplines
- Physician Training
- Identify and promote brief screening instrument regarding child and adolescent substance use

Assessment

- The CAFAS instrument is currently required by CSA to assess child and adolescent mental health and behavioral disorders. Although the CAFAS is not designed to measure treatment outcomes, information collected through the instrument has also been used to document outcomes... The Workgroup strongly recommended that a universal instrument be adopted to assess child and adolescent substance use; however, they felt that the CAFAS was not the appropriate assessment instrument and that an instrument specifically designed to assess outcomes was needed. In order to identify a more appropriate instrument and a cost and clinically effective implementation plan, group recommended a workgroup be formed and that the state seek technical assistance from a local university, the Center for Treatment, or another entity with expertise in this area to assist the workgroup.

The workgroup should include representation from

- CSBs – director and line staff level to provide input regarding both clinical and implementation.
- A psychiatrist with adolescent experience
- A pediatrician
- Other agencies providing direct treatment services such as DJJ, DSS, DOE
- Agencies, that provide transitional and adjunctive services

Select standardized instruments that can be used across systems to 1) assess substance use and 2) track outcomes. These instruments must address

- Cultural competency
- Co-occurring disorders
- Trauma
- Literacy
- Learning disorders
- Family functioning

- Train appropriate providers from agencies such as CSBs, DJJ, and DSS in the recommended use of assessment and outcome instruments. Provide booster sessions at appropriate recommended intervals to ensure adherence to instruments
- The State should provide financial support for costs associated with application of these instruments including purchase, training, and license technology involved in collecting or analyzing data.
- Train CSA, DJJ, and DSS, staff in application of the instrument

Residential Treatment

- The group felt strongly that the state ought to fund at least one adolescent residential treatment program. Virginia has only one residential treatment program in the state – Deep Run Lodge/ Vanguard - that specifically addresses

Services for Youth age 18 – 21

The group expressed concern that:

- This population is not seen as a treatment priority.
- Adult services provide less aggressive outreach than adolescent programs and youth are more likely to drop out when transferred to adult services.
- Staff that serves this population lack training regarding co-occurring disorders.

Recommendations:

- Develop independent living services for 18 –21 year olds.
- Increase priority to treat this population.
- Develop and provide support services.
- Remind /change policy to require that CSBs treat similarly to mental health.
- Increase funding. (CSA cuts off at 18 years old; Medicaid eligibility and coverage)

Create Infrastructure to Develop and Support Adolescent Services

The OCFS submitted an adolescent infrastructure grant proposal to CSAT which included the hiring of an Adolescent treatment Coordinator, creation of an interagency workgroup dedicated to addressing and resolving adolescent treatment needs and service delivery across systems, provision of workforce development activities specific to adolescent substance use and co-occurring disorders and a commitment to sustaining these activities beyond the 3 year grant period. The workgroup felt these activities are essential to the provision of adolescent SA services and that a plan needed to be

developed to 1) provide these activities in the event the grant application is not funded and 2) sustain activities if grant funding is awarded.

- Identify resources for adolescent substance abuse within the CSBs and communities
- Develop a formal interagency substance abuse workgroup to address child and adolescent substance abuse and co-occurring disorders treatment needs and which would be responsible for providing recommendations to CFBHPPC. If the Adolescent grant is funded, this workgroup will serve as the basis for the interagency Adolescent Substance Abuse Work group proposed in the grant application.
- Request funding from the General Assembly to support funding for an Adolescent Substance Abuse Coordinator position in OCFS
  - Effective SFY 2008 if grant funding awarded
  - Effective sooner if grant not awarded
- Encourage development of a provider network/coalition for adolescent substance abuse treatment providers. OCFS will identify CSB staff responsible for provision of adolescent substance abuse services and develop an e-mail distribution list to share information regarding trainings and other issues of interest. BRBH has expressed interest in convening interested providers to develop an Adolescent Substance Abuse Coalition.
- Increase participation of Adolescent substance abuse providers on VACSB's Child and Family Task Force. Identify other workgroups and coordinate efforts.

Funding

Medicaid

- Approve specialized coverage for residential and intensive outpatient treatment services for adolescent treatment. The state currently has specialized provisions to provide residential and Intensive Outpatient Program (IOP) substance abuse services to pregnant women; the group recommended that coverage also be introduced for adolescents).

Private insurance

- Regulations need to be consistent with treatment needs
- VA insurance Commission needs develop regulations for adolescent IOP based on adolescent treatment needs and realities rather than adult requirements.

Schools

- The workgroup expressed concern that schools are reluctant to identify substance abuse because it obligates them to fund through age 22
- Encourage Memoranda of Understanding (MOUs) between schools & CSBs; provide/arrange for technical assistance to develop such MOUs

CSB School based services

- Need consistent format across CSBs for charts and other record keeping

- Decrease paperwork and charting requirements to free up time for increased services: set minimal requirements and allow weekly note; don't replicate medical history - allow CSB use school's health information
- FERPA requirements

Workforce Development

- Support professional licensure and accreditation process
  - Provide necessary supervision
  - Provide training re: adolescent substance abuse treatment needs and best practices

Documentation and Information Sharing

- Allow CSBs to combine substance abuse and mental health notes in same chart
- Clarify confidentiality procedures for youth

Appendix I - Office of Child and Family Services Committee/Task Force List

Name of Committee/ Task Force	Meeting Frequency	Purpose
State Executive Council of CSA	Quarterly Meeting	Assure collaborative programmatic policy development, fiscal policy development and administrative oversight for the efficient and effective provision of child centered services to eligible emotionally and behaviorally troubled children/youth and their families in the least restrictive environment.
Sate and Local Advisory Team	Monthly	Address day to day issues regarding CSA for troubled youths and their families
Training and TA Workgroup for CSA	Ongoing	Provide guidance on training needs for CSA
State Child Fatality Review Team	6x per year	Confidential case reviews related to deaths of children in vehicles, due to accidents, hypothermia and unknown causes.
329 G /330 F Child and Family Behavioral Health Policy and Planning Committee	Monthly	Legislative mandate to develop integrated policy and planning, including the necessary legislation and budget amendments to provide and improve access to mental health, mental retardation and services for children and adolescents
Advisory Council for Juvenile Justice	Quarterly	Advises DJJ on issues impacting children
Mental Health Planning Council	Quarterly	Serve as children representative and advocate for family-oriented, integrated and community-based system of highly quality mental health care.
VA CSB Child and Family Task Force	Quarterly	Provide forum for implementation issues related to children's services and for policy issues.
School Health Advisory Committee	2x per year	To promote improved health for school readiness and the Governor's PASS Initiative.
National Association State Mental Health Program Directors (NASMHPD)	2x per year	Address issues at national level impacting children with SED
State Special Education Advisory Council	Quarterly	Advisory group that deals with issues regarding special education and transition services
Virginia Intercommunity Transition Council	Quarterly	To provide successful transition outcomes for youth and young adults with disabilities by providing leadership and innovation in employment, education, training, and community support systems for all children
Virginia Department of Health Interagency Advisory Committee on Suicide Prevention	Quarterly	To oversee implementation of Virginia's Youth Suicide Prevention Plan recommendations. VDH is the lead agency for suicide prevention.

Name of Committee/ Task Force	Meeting Frequency	Purpose
Mental Retardation Advisory Council Meeting	Quarterly	Committee to deal with implementation issues for services for adults with MR.
Virginia Interagency Coordinating Council	Quarterly	Committee established in Part C of IDEA with the role of advising and assisting the lead agency in the implementation of Part C of IDEA.
Early Intervention Management Team Meeting	6 x per year	State interagency committee that oversees the implementation of Part C of IDEA.
CoCOA	Quarterly	Committee of local council coordinators that meets to deal with local implementation issues and identifies statewide issues regarding Part C of IDEA.
Safe Families in Recovery Project	6 X per year	Decisions making group for services for parents with substance abuse problems whose children are in state custody.
Restructuring Policy Advisory Group	Quarterly	Address strategic planning for restructuring children's mental health, mental retardation, and substance abuse services across the Commonwealth
Virginia Early Childhood Comprehensive System	Monthly	To support the development of a strategic plan to improve the effectiveness and efficacies of state agencies and non-profit organizations and community organizations providing services to children 0-5 year old
Early Child Care Committee	Quarterly	Advisory committee to VDSS for promoting quality child care
Early Intervention Autism Initiative	Monthly	Advisory committee related to autism.
Advisory Council Newborn Hearing Screening	Quarterly	Advisory committee to VDH for implementing newborn hearing screening mandate.
Virginia Genetic Advisory Committee	Quarterly	Advisory committee to VDH on congenital anomalies.
System Leadership Forum	Quarterly	Discuss issues about children that impact state and local levels
Relinquishment of Custody Workgroup	Monthly	Address issues resulting in families having to give up custody of their children so that the children can receive needed mental health services
Child and Family Advisory Committee	Quarterly	Advise and assist the new Office of Child and Family Services
3P's of Perinatal Depression Grant	Quarterly	Provide technical assistance related to women's SA and MH needs, health care needs, improving service capacity & provider training.
Advisory Council on Juvenile Justice	2 x per year	Review grant application
The Commonwealth Partnership	Quarterly	An advisory group for issues dealing with pregnant women and children

Appendix J – Description of System of Care

The definition of a system of care:
A system of care incorporates a broad array of services and supports that is organized into a coordinated network, integrates care planning and management across multiple levels, is culturally and linguistically competent, and builds meaningful partnerships with families and youth at service delivery, management, and policy levels.

Vision and Guiding Principles
The National Technical Assistance Center for Children's Mental Health at Georgetown University provides a framework to help states and communities design their own systems of care. This section incorporates this system of care framework into Virginia's vision for providing and improving access to mental health, mental retardation, and substance services for children and adolescents. The guiding principles and organizing framework for this work are as follows:

Build a system of care using the strengths of the National Technical Assistance Center for Children's Mental Health at Georgetown University's framework and the system of care principles codified in Virginia statute with the Comprehensive Services Act.

Keep focused on children and families, always incorporating their strengths, needs, and viewpoints as a central component in all decisions.

Ensure families have appropriate, timely, and equal access to services.

Provide families information so they know where and how to access services, resources and support.

Integrate health care and behavioral health care since they are inextricably intertwined for children and families.

Provide behavioral health care services in the schools.

Develop preventive and early intervention programs to prevent more serious problems that lead to more intensive and expensive care in the future.

The National Technical Assistance Center for Children's Mental Health at Georgetown University identifies three core values of a system of care. A system of care is

- Child centered and family driven,
- Community based, and
- Culturally competent.

The principles present in an effective system of care are:

- Comprehensive array of services;
- Individualized services guided by an individualized service plan
- Least restrictive environment that is clinically appropriate;
- Families and surrogate families as full participants in all aspects of the planning and delivery of services;
- Integrated services; and
- Care management and similar mechanisms;

- Early identification and intervention;
- Smooth transitions;
- Rights protected, and effective advocacy efforts promoted; and
- Receive services without regard to race, religion, national origin, sex, physical disability, or other characteristics and services should be sensitive and responsive to cultural differences and special needs.

Families and youth play key partnership roles in systems of care. The National Technical Assistance Center for Children's Mental Health at Georgetown University identifies three main points related to involving families and youth:

- Family and youth involvement, support and development at all levels of the system structured, that is, deliberately organized utilizing multiple strategies to engage the families affected by systems of care;
- Structures to involve families and youth include those at the policy, management service levels; and
- Careful consideration must be given to how to maximize family and youth involvement given stakeholder experiences, perceptions, and community/state/locale specific perspectives.

A few states have already begun developing local systems of care that demonstrate positive outcomes for children and families. Those states have started to reverse the trend of sending children out-of-state to receive intensive behavioral health services.

Appendix K- References

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