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, 2005- June 30, 2006

To the Governor and Chairmen 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

Our vision is of a consumer-driven system of services and supports that promotes self-determination, empowerment, recovery, resilience, health, and the highest possible level of consumer participation in all aspects of community life including work, school, family and other meaningful relationships.

COMMONWEALTH of VIRGINIA

DEPARTMENT OF
MENTAL HEALTH, MENTAL RETARDATION AND SUBSTANCE ABUSE SERVICES
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June 28, 2006

The Honorable John H. Chichester, Chairman
Senate of Virginia
P.O. Box 396
Richmond, VA 23218

Dear Senator Chichester:

Pursuant to 2005 budget item 330-F the Department of Mental Health, Mental Retardation and Substance Abuse Services is required to submit a report on *A Policy and Plan to Provide and Improve Access to Mental Health, Mental Retardation and Substance Abuse Services for Children and Adolescents by* June 30th of each year.

This Budget item directs the DMHMRSAS and the Department of Medical Assistance Services, in cooperation with the Office of Comprehensive Services, Community Services Boards, Court Service Units and representatives from community policy and management teams representing various regions of the Commonwealth to 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. Each year the budget number changes for this report and to make sure we keep the stakeholders involved and focused, the Department is calling the committee charged with assisting the Department develop the plan and policy, Child and Family Behavioral Health Policy and Planning Committee.

This report details DMHMRSAS' activities for 2005-2006 to provide and improve access by children and their families to mental health, mental retardation and substance abuse services and includes recommendations for the 2006-2007 fiscal year.

Please feel free to contact me if you have any questions regarding the attached report.

Sincerely,

James Reinhard / J.Y.

James S. Reinhard, M.D.

JSR/sr

Cc: The Honorable William C. Wampler, Jr.
The Honorable Marilyn Tavenner, Secretary of Health and Human Resources
The Honorable Phillip Hamilton
Steve Harms, Deputy Secretary of Health and Human Resources
Susan Massart
Joe Flores
Angie Murphy
Frank L. Tetrick, III
Shirley Ricks

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June 28, 2006

The Honorable Vincent F. Callahan, Jr., Chairman
House Appropriations Committee
General Assembly Building
P.O. Box 406
Richmond, Virginia 23218

Dear Delegate Callahan:

Pursuant to 2005 budget item 330-F the Department of Mental Health, Mental Retardation and Substance Abuse Services is required to submit a report on *<u>A Policy and Plan to Provide and Improve Access to Mental Health, Mental Retardation and Substance Abuse Services for Children and Adolescents</u> by* June 30th of each year.

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Table of Contents

Executive Summary

General Assembly Guidance

In 2003 and 2004, the General Assembly issued Budget Items 329-G and 330-F respectively. These budget items directed the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) to continue the committee with the same budget language related to improving access to services for children and their families across disabilities and requires DMHMRSAS to report the plan to the Chairmen of the Senate Finance and House Appropriations Committees by June 30th of each year. In September 2005, the Department of Mental Health, Mental Retardation and Substance Abuse Services submitted a third report, *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 330-F and the report delineated the recommendations to improve access to mental health, mental retardation and substance abuse services for children and their families. The report included 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 needs in rural communities.

The current budget language of the 2005 Appropriations Act, Budget Item 330 F:

> *"The Department of Mental Health, Mental Retardation, and Substance Abuse Services, the Department of Juvenile Justice and the Department of Medical Assistance Services, in cooperation with the Office of Comprehensive Services, Community Services Boards, Court Service Units, 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 cost and source of funding for the services, the strengths and weaknesses of the current service delivery system and administrative structure, and recommendations for improvement. The plan shall also examine funding restrictions of the Comprehensive Services Act which impede rural localities from developing local programs for children who are often referred to private day 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 cost 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."*

Several studies have been completed in the last five years demonstrating that there is much interest in, and awareness of, the significant problems in the children's behavioral health services system in Virginia. Children make up 24% of the population in Virginia, but receive only 10% of state behavioral health funds; an inequity that undermines the development of needed services for children. When one examines Virginia's behavioral health care system several themes emerge:

Total System Transformation Dollars

Children's

- Lack of service capacity;
- Poor access to care;
- A shortage of child and adolescent psychiatrists and psychologists;
- Fragmentation of services;
- Lack of knowledge about what services are available;
- Lack of family involvement; and
- Other systems are left to provide care.

As noted in the 2005 report:

> "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."

General Assembly Support

Many people have been concerned about the very large sums that the Commonwealth has spent in recent years on residential treatment services. It is a problem that referral sources are accustomed to placing children in residential care. However, the main reason that children are placed in residential treatment is that the community-based services that children need to stay out of residential treatment do not exist, leaving families and communities with no other option but to place their children in residential care. The Virginia General Assembly has responded by providing funding for children's services as part of a broader transformation initiative for community services for children's behavioral health care.

Report Linkages with DMHMRSAS

DMHMRSAS is engaged in a major transformation of its mental health system that is 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. The system of care concept of serving children and their families is an approach that effectively supports this vision. DMHMRSAS worked in collaboration with the Office of Comprehensive Services (OCS) in developing this guidance, a reflection of the shared commitment to gaining the greatest impact from this funding initiative. The DMHMRSAS will fund two projects that create a capacity to serve youth in the most natural setting possible and that demonstrate local or regional intent to maximize all available funding streams in support of developing systems of care. Funded projects shall also demonstrate a commitment to provide services in a manner that utilizes evidence-based practices for serving youth with behavioral health needs.

This report builds on the 2005 report by outlining a ten-year plan for developing children's behavioral health services in Virginia organized around three goals with strategies, activities, and measures. The goals are:

- Healthy, strong, resilient, stable families as evidenced by children who live in a safe home, attend school, make educational progress and are involved in positive peer activities and have their needs for healthy development met in their homes and communities.
- Equitable access to services without regard to racial/ethnic status, socioeconomic status, and geographic location as evidenced by all children having health insurance, mental health and substance abuse services that are covered under private insurance, and children and families who have access to behavioral health services and supports when they need them.
- Children are provided with humane, least-restrictive and effective services that support healthy child development, as evidenced by children's needs that are accurately assessed, children's needs that are matched to appropriate treatment interventions and levels of care, and family and child preferences and strengths that are driving forces in treatment planning. Additionally, clinicians and treatment programs utilize evidence-based, promising and best practices. (See Appendix B)

Priority Funding Recommendations for FY 2008

1. **Increase Service Capacity:**
    - Provide mental health services in all eight remaining juvenile detention centers without them @ $1.2 million
    - Provide school-based mental health clinicians in 20 middle schools in five regions @ $1.8 million
    - Fund four new pilot projects @ $2 million
    - Fund a web-based acute psychiatric bed reporting system @ $75,000

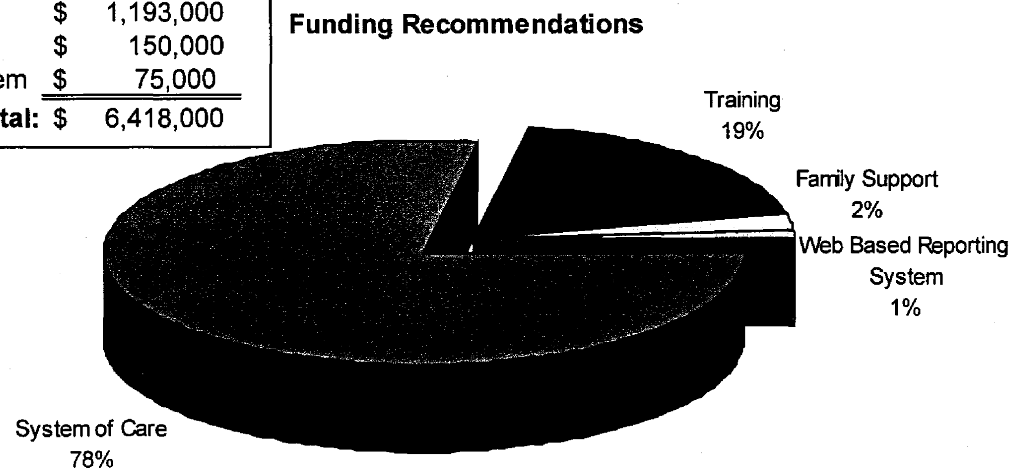
2. **Increase the Size of the Workforce:**
    - Fund four child psychiatry fellowship and four child psychology internship slots @ $493,000 with payback provisions to work in underserved areas in Virginia

3. **Enhance Workforce Capacity:**
    - Establish a university-based teaching center to organize, coordinate and lead the training of clinicians in evidence-based, promising and best practices for children's behavioral health treatment across the Commonwealth @ $300,000
    - Fund trainings – including regional, web-based, telemedicine and other forms of education – in evidence-based children's behavioral health services for behavioral health clinicians @ $200,000
    - Fund trainings – including regional, web-based, telemedicine and other forms of education – in children's behavioral health services for pediatricians and family practitioners @ $200,000

4. **Provide Families with Information and Support:**
    - Expand funding for a statewide family education, information and support network @ $150,000 to provide families with information about services available to their children, link families with support systems, and educate the public about the needs of children with behavioral health problems

Total Cost of Recommendations: $6,418,000

System of Care	$	5,000,000
Training	$	1,193,000
Family Support	$	150,000
Web Based Reporting System	$	75,000
Total:	$	6,418,000



Full Report

Introduction

Mental health is a critical component of children's learning and general health. Fostering social and emotional health in children as a part of healthy child development must be a priority. Virginia's Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) embarked on reform of the public child behavioral health service system as early as 2002. The impetus for this reform was in response to growing concern about serious bottlenecks and quality issues in children's mental health services. The General Assembly required the Department of Mental Health, Mental Retardation and Substance Abuse Services to convene an advisory committee and to submit a report with recommendations for improving access to services for children and their families across disabilities. The legislative intent of the budget language included financing and service delivery system mechanisms for children's behavioral health, recommendations for policy changes, and family involvement. The creation of the Office of Child and Family Services in 2004 was designed to eliminate the major infrastructure gaps and barriers that have plagued children's behavioral health in recent years and allow children with behavioral health problems to grow and develop within nurturing family environments, increasing their ability to succeed in their homes, schools and communities. The Office builds on system of care principles that are family-driven and family-focused services, giving families choice and helping families to care for children who have behavioral health challenges. The Office supports and emphasizes the strengths of individual families and children and is culturally responsive.

For this vision to succeed, a partnership is required among families, providers, community members, and other State agencies. Building this new system is an evolutionary process that will require time for planning, training and capacity building, and a gradual phase-in of fully working systems. It will also require changes in structure, organization, management, financing, practice, and philosophy, affecting those involved at every level, from families to providers to state agencies. This report outlines a framework for transforming the child and adolescent behavioral health system 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.

Current Status of Initiatives

Since one in five children has a mental health disorder and one in nine has a serious mental health disorder, many children are not receiving the treatment they need because of lack of funding. Developing community-based systems of care will allow localities to shift monies from high-cost, highly restrictive treatments like residential treatment and move them toward lower costs, effective services like day treatment and wraparound services, thereby allowing more children to be served and in settings that are either at home or close to their home community. At present, most of the children with serious mental health disorders in Virginia are not being served. They are on waiting lists at local Community Services Boards. Of those who do receive services, most receive only the most basic of services, case management and possibly medication management. Very few children receive individual or family therapy. Even fewer receive mid-level services, such as day treatment or wraparound services, that allow them to function successfully in their communities and keep them out of hospitals and residential treatment centers. As a result of not being able to access needed services in the community, families have to give up custody to DSS so that their children may receive costly out of home residential treatment services. Others end up involved in the juvenile justice system including detention and incarceration in state facilities, costing a great deal of money that could be saved if they had been provided with less costly mental health services in the community.

Two key recommendations of the 2005 report that the General Assembly supported were expanding the capacity of the family behavioral health services system for community-based services by funding to expand system of care demonstration projects and juvenile justice/mental health projects. The impetus for the request came from two sources. First, the vast majority of money for child and adolescent mental health is spent on a small number of children in foster care and children whose school Individual Education Plans specify that they require residential treatment. Second, most of the money that is spent pays for residential treatment, rather than community-based alternatives that keep children with or close to their families. Both of these initiatives brought the children's behavioral health system closer to achieving the goal of meeting the growing need for families to receive services in their own communities, thereby ensuring that they would be fully integrated into community living. (Appendix A)

The system of care framework is designed to coordinate and integrate care planning and management through partnerships with families and youth. This coordination occurs at multiple levels, from service delivery to public policy and is built on a foundation that is both culturally and linguistically competent. [1]

Two collaborative programs to demonstrate evidence-based practices within a system of care framework were initiated in September 2005 with Community Services Boards. The target populations for these demonstration projects are:

- Children with serious emotional disturbances who are involved with the juvenile justice system
- Children who will be returned from residential care with appropriate community services funded by this demonstration project
- Children who have co-occurring mental health and substance abuse problems.

System of Care Demonstration Projects

Two CSBs participated in the first round of demonstration projects made possible by the support of the General Assembly. Richmond Behavioral Health Authority (RBHA), with the assistance of the Virginia Treatment Center for Children, implemented MultiSystemic Therapy (MST), an intensive family- and community-based treatment that addresses the multiple determinants of serious antisocial behavior in juvenile offenders. This approach views individuals as being nested within a complex network of interconnected systems that encompass individual, family, and extra familial (peer, school, neighborhood) factors. Intervention may be necessary in any one or a combination of these systems.[2]

Based on the literature regarding outcomes for MST, the number of arrests and days spent in foster care, psychiatric facilities and corrections can be expected to decrease as the youth complete the MST program. Also expected are decreases in drug and alcohol use and increases in school attendance. Expected outcome measures for this evaluation include, but are not limited to, improved family relations, decreased psychiatric symptoms, decreased re-arrests and decreased substance use. The RBHA program has successfully completed a series of implementation steps, including meeting with referral sources, MST Services consultants and others; hiring staff; establishing office space; and procuring needed computers, cell phones and transportation. The program's clinical supervisor and two of the three clinicians have completed the initial five-day MST training. The program is currently recruiting for a fourth clinician.

The program began serving children in February 2006. Preliminary data on children served at the end of one quarter include the following information: 30 children have been referred to and reviewed for project services. Complete initial data is available on 19 children and these data include measures taken as the adolescents enter the MST program. The average age of children enrolled was 16 years. All were non-Hispanic African-Americans. Seventeen were male and 2 were female. The table below provides data available at the end of the first quarter of serving children.

Preliminary Data on Children Referred to and Served by RBHA MST Project

Total number of children referred	30	
Total number of children enrolled for service	19	
Average age	16	
Number of arrests in the past year (average)	2.8	
Days in foster care in the past year (average)	0	
Days in psychiatric facility in past two years (average)	2.1	*No days* 70%
Day in corrections in the past year (average)	42	*No days* 50%
Any drug or alcohol use	Yes 11	No 7
Attending school regularly	Yes 9	No 8

Services provided to participating youth include individual therapy, family therapy, case management, and crisis intervention. Only one youth has dropped out of the program. Currently, all participants remain in the home with either a parent or legal guardian. Three teens were placed out of the home on a temporary basis, two were hospitalized and one was placed in detention. These youth have returned home and are currently receiving community services.

The Planning District 1 Demonstration Project involves the implementation of Functional Family Therapy (FFT), which is a family based prevention and intervention program that has been applied successfully in a variety of situations to assist youth and their families. The model consists of a systematic and multi-phase intervention map that provides a framework for clinical decisions within which the therapist can adjust and adapt the goals to the individual needs of the family. An FFT team is made up of 3-8 clinicians who receive intensive, sustained training.[3] Expected outcome measures for this project include but are not limited to improved relational skills (e.g., communication, parenting) and preventing matriculation into more restrictive, higher cost services.

For the Planning District 1 project, many of the implementation steps are complete, including hiring of clinical staff and a family/parent partner to assist with family groups, procurement of child psychiatry services, equipment and transportation, acquiring the appropriate licensing agreements and outcome measure requirements from the FFT consultants. The program has experienced some challenges in filling all of the necessary positions and some subsequent delays in scheduling the required FFT training for each staff member hired. Experience in establishing these two demonstration projects using evidence-based practices indicates that some delays and obstacles in hiring and initial program start-up are to be expected. Evidence-based practices require highly qualified staff and supervision, as well as flexibility regarding the working environment. Planning District 1 anticipates beginning to serve children in July 2006. Referrals will be accepted to the program at that time and assessed for their appropriateness for the FFT.

These two sites are participating in an evaluation process led by DMHMRSAS and an evaluation advisory group. The evaluation will focus on child and family-specific outcomes resulting from the provision of these evidence-based practices in a system of care context. Baseline data will be collected on each child and progress will be tracked according to core outcomes associated with the specific evidence-based practice. Additionally, the evaluation will also assess parent involvement with services. Initially, these projects will serve 60 to 75 children each year who have severe behavioral health needs.

Both programs generate referrals primarily from the juvenile justice system. They regularly meet with community stakeholders from the Department of Juvenile Justice, the Department of Social Services, Detention Centers and others to establish, coordinate, and refine the referral protocols to ensure timely access to services. DMHMRSAS staff has participated and provided guidance to each project site through technical assistance visits, teleconferences and other communications. Each site has presented information to the Juvenile and Domestic Relations Court judges, Court Services Unit Director, and others in its community regarding how these new evidenced-based practices will complement existing programming.

Mental Health/Detention Center Projects

Eight Community Services Boards (CSBs) are currently providing mental health and substance abuse services in juvenile detention centers. CSBs house staff (a clinician and a case manager) at the local juvenile detention centers to provide mental health screening/assessment and other mental health and substance abuse services as indicated by the initial intake and assessment process. Five of the projects are funded with a combination of federal and state funding, while three programs are fully funded with state general funds. The eight CSBs and their detention center partners involved with this initiative are:

- Central Virginia CSB/Lynchburg Juvenile Detention Center
- Chesapeake CSB/Chesapeake Juvenile Justice Center
- Chesterfield CSB/Chesterfield Juvenile Detention Home
- Crossroads CSB/Piedmont Juvenile Detention Home
- Norfolk CSB/Norfolk Juvenile Detention Home
- Planning District One Behavioral Health/Highlands Juvenile Detention Home
- Richmond Behavioral Health Authority/Richmond Juvenile Detention Center
- Valley CSB/Shenandoah Juvenile Justice Center.

Data gathered from all eight programs involving 1,217 youth admitted to the eight detention centers in the first quarter of calendar year 2006 includes the following information:

- 1,081 mental health assessments were performed on youth in detention
- Case management services were provided to 689 youth
- Individual counseling services were provided to 457 youth
- Group counseling services were provided to 340 youth
- 75 youth received crisis intervention services while in detention
- 60 youth were prescribed psychotropic medications
- Only 19 youth were referred for psychiatric inpatient services.

Consistent Themes and Recommendations from Previous Reports

Many people continue to be concerned about the very large sums that the Commonwealth has spent in recent years on residential treatment services. It is a problem that referral sources are accustomed to placing children in residential care; however, **the primary reason that children are placed in residential treatment is that the mid-level community-based services that children need to stay out of residential treatment do not exist**, leaving families and communities with no other option but to place their children in residential care.

The lack of capacity that exists in children's behavioral health services means that not only are services unavailable in many areas, 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 where 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 services.**

This report is a follow-up to the 2005 report to the Legislature. As such, it does not repeat the findings of last year's report, which can be found in Appendix A. To summarize the past several reports about Virginia's behavioral health care system for children, several themes emerge:

- Lack of service capacity;
- Limited access to care;
- Lack of a full continuum of community-based care;
- A shortage of child and adolescent psychiatrists and psychologists;
- Fragmentation of services;
- Lack of knowledge about what services are available;
- Lack of family involvement;
- Lack of statewide evidence-based treatments; and
- Other systems are left to provide care.

Primary Challenges To the Behavioral Health Care System in Virginia

There has been some improvement in the service system for children receiving behavioral health services in the Commonwealth over the last two years. The 2005 report identified significant problems in the current way services are organized, financed, and delivered and pointed to five major needs of the service system. This report continues to emphasize the challenges identified in the 2005 report, which are:

1. Better mechanisms for coordination of care;
2. Enhanced community-based resources and treatment alternatives;
3. Integrated funding;
4. Family involvement in policy as well as service planning for their own children; and
5. Redistribution of resources and refinancing of the service system.

Community Improvement - A Ten Year Plan For Children's Behavioral Health Services in Virginia

This year's report focuses on a 10-year plan for children's behavioral health in the Commonwealth. The plan, which is outlined in Appendix B, attempts to achieve three goals:

1. Healthy, strong, resilient, stable children and families;
2. Equitable access to health and behavioral health services; and
3. Humane, least restrictive, and effective services that support healthy child development.

The plan outlines broad strategies to meet these goals, activities that carry out the strategies, and measures of outcomes to determine whether the goals have been met. While it is extensive, the plan is not intended to be exhaustive; that is, strategies, activities and measures may be added or amended as needed. Rather, the plan is intended to outline an initial roadmap towards the development of healthy children and families in the Commonwealth over the next decade. The following discussion will touch upon the highlights of the plan, particularly focusing on those priority areas in which the Committee is making recommendations for the 2007-2008 fiscal year. For a more detailed listing of strategies and activities, please refer to the plan in Appendix B.

The goals are:

Goal 1: Healthy, strong, resilient, stable children and families

Increase service capacity. We all want our children to live in safe, nurturing homes; to attend and make progress in school; to be involved in positive peer activities; and to have their needs for healthy development met in their homes and communities. The Committee believes that this can best take place in communities and regions that have systems of care in which the agencies and service providers (schools, doctors, therapists, etc.) communicate and collaborate to provide children and families with the best possible care and services.

To create systems of care, services must first be available, and then be interwoven around the needs and strengths of the family. As the 2006 CFBHPPC Report (Appendix A) stated, **the biggest single obstacle to creating systems of care for children and families in Virginia is lack of service capacity**. Virginia ranks 30th among states in spending on behavioral health services, but even that funding is disproportionately spent on adults with mental illnesses. **While children make up 24% of the state's population, only 10% of the state's funding for behavioral health services goes to children**. Mid-level services such as wraparound services, day treatment programs, after school behavioral health programs, intensive outpatient programs, crisis intervention programs, and respite care serve to keep children in their homes and communities rather than placing them in expensive residential care away from their families.

- **To build service capacity for children and families, the Committee recommends that a fund be created to provide incentive grants to start up new behavioral health services. In particular, there is a very strong need to initiate mid-level services that are in-between outpatient and inpatient/residential care.**

Other interventions would also increase the capacity of the children's behavioral health system. Adding adolescent substance abuse services to the state Medicaid plan would facilitate the treatment of youthful substance abusers rather than waiting until they are older and their substance abuse becomes more entrenched or turns into an addiction. It would be useful to conduct a study of what would be required for Medicaid to suspend rather than end Medicaid benefits when adolescents are placed in detention to determine whether suspension of benefits would allow them to obtain behavioral health services more quickly and spend fewer days in detention awaiting services. Finally, if the Office of Comprehensive Services were authorized to use current CSA funds more flexibly to help start new services, service capacity could be built more quickly.

- **Since the current programs providing mental health services to youth in detention centers have resulted in lower rates of recidivism, we recommend that mental health services should be provided in the eight remaining detention centers that do not currently have them.**

Build the workforce. Even if more behavioral health services are funded, service capacity cannot increase without both growth and enhancement of the workforce. **Virginia faces a critical shortage of specially trained child and adolescent behavioral health clinicians. In particular, we face a shortage of child and adolescent psychiatrists and psychologists.** One means of growing the workforce would be to fund four two-year university-based training slots for child psychiatry fellows and four one-year university-based training slots for child psychology interns. Fellows and interns would be required to repay the Commonwealth for their training by serving in underserved areas for an amount of time equivalent to the amount of time they spent in subsidized training. That way, the Commonwealth could ensure an increased number of well-trained child and adolescent clinicians working in areas that currently do not have a sufficient number of specialized behavioral health providers.

Building the workforce by funding additional training slots is a strategy that will become effective over time; however, the critical workforce shortage requires that additional steps be taken now to enhance the current workforce. Methods of teaching might include regional and web-based trainings, video- and teleconferences, telemedicine, consultation and technical assistance.

- **We recommend that the Commonwealth *establish a university-based teaching and training center* to coordinate and lead the training of clinicians in evidence-based, promising and best practices for children's behavioral health treatment. This center would provide the infrastructure to establish competency standards and organize behavioral health training and consultation.**

To build the skills of the workforce, we recommend two sets of specific trainings around the most effective methods of treatment for children, youth and families. One set of training would be provided to psychiatrists, therapists and counselors who do not currently specialize in the treatment of children and youth, so that they could expand their practices to treat children under the age of 18. Another set of training would be provided to pediatricians, family practitioners and other physicians who currently provide some of the behavioral health care for children and 80% of the psychotropic medication for them. Further trainings could be provided in areas such as how to do wraparound services. These would be followed by technical assistance and consultation by training center staff, some conducted in person, others via telemedicine. Combining trainings with individual and small group follow-up would enhance the skill sets of clinicians around the state who work with or wish to work with children and families.

Service agency collaboration. For services to work efficiently and not at cross-purposes, service providers need to communicate, collaborate, and coordinate their efforts around families. There are both structural and functional barriers to collaboration. Because lack of reimbursement provides a disincentive to coordinate care, we recommend that providers be reimbursed for communicating with each other to coordinate patient care. **Neither the public sector nor the private sector alone can solve the problems of the children's behavioral health system; both must be engaged.** Allowing public-private partnerships to collaborate around seeking funding for new services will allow knowledge about how to develop a system of care to spread from locality to locality, which is critical because of our locally-based system of government in the Commonwealth.

- **Therefore, we recommend that the public system continue to collaborate and strengthen private partnerships in order that the public system use state funds for new services. DMHMRSAS should develop criteria to identify two local Centers of Excellence in Systems of Care, then provide funds for those Centers to train and mentor similar localities.**

Share information. Systems of care are efficient in part because families who utilize one part of the system gain access to needed services throughout the system. One important tool that would help families to access services through any door is to develop and implement a single intake instrument for families that contains core information required by any service provider. DMHMRSAS, DSS, DJJ, VDH, DOE, and OCS should work together to develop a single intake instrument that shares core information, while collecting information related to only one area in a module specific to that area. Ideally, all state child-serving agencies will one day develop a shared management information system so that information can be easily shared.

In the meantime, it is important to develop shared sets of information to improve children's behavioral health services in the Commonwealth. One critical area about which we need to gather and share information is the need for acute psychiatric beds for children and youth, since there are complaints throughout the Commonwealth about a shortage of beds when children are in crisis.

- **Therefore, we recommend that the state develop a web-based psychiatric bed reporting system, that would not only provide persons seeking a bed for a child with information about available beds quickly, thereby saving valuable time, but also would collect information about when, where, and how much of what kinds of beds are unavailable. Only then will we be able to determine how serious the reported psychiatric bed shortage is.**

Maximize EPSDT. One mechanism to increase access to services is through the use of Early Periodic Screening and Diagnostic Testing (EPSDT). Under federal law, when a physician conducts an EPSDT evaluation, problems that are identified during the evaluation can be treated with services that are paid for by Medicaid, even if those services are not in the Medicaid state plan. For example, if an adolescent is found to have a substance abuse problem during an EPSDT screen, he can receive substance abuse treatment that is reimbursed by Medicaid. **EPSDT screenings could be used to access a variety of needed services, such as substance**

abuse treatment, wraparound, crisis stabilization, residential treatment for co-occurring disorders, and intensive outpatient programs. However, this is only true if – and this is a big if – those services exist in the first place, which is why capacity enhancement is the foundation of reform of the children's behavioral health system in Virginia.

Keep children in school. Children with behavioral health problems need to be in school just like any other child. Some of them are labeled as behaviorally disordered or seriously emotionally disturbed (SED) and receive services through their Individual Education Programs (IEPs). **One in nine children meet criteria for SED, but far fewer receive IEPs that address their serious emotional disturbances**. Moreover, **only 1 in 5 children with a serious emotional problem receives treatment**. Many children and adolescents with untreated psychiatric problems act out in school, some becoming destructive and/or violent. They are often suspended and sometimes expelled for their actions. Sometimes they are even arrested. The result is that **children with behavioral health disorders are punished for their disorders by being removed from school, and having their behavior criminalized punishes some**. This is not only a serious problem; it is also a violation of federal law.

There are better ways of managing children's behavioral health problems in school. There is a nationwide movement towards providing mental health services in schools, which has been shown to keep children in school, improve grades, decrease truancy and dropout rates, and decrease referrals to detention. Virginia does not have a strong school-based mental health program.

- **We recommend funding a pilot program that provides school-based mental health therapists in 20 middle schools across five regions of the state. Other strategies for keeping children with behavioral health problems in school include funding bullying prevention programs, promoting alternative education programs for children with SED, and expanding care connection centers to include children's behavioral health.**

Keep children with behavioral health problems in their homes. A 2005 State Executive Council study found that **nearly 2,000 children, or 1 in 4, in state custody were placed there solely to obtain needed behavioral health services**. **This is a tragedy**. The DMHMRSAS, DSS, VDH and the Office of Comprehensive Services need to work together to develop and implement strategies that prevent children from being placed in DSS custody to access behavioral health services. To do this, Family Assessment and Planning Teams need to use CSA funds to serve all children at risk of out of home placement, not just those in DSS custody. Because funds will be used for children in their homes rather than in state custody, serving children at home will keep families together and will not increase costs to the state.

- **We recommend that DSS eliminate the practice of accepting children into custody to obtain mental health services.**

Prevent child abuse. One of the most common factors leading to mental health problems is child abuse. In fact, child abuse has been linked to almost every serious teenage problem, including psychiatric problems, substance abuse, teen pregnancy, truancy, dropout, school failure, and juvenile delinquency, all of which are linked to children's behavioral health problems. **Home visitation of at-risk children by nurses during pregnancy and the first two years of a child's life has been shown to significantly decrease rates of all of the problems listed above and more, while saving $4 for each $1 invested**. The child abuse prevention program with the best long-term results is the Nurse-Family Partnership program originated by David Olds. Both the Nurse-Family Partnerships and Child-Parent Centers are evidence-based programs with many years of research supporting them.

- **We recommend that the state fund Nurse-Family Partnerships around the Commonwealth to serve high-risk families. We also recommend that the state fund Child-Parent Centers in preschools and elementary schools in high-risk neighborhoods, since they have been shown to reduce child abuse, psychiatric problems, and substance abuse while improving educational and economic outcomes. Finally,** we **recommend that the state evaluate the outcomes of existing child abuse prevention programs and compare them with the outcomes of evidence-based programs to determine which programs to fund in the future.**

Goal 2: Equitable access to services without regard to racial/ethnic status, socioeconomic status, and geographic location as evidenced by all children having health insurance, mental health and substance abuse services that are covered under private insurance, and children and families who have access to behavioral health services and supports when they need them.

Children and their families must be able to attain equitable access to services and supports when they need them without regard to racial/ethnic status, socioeconomic status, or geographic location. In order to have this level of access, all of Virginia's children first must have health insurance, including parity for mental health and substance abuse services and supports. To accomplish this we must implement several steps.

Provide health insurance coverage and behavioral health parity for children. First, we need to examine the current health insurance model in Virginia and other states to determine the best approach to increase the number of children covered by health insurance. Recently, Massachusetts implemented a popular health coverage program for children.

- **We recommend that the General Assembly study this program to determine if the Massachusetts model can be replicated in Virginia. Concomitantly, we ask that the General Assembly promote legislation that provides health insurance for all of Virginia's children.**

Next, although parity in mental health and substance abuse coverage is a federal requirement, actual coverage among insurance companies varies greatly. A recent study of parity across many plans demonstrates that companies who have higher mental health and substance abuse coverage do not incur greater costs (see Appendix I). We need to educate private insurers regarding cost offsets and the positive economic impact of insurance coverage for mental health and substance abuse services.

- **To remedy this wide range of service coverage options, we recommend that Virginia work to expand the number of private insurers who offer parity in mental health and substance abuse service coverage.**

Return to the original intent of the Comprehensive Services Act (CSA). An important step in this process of improvement of services for children with behavioral health problems is to enact the original intent of (CSA) so that at-risk children with behavioral health problems can access services and supports not currently provided to them. CSA has been a wonderful way for many children and families to gain access to services that followed the systems of care approach. However, most children with significant behavioral health service needs do not get those services because they are not in DSS custody or do not require residential services in their IEPs. This must be changed to meet the needs of behavioral health needs of children and their families. To do this, CSA must: eliminate the distinction between mandated and non-mandated children and, require FAPT teams to serve all children at risk of out-of-home placement for behavioral health problems.

Fund community-based systems of care. Next, Virginia needs to provide a public safety net for the mental health, substance abuse, and mental retardation service needs of children and their families. In order for this to happen, we need to support a full array of services in communities. We recommend that the General Assembly provide public and private agencies that subscribe to system of care (SOC) principles access to additional funding to start up new community-based behavioral health services that are evidence-based or promising practices, particularly mid-level services such as: wrap-around services; day treatment; after-school behavioral health programs; intensive outpatient programs; crisis intervention programs; respite care; in-home family therapy; intensive case management; mobile crisis teams; drop-in clinics for teens; and clinics for children with co-occurring mental health/substance abuse disorders. Additionally, we see the need for equity and consistency across CSBs in providing children's behavioral health services.

- **We recommend that Virginia continue to fund additional SOC pilot projects in Virginia communities. In addition we recommend that the legislature appropriate funds to provide school-based mental health services across the state and for the provision of mental health services in all of the remaining juvenile detention centers without them. We recommend that the Legislature fund and DMHMRSAS require all CSBs to have designated child and adolescent service providers for mental health, mental retardation, and substance abuse services.**

One of the major reasons providers give for closing some services (such as children's inpatient psychiatric beds) and declining to provide others (such as day treatment) is that the Medicaid reimbursement rates for such services are too low. **There has not been a Medicaid rate study for behavioral health services since 1994.**

- **We strongly recommend that DMAS conduct a comprehensive rate study to assess whether behavioral health service rates need to be increased, particularly in the following areas: outpatient psychiatry; primary care physicians who provide behavioral health services; acute in-patient hospitalization; day treatment; and, intensive in-home family services.**

Provide families with information and support. Lastly, we need to strengthen family and professional partnerships to improve access to services so that entry into and on-going use of services within the system is less fragmented and readily available to families in crisis.

- **To do this, we recommend that the General Assembly expand funding for a statewide family information and support network to provide families with information about services available to their children link families with support**

systems, and educate the public about the needs of children with behavioral health problems. We also recommend that Virginia work to expand membership of families on local, regional, and state boards, councils, and committees that make decisions about children's behavioral health services, thereby ensuring authentic involvement of families in policy development that has an impact on service development in the Commonwealth.

Goal 3: Children are provided with humane, least-restrictive and effective services that support healthy child development as evidenced by children's needs being accurately assessed, and that are matched to appropriate treatment interventions and levels of care, and family and child preferences and strengths that are driving forces in treatment planning. Additionally, clinicians and treatment programs utilize evidence-based, promising and best practices.

While the first two goals focus on resilient children, stable families, and equitable access to services, goal three addresses the quality of services that are provided.

Four indicators have been identified that support this goal.

Accurately assess children's behavioral health needs. One of the President's New Freedom Commission on Mental Health's goals is that early mental health screening, assessment, and referrals to service become common practice. **The report states early assessment and treatment prevents mental health problems from compounding and poor life outcomes from accumulating.** The report also emphasizes that early detection, assessment, and links with treatment and supports that can prevent mental health problems from worsening. It is essential that Virginia set standards for comprehensive assessments and provide training across child providers.

A uniform comprehensive assessment should be developed that addresses the needs of the child and family using a strengths-based approach which incorporates the capabilities of the child, their current level of functioning, family functioning, availability of natural resources, and social supports, as well as safety issues and risk factors (individual, family, peer, and community). Comprehensive assessment utilizes information gathered by previous service providers; such assessment included needed testing and/or assessments; and utilize the expertise of a multi-disciplinary team to develop diagnostic impressions and practical recommendations for treatment. Gathering information from those who know the child in their natural environment, having a local resource for evaluations, and providing timely reports and recommendations, will result in better services to children and families and improved utilization of state and community resources.

Match children's needs to appropriate treatment interventions and levels of care. Accurate assessments mean little if services are not available. Even if they are available, that does not guarantee that children's needs will be met at the appropriate levels and intensity of treatment. The evaluators who assess children's behavioral health needs will need to be familiar with the services available in their home communities and match the child's needs to available, appropriate and effective treatment resources.

Focus on family and child preferences. Third, family and child preferences and strengths are driving forces in the assessment and treatment plan. In the past, families have not always been included in a meaningful way in service planning for their children. All comprehensive assessments conducted should reflect family and child preferences. Once uniform assessment tools for behavioral health clinicians have been adopted, including family preferences in assessment and planning will become institutionalized as standard practice.

Utilize evidence-based, promising, and best practices. The provision of services is meaningless if quality is not ensured. The Commonwealth must promote the use of and train clinicians on evidence-based, best practice and promising treatment models. The Commission on Youth's resource "The Collection of Mental Health Treatments for Children and Adolescents" is strength on which to build. The state should hold alternating annual conferences on systems of care and evidenced based practices in the treatment of children with mental health, mental retardation, and substance abuse problems, coupled with technical assistance, to follow up on those trainings, funding to offset licensing and other costs of evidences based programs to produce better outcomes for children.

Evaluate outcomes. A final component of Goal 3 that supports all four described indicators is the development and implementation of an evaluation process with uniform performance measures for children's behavioral health. Tracking consistent indicators across programs and implementing a standardized evaluation system is essential for measuring success. Having such data will assist policy makers at the state and local levels to make well-informed funding decisions to support a statewide effective system of care for children.

Priority Recommendations For FY 2008

The Child and Family Behavioral Health Policy and Planning Committee recognizes that it is not possible to do all that is necessary to repair the children's behavioral health system in Virginia in one or two or even five years. It will take increasing and sustained efforts over a 10 year period. This year's report priority recommendations follow on those of the 2005 report. Where the 2005 recommendations were partially funded for the biennium, we recommend they be fully funded. Some recommendations have been clarified, and some of the funding costs have been revised downward. The following are the priority recommendations for FY 2008:

Additionally, this report outlines a framework and plan for improving the behavioral health and lives of Virginia's children, adolescents and families. It follows up on the 2006 Child and Family Behavioral Health Policy and Planning Committee report to the Legislature. The recommendations listed below either came directly from the 2006 report or are amendments of the report recommendations. Thus these recommendations represent continuity within the biennial funding cycle. (See Appendix A)

Recommendation 1: Increase Service Capacity

- Provide mental health services in the eight remaining juvenile detention centers without them at a cost of $1.2 million.

  In FY 2007, the number of Mental Health/Detention Center Demonstration Projects will expand from 7 to 14. A 50% state/federal match funds the Demonstration Projects, which provide specialized mental health services to juveniles detained in the targeted local community detention facilities. Outcome data from the current Demonstration Projects has shown a significant reduction in recidivism among that target population as a result of the specialized services provided. Therefore, we recommend that the State increase the number of MH/Detention Center Projects by funding mental health services in the remaining eight Detention Centers in Virginia.

- Provide school-based mental health clinicians in 20 middle schools in five regions at a cost of $1.8 million.

  Children and schools in Virginia will benefit from initiating school-based mental health services across the state. We propose funding 20 School-Based Mental Health Demonstration Projects, four each in five regions of the state. The Demonstration Projects will provide a full-time therapist employed by the local CSB at each of the selected middle schools, targeting students who experience educational difficulties as a result of psychiatric and/or substance abuse problems. Projects will utilize national best-practice service models that effectively reduce behavioral and emotional disorder-related problems in schools, and improve academic attendance and school performance. Funding for outcome evaluations is included in the request. The results will be disseminated to other CSBs and school systems throughout the state.

- Fund four new evidence-based System of Care demonstration projects at a cost of $2 million.

  Currently the Legislature has funded two System of Care demonstration projects, and two more are slated to be added in FY 2007. We recommend that the Legislature continue funding for the current projects and add four more. These projects will target underserved youth and children by providing evidence-based services that are not currently available in their localities. These services will be used keep children in their homes and communities and to seed the development of Systems of Care in those communities.

- Fund a web-based acute psychiatric bed reporting system at a cost of $75,000.

  While many complaints have been made regarding a shortage of acute psychiatric beds for children and adolescents in the Commonwealth, the extent of the problem is unclear. Moreover, even if a bed may be available, a referral source may have to spend hours locating it. Creating a web-based psychiatric bed reporting system can easily solve the latter problem. The system can also be used to determine how often local, regional and state beds are unavailable, what types of beds are needed, where those beds need to be located, when the shortages occur, and how many children are affected by the problem.

Total Cost of Recommendation 1: $5,075,000

Recommendation 2: Increase the Size of the Workforce

- Fund four child psychiatry fellowship and four child psychology internship slots at a cost of $493,000 with payback provisions to work in underserved areas in Virginia

  Virginia has a shortage of specially trained child and adolescent clinicians, particularly child psychiatrists and psychologists. It has a particular shortage of children's behavioral health service providers in rural areas. The Committee recommends funding four new two-year child psychiatry fellowship slots and four new one-year child psychology internship positions in already existing fellowship and internship programs at state universities and academic medical centers. These positions should include payback clauses stating that for each year of funding provided, the fellow or intern agrees to provide one year of behavioral health services in an underserved area of Virginia.

Total Cost of Recommendation 2: $493,000

Recommendation 3: Enhance Workforce Capacity

- Establish a university-based teaching center to organize, coordinate and lead the training of clinicians in evidence-based, promising and best practices for children's behavioral health treatment across the Commonwealth at a cost of $300,000

  To provide more behavioral health services to children, youth and their families, we need to increase the skills of providers who specialize in working with children, those who work with children but have received minimal training in how to treat children effectively, and those who could work with them, such as adult therapists, but currently do not. Enhancing the capacity of the children's behavioral health workforce requires building a training infrastructure by establishing a university-based teaching and training center to develop competency standards and train the current and future workforce in evidence-based treatments.

- Fund trainings in evidence-based children's behavioral health services for behavioral health clinicians at a cost of $200,000

  The university-based teaching and training center will train both current child-serving clinicians and other clinicians who do not currently serve children in effective, evidence-based treatments for children and youth. Multiple forms of teaching will be used, including regional and web-based trainings, videoconferences, telemedicine, consultation, and technical assistance.

- Fund trainings – including regional, web-based, telemedicine and other forms of education – in children's behavioral health services for pediatricians, family practitioners, and primary care physicians at a cost of $200,000

  Because pediatricians and family practitioners treat the behavioral health problems of children, they need to be trained to use effective treatments. The university-based teaching and training center will train pediatricians, family practitioners, and primary care physicians in effective, evidence-based treatments for children and youth. Multiple forms of teaching will be used, including regional and web-based trainings, videoconferences, telemedicine, consultation, and technical assistance.

Total Cost of Recommendation 3: $700,000

Recommendation 4: Provide Families with Information and Support

- Expand funding for a statewide family education, information and support network at a cost of $150,000 to provide families with information about services available to their children, link families with support systems, and educate the public about the needs of children with behavioral health problems

Even in communities where behavioral health services for children are available, families often do not know what kinds of services are available or where to find them. Virginia needs a statewide family information and support network to link families in need with available services and to provide them with peer support from others who have gone through or are going through similar problems. The proposed network will utilize and build upon current resources such as the 211 initiative. It will also facilitate family participation in the development and submission of federal grant applications to increase the state's funding for children's behavioral health services.

Cost of Recommendation 4: $150,000

Total Cost of Recommendations 1-4: $6,418,000

Recommendations that do not require funding

While funding recommendations are a major focus of this report, other recommendations propose policy, legislation, and administrative practice changes that support the transformation process. Many of them repeat or refine recommendations made in earlier reports, while others are new. We recommend the following:

1. **Conduct a rate study to determine if current Medicaid reimbursement rates are sufficient to pay for the costs of behavioral health services.** DMAS should conduct a rate study to analyze current reimbursement rates and determine if and where adjustments need to be made. In particular, the rates of reimbursement for outpatient psychiatric care (all types), acute psychiatric inpatient hospitalization, day treatment services, intensive in-home family services, and primary care physicians who provide behavioral health services should be examined. This is a new recommendation this year.

2. **Adopt children's behavioral health services as a very high priority.** The Department needs to emphasize through policy that children's behavioral health policies, plans, services and funding are of the highest priority.

3. **Use 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 in their communities at the same or lower cost.

4. **Study the possibility of suspending rather than ending Medicaid benefits when youth enter Juvenile Justice facilities.** DMAS should conduct a study of what would be required to suspend rather than end Medicaid benefits when youth enter detention and prison facilities. This is a refinement of a previous recommendation.

5. **Develop standards for case management:** The DMHMRSAS should develop uniform case management standards for Community Service Boards throughout the state.

6. **Coordinate and lead 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 plays a role in the welfare of children in the Commonwealth. The DMHMRSAS should coordinate and lead the planning for children with behavioral health needs.

7. **Provide guidance to local offices to maximize children's behavioral health funding.** The Department should develop a guidance document to help local offices maximize third party funding for children's behavioral health services.

8. **Expand the membership on the Child and Family 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.

9. **Make 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.

10. **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 "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 and value the central role families play in the care of their children.

A Family's Story

A family's story: Transitioning Amanda from Child to Adult Services written by her parents.

We adopted Amanda when she was two years old and were told we were adopting a healthy little girl who needed a family. We had a biological child and really wanted another but were unable to. The adoption was a perfect fit. Amanda is a very special loving child who we adore.

About a year later, when the adoption process was finalized, we received a letter from the county outlining Amanda's past, her parents and the environment she had come from. To our astonishment drugs and alcohol were in prevalent use during pregnancy. We were discouraged by the letter and its timing but we loved Amanda and prayed she would be spared the harmful effects caused by her biological mother's abuses.

Today, Amanda is 19 years old, living in residential care, and a diagnosis of

- *Schizo affective Disorder, Bipolar type*
- *Cognitive Disorder*
- *Oppositional Defiant Disorder*
- *Fetal Alcohol Syndrome*

Middle school is where Amanda's mental problems and developmental dysfunctions really escalated. She started hearing voices and having delusions. She became suicidal and psychotic requiring acute care almost monthly. She was put on several psychotic medications, which had side effects. Amanda went from 100 pounds to 175 pounds within six months. She was miserable, hated life, and wanted to die. Our life and our other daughter's life were upside down and inside out. We were in crises and had no idea what to do. Our insurance was limited, co-payments were exceeding $1,000 a month, and Amanda needed residential care, which was not covered by insurance and we could not afford. We turned to God and to the county from which we adopted Amanda.

After approaching the county with our circumstance, they offered us an adoption subsidy, which covered all medical cost beyond what our insurance would pay. This allowed us to get Amanda into residential care and the treatment she so desperately needed.

Here's our dilemma now; Amanda's subsidy expires when she turns 21year old. Cognitively, she is about 15. She wants to come home, not take medications, drive a car, etc.... Without the medications she is not safe. Physically or mentally, we cannot protect and monitor her 24/7. We believe a group home setting here in Virginia would be a good start for her and give her some time to mature and improve her cognitive processing. The ultimate goal would be for her to live independently with support services. We have been told there is no funding for this. We contacted the county where we adopted Amanda and were told it's not their problem since we moved to a neighboring county. The county we live in has been very supportive but does not have a revenue source to continue her residential treatment. We are left with limited options and are looking at the possibility of obtaining a waiver. Our goal in life has been to give our daughters the opportunity to enjoy life. We were very successful with our oldest. We are struggling with Amanda, and that hurts. Mom and Dad can't fix this, we need help, and the help we need we haven't found yet. The thought that Amanda may end up in a state institution when other options should be available is overwhelming. We will continue to look for solutions, we have learned a lot. The foremost is we should never lose faith. God gave us Amanda as a gift. She deserves adequate treatment for her illness. An illness that is, and should not be, discriminated against by state and federal funding. While services for children are limited, transitioning from child to adult services is frightening. Funding sources are cut off or are significantly reduced as if the illness or disease no longer exists. Mental and developmental diseases are just as serious as other organ diseases like cancer and heart disease. It would be considered inhuman to cut off or severely curtail someone's cancer or heart treatment when they turned 21 and were making progress, why are mental diseases an exception?

Looking for answers and desperate for solutions.

Conclusion

We face many challenges in addressing behavioral health needs of children and adolescents in Virginia. The following statistics illustrate one of the central challenges about why funding is needed:

- 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).

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 considerably 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) for adults, 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 Child and Family Behavioral Health Policy and Planning 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 $6,418,000 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 an investment in Virginia's future.

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[1] Pires, Sheila A., Building Systems of Care: A Primer, 2002

[2] Multisystemic therapy http://www.mstservices.com

[3] Functional family therapy http://www.omh.state.ny.us/omhweb/ebp/children_fft.htm

APPENDICES

Appendix A	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
Appendix B	STRATEGIC PLAN
Appendix C	CHILD AND FAMILY BEHAVIORAL HEALTH POLICY AND COMMITTEE (330-F) MEMBERSHIP LIST
Appendix D	2006 REPORT WRITING COMMITTEE
Appendix E	JUVENILE JUSTICE-RELATED RECOMMENDATIONS CHILD AND ADOLESCENT BEHAVIORAL SERVICES POLICY AND PLANNING COMMITTEE
Appendix F	SUBSTANCE-EXPOSED INFANTS WORKGROUP RECOMMENDATIONS
Appendix G	EXPANDING INNOVATIVE COMMUNITY SERVICES JOINT TASK GROUP
Appendix H	STATE FACILITIES SUB-COMMITTEE REPORT
Appendix I	BEHAVIORAL HEALTH INSURANCE PARITY FOR FEDERAL EMPLOYEES Howard H. Goldman, M.D. et al, University of Maryland School of Medicine, Baltimore
Appendix J	MEDICAL HOME POLICY ON BEHAVIORAL HEALTH ISSUES (AAP)

Appendix A

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

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

Table of Contents

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, <u>the report prioritizes three funding recommendations for the 2006-2007 biennium</u>.

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:

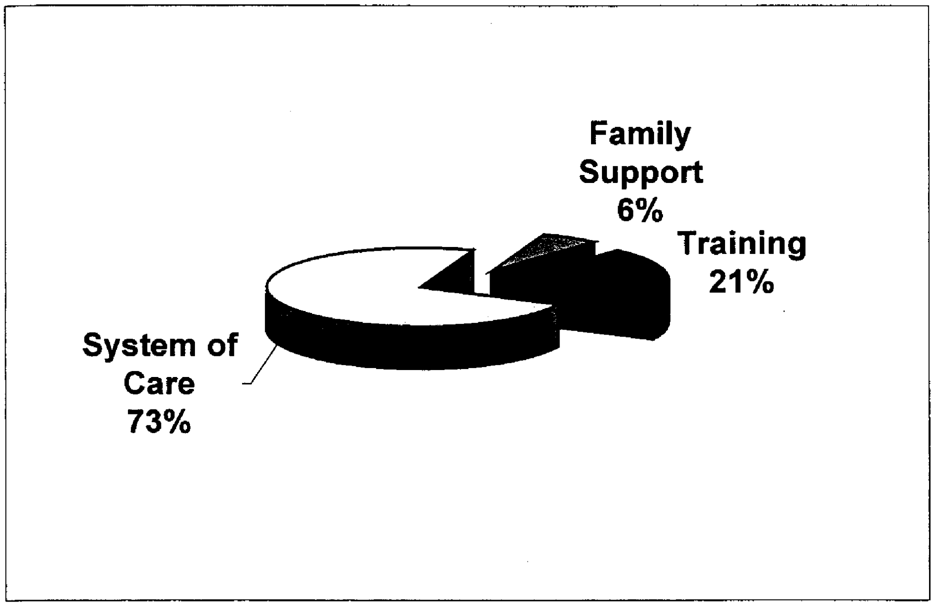
> **Adopting Children's Behavioral Health Services as a Very High Priority.** The DMHMRSAS needs to emphasize through policy that children's behavioral health policies, plans, and services are of the highest priority.
>
> **Using CSA funding Flexibly and Creatively to Develop Additional Services.** The 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. **Lack of family involvement.** 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. **Lack of comprehensive quality standards and minimum competencies.** 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. **Lack of evidence-based treatments.** 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

Recommendation 3: 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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Appendix B

TEN YEAR STRATEGIC PLAN

Ten Year Strategic Plan for Children's Behavioral Health

Goals	Steps or Strategies	Interventions/Activities	Measures/Targets
1. Healthy, strong, resilient, stable families as evidenced by children who: ◆ Live in a safe, nurturing home ◆ Attend school ◆ Make educational progress ◆ Are involved in positive peer activities ◆ Can have their needs for healthy development met in their homes and communities	1. Create local or regional systems of care by: A.1. Build the capacity of the children's behavioral health system	1.A.1.a. Create a $6 million fund to provide incentive grants to start up new behavioral health services, particularly mid-level services such as: ◆ Wrap-around ◆ Day treatment ◆ After-school behavioral health programs ◆ Intensive outpatient programs ◆ Crisis intervention programs ◆ Respite care ◆ In-home family therapy ◆ Intensive case management ◆ Mobile crisis teams ◆ Drop-in centers for teens ◆ Outpatient co-occurring disorders clinics ◆ Residential treatment for youth with both mental health and substance abuse disorders ◆ Residential treatment for children with both mental retardation and mental health disorders	1.A.1.a.1. There will be a proportional increase in utilization of middle intensity behavioral health services and decrease in the use of high level services 1.A.1.a.2. There will be a decrease in days children spend in out-of-home placements 1.A.1.a.3. There will be a decrease in days children spend in out-of-community placements
		1.A.1.b. Increase funding for mid-level services in the Medicaid state plan	
		1.A.1.c. Add adolescent substance abuse services to the Medicaid state plan and request $5.5 million in funding	
		1.A.1.d. **Conduct a study of what would be required for DMAS to suspend rather than end Medicaid benefits when a youth is placed in detention**	
		1.A.1.e. **Provide mental health services in all eight remaining juvenile detention centers without them @ $1.2 million**	1.A.1.e.1. There will be fewer admissions to detention centers for youth with primary MH and SA problems 1.A.1.e.2. There will be decreased recidivism to detention centers for youth with primary MH and SA problems
		1.A.1.f. Fully fund early intervention services for at-risk children, including Part C and identification of and services for substance-exposed infants	

Ten Year Strategic Plan for Children's Behavioral Health

Goals	Steps or Strategies	Interventions/Activities	Measures/Targets
		1.A.1.g. **Authorize the Office of Comprehensive Services to use CSA funds flexibly to help start up new services and programs**	
	1.A.2. Build the workforce of the children's behavioral health system	**1.A.2.a.** Fund four child psychiatry fellowship and two child psychology internship slots @ $438,000 with payback provisions to work in underserved areas in Virginia	1.A.2.a.1. There will be an increase in practicing child psychiatrists in Virginia 1.A.2.a.2. There will be an increase in practicing child psychologists in Virginia
		1.A.2.b.1. **Establish a university-based teaching center to organize, coordinate and lead the training of clinicians in evidence-based, promising and best practices for children's behavioral health treatment across the Commonwealth @ $300,000**	
		1.A.2.b.2. **Fund regional trainings in evidence-based children's behavioral health services for behavioral health clinicians @ $200,000**	
		1.A.2.b.3. **Fund regional trainings in children's behavioral health services for pediatricians and family practitioners @ $200,000**	1.A.2.b.3. 100 pediatricians and family practitioners will receive training in children's behavioral health through the efforts of the university-based teaching center
		1.A.2.b.4. **Establish best practice competency standards**	
		1.A.2.b.5. Provide local and regional trainings in how to do wraparound services	
	1.A.3. Service agencies communicate and collaborate to meet those needs	1.A.3.a. Provide reimbursement for care coordination and interagency communication between providers	
		1.A.3.b. Allow public-private partnerships to jointly apply for state funds	
		1.A.3.c. DMHMRSAS will develop criteria to identify local Centers of Excellence in systems of care	1.A.3.c. The DMHMRSAS will identify two Centers of Excellence that have developed systems of care
		1.A.3.d. Fund mentorship/training from local Centers of Excellence to similar communities	

Ten Year Strategic Plan for Children's Behavioral Health

Goals	Steps or Strategies	Interventions/Activities	Measures/Targets
		1.A.3.e. Utilize one lead case manager/care coordinator per family 1.A.3.f. Co-locate providers and agencies and align infrastructure to support collaboration	
	1.A.4. Services can be accessed through any door	1.A.4.a. Develop and implement a single intake instrument for families with core information for use by DMHMRSAS, DSS, DJJ, VDH, DOE, and OCS 1.A.4.b. Evaluate and make recommendations regarding the possible development and implementation of a uniform management information system for use by DMHMRSAS, DSS, DJJ, VDH, DOE, and OCS 1.A.4.c. **Fund a web-based acute psychiatric bed reporting system @ $75,000**	
	1.B. Maximize the use of EPSDT screenings	1.B.1. Provide regional trainings and technical assistance on EPSDT to pediatricians, family practitioners, case managers, and other service providers	1.B.1.a. There will be an increase in the number of children receiving EPSDT screenings 1.B.1.b. There will be an increase in the number of services authorized by EPSDT screenings
	1.C. DMHMRSAS, DOE and VDH will collaborate to develop and implement strategies to keep children with behavioral health problems in school rather than suspend or expel them.	1.C.1. **Provide school-based mental health clinicians in 20 middle schools in five regions @ $1.8 million**	1.C.1.a. There will be a decrease in the number of school suspensions of children with primary MH and SA problems 1.C.1.b. There will be a decrease in the number of school expulsions of children with primary MH and SA problems 1.C.1.c. There will be a decrease in the school drop out rate for children with primary MH and SA problems from schools 1.C.1.d. There will be an increase in the number of children with behavioral interventions in their IEPs and 504 plans

Ten Year Strategic Plan for Children's Behavioral Health

Goals	Steps or Strategies	Interventions/Activities	Measures/Targets
		1.C.2. Fund bullying prevention programs in schools 1.C.3. Promote alternative education strategies and programs for children with behavioral health problems 1.C.4. Expand care connection centers to include children's behavioral health 1.D.1. DSS will eliminate the practice of placing children in DSS custody solely so that they may access behavioral health services 1.D.2. FAPT teams will be required to serve all children at risk of out of home placement for behavioral health problems 1.E.1. Fund pilots for Nurse Home Visitation (ref. David Olds) programs for at-risk pregnant women 1.E.2. Fund pilots for Child-Parent Centers in preschools and elementary schools in high-risk neighborhoods	
	1.D. DMHMRSAS, DSS, OCS and VDH will collaborate to develop and implement strategies to prevent children from being placed in DSS custody solely to access behavioral health services		1.D.1. No child will be placed in DSS custody solely to access and receive behavioral health services 1.D.2. The number of children served by CSA who are not in DSS custody will increase
	1.E. DMHMRSAS, DSS, OCS, VDH and DOE will collaborate on new child abuse prevention efforts		1.E.1.a. The numbers of children alleged to be abused or neglected will decrease 1.E.1.b. The numbers of children substantiated as abused or neglected will decrease
		1.E.3. Evaluate the outcomes of the existing child abuse and neglect prevention programs in Virginia and compare them with the outcomes of evidence-based programs	1.E.3. Initiatives that do not demonstrate reductions of child abuse and neglect will be replaced with evidence-based and promising programs

Ten Year Strategic Plan for Children's Behavioral Health

Goals	Steps or Strategies	Interventions/Activities	Measures/Targets
2. Equitable access to services without regard to racial/ethnic status, socioeconomic status, and geographic location as evidenced by:			
A. All children have health insurance	2.A. Examine the current health insurance model in Virginia and other states to determine the best approaches to increase the number of children with health insurance	2.A.1. Increase the eligibility level for the FAMIS mother's program to 200% of poverty 2.A.2. Examine the Massachusetts model for providing health insurance to all children to determine if it can be replicated in Virginia	2.A.1. There will be an increase in the number of children enrolled in FAMIS
		2.A.3. Promote legislation that provides health insurance for all of Virginia's children	2.A.3. Increase the percentage of children with health insurance
2.B. Mental health and substance abuse parity in insurance	2.B. Expand the number of private insurers who offer mental health and substance abuse parity	2.B. Educate private insurers regarding the cost offsets and positive economic impact of insurance coverage for mental health and substance abuse	2.B. Increase the number of health insurance programs in Virginia that offer parity for mental health and substance abuse
2.C. Children and families have access to behavioral health services and supports when they need them	2.C.1. Enact the original intent of the Comprehensive Services Act to serve at-risk children with behavioral health problems using a system of care approach	2.C.1.a. Require FAPT teams to serve all children at risk of out of home placement for behavioral health problems 2.C.1.b. The Office of Comprehensive Services will eliminate the distinction between mandated and non-mandated children	2.C.1.a. There will be an increase in the number of communities that have strong systems of care to meet the behavioral health needs of children and families
	2.C.2. Provide a public safety net for the mental health, substance abuse and mental retardation needs of children and their families	2.C.2.a. Provide public and private agencies that subscribe to SOC principles @ $6/ million in additional funding as to start up new behavioral health services as described in 1.A.1.a.	2.C.2.a.1. Families and children with behavioral health emergencies will receive services immediately
			2.C.2.a.2. Families and children in urgent crises will receive services within 24 hours of initial contact
			2.C.2.a.3. All families and children in need of behavioral health services will receive them within two weeks of initial contact

Ten Year Strategic Plan for Children's Behavioral Health

Goals	Steps or Strategies	Interventions/Activities	Measures/Targets
		2.C.2.b. Fund system of care pilot projects in 50% of Virginia communities over a 10 year period **(Fund four new pilot projects @ $500,000 each in FY 2008)**	
		2.C.2.c. Fund a designated child and adolescent service provider for mental health, mental retardation, and substance abuse services in each CSB	
		2.C.2.d. **Conduct rate studies for Medicaid behavioral health services, particularly for:** ♦ **Outpatient psychiatric care** ♦ **Primary care physicians who provide behavioral health services** ♦ **Acute inpatient hospitalization** ♦ **Day treatment services** ♦ **Intensive in-home family services**	
	2.C.3. Strengthen family-professional partnerships to improve access to services	2.C.3.a. **Expand funding for a statewide family education, information and support network @ $500,000 to provide families with information about services available to their children, link families with support systems, and educate the public about the needs of children with behavioral health problems**	
		2.C.3.b. Expand and sustain membership of families and youth on local, regional and state boards, councils and committees that make decisions about children's behavioral health services, thereby ensuring authentic involvement of families in policy development that impacts service development in the Commonwealth	2.C.3.b. There will be an increased number of family and youth memberships on local, regional and state boards, councils and committees that make decisions about behavioral health services for children and families
3. Children are provided with humane, least-restrictive, and effective services that support healthy child development as evidenced by: ♦ Children's needs are accurately assessed	3.A.1. Develop and distribute standards for uniform screening and comprehensive assessment for children ages 0-21	3.A.1.a. Identify a uniform screening tool to match children in need of behavioral health services to the appropriate levels and types of treatment 3.A.1.b. Identify uniform assessment tools for behavioral health clinicians that support appropriate treatment interventions that are strengths-based, utilize evidence-based and promising practices, and accurately assess children's needs and required levels of care	

Ten Year Strategic Plan for Children's Behavioral Health

Goals	Steps or Strategies	Interventions/Activities	Measures/Targets
♦ Children's needs are matched to appropriate treatment interventions and levels of care ♦ Family and child preferences and strengths are driving forces treatment planning ♦ Clinicians and treatment programs utilize evidence-based, promising, and best practices			
	3.A.2. Provide training in the standards for uniform screening and comprehensive assessment	3.A.2. Fund statewide trainings on uniform assessment tools@ $600,000	
	3.A.3. Implement screening tools that match children's needs and strengths to appropriate treatments and levels of care		
	3.A.4. Implement comprehensive assessments that are behavioral, functional and strengths-based and accurately assess all areas of the child's and family's needs including home, school, and community	3.A.4.a. Implement uniform assessment tools statewide @ $500,000	3.A.4.a.1. There will be an increase in the use of uniform assessment tools that accurately assess children's needs and strengths and required levels of care
			3.A.4.a.2. All CSBs will implement uniform assessment tools for evaluating children's needs, strengths and required levels of care
		3.A.4.b. Place the selected uniform assessment tools in the statewide, shared Management Information System referenced in 1.A.4.b	

Goals	Steps or Strategies	Interventions/Activities	Measures/Targets
	3.A.5. Comprehensive assessments will reflect family and child preferences		
	3.A.6. Comprehensive assessments will include community-based recommendations for the least restrictive, most normative environment that is clinically appropriate		
	3.B.1. DMHMRSAS, the Commission on Youth (COY), DOE, OCS, DSS and VDH will promote the use of evidence-based and promising practices	3.B.1.a. Update the COY website on evidence-based practices annually with assistance from partner agencies	3.B.1.a. There will be an increase in the number of Virginians who visit the Commission on Youth website annually
		3.B.1.b. Disseminate information about what is new in evidence-based treatments to CSBs annually	
		3.B.1.c. Expand the COY website to include promising practices	
		3.B.1.d. Provide technical assistance in evidence-based practices by doing on-site visits to each CSB annually	
		3.B.1.e. Establish a fund in the OCFS in DMHMRSAS to offset costs of licensure, training and supervision in evidence-based practices	3.B.1.e. Each CSB will implement one new evidence-based practice
	3.B.2. Train clinicians on evidence-based treatment models	3.B.2. Hold alternating annual conferences on systems of care and evidence- based practices in the treatment of children with mental health, mental retardation and substance abuse problems	3.B.2.a. There will be a decrease in days children spend in out-of-home placement
			3.B.2.b. There will be a decrease in days children spend in out-of-community placements
			3.B.2.c. There will be a decrease in admissions to detention centers for youth with primary mental health and substance abuse problems
	3.C. Develop and implement uniform statewide performance measures and an evaluation/ monitoring process for children's behavioral health services	3.C.1. Fund the development and annual project management costs of a data management system for children's behavioral health outcomes @ $500,000	

Ten Year Strategic Plan for Children's Behavioral Health			
Goals	**Steps or Strategies**	**Interventions/Activities**	**Measures/Targets**
		3.C.2. Require all entities receiving funding for children's behavioral health services to collect and report data elements and outcome measures specific to children's behavioral health services in their contracts 3.C.3. Outcome data will be reported to DMHMRSAS quarterly 3.C.4. Build in the selected outcome measures into the statewide MIS referenced in 1.A.4.b	3.C.2. Entities receiving funding for children's behavioral health services will be in full compliance with federal and state requirements

Recommendations for FY 2008 are in bold

Appendix C

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Appendix D

2006 REPORT WRITING COMMITTEE

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Appendix E

JUVENILE JUSTICE-RELATED RECOMMENDATIONS CHILD AND ADOLESCENT BEHAVIORAL SERVICES POLICY AND PLANNING COMMITTEE

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

SUBSTANCE-EXPOSED INFANTS WORKGROUP RECOMMENDATIONS

Substance-Exposed Infants Workgroup Recommendations

Funding Recommendations

1. Adolescent Services

1) State Adolescent SA Coordinator position within OCFS effective
   - i. July 1, 2006 if Adolescent Infrastructure grant is not funded
   - ii. July 1, 2008 to sustain position if grant is funded

2) Residential substance abuse treatment program for adolescents with a substance use or co-occurring disorder
3) Medicaid funding for IOP and residential (depending on how the EPSDT services are developed this may already be covered)

2. Substance Exposed Infants

1) Medicaid reimbursement for behavioral health screening. Pregnant and parenting women who use substances, have a mental health disorder or who experience sexual assault or domestic violence place their children "at risk" for adverse consequences in utero and postnatally. A separate reimbursement to conduct a behavioral health screening provides additional incentive to medical providers to conduct a standardized screening on all women regarding mental health (including depression), substance use, sexual assault, and domestic violence and refer those in need to the appropriate services.

1. Recommendations for Unfunded Activities

A. Substance Exposed Infants

Virginia legislation requires that:

1) pre-natal care providers screen all pregnant women regarding licit and illicit substance use (54.1-2403.1)
2) delivering physicians report substance exposed newborns to child protective services (63.2-1509) and
3) hospitals refer identified postpartum substance using women to their CSB for services. Despite these 3 pieces of legislation, few substance-using women are identified and referred to treatment during their pregnancy or at the time of delivery.

Greater efforts are needed to inform both the public and service providers regarding the risks of maternal substance use, the benefits of treatment and the need for services to be coordinated across systems. A substance abuse sub workgroup should be created within CFBHPPC tasked with addressing the service delivery needs of substance-exposed infants as well as substance using youth and their families.

All state level interagency workgroups that address the needs of young children should routinely address the treatment and service needs of substance exposed children and their caretakers. Child welfare, early intervention, education and substance abuse workgroups must be aware of and address linkages between their respective services in order to ensure service coordination and seamless transition as child ages out of certain services and into others. It is also critical that these same workgroups are knowledgeable about and address all state and federal mandated services e.g. Child Abuse Prevention and Treatment Act (CAPTA), the Adoption and Safe Families Act (ASFA), Virginia's Program Improvement Plan (PIP), the Women's Set aside of the Substance Abuse Prevention and Treatment Block Grant (SAPT BG) which impact on the population they serve and ensure that appropriate cross training is provided to providers as indicated.

All public and private pre-natal care providers should be trained regularly and routinely regarding perinatal substance use. Child welfare, early intervention, mental health and substance abuse providers who work with this population require similar training. Training needs to include information regarding the legislation as well as the prevalence of Perinatal substance use, co-occurring mental health and behavioral health concerns, screening (preconception and throughout pregnancy), and where and how to refer a woman for treatment. Training should be mandated by each discipline, and/or profession involved and provided by the entity responsible for their respective training. Training opportunities include 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

Resources and services for the treatment of perinatal addiction as well as services for substance-exposed infants should be identified and made available to providers and the public. Family advocacy groups need to outreach these families. In the future, a media campaign would serve to raise public awareness regarding the risks of maternal substance use and how to access treatment.

B. Adolescent Substance Abuse

As previously noted, a substance abuse sub workgroup needs to be created to address the provision of and access to adolescent substance abuse treatment and which will serve in an advisory capacity to CFBHPPC. If the adolescent infrastructure grant is funded in 2005, this workgroup would serve as the basis for the interagency workgroup outlined in the application for that grant.

Virginia should adopt and promote routine, integrated substance abuse and mental health screening and assessment of youth. CAFAS, the assessment instrument currently required by CSA and the CSBs, does not adequately screen for substance use nor does it provide needed outcome measures. Instruments and tools that can be used across systems to screen, assess and measure outcomes need to be identified and promoted. Training and supervision regarding the use of these instruments also need to be provided at regular intervals. Funding to support costs associated with application of these instruments needs to be supported by the state. With input from CSAT, a local university or another entity with expertise in this area, the substance abuse workgroup will identify an implementation plan that is both cost and clinically effective.

Additional activities for the interagency substance abuse workgroup to address in the coming year include workforce development, funding of services, documentation, information sharing between agencies as well as strategies to support the development of school based services. Virginia lacks specialized substance abuse treatment services for youth 18 –21 that meet their unique developmental needs. The workgroup needs to develop strategies that will encourage communities to place greater priority on serving this population and develop appropriate substance abuse treatment and support services as well as independent living arrangements.

Appendix G

EXPANDING INNOVATIVE COMMUNITY SERVICES JOINT TASK GROUP

Expanding Innovative Community Services
Joint Task Group

Impetus/Challenges/Opportunities:

A primary statutory purpose of the Comprehensive Services Act *(CSA)* is to preserve and strengthen families through providing appropriate services in the least restrictive environment, enabling children to remain in their homes and communities when possible, while protecting the welfare of children and maintaining public safety.

One out of every four CSA children *(4,046 of 16,272 children)* was placed in residential care, often out of the community, at some point during program year 2005. Over $185 million in state, local and federal funds was spent on residential services for these children, not including federal IV-E and other Medicaid expenditures during the placements. While residential care is an important part of a continuum of care, many localities report that they are not able to effectively serve some CSA children in the community for several reasons. Rather, these children are placed in more restrictive, out-of-community care than necessary, which is not the best way to meet their needs and often results in higher costs.

To ensure access to appropriate community services, communities report needing:

- Access to expertise, resources, training and/or experience in:
    - Conducting comprehensive child and family assessments from a strengths-based perspective.
    - Identifying strategies for effectively serving children in family, school and community settings based on the strengths and needs of individual children and their families.
    - Developing creative service plans with families that build upon natural family and community supports.
    - Providing intensive care management across agencies for children with serious emotional/behavior problems and their families.
    - Effectively transitioning children back to the community as soon as appropriate.
- Providers willing to develop specialized, wraparound services and supports for difficult children and their families to be provided in family, school and community settings.
- Flexible pooled funds:
    - Instituting start up funds to spark development of innovative services in family settings, schools, and communities.
    - Creating a "community pool" of resources across agencies/organizations (eg, CSA mandated and nonmandated funds, Mental Health Initiative Funds, VJCCCA funds, Safe and Stable Families Funds).
    - Pooling funds across several communities to provide economies of scale.
    - Using CSA funds flexibly.
    - Using funds to tailor services to meet the individual strengths and needs of children and their families;

  - Assessing the service needs across all children (mandated and nonmandated) in the community and strategically determining how best to use the pool of resources to meet the needs of children.

Framework and Context for Work

The mission of the Comprehensive Services Act for At-Risk Youth and Families *(CSA)* is to create a collaborative system of services and funding that is child-centered, family-focused, community-based and cost-effective when addressing the strengths and needs of troubled and at-risk youths and their families in the Commonwealth.

CSA Values

- ***Family focused:*** Ensures families and caretakers are partners in decision-making on the assessment, design, delivery and management of services.
- ***Strength based:*** Ensures that the design and provision of services respond to the unique and diverse strengths, needs and potential of children and their families, and build upon natural family and community supports.
- ***Continuum of care:*** Provides access to a continuum of assessment, early intervention, treatment, and transition services and supports in communities.
- ***Community based:*** Provides appropriate services in the least restrictive environment, striving to preserve and strengthen families, and enabling children to remain in their homes and communities, balanced with the need to protect the welfare of children and maintain public safety.
- ***Integrated care:*** Provides integrated services and funding for children and their families with designated care management to ensure multiple services are coordinated across agencies and evolve over time to meet the changing strengths and needs of children and their families.
- ***Culturally & linguistically responsive:*** Provides services and supports that are responsive to the culture and language of the child and family.
- ***Collaborative:*** Supports open communication, active participation, and collaboration among CSA stakeholders across all sectors and at all levels on program and fiscal policy development, service delivery and management. Encourages public-private partnerships in service delivery.
- ***Strong state leadership:*** Ensures policies, uniform guidelines, services, funding and practices support systems of care in communities that can be tailored to meet the unique strengths, resources, and needs of children, families and communities.
- ***Flexible funds:*** Provides communities flexible funds, authorizes them to make decisions and to be accountable for providing services in concert with the CSA.
- ***Fiscally accountable:*** Ensures funds are spent effectively, efficiently and equitably, maximizing the use of all federal, state, local & private funding streams.
- ***Outcome & quality improvement:*** Improves program quality using customer feedback, child and family outcomes, and program and fiscal data.

Members:

CSA State and Local Advisory Team (SLAT)

Mike Mastropaolo *(Director, 15th District Court Service Unit, SLAT, DJJ, Court Service Unit Directors)*
Paul Scott, Vice Chair *(SLAT Task Group Member, Institute of Family Centered Services)*
Charlotte McNulty *(Executive Director, Harrisonburg-Rockingham Community Service Board, SLAT, Virginia Association of Community Service Boards)*
James Howard *(Director, Greene County Department of Social Services, SLAT Chair, League of Social Services Executives)*
Tamara Tamoney *(Virginia Department of Social Services (not definite))*
Wanda Sadler, *(Hallmark Youthcare, SLAT Task Group Member, Virginia Coalition of Private Provider Associations, Virginia Association of Specialized Education Facilities)*
Vicki Hardy-Murrell *(SLAT Task Group Member, parent)*
Pam Fisher *(CSA Technical Assistance Coordinator, OCS)*
Kim McGaughey *(Executive Director, Office of Comprehensive Services)*

Child and Family Behavioral Health Policy & Planning Committee (CRBHPPC)

Pat Haley, Co-chair *(Presbyterian Home and Family Services)*
Lloyd Tannenbaum *(Rivermont Schools, Lynchburg; Chair, Central Virginia Regional CPMT – Amherst, Appomattox, Bedford City/County, Campbell, Lynchburg)*
Joyce Kube *(Virginia Federation of Families)*
Martha Kurgans *(DMHMRSAS Child and Family Services)*
Joanne Smith *(Detention Superintendent?)*
Shirley Ricks *(Director, DMHMRSAS Child and Family Services)*
Brian Meyer *(Chair, Virginia Treatment Center for Children)*
Wayne Barry, *(Department of Education)*
Gina Wilburn, *(Community Services Board Child and Adolescent Director)*

Reporting of recommendations for discussion to:

- Child and Family Behavioral Health Policy & Planning Committee *(CFBHPPC)*
- CSA State and Local Advisory Team *(SLAT)*

SLAT will make final recommendations to the State Executive Council

Appendix H

STATE FACILITIES
SUB-COMMITTEE REPORT

State Facilities Subcommittee

The DMHMRSAS requested that the CFBHPPC and the Child and Adolescent Special Populations Workgroup review the current status of public mental health beds in Virginia. This request was prompted by questions asked by the DHMRSAS' Inspector General and his staff related to bed utilization and future services requirements. The subcommittee met four times between February 2006 and May 2006 to discuss and answer the following questions:

1. Who are the state facilities serving now? Why?
2. How well are they served and how do we know?
3. What indicators do we have that demonstrate that we are serving children and families in the intended way?
4. Who should the facilities be serving in 5 years? In 10 years?
5. Describe the future plan for the system of care for children and adolescents in the Commonwealth and the role of the state facilities in that system.
6. What priority community-based services are needed to accomplish the plan?
7. What role should the private sector play in the desired system of care? Acute? Residential?
8. How will we strategically engage the private sector to continue to play the needed role in the system of care?
9. What are indicators that demonstrate that the public and private providers are being used in the way we need them to be used?
10. Describe the plan to transition existing public beds for children and adolescents from current services to the desired future services.

The following people were participants in the subcommittee: Sandy Bryant, Central Virginia CSB; Don Roe, CCCA; Lloyd Tannenbaum, CentraHealth, Rivermont School; Joyce Kube, Virginia Federation of Families; Kathy Wittig, parent; Gina Wilburn, Blue Ridge Behavioral Health Authority; Wayne Barry, DOE; Barb Shue, CCCA; Roger Burket, University of Virginia; Stacie Fisher, DMHMRSAS; Sue Akers, SWVMHI; Joe Tuell, CCCA; Tim Dotson, Highlands Detention Center; Anna Csaky-Chase, Mount Rogers CSB; Clark Bates, CCCA; Martha Kurgans, DMHMRSAS; Cynthia McClaskey, SWVMHI; Tim Smith, Shenandoah Valley Detention Center; Peter Cooper, CCCA; Janet Lung, DMHMRSAS; Russell McGrady, SWVMHI; Teri Sumey DOE/CCCA; Bill Wittig, parent;

The final report will be completed by June 30 2006. At that time, responses to the questions and a list of recommendations will be sent to the Office of the Associate Commissioner of the Division of Facility Management at the DMHMRSAS.

Appendix I

BEHAVIORAL HEALTH INSURANCE PARITY FOR FEDERAL EMPLOYEES

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The NEW ENGLAND JOURNAL of MEDICINE

SPECIAL ARTICLE

Behavioral Health Insurance Parity for Federal Employees

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ABSTRACT

BACKGROUND

To improve insurance coverage of mental health and substance-abuse services, the Federal Employees Health Benefits (FEHB) Program offered mental health and substance-abuse benefits on a par with general medical benefits beginning in January 2001. The plans were encouraged to manage care.

METHODS

We compared seven FEHB plans from 1999 through 2002 with a matched set of health plans that did not have benefits on a par with mental health and substance-abuse benefits (parity of mental health and substance-abuse benefits). Using a difference-in-differences analysis, we compared the claims patterns of matched pairs of FEHB and control plans by examining the rate of use, total spending, and out-of-pocket spending among users of mental health and substance-abuse services.

RESULTS

The difference-in-differences analysis indicated that the observed increase in the rate of use of mental health and substance-abuse services after the implementation of the parity policy was due almost entirely to a general trend in increased use that was observed in comparison health plans as well as FEHB plans. The implementation of parity was associated with a statistically significant increase in use in one plan (+0.78 percent, $P<0.05$) a significant decrease in use in one plan (−0.96 percent, $P<0.05$), and no significant difference in use in the other five plans (range, −0.38 percent to +0.23 percent; $P>0.05$ for each comparison). For beneficiaries who used mental health and substance-abuse services, spending attributable to the implementation of parity decreased significantly for three plans (range, −\$201.99 to −\$68.97; $P<0.05$ for each comparison) and did not change significantly for four plans (range, −\$42.13 to +\$27.11; $P>0.05$ for each comparison). The implementation of parity was associated with significant reductions in out-of-pocket spending in five of seven plans.

CONCLUSIONS

When coupled with management of care, implementation of parity in insurance benefits for behavioral health care can improve insurance protection without increasing total costs.

From the University of Maryland School of Medicine, Baltimore (H.H.G.); Harvard Medical School (R.G.F., H.A.H., S.-L.T.N., V.A., A.B.B.) and Harvard School of Public Health (S.-L.T.N.) — both in Boston; RAND, Santa Monica, Calif. (M.A.B., M.S.R.); Department of Veterans Affairs, Los Angeles (A.S.Y.); UCLA School of Medicine, Los Angeles (A.S.Y.); Yale University School of Medicine, New Haven, Conn. (C.L.B.); McLean Hospital, Belmont, Mass. (A.B.B.); Westat, Rockville, Md. (S.T.A., G.M.); Northrop Grumman Information Technology, Federal Enterprise Solutions, Health Solutions, Rockville, Md. (C.L.); and CSR, Arlington, Va. (M.B.). Address reprint requests to Dr. Goldman at the University of Maryland School of Medicine, 3700 Koppers St., Suite 402, Baltimore, MD 21227, or at hh.goldman@verizon.net.

N Engl J Med 2006;354:1378-86.

PARITY IN INSURANCE COVERAGE FOR mental health services has been the Holy Grail of mental health policy for decades.[1,2] Ever since President John F. Kennedy directed the Civil Service Commission to offer federal employees mental health benefits on the same basis as benefits for other medical services, parity has been a standard for excellent mental health insurance coverage. The Federal Employees Health Benefits (FEHB) Program, like other competitive insurance markets, was unable to maintain equal coverage for mental health care because of high costs.[3] Strictly limiting coverage for mental health and substance-abuse care is an effective means of controlling costs, but it also limits access and distorts the insurance market. Responding to such concerns, government payers and some private payers have intervened by setting minimum standards for coverage of mental health and substance-abuse care. Parity is intended primarily to correct insurance-market failure and the unfair design of insurance benefits. Advocates have hoped that it would increase access to care. The main argument against parity has been a concern that more generous coverage of these services would result in large increases in spending.[3] Opposition to legislation requiring parity of coverage has been strong, but the successes of managed care in controlling spending on mental health and substance-abuse services offer a counterweight to cost considerations.[4-6] The use of managed care, however, raises concerns about access and quality.

In June 1999, President Bill Clinton directed the Office of Personnel Management to ensure parity of mental health and substance-abuse benefits for the FEHB Program. He also proposed an evaluation to guide federal policy — the first national study of comprehensive parity. This article reports on the effects of parity of mental health and substance-abuse benefits on access, cost, and quality in seven large FEHB plans.

METHODS

EXAMINATION OF PARITY OF MENTAL HEALTH AND SUBSTANCE-ABUSE CARE IN THE FEHB PROGRAM

The FEHB Program has 8.5 million enrollees; approximately 25 percent are current federal employees, 25 percent are retirees, and 50 percent are spouses or dependents of current or retired employees. Enrollees select from over 350 health insurance products.[7] Beginning on January 1, 2001, the Office of Personnel Management required parity of coverage for mental health and substance-abuse care, defined as coverage that is "identical with regard to traditional medical care deductibles, coinsurance, co-pays, and day and visit limitations."[8] Parity applied only to in-network insurance benefits.[9] Providers and beneficiaries were informed about the policy change by direct mail from the plans.

The Office of Personnel Management encouraged the plans to employ managed-care techniques to control anticipated increases associated with expanded mental health and substance-abuse coverage. Before 2001, some plans had already contracted with managed behavioral health care organizations to control costs (in a process known as a "carve-out").[9]

We analyzed the results of this natural experiment by using a quasi-experimental design to account for secular trends in the use of and spending on mental health and substance-abuse care not associated with implementation of parity of coverage. (Previous evaluations of parity studied a single health plan before and after the implementation of parity and were unable to account for secular trends.) We compared spending in seven large FEHB plans during the period from 1999 through 2002 with spending in a matched set of health plans without parity of coverage or changes in mental health and substance-abuse coverage from Medstat's MarketScan database. Most of the comparison plans were operated by large, self-insured employers. We matched plans according to location and type of plan.

Initially, nine FEHB plans were selected for study on the basis of location, type of plan (health maintenance organization [HMO] or point-of-service plan vs. preferred-provider organization [PPO]), population size, and interest in participation. Enrollees between the ages of 18 and 64 years were included in the study. Table 1 characterizes the nine FEHB plans and the comparison plans. It shows that the parity policy improved mental health and substance-abuse benefits for seven of the FEHB plans. Two HMOs, which were close to parity in 2000, did not show a substantial change in benefits. The analysis focuses on the seven PPO plans for which an effect of the implementation of parity could be expected. (The data on the effects on HMO plans are available at www.aspe.hhs.gov.)

Table 1. Characteristics of Nine FEHB Program Plans and Their MarketScan Comparison Plans before and after Implementation of Parity of Coverage for Mental Health and Substance-Abuse Services in 2001.*

Characteristic	FEHB Program Plans		Comparison Plans†	
	2000	2001	2000	2001
	National PPO (N=365,137)		Comparison Plan (N=306,127)	
Annual limit of days of coverage for inpatient	45	No limit	50	50
Cost shared by inpatient	30%	0	Low‡	Low‡
Annual limit of outpatient visits	20	No limit	30–50	30–50
Cost shared by outpatient	30%	$15	Low§	Low§
Carve-out status¶	No‖	Yes	6 of 15	5 of 15
	Mid-Atlantic PPO 1 (N=108,460)		Comparison Plan (N=20,392)	
Annual limit of days of coverage for inpatient	100	No limit	30	30
Cost shared by inpatient	40%	0	Low‡	Low‡
Annual limit of outpatient visits	25	No limit	30	30
Cost shared by outpatient	$25	$15	Low§	Low§
Carve-out status¶	Yes	Yes	4 of 7	3 of 7
	Mid-Atlantic PPO 2 (N=75,676)		Comparison Plan (N=20,392)	
Annual limit of days of coverage for inpatient	100	No limit	30	30
Cost shared by inpatient	40%	0	Low‡	Low‡
Annual limit of outpatient visits	25	No limit	30	30
Cost shared by outpatient	$25	$15	Low§	Low§
Carve-out status¶	No	No	4 of 7	3 of 7
	Northeastern PPO 1 (N=38,716)		Comparison Plan (N=20,392)	
Annual limit of days of coverage for inpatient	100	No limit	30	30
Cost shared by inpatient	40%	0	Low‡	Low‡
Annual limit of outpatient visits	25	No limit	30	30
Cost shared by outpatient	$25	$15	Low§	Low§
Carve-out status¶	Yes	Yes	4 of 7	3 of 7
	Northeastern PPO 2 (N=21,459)		Comparison Plan (N=20,392)	
Annual limit of days of coverage for inpatient	100	No limit	30	30
Cost shared by inpatient	40%	0	Low‡	Low‡
Annual limit of outpatient visits	25	No limit	30	30
Cost shared by outpatient	$25	$15	Low§	Low§
Carve-out status¶	Yes	Yes	4 of 7	3 of 7

We studied the responses of persons who were continuously enrolled in a plan before and after the implementation of parity of coverage. Using data from all enrollees could confound the effects of parity with those of changes in plan composition. We examined plan benefits to assess the implementation of parity and then assessed the outcomes. The key outcomes examined were the rate of use of mental health and substance-abuse services, the total spending for such services among users, out-of-pocket spending on such services, and one measure of quality of care, the duration of follow-up for treatment of depression.

Table 1. (Continued.)

Characteristic	FEHB Program Plans		Comparison Plans[†]	
	2000	2001	2000	2001
	Western PPO (N=51,902)		Comparison Plan (N=27,376)	
Annual limit of days of coverage for inpatient	100	No limit	30	30
Cost shared by inpatient	40%	0	Low[‡]	Low[‡]
Annual limit of outpatient visits	25	No limit	30	30
Cost shared by outpatient	$25	$15	Low[§]	Low[§]
Carve-out status[¶]	No[**]	Yes	5 of 11	4 of 11
	Southern PPO (N=68,808)		Comparison Plan (N=27,376)	
Annual limit of days of coverage for inpatient	100	No limit	30	30
Cost shared by inpatient	40%	0	Low[‡]	Low[‡]
Annual limit of outpatient visits	25	No limit	30	30
Cost shared by outpatient	$25	$15	Low[§]	Low[§]
Carve-out status[¶]	Yes	Yes	5 of 11	4 of 11
	Western HMO (N=17,902)		Not applicable	
Annual limit of days of coverage for inpatient	30	No limit		
Cost shared by inpatient	0	0		
Annual limit of outpatient visits	40	No limit		
Cost shared by outpatient	$20	$20		
Carve-out status[¶]	Yes[††]	Yes		
	Northeastern HMO (N=32,352)		Not applicable	
Annual limit of days of coverage for inpatient	No limit	No limit		
Cost shared by inpatient	0	0		
Annual limit of outpatient visits	40	No limit		
Cost shared by outpatient	$10	$10		
Carve-out status[¶]	Yes	Yes		

[*] Since the characteristics of the plans in 2000 were nearly identical to those in 1999, we show only the 2000 characteristics for the period before the implementation of parity on January 1, 2001. Similarly, since the plan characteristics in 2001 were nearly identical to those in 2002, we show only the 2001 characteristics for the period after the implementation of parity. The data are from persons who were continuously enrolled in a health plan before and after the implementation of parity. PPO denotes preferred-provider organization, and HMO health maintenance organization.

[†] The comparison "plan" is actually a group of plans from MedStat's MarketScan database. Thus, some of the plan characteristics are best represented as a range of values, a proportion, or a weighted average.

[‡] The proportion of the cost shared by the inpatient ranged from 0 to 20 percent, with a weighted average of 5 percent. We consider this to be a low level of cost sharing.

[§] The proportion of the cost shared by the outpatient ranged from 0 to 50 percent, with a weighted average of 15 percent. We consider this to be a low level of cost sharing.

[¶] For FEHB program plans, we indicate whether the plan contracted with a managed behavioral health care company in a carve-out arrangement. As noted above, the comparison plan is composed of a group of plans, some of which contracted with a managed behavioral health care company in a carve-out arrangement. We show the proportion of component plans that did so in relation to the total.

[||] The plan contracted with a managed behavioral health care company in December 2000 in anticipation of the FEHB program's parity policy beginning in January 2001.

[**] The plan implemented a carve-out arrangement for their other insurance products in response to the state government's requirement for parity in 2000, but they did not implement a carve-out arrangement for FEHB Program enrollees until January 2001.

[††] The managed behavioral health care vendor is a wholly owned subsidiary of the health plan.

DATA

From the seven plans, we obtained four years of data on the design of benefits, enrollment, and medical and pharmacy claims, including two years before and two years after the implementation of parity of coverage for FEHB plans. We analyzed data from a random sample of 20,000 enrollees per plan. We also obtained data on benefits, enrollment, and claims for the matched comparison group during the same period from the MarketScan database.

IDENTIFYING MENTAL HEALTH AND SUBSTANCE-ABUSE SERVICES

We classified inpatient and outpatient services associated with specified mental health and substance-abuse diagnoses and psychotropic medications as mental health and substance-abuse services. (A detailed description is available at www.aspe.hhs.gov.) Mental health and substance-abuse diagnoses were defined as those with diagnostic codes 291, 292, 295 through 309 (except 305.1 and 305.8), and 311 through 314 in the *International Classification of Diseases, 9th Revision, Clinical Modification* (ICD-9-CM). An inpatient was considered a user of mental health and substance-abuse services if the last primary diagnosis and the majority of all primary diagnoses in the inpatient record were mental health and substance-abuse diagnoses. An outpatient was considered a user of mental health and substance-abuse services if any of the following was indicated: a mental health and substance-abuse primary diagnosis, a procedure specific to mental health and substance-abuse care, or a face-to-face encounter with a provider of such care or treatment at a facility specializing in mental health and substance-abuse care. To identify use of psychotropic medications, we developed two lists: a restricted list of medications that are used only for mental health and substance-abuse disorders and an expanded list of medications that are used for both mental health and substance-abuse disorders and other conditions. Expenditures for any medications on the restricted list counted as spending on mental health and substance-abuse care. If the patient made any other use of mental health and substance-abuse services or incurred any related expenditures during the year, then expenditures for any medications on the expanded list counted as spending for mental health and substance-abuse care.

To assess the quality of care for depression, we examined data from patients with a diagnosis of major depressive disorder (codes 296.2 and 296.3). Outpatients were included only if the diagnosis appeared on at least two service dates; inpatients were included if a primary diagnosis of major depressive disorder was the reason for hospitalization.

STATISTICAL ANALYSIS

We estimated the economic effect of parity by the difference-in-differences method. The difference in differences is the average difference (before and after the implementation of parity) in outcomes of interest in the comparison plans subtracted from the average difference before and after implementation of parity in the FEHB plans. This approach permitted us to account for any secular trend in outcomes. Any remaining significant differences in outcome are attributed to parity.

To estimate the difference in differences, we had to address two important characteristics of data on health care spending. Most people do not receive mental health and substance-abuse care in any given year (i.e., they have zero spending), and among those who do receive such care, a disproportionate number have high levels of spending. To account for these features, we examined a number of competing approaches that have been discussed in the literature.[10] After testing competing models, we settled on the two-part model because it best fitted the data. We used the generalized linear model to estimate the relation between spending on mental health and substance-abuse care and parity. After checking several link functions and distributional assumptions, we used a normal model to characterize spending. Correlation among repeated annual observations was accounted for by the use of a generalized estimating equation approach.

The first part of the two-part model used logistic regression to estimate the effect of the implementation of parity of coverage on the probability that a person would use mental health and substance-abuse services. The unit of observation was the person-year. In those regressions, we adjusted for the demographic characteristics of the person (age and sex) and the person's relationship to the policyholder (child or spouse). The age variable was used to adjust for any time trend. The key variables of interest were an indicator variable that was assigned a value of one for the postparity period and zero for the preparity period, an indicator variable that was assigned a value of one for the members of FEHB plans and zero for the members of comparison groups, and the interaction of the two indicator variables. Because the logistic model is nonlinear, the net effect of the parity policy on an outcome could not be calculated directly from the coefficient of the interaction term.[11] Instead, we calculated the average effect on the probability of using mental health and substance-abuse services by employing simulation methods based on the estimated regression model. Using the bootstrap samples, we constructed 95 percent confidence intervals for our final estimates.[12]

The second part of the two-part model used a least-squares regression approach to analyze individual spending on mental health and substance-abuse services for those who used any such services. In this model, we used the same independent variables as in the first part, as well as indicator variables for the diagnosis for which a service user received treatment. The coefficient of the interaction term allowed us to estimate any change in spending on mental health and substance-abuse care due to the parity policy, while accounting for the secular trend in such spending among users of mental health and substance-abuse services. A generalized estimating equation was used to estimate the standard errors of the model's coefficients.

We performed a before-and-after analysis of administrative data to assess any changes in the quality of care, as measured by the duration of follow-up treatment for acute-phase depression. Receiving services (any visits for mental health and substance-abuse care or prescriptions for antidepressant medications) for four months or more is considered a guideline for the quality of treatment of acute-phase depression.[13-15] Episodes of depression care from six of the seven FEHB plans were studied before and after the implementation of parity to assess the proportion of patients with four months or more of follow-up treatment. The national PPO (Table 1) was not studied because the data were different from those in the other plans, and the differences limited comparability. Logistic regression was used to estimate the association between the postparity period and the quality measure. We constructed a 95 percent confidence interval for the adjusted odds ratios and used a generalized estimating equation approach to account for repeated observations.

RESULTS

Table 1 shows that the comparison plans did not have parity benefits before 2001 and that they changed very little over the course of the study. Three of the seven FEHB plans did not use a carve-out vendor as a means of managing their mental health and substance-abuse benefits before implementing parity; only PPO 2 in the Mid-Atlantic region was not carved out by 2001. Roughly half the plans that served as comparison groups were carved out before the implementation of parity; only minor changes in carving out occurred in 2001.

Table 2 reports descriptive data on rates of use of mental health and substance-abuse services and spending for service users. For all plans, the rates of use and spending increased during the study period. Table 2 also reports difference-in-differences estimates for the probability of use of mental health and substance-abuse services and for spending on such services. After accounting for secular trends in the use of mental health and substance-abuse services, we found a positive and significant effect of parity on the probability of use for one plan, Mid-Atlantic PPO 2; the increase in the rate of use of mental health and substance-abuse services in this plan was 0.78 percentage point greater than the increase in its matched comparison plan. For the remaining six plans, the estimated effect of the implementation of parity on the probability of use either was positive and not significantly different from zero or was significant but negative. Thus, the difference-in-differences analysis indicated that the observed increase in the rate of use of mental health and substance-abuse services after the implementation of parity was almost entirely due to a secular trend in the increased use of such services. The difference-in-differences estimates for spending on mental health and substance-abuse services show significant decreases in spending attributable to parity for three plans, ranging from −$68.97 to −$201.99. The estimated effects on spending for the other four plans were moderate, ranging from −$42.13 to +$27.11, and did not differ significantly from zero. Thus, this analysis offers no evidence of significant increas-

Table 2. Probability of Use of Mental Health and Substance-Abuse Services and Total Spending by Service Users.*

Plan	Probability of Use of Mental Health and Substance-Abuse Services†		Total Mental Health and Substance-Abuse Spending per User†		Change in Value before and after the Implementation of Parity‡	
	Preparity	Postparity	Preparity	Postparity	Probability of use of mental health and substance-abuse services	Total spending on mental health and substance-abuse care per user
	percent		*$*		*percent (95% CI)*	*$ (95% CI)*
National PPO	14.05	16.40	637.00	692.50	−0.12 (−0.66 to 0.44)	−68.97 (−89.02 to −48.92)§
Comparison plan	20.60	23.05	938.50	1,058.00		
Mid-Atlantic PPO 1	18.70	20.35	1,199.50	1,256.50	−0.96 (−1.46 to −0.38)§	−42.13 (−126.32 to 42.05)
Comparison plan	17.25	19.40	943.50	1,071.00		
Mid-Atlantic PPO 2	18.55	21.50	751.50	841.00	0.78 (0.20 to 1.39)§	27.11 (−110.96 to 56.74)
Comparison plan	17.25	19.40	943.50	1,071.00		
Northeastern PPO 1	15.05	17.55	822.00	911.00	0.23 (−0.31 to 0.74)	−5.50 (−96.20 to 85.10)
Comparison plan	17.25	19.40	943.50	1,071.00		
Northeastern PPO 2	14.45	16.30	1,302.00	1,284.50	−0.38 (−0.89 to 0.23)	−119.26 (−234.46 to −4.06)§
Comparison plan	17.25	19.40	943.50	1,071.00		
Western PPO	16.15	18.35	874.00	976.00	−0.24 (−0.77 to 0.27)	−22.60 (−84.44 to 39.25)
Comparison plan	18.05	20.40	768.00	888.50		
Southern PPO	17.60	20.35	791.00	734.00	−0.35 (−0.17 to 0.91)	−201.99 (−255.85 to −148.13)§
Comparison plan	18.05	20.40	768.00	888.50		

* CI denotes confidence interval, and PPO preferred-provider organization.

† Descriptive data are shown. Preparity and postparity figures are two-year averages for the years from 1999 through 2000 and from 2001 through 2002, respectively.

‡ A difference-in-differences analysis was used to account for secular trends.

§ P≤0.05.

es in spending attributable to the implementation of parity of coverage.

Table 3 summarizes the effects of parity on out-of-pocket spending by users of mental health and substance-abuse services. In five of seven plans, the parity policy was associated with significant reductions in out-of-pocket spending, ranging from $13.82 to $87.06. There was a small but significant increase in out-of-pocket spending by service users in the national PPO.

The findings on the quality of depression treatment are presented as odds ratios derived from regression analyses. The results for all plans showed an increased likelihood of providing follow-up services to persons undergoing treatment for acute-phase depression. The improvement was significant for three plans. The odds ratio was 1.72 (95 percent confidence interval, 1.22 to 2.41) for the Western PPO, 2.33 (95 percent confidence interval, 1.31 to 4.14) for Northeastern PPO 2, and 1.60 (95 percent confidence interval, 1.19 to 2.16) for the Southern PPO.

DISCUSSION

Our results demonstrate that the growth in the use of mental health and substance-abuse services and spending on these services in seven FEHB plans was similar to or less than that in other large, privately insured populations. The only plan that had an increase in use attributable to the implementation of parity of coverage was Mid-Atlantic PPO 2, which was the only plan that did not contract with a carve-out managed-care vendor. These results are negative, in the sense that there were few significant differences in the probability of service use or in the amount of expenditures that could be explained by the implementation of parity. A finding of negative results always raises the question of whether the effect of parity on use and spending was really limited or whether the evaluation lacked the necessary power to detect an effect. Two factors lead us to believe that the effect really was limited: the estimated differences between the results for enrollees in the FEHB Program and comparison enrollees were relatively small in magnitude. The sample sizes used in the analysis were large and were sufficient to show significant effects of similar policy measures, such as the effect of carving out mental health and substance-abuse care while holding the benefit design constant.[16] For these reasons, we believe the evidence points to a finding of little or no effect of the implementation of parity of coverage for mental health and substance-abuse services on use and total spending, rather than reflecting a type II error.

Although spending increases resulting from the implementation of parity did not occur, neither did access to mental health and substance-abuse services increase. Advocates of parity might be pleased about the observed increases in the use of mental health and substance-abuse services in all plans, but these changes were consistent with the presence of secular trends and not attributable to the implementation of parity.

The parity policy reduced out-of-pocket spending by users of mental health and substance-abuse services in all but one of the seven plans. Spending decreased significantly in five plans. There was a small but significant increase in out-of-pocket spending by enrollees in the national PPO, probably as a result of the relatively high cost-sharing requirements of the prescription-drug plan for this PPO.

Some policymakers have expressed concern that any increase in the use of managed care associated with the implementation of parity might result in deteriorating quality. Studies of quality using claims data to compare adherence to guidelines for the treatment of depression and substance abuse before and after the implementation of parity have found little change (see www.aspe.hhs.gov). The measure of quality we used — the duration of follow-up after treatment for depression — did not decline in this study, and in three of the plans, it showed a small improvement. Because we were not able to perform a difference-in-differences analysis of the quality measures, it is quite possible that our results reflect secular trends that are independent of the implementation of parity. The findings are quite similar to recent findings that used Health Plan Employer Data and Information Set (HEDIS) measures of follow-up in the treatment of depression.[17] (To put these results in perspective, the measure we used improved at an annual rate of 2.4 percentage points, whereas the HEDIS measures of follow-up for acute- and continuation-phase depression improved by 2.9 and 2.7 percentage points, respectively, between 2001 and 2002.)

Table 3. Difference-in-Differences Results for Amount of Out-of-Pocket Spending per User for Mental Health and Substance-Abuse Services before, as Compared with after, the Implementation of Parity.

Plan	Change per User (95% CI)*
	$
National PPO	4.48 (0.91 to 8.06)†
Mid-Atlantic PPO 1	−15.43 (−26.14 to −4.73)†
Mid-Atlantic PPO 2	−13.82 (−23.96 to −3.67)†
Northeastern PPO 1	−8.78 (−21.14 to 3.57)
Northeastern PPO 2	−48.12 (−66.85 to −29.39)†
Western PPO	−49.80 (−61.17 to −38.43)†
Southern PPO	−87.06 (−99.73 to −74.38)†

* CI denotes confidence interval, and PPO preferred-provider organization.
† $P \leq 0.05$.

Our study had several limitations. First, as in all quasi-experimental studies, there is a risk of nonequivalence of intervention and comparison groups, particularly with respect to time trends over the length of the period before the implementation of parity. However, the consistency of key findings for multiple matched sets of health plans is reassuring. Second, mental health and substance-abuse diagnoses may be underreported in claims data, resulting in an undercount of use of such services and spending on these services. To address this issue, we employed multiple methods of identifying the use of mental health and substance-abuse services, including a procedure code specific to such services, indication of a face-to-face encounter with a mental health and substance-abuse provider, and indication of treatment at a facility specializing in mental health and substance-abuse care. Third, the use of data only from persons continuously enrolled before and after the implementation of parity eliminated those who changed plans, and the restriction of the analysis to only seven of the FEHB plans potentially limited the generalizability of the findings. However, the study included diverse plans (with different managed-care arrangements) with more than 3 million FEHB beneficiaries from across the United States, including more than 700,000 continuously enrolled adults, who were the focus of this analysis.

The goals of parity include providing equal coverage and increased financial protection for persons with mental health and substance-abuse disorders. The primary concern has been that the existence of parity would result in large increases in the use of mental health and substance-abuse services and spending on these services. With respect to the seven FEHB plans we studied, these fears were unfounded. In addition, the goal of expanding financial protection by decreasing out-of-pocket spending was realized in all but two of the plans. These findings suggest that parity of coverage of mental health and substance-abuse services, when coupled with management of care, is feasible and can accomplish its objectives of greater fairness and improved insurance protection without adverse consequences for health care costs.

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Appendix J

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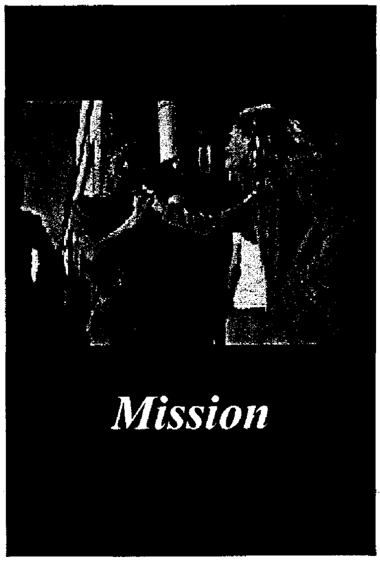

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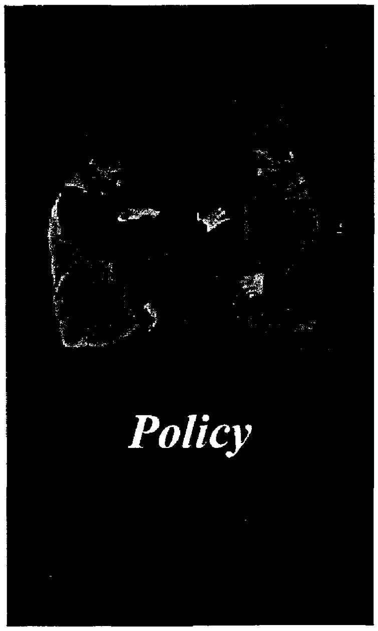

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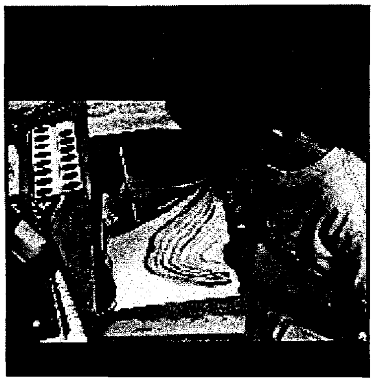

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