FINAL REPORT OF THE
VIRGINIA COMMISSION ON YOUTH

At-Risk Youth Served in Out-of-State Residential Facilities

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

COMMISSION ON YOUTH REPORT DOCUMENT

COMMONWEALTH OF VIRGINIA
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COMMONWEALTH of VIRGINIA

Commission on Youth

Senator Harry B. Blevins, *Chairman*
Delegate John S. Reid, *Vice Chairman*

July 1, 2006

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TO: The Honorable Timothy M. Kaine, Governor of Virginia
and
Members of the Virginia General Assembly

In 2005, the Commission on Youth unanimously approved action directing the Commission on Youth to undertake a one-year study on the practice of placing troubled and at-risk youth and adolescents in out-of-state for residential treatment. Staff was directed to determine the number of children receiving services in out-of-state residential treatment centers in lieu of being served in the Commonwealth; to determine the reasons these children are being placed outside of the Commonwealth, as well as the cost; and to assess whether there is service ability in the Commonwealth to serve these children.

This report, consisting of an executive summary and recommendations, is submitted for your consideration. The Commission on Youth would like to recognize the assistance provided by a number of agencies, organizations and individuals in completing this study.

Respectfully submitted,

Amy M. Atkinson
Executive Director

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R. Edward Houck
Yvonne B. Miller

From the Virginia House of Delegates

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I. Authority for Study

Section 30-174 of the *Code of Virginia* establishes the Virginia Commission on Youth and directs it to "... study and provide recommendations addressing the needs of and services to the Commonwealth's youth and their families." This section also directs the Commission to "...encourage the development of uniform policies and services to youth across the Commonwealth and provide a forum for continuing review and study of such services."

Following the 2005 General Assembly Session, the Virginia Commission on Youth unanimously approved action directing Commission staff to review the practice of placing troubled and at-risk youth and adolescents in out-of-state for residential treatment. The Commission also directed staff to report the findings of this review prior to the 2006 General Assembly Session. This document presents the findings and recommendations of this study.

II. Members Appointed to Serve

The Virginia Commission on Youth is a standing legislative commission of the Virginia General Assembly. It is comprised of twelve members: six Delegates, three Senators and three citizens appointed by the Governor.

Members of the Commission on Youth are:

Senator Harry B. Blevins, Chair, Chesapeake
Delegate Mamye E. BaCote, Newport News
Delegate Robert H. Brink, Arlington
Delegate Mark L. Cole, Fredericksburg
Delegate William H. Fralin, Jr., Roanoke
Senator R. Edward Houck, Spotsylvania
Senator Yvonne B. Miller, Norfolk
Delegate John S. Reid, Vice Chairman, Richmond
Delegate Robert Tata, Virginia Beach
Miss Vanessa Cardenas, Arlington
Mr. Glen Francis, Portsmouth
Mr. Marvin H. Wagner, Fredericksburg

III. Executive Summary

In March 2005, the Virginia Commission on Youth directed staff to study the practice of placing troubled and at-risk youth and adolescents in out-of-state for residential treatment. Staff was directed to:

- Determine the number of children receiving services in out-of-state residential treatment centers in lieu of being served in the Commonwealth;
- Determine the reasons these children are being placed outside of the Commonwealth, as well as the cost; and
- Assess whether there is service ability in the Commonwealth to serve these children.

Virginia policymakers and mental health practitioners recognize the benefits associated with children remaining within the home and receiving treatment in the community. When it is impossible for the child to receive the necessary treatment within the home or in a community-based environment, Virginia seeks to place the child in a setting that is as close to the home as possible.

There are instances, however, whereas a child's mental needs exceed the service capacity that can be provided within the home, community or the Commonwealth. Most of the children who are placed out-of-state require specialized treatment that is not available within the Commonwealth. These out-of-state placements are made to ensure that the child receives the necessary and most adequate treatment possible.

The practice of placing youth and adolescents in out-of-state for residential treatment poses a number of concerns, including the:

- Impact and effect on children who are placed out-of-state;
- Conditions for which youth are placed out-of-state; and
- Fiscal impact of placing youth out-of-state.

This report focuses on Virginia's troubled and at-risk children and adolescents who receive services in out-of-state residential treatment centers in lieu of being served in the Commonwealth. The purpose of this report is to determine the reasons why children are being placed out-of-state, the consequences and impact of placing children out-of-state and the best scenario for children who have needs that exceeds Virginia's ability and/or capacity to treat.

In studying the issue of out-of-state placements, the Virginia Commission on Youth examined two areas of interest: the Interstate Compact for the Placement of Children (ICPC) and the Office of the Comprehensive Services for At-Risk Children and Families (OCS). Based on analysis of the identified issues, the Virginia Commission on Youth adopted the following recommendations.

VIRGINIA DEPARTMENT OF SOCIAL SERVICES

Recommendation 1

Request that the Department of Social Services update its policy manual for the Interstate Compact for the Placement of Children by June 30, 2006.

Recommendation 2

Request the Department of Social Services, in conjunction with the Virginia Institute for Social Services Training Activities, to develop a training manual for the Interstate Compact for the Placement of Children (ICPC) progress. All local social services workers in the areas of foster care and adoption and their supervisors should be trained on the ICPC progress. This training should be ongoing and shall be included in the training of all new social services case workers in the areas of foster care and adoption.

Recommendation 3

Request the Department of Social Services to monitor the placement of children served by the Interstate Compact for the Placement of Children (ICPC) through an automated reporting and tracking system. This will include information on children served by ICPC, including those referred by other agencies. The Department of Social Services, in

developing this system, will determine whether this system should be linked to the OASIS system, as well as other existing data systems. The Department of Social Services shall report on these activities to the Virginia Commission on Youth prior to the 2007 General Assembly Session.

Recommendation 4

Request the Department of Social Services to report annually to the General Assembly about the number of Virginia's children being served in out-of-state placements, including those being served in residential facilities. The report shall include information regarding the number of children receiving services in out-of-state residential treatment centers, the reasons these children are being placed out of the Commonwealth and the cost.

Recommendation 5

Request that the Department of Social Services review the state's Interstate Compact for the Placement of Children (ICPC) system, including its management, staffing, caseloads, paper and electronic process, tracking systems and databases to develop a more efficient, accountable ICPC system for all those who participate in the ICPC process. Further, the Department of Social Services shall ensure that Virginia is in compliance with all state and federal laws and regulations. The Department of Social Services shall report on these activities to the Commission on Youth prior to the 2007 General Assembly Session.

OFFICE OF THE COMPREHENSIVE SERVICES FOR AT-RISK CHILDREN AND FAMILIES

Recommendation 6

Request the Secretary of Health and Human Resources, in conjunction with the State Executive Council (SEC), to investigate the feasibility of utilizing a unique child identifier across all child-serving agencies. Request the SEC to coordinate with the data workgroup to evaluate the need to modify the reasons for service fields so that they are more helpful for ascertaining the reasons for service for program development. A report on these activities shall be made to the Virginia Commission on Youth prior to the 2007 General Assembly Session.

Recommendation 7

Request that the Office of Comprehensive Services for At-Risk Children and Families (OCS) to improve the information available in and revise the system through which provider information is placed in the Service Fee Directory. Request that OCS update the Directory and request that locality-specific, service-specific and licensing information be included.

Recommendation 8

Request the State Executive Council to coordinate with the data workgroup to evaluate the need to modify the reasons for service fields so that they are more helpful for ascertaining the reasons for service for program development.

IV. Study Goals and Objectives

Under the direction of the Virginia Commission on Youth (hereinafter referred to as the Commission), the following study goals were developed by Commission staff and approved by the Commission in March 2005.

- Determine the number of children receiving services in out-of-state residential treatment centers in lieu of being served in the Commonwealth;
- Determine the reasons these children are being placed outside of the Commonwealth, as well as the cost; and
- Assess whether there is service ability in the Commonwealth to serve these children.

In studying the issues of placing children out-of-state for residential treatment, Commission staff identified several concerns which centered around three main areas: the number of children who are being placed out-of-state, the conditions in which these children are placed out-of-state and the fiscal impact.

- The number of troubled or at-risk youth being placed out-of-state for service needs:
  - Service capacity/availability in-state;
  - Weakening family relationships;
  - Diminishing supportive ties; and
  - Family preference.
- The conditions under which youth and adolescents are placed out-of-state for residential treatment:
  - Services are not available at in-state residential treatment facilities; and
  - Out-of-state residential services may actually be closer in proximity to the child and the family.
- The fiscal impact for youth to receive services at out-of-state residential facilities:
  - Increases the cost of providing services to youth compared to the cost of providing services within their community or the Commonwealth; and
  - Increases depletion of state funds for the Comprehensive Services Act for At-Risk Youth and Families (CSA).

To fulfill the mandate of this study, Commission staff undertook the following activities:

- Identified data sources regarding out-of-state placements;
- Reviewed the Interstate Compact on the Placement of Children to ascertain if there is adequate documentation regarding out-of-state placements;
- Met with state agencies that place children to ascertain affected population;
- Met with other child-serving local agencies to determine frequency of out-of-state placements;
- Compiled a data collection instrument to review the use of out-of-state residential facilities. The data included the:
  - Number of children residing in out-of-state residential facilities; and
  - Services recommended for youth who are placed out-of-state;
- Compiled a description of services provided in out-of-state facilities that are not available within the Commonwealth;

- Provided a cost analysis of out-of-state placements;
  - Determined which funding streams are being used to pay for out-of-state placements, along with a breakdown of those funding sources;
- Assessed unmet needs;
  - Determined system and case factors responsible for unmet needs;
- Developed recommendations; and
- Synthesized findings.

V. Methodology

The findings of this study are based on several different methodologies. The methodologies include statutory analysis, data collection from the Virginia Department of Social Services (DSS) and the Virginia Office of Comprehensive Services for At-Risk Youth and Families (OCS), telephone surveys of local Comprehensive Services Act for At-Risk Youth and Families (CSA) coordinators, research and literature review and observations of local Family Assessment and Planning Team (FAPT) meetings.

A. STATUTORY ANALYSIS

The Commission focused on current statutes within Virginia that regulate the treatment provided to troubled and at-risk youth and adolescents. The Commission focused this statutory analysis on two specific areas: CSA and the Interstate Compact for the Placement of Children (ICPC). Staff researched and reviewed the *Code of Virginia* (hereinafter referred to as the *Code*) for laws pertaining to CSA and ICPC. Appendix A enumerates sections from the *Code* related to these two areas of focus.

B. DATA COLLECTION

Department of Social Services

Local departments of social services enter data through the On-line Automated Services Information System (OASIS). OASIS, which is operated by DSS, is a comprehensive system documenting the day-to-day activities performed by child welfare workers.[1] This system currently supports foster care, adoption and child protective services. It provides users with the basic abilities needed to record case information and report the case data that is required to be reported to the federal government. DSS intends to use OASIS to record and report on other services, including child day care and adult services.[2]

In addition to OASIS, data is also collected through the Adoption Reports and Resource Information System (ARRIS) database. This data is collected by the ICPC Unit of DSS for children who are being placed out-of-state or out-of-country, as well as for children who are received by Virginia from other states or countries. ARRIS database is not available for local child welfare workers.

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[1] Virginia Department of Social Services, *Evaluation of the Differential Response System*, 2005. [Online]. Available: http://leg2.state.va.us/dls/h&sdocs.nsf/By+Year/RD2722005/$file/RD272.pdf. [March 2006].

[2] Virginia Joint Legislative Audit and Review Commission, Special Report: *Review of the On-line Automated Services Information System (OASIS) at the Department of Social Services*, 2000. [Online]. Available: http://jlarc.state.va.us/reports/rpt247.pdf. [March 2006].

Commission staff requested data from DSS regarding children served out-of-state. Unfortunately, DSS was unable to provide the Commission with this information because of the methods of data collection at DSS.

Office of the Comprehensive Services for At-Risk Children and Families

Local governments report demographic, assessment, service need, placement and financial data on children receiving services through CSA. Local governments report this information to OCS. OCS collects gathered data for reporting periods ending December 31, March 31 and June 30 of each year. Localities have various options as to the collection methodology at the local level; however, localities must adhere to specific reporting requirements. These requirements are agreed upon by the Information Technology Workgroup of the State Executive Council (SEC).

OCS offers a free web system for localities to report this data. This system is currently utilized by 65 of Virginia's 131 localities. The remaining local governments use locally supported software systems and download the information into a central system at OCS. OCS ensures that all reporting, regardless of reporting methodology, is consistent and properly submitted. OCS transfers verified data from all localities into the DSS data warehouse.

Commission staff reviewed CSA Fiscal Year 2004 reports on the number of children placed out-of-state and related CSA expenditures.

C. TELEPHONE SURVEY

Commission staff conducted a telephone survey with approximately 21 local CSA coordinators. The goal of the survey was to identify key issues and themes in relation to children who have been placed out-of-state for treatment. CSA coordinators were asked questions about the reasons why children in their localities were being placed out-of-state for treatment, the length of time that these children have been out-of-state and any medical diagnosis that would further explain the out-of-state placement.

The CSA coordinators who were contacted represent each region within the Commonwealth, including rural, urban and suburban areas. Some of the localities contacted include Albemarle, Alleghany, Arlington, Chesterfield, Mecklenburg, Norfolk and Spotsylvania. The individuals contacted were asked to identify common areas of concerns in providing services for those children. This information was shared with Commission members to describe issues that confront youth being served out-of-state.

The contacted localities were determined by the expenditure amount of a child within that particular locality who had been placed out-of-state, as well as the total expenditure of the child. Table 1 provides the average, highest and lowest expenditure amounts and total expenditure of the sample that was used to conduct this telephone survey. The total expenditure includes the expenditure amount and the expected expenditure amount. The expenditures refer to the amount that it cost the Commonwealth to place the particular child out-of-state for treatment.

Table 1

CSA Out-of-State Placement Expenditures
Fiscal Year 2004

	Expenditure Amount	Total Expenditure
Average	$231,010	$260,118
Lowest	$26,066	$31,211
Highest	$222,229	$239,533

Source: Office of Comprehensive Services for At-Risk Children and Families, based on Virginia Commission on Youth telephone surveys of CSA coordinators, 2005.

D. RESEARCH

Over the last two decades, CSA has been the subject of numerous studies. Many organizations have conducted research and analysis on CSA, troubled and at-risk youth and adolescents, child mental health and placement options. Many of these organizations include government agencies within Virginia, public and private organizations, health associations and federal government agencies. Additionally, some localities have produced studies that focus on local perspectives of CSA and its implementation. Some of these organizations within Virginia include the Commission, OCS, Secretary of Health and Human Resources, Mental Health Association of Virginia, Joint Commission on Health Care and Department of Mental Health, Mental Retardation and Substance Abuse Services.

Commission staff researched and reviewed various studies on this issue through Internet and library searches. Additionally, staff made personal contact with a number of private organizations and government agencies within other states in search of related studies. Appendix B encapsulates 39 studies published from 1988 to 2005 related to the delivery of mental health services to youth and adolescents. Commission staff used these previous studies to analyze changes made or recommendations offered as a result of each study effort.

E. LOCAL FAMILY ASSESSMENT AND PLANNING TEAM MEETINGS

Commission staff attended local FAPT meetings in the Richmond metropolitan area. Staff observed how each locality handled children who were going through CSA in order to receive services.

VI. Terminology

For the purposes of this study, out-of-state residential treatment may include the following types of services:

- **Residential Treatment Facility:** Children placed outside of their family homes in purchased, licensed residential care facilities (i.e. secure residential facility, campus-style residential) where 24-hour supervised care and intensive treatment services are offered, such as medication management, nursing care, occupational therapy, special and regular education services, social skills training, group therapy, individual therapy, family therapy, etc.
- **Treatment/Therapeutic Foster Care (TFC):** Placement of a child in a home where a trained foster parent provides care through a licensed child-placing agency or local agency's defined foster care therapeutic program. The parent may receive an additional payment for added daily supervision required for children who have identified emotional/behavioral, developmental, physical or mental disorders.
- **Special Education (SPED) Residential:** Children placed for services for purposes of special education and related services in an approved private day school educational placement.
- **Psychiatric Hospital Placement:** Children placed in an acute care psychiatric unit of a licensed medical hospital or licensed free-standing psychiatric hospital for stabilization of harmful behaviors (to self or others) and/or mental health issues, such as psychosis.
- **Group Home:** Placement in a licensed residential setting characterized by a supervised home-like environment that serves groups of children and adolescents with behavioral/emotional difficulties and/or physical or mental disabilities. Group homes are usually a step-down placement from a more secure residential treatment placement. Group homes may provide transitional services such as social skills training and/or vocational training or emergency placements.[3]

VII. Background

The Comprehensive Services Act for At-Risk Children and Families (CSA) was enacted by the Virginia General Assembly in 1992 to establish a comprehensive system of services and funding through interagency planning and collaboration in order to better meet the needs of troubled and at-risk children and their families. CSA was created to combat issues associated with providing such services, including service delivery, fragmentation, absence of cooperative planning among child-serving agencies and an over-reliance of the use of hospitalization and residential placements for children. The overarching goal of CSA is to provide high-quality, cost efficient, child-centered, family-focused and community-based services to troubled and at-risk youth and their families.

Within Virginia, a state pool of funds was created to allow local Community Policy and Management Teams (CPMTs) and Family Assessment and Planning Teams

[3] Virginia Office of Comprehensive Services for At-Risk Children and Families, *CSA Web Based Data Set Instruction Manual*, 2004. [Online]. Available: http://www.csa.state.va.us/cdb/cdbinstructions.doc. [September 2005].

(FAPTs) to draw upon funding in a manner that would better address the needs of these children and their families by creating that comprehensive system of services.

Virginia policymakers and mental health practitioners recognize the importance of and benefits associated with children remaining within the home and community-based environment. When it is impossible for the child to receive the necessary treatment within the home or in a community-based environment, Virginia seeks to place the child in a setting that is as close to the home as possible. *House Document 23, Youth with Emotional Disturbance Requiring Out-of-Home Placement* (2002) provides further information.[4]

There are instances when a child's mental needs exceed the service capacity that can be provided within the Commonwealth. In these cases, the child is placed out-of-state for treatment. Most of the children who are placed out-of-state require specialized treatment that is not available within the Commonwealth. These out-of-state placements are made to ensure that the child receives the necessary and most adequate treatment possible. An example of a child who might be placed out-of-state is a female who is exhibiting sex offending behaviors or a child who is diagnosed with mental retardation and substance abuse.

CSA models some of its core principles of services, such as services being child-centered, family-focused and community-based, after the federal System of Care approach. In 1992, the U.S. Congress established a System of Care model for providing treatment. This model focuses on providing community-based, integrated and comprehensive services to at-risk youth and their families. The System of Care model was designed with the premise that the mental health needs of troubled and at-risk youth and their families can be achieved within the home, school and community environment. The goal of this model is to develop community-based treatment programs so that children can remain in and near their homes and communities.[5] This goal is established for three reasons:

- To protect and safeguard the integrity of the family;
- To develop a support system in which the child and family is in contact with community agencies, individuals and other entities; and
- To strengthen the family so that the family is able to effectively and safely cope within the community once treatment is completed.[6]

Extensive research has been conducted that shows that mental health needs of children and adolescents are best treated within the context of a System of Care model. Troubled and at-risk youth and adolescents who participated in this care model funded from 1993 to 1994 experienced positive changes and decreased emotional and behavioral symptoms. Among these changes were:

- Improvements with behavioral and emotional problems;

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[4] Virginia Commission on Youth, *Youth with Emotional Disturbance Requiring Out-of-Home Treatment*, 2002. [Online]. Available: http://leg2.state.va.us/dls/h&sdocs.nsf/By+Year/HD232002/$file/HD23_2002.pdf. [March 2006].

[5] U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, Division of Service and Systems Improvement, *Systems of Care*, 2005. [Online] Available: http://www.mentalhealth.samhsa.gov/cmhs/ChildrensCampaign/grantcomm.asp. [April 2006].

[6] U.S. Department of Health and Human Services, *Mental Health: A Report of the Surgeon General--Children and Mental Health, Chapter 3*, 1999. [Online]. Available: http://www.surgeongeneral.gov/library/mentalhealth/pdfs/c3.pdf. [April 2006].

- Improvements in social functioning;
- Improvements in school attendance and academic performance;
- Improvements in residential stability; and
- Reductions in law enforcement contacts.[7]

In 2001 and 2002, the Commission conducted a two-year study on youth and adolescents with serious emotional disturbance requiring out-of-home treatment.[8] One of the study findings was that many of the mental health treatment needs of troubled or at-risk youth and adolescents can, in fact, be managed at a community and non-residential level. The study also cited the need for early identification and intervention in a community system of care. An effective community-based system of care may eliminate the need for many out-of-home and out-of-state placements.

In addition to providing a comprehensive system that is high-quality, cost efficient, child-centered, family-focused and community-based for troubled and at-risk youth and their families, Virginia also strives to create a system of service that reduces, to the greatest extent possible, instances in which children are placed out-of-state. Out-of-state placements are not only expensive, but also impose negative consequences on children who are placed out-of-state and their families. These consequences must be thoroughly considered in determining the treatment location for children.

A. INTERSTATE COMPACT ON THE PLACEMENT OF CHILDREN

While following the work plan for this study, it became apparent that attaining the number of Virginia children placed in out-of-state residential treatment facilities would be extremely difficult and complex. The Commission identified two sources of data information: The Department of Social Services (DSS) and the Office of the Comprehensive Services for At-Risk Children and Families (OCS). DSS houses the Interstate Compact for the Placement of Children (ICPC) unit and OCS collects data from localities that receive funds from CSA. OCS ensures that all reporting, regardless of reporting methodology, is consistent and properly submitted. OCS transfers verified data from all localities into the DSS data warehouse.

All 50 states, the District of Columbia and the Virgin Islands participate in ICPC. ICPC is a statutory law that serves as a binding contract between jurisdictions. It establishes legal and administrative procedures that are uniform to govern the out-of-state placement of children.[9] It also governs the uniform process in which states place children in other states and in which states receive children from other states. As the ICPC administrator in Virginia, DSS is responsible for the compliance of this law. The administrators are also responsible for coordinating with local DSS and other states on the provision of services for children being served in states outside of Virginia.

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[7] U. S. Department of Health and Human Services Substance Abuse and Mental Health Service Administration, Center for Mental Health Services, *2000 Annual Report to Congress on the Evaluation of the Comprehensive Community Mental Health Services for Children and Their Families Program*, 2000. [Online]. Available: http://www.mentalhealth.samhsa.gov/publications/allpubs/CB-E200/default.asp. [March 2006].

[8] Virginia Commission on Youth, 2002.

[9] The Association of Administrators of the Interstate Compact on the Placement of Children. [Online]. Available: http://icpc.aphsa.org. [February 2006].

The information on ICPC outlined below was presented to Commission during the September 22, 2005 meeting.[10]

What is ICPC?

- ICPC is a uniform law that establishes orderly procedures for the interstate placement of children and fixes responsibilities for those involved in placing the child. ICPC has been enacted by all 50 states, as well as the District of Columbia and Virgin Islands.
- ICPC ensures that children who are placed across state lines for foster care, residential treatment or adoption receive the same protections and services that would be provided if they remained in their home states.
- ICPC assures that children placed out-of-state may return to their original jurisdictions should placements prove not to be in the best interest of the child or if the need for out-of-state services cease.

Why is there a need for ICPC?

- To regulate the safe interstate movement of children;
- To provide protections for children in approved placements;
- To extend a court and state's jurisdiction beyond its borders;
- To ensure that supportive services are in place;
- To ensure that financial and planning responsibilities remain with the sending state;
- To ensure that placements remain in compliance with appropriate licensure laws and regulations.

What does ICPC accomplish?

- Defines the type of placements applicable to and excluded from the law;
- Specifies who is subject to comply with the law;
- Outlines the notice procedures;
- Addresses violations of ICPC;
- Outlines sending and receiving agency's responsibilities; and
- Provides specific protections, services and requirements.

What types of placements are covered under ICPC?

- Placements preliminary to an adoption;
- Placements into foster care. This includes placements into foster homes, group homes, residential treatment facilities, residential treatment facilities and institutions;
- Placements with parents and relatives when a parent or relative is not making the placement; and
- Placements of adjudicated delinquents in institutions in other states.

What are the safeguards offered by ICPC?

- Provides the sending agency the opportunity to obtain home studies and an evaluation of the proposed placement;
- Allows the prospective receiving state to ensure that the placement is not "contrary to the interest of the child" and that its applicable laws and policies have been followed before it approves the placement;
- Guarantees the child legal and financial protection by fixing these responsibilities with the sending agency or individual;
- Ensures that the sending agency does not lose jurisdiction over the child once the child moves to the receiving state; and

[10] The Association of Administrators of the Interstate Compact on the Placement of Children, *Guide to the Interstate Compact on the Placement of Children*, 2002. [Online]. Available: http://icpc.aphsa.org/documents/Guidebook_2002.pdf. [September 2005].

- Provides the sending agency the opportunity to obtain supervision and regular reports on the child's adjustment and progress in the placement.

What are the procedures for making compact placements?

- As specified by ICPC, a state agrees to follow uniform procedures when it makes or accepts interstate placements; and
- Since ICPC is a contract among party states, as well as a statute in each of them, it must be interpreted and implemented uniformly by all of them.

What are the procedures for administering ICPC?

- Each state appoints a compact administrator and one or more deputy administrator(s);
- In each state, the administering office and personnel are located in an office that is part of the department of public welfare or the state's equivalent agency;
- The compact administrator is designated to serve as the central clearing point for all notices and interstate placements;
- The administrator and deputies are authorized to conduct an investigation of the proposed placement and to determine whether the placement is contrary to the child's interest;
- After the placement is approved and the child is moved into the state, the compact administrator is responsible for overseeing the placement until it is terminated in accordance with ICPC laws and regulations; and
- When placement is denied, the compact administrator enforces ICPC laws to ensure that the placement is not made into the receiving state.

How can a state recognize the placement that is covered by ICPC?

- The state in which the child resides and the state to which the child is to be sent must both be a party of ICPC;
- A relative, caregiver or designee is sending the child to live with someone other than a close relative or non-agency guardian as specified in ICPC;
- A party that may or may not have legal custody of the child is sending, bringing or causing the child to be brought or sent into a party state, without regard to the present location of the child; and
- The child is being placed with someone or some agency other than a medical facility, a boarding school or a mental health or mental retardation facility.[11]

In Virginia, the statutory authority of ICPC is in the *Code* §63.2-1000 through §63.2-1105. Section 63.2-1000 forms ICPC and gives the uniform authority from state to state. Article I of §63.2-1000 states the purpose and policy of ICPC, which is that states are to cooperate with each other in a uniform matter for the interstate placement of children in order to ensure that:

- Each child requiring placement shall receive the maximum opportunity to be placed in a suitable environment and with persons or institutions having appropriate qualifications and facilities to provide a necessary and desirable degree and type of care;
- The appropriate authorities in a state where a child is to be placed may have full opportunity to ascertain the circumstances of the proposed placement, thereby promoting full compliance with applicable requirements for the protection of the child;

[11] The Association of Administrators of the Interstate Compact on the Placement of Children, *Guide to the Interstate Compact on the Placement of Children*, 2002.

- The proper authorities of the state from which the placement is made may obtain the most complete information on the basis of which to evaluate a projected placement before it is made; and
- Appropriate jurisdictional arrangements for the care of children will be promoted.

Section 63.2-1104 of the *Code* addresses the interstate-intercountry placement of children into Virginia. Whereas, §63.2-1105 applies to the placement of resident children out of the Commonwealth. Appendix A enumerates additional *Code* sections related to ICPC and OCS.

In order for DSS to process an ICPC request, the requesting agency or individual must submit the written notice for the request to the compact administrator. Appendix C details the entire process for placing a child out-of-state.

The written request is made by completing the ICPC-100A form, which is provided as Appendix D. After receiving the request, the compact administrator reviews the request to ensure compliance with specified placement laws and regulations. When the request to place a child has been approved by the state in which the child will be placed, the sending agency collaborates with the receiving parties to develop the details of the actual placement. After all plans and agreements have been completed, the child is placed out-of-state. A notification of this placement is given by the sending agency to the state in which the child is placed. This notification is made by completing form ICPC-100B, which is provided as Appendix E. Appendix F further details this process.

B. VIRGINIA DEPARTMENT OF SOCIAL SERVICES

As a result of DSS' central role with ICPC, the Commission requested that DSS provide a copy of its most recent ICPC regulations and training guidelines. The copy provided by DSS was dated July 1983, which pre-dates the implementation of CSA in Virginia. This document is attached as Appendix G. The 1983 guidelines do not include DSS' plan to promulgate regulations for ICPC. DSS has not updated the ICPC policy since 1983.

Additionally, the Commission requested the following information from DSS:

- How many children were placed in residential placements during FY05?
- What were the types of placements?
- Who was the referring agency?
- What was the age of the children?
- From what locality did the children reside?
- What were the diagnoses of the children?
- What was the average length of stay?
- What was the cost of the placements?
- In what state were the children placed?
- What were the reasons for the out-of-state placements?
- How many children are currently residing in out-of-state residential settings?
- How many children from other states and countries are currently residing in Virginia for residential placements?

DSS attributed its difficulty responding to requests for information to its methods of data collection. Local departments of social services enter data through On-line

Automated Services Information System (OASIS) which currently supports foster care, adoption and child protective services. OASIS is a comprehensive system documenting the day-to-day activities performed by child welfare workers.[12] In addition to the OASIS system, DSS' ICPC Unit and Adoption Units collect data through the Adoption Reports and Resource Information System (ARRIS) database for those children being placed out of state or out of the country. The ARRIS database is not available to local child welfare workers. Furthermore, the computer systems used by DSS and local departments of social services are not fully compatible. As a result, DSS cannot readily obtain data on the children being served through ICPC.

According to the U.S. Office of the Inspector General, only 27 of the 52 Compact states were able to report on the number of children placed through ICPC in 1997, including the number of adoption, foster care and residential placements. The states unable to report on the number of children placed into or out of the state through ICPC attributed to the poor quality and inconsistency of their tracking systems. The tracking systems either had differing standards among the states or ineffective tracking techniques.[13] Virginia's ICPC office does not utilize a data tracking system such that case information can be readily accessed. As a result, ICPC can only access information regarding the number of requests for out-of-state placements, not the actual number of out-of-state placements made. This causes confusion about which cases fall under the requirements of ICPC.

In response to the Commission's study on at-risk youth placed in out-of-state residential facilities, DSS conducted a programmatic assessment on Virginia's ICPC process.[14] At the Commission's November 21, 2005 meeting, DSS staff presented the results of its assessment.

According to DSS' findings, training for ICPC staff is not adequate. Specifically, the assessment identified the following:

- There is no formal ICPC training plan;
- Training requires an inordinate amount of staff effort;
- Training is not standardized;
- DSS staff does not regularly attend the American Public Human Services Association conferences. This organization provides participants and members with up-to-date information on ICPC; and
- Funding for training is unavailable.

Additionally, the assessment showed that training for local DSS staff is also inadequate.

- Local office staff have not received formal ICPC training in two years;

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[12] Virginia Department of Social Services, Annual Report on the Implementation of the Child-Protective Services Differential Response System, 2005. [Online]. Available: http://leg2.state.va.us/dls/h&sdocs.nsf/By+Year/RD2722005/$file/RD272.pdf. [January 2006].

[13] U.S. Department of Health and Human Services, Office of the Inspector General, *The Interstate Compact on the Placement of Children: State Structure and Process*, 1998. [September 2005].

[14] Virginia Department of Social Services, *Findings from a Programmatic Assessment of the Office of Interstate Compact on the Placement of Children, Division of Family Services*, 2005. [Online]. Available: http://coy.state.va.us/docs/DSSInterstateCompact112105.ppt. [November 2005].

- The one-on-one training and technical assistance require tremendous staff effort and resources; and
- One-on-one training approach leads to varied interpretation and understanding of information.[15]

Parties placing children in out-of-state placements need consistent and comprehensive training on the ICPC process. In addition, those participating in the ICPC process need clear guidance and policy direction from the state child welfare agency or DSS.

According to findings from an ICPC programmatic assessment of Virginia:

- A true "round robin" approach to case assignment does not exist;
- Program specialists differ in their area of expertise and are, therefore, targeted to receive certain types of cases;
- Part-time program specialists have an equal chance of getting a case as full-time staff. However, part-time staff are unable to address cases on a timely basis due to shorter work schedules;
- The "round robin" approach to case assignment does not result in equitable distribution of work. Simply counting cases does not accurately reflect the level of effort involved in a given case;
- There is no system currently in place that can accurately measure workload and productivity;
- Staff report being overworked. Staff indicated that productivity is achieved at a cost to workers (i.e. staff do not have time to take breaks and staff often eats lunch at their desks);
- A backlog of cases exists that specialists do not have time to address;
- A staff backup plan does not exist; and
- A contingency plan is needed that addresses the process for work distribution when staff is absent, on leave or resigns. In the absence of such a plan, cases continue to be assigned to individuals, even when they are out of the office. Workloads pile up in such situations and cases become backlogged.[16]

C. VIRGINIA OFFICE OF COMPREHENSIVE SERVICES ACT FOR AT-RISK CHILDREN AND FAMILIES

The second resource for attaining data information was OCS, which collects and maintains CSA data. Since CSA is the main funding resource for placing children in residential placements, OCS plays an important role in reporting. During Fiscal Year 2005, OCS spent over $273 million to serve at-risk children in the Commonwealth.

Local governments report demographic, assessment, service need, placement and financial data on all children receiving services through CSA. Local governments report this information to OCS. OCS collects gathered data for reporting periods ending December 31, March 31 and June 30 of each year. Localities have options as to the collection methodology at that level; however, localities must adhere to specific

[15] Virginia Department of Social Services *Findings from a Programmatic Assessment of the Office of Interstate Compact on the Placement of Children, Division of Family Services*, 2005.
[16] Virginia Department of Social Services, *Findings from a Programmatic Assessment of the Office of Interstate Compact on the Placement of Children, Division of Family Services*, 2005.

reporting requirements, agreed upon by the Information Technology Workgroup of the State Executive Council (SEC).

OCS offers a free web system for localities to report this data. This system is currently utilized by 65 of Virginia's 131 localities. The remaining local governments use locally supported software systems and download the information into a central system at OCS. OCS ensures that all reporting, regardless of reporting methodology, is consistent and properly submitted. OCS loads verified data from all localities into the DSS data warehouse. Different systems among child-serving agencies in local and state governments use different child identifiers, so consistent and reliable data on children being served cannot be retrieved.

Virginia law requires each locality to have at least two different interagency teams In order to receive CSA funding: CPMT and FAPT. (For *Code* sections, see Appendix A.) The CSA process begins when a child is referred, by typically, a parent or a local child-serving agency to the local team. Next, the child is screened based on CSA eligibility criteria. If the child meets the eligibility requirements, then he or she is assessed for treatment needs. FAPT works with the family to develop the Individual Family Services Plan (IFSP). If the services needed are beyond what is available in the participating agencies and there are no other family or community resources available, the team may choose to purchase the services with local CSA pool funds.[17] Due to Virginia's funding structure, the majority of children being served in out-of-state residential placements would, more than likely, go through the CSA progress to secure funding.

In 2002, the Commission conducted a study[18] on the use of the CSA Service Fee Directory. During the course of this study, it became apparent that the CSA Service Fee Directory is not widely used. Two primary reasons are that 1) local FAPT members are aware of the services offered by providers in their locality and 2) the information contained in the Directory is inaccurate.

Related to the first reason, in the event a known provider cannot meet a child's needs, the person working to find a placement will contact colleagues in other localities seeking their recommendation for potential placement. The benefit behind such action is that not all providers are of the same quality or are not appropriate for every child or situation. This type of information cannot be gained from consulting the Directory.

The second reason is the inaccuracy of the information. This became evident when Commission staff attempted to use the data contained in the directory to gather information on the capacity of residential services for children. Using data from the Directory, staff created a report for each of the focus group regions. When this information was presented to focus group members, a number of flaws were identified.

One prominent flaw related to the service codes that identify what types of services the provider offers. Payment for services through CSA can only be made to providers who are listed in the Directory and have indicated that they provide the service for which payment is requested. Providers appear to indicate the provision of services they do

[17] Virginia Office of Comprehensive Services. [Online]. Available: http://www.csa.state.va.us/html/about/about.cfm. [September 2005].
[18] Virginia Commission on Youth, 2002.

not routinely provide to ensure payment in the event they do provide the service; thereby, inflating the apparent availability of a service in that region.[19]

The Commission found that much of this data was not up-to-date. For example, it was noted that providers would frequently list services on the Directory that they actually did not provide. Local CSA coordinators and FAPT members are still not utilizing the Service Fee Directory because it is not up-to-date and it does not include recent licensure information.

D. OUT-OF-STATE PLACEMENTS OF VIRGINIA'S CHILDREN

Children who are currently being placed in out-of-state residential facilities suffer from multiple, co-occurring mental health and behavioral disorders. These children require specialized treatments that are limited and/or not offered within Virginia. These children usually suffer from several of the following disorders:

- Bipolar disorder;
- Severe autism or mental retardation;
- Sex offenders or sexual offending behaviors;
- Conduct disorders, violent behaviors or self-injurious;
- Substance abuse or polysubstance abuse;
- Attention Deficit Hyperactivity Disorder (ADHD);
- Post Traumatic Stress Disorder following incidents of abuse and neglect; and/or
- Suicidal behavior.

These children may also have accompanying physical limitations that require intense levels of care. Many of these children are special education placements. Others enter into the system:

- Through the courts and foster care systems as abused and neglected cases;
- As children who are in need of supervision or services (CHINS) cases; or
- As children who are alleged to have committed a delinquent act.

Children may also enter into acute-care psychiatric facilities through temporary detention orders (TDOs) in order to receive the required services. TDOs are available and granted to children who are in imminent danger to themselves and/or other individuals. These children usually suffer from mental illness. TDOs are also available and issued for children who are unable to care for themselves due to a serious mental illness and are unable to volunteer for treatment.[20]

The children who are placed out-of-state have needs that exceed Virginia's ability to treat. Currently, one percent of the total number of children served under CSA resides in out-of-state facilities. Chart 1 contrasts the total number of children in out-of-state placements to children who are served in-state.

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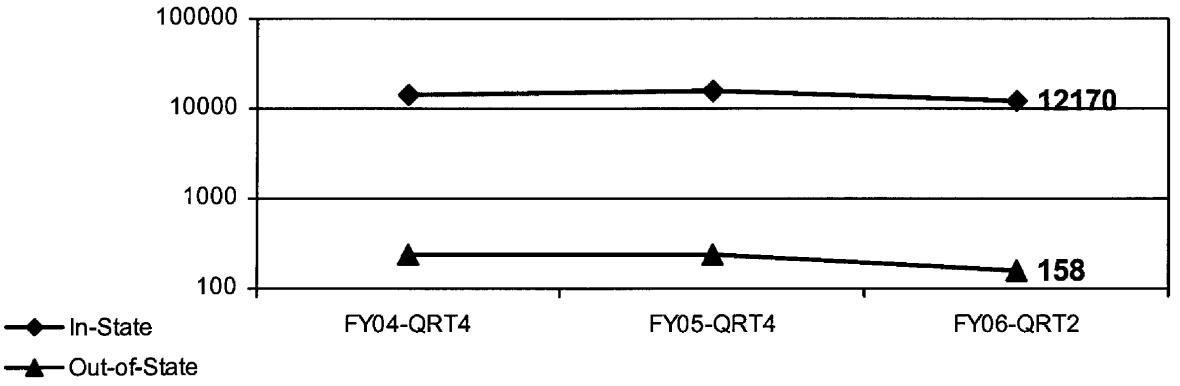
[19] Virginia Commission on Youth, 2002.

[20] Virginia Department of Medical Assistance Services, *Temporary Detention Order*, 2006. [Online]. Available: http://www.dmas.virginia.gov/rcp-temporary_detention_order.htm. [May 2006].

Chart 1

In-State versus Out-of-State Placements
Fiscal Years 2004-06 *



*** Cases may be duplicated.**

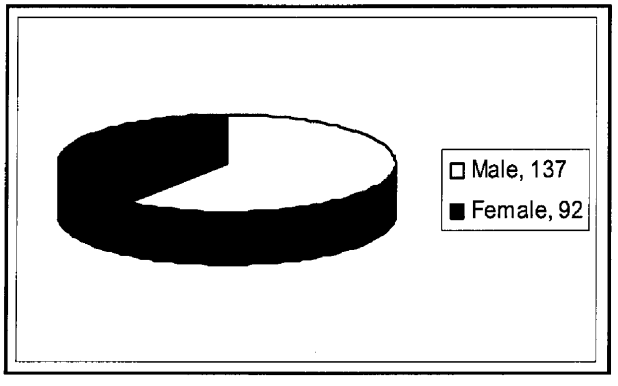
Source: Virginia Commission on Youth Graphic of Virginia Office of Comprehensive Services for At-Risk Children and Families data, 2006.

The majority of the children served within the Commonwealth are served through community-based interventions. As indicated in Chart 2, Virginia serves an overwhelming percentage of troubled or at-risk children in-state. Over three consecutive fiscal years, 99 percent of children under CSA care remained within Virginia.

In Virginia, the majority of youth who are placed out-of-state for residential treatment are males. As shown in Chart 2, over 60 percent are males.

Chart 2

Out-of-State Placements By Gender *



*** n=229 (Cases may be duplicated.)**

Source: Virginia Commission on Youth Graphic of Virginia Office of Comprehensive Services for At-Risk Children and Families data, based on 4th Quarter FY 05, 2006.

As well, the majority of youth in out-of-statement placements are receiving community-based interventions. Table 2 details the various services and placement types provided to youth.

Table 2

Out-of-State Placements By Type *

Type of Placement	Percentage of Total
Community-based Interventions	33
Foster Care Maintenance & Other Services	17
Therapeutic Foster Home	15
Residential Treatment Facility	15
SPED Day Placement	12
Group Home	8

*** Cases may be duplicated.**

Source: Virginia Commission on Youth Graphic of Virginia Office of Comprehensive Services for At-Risk Children and Families data, based on 2nd Quarter FY 06, 2006.

Virginia's children are being served in 14 states: Alabama, Colorado, Florida, Georgia, Maryland, Massachusetts, Michigan, New York, North Carolina, Ohio, Pennsylvania, South Carolina, Tennessee and Texas. Children are also served within the District of Columbia.

The children who are referred for out-of-state placements are referred from various agencies, including private child-placing agencies, public agencies, Court Service Units, judges, school divisions, parents and state agencies. Such state agencies include the Departments of Juvenile Justice, Social Services and Education. In some localities, children are also referred by local Interagency Teams or Interagency Offices.

On average, children who are placed in out-of-state group home and residential facilities have a length of stay of 1,475 days. The longest length of stay is 6,214 days, whereas the shortest length of stay is seven days. The average age of children placed out-of-state is 15.88 years old.

The majority of the children who are placed out-of-state in the period indicated were placed into residential treatment facilities. Table 3 shows the percentage of children in each placement location out-of-state.

Table 3

Out-of-State Placements
By Placement Location

Type of Placement	Percentage of Total
Residential Treatment Facility	45
Community-based	18
FC Maintenance & Other	9
Therapeutic FC Home	8
Group Home	6
Family FC Maintenance Only	5
SPED Day Placement	5
Specialized FC Home	2
SPED Other Day Services	1
Independent Living	1
Psychiatric Hospital	0

*** Cases may be duplicated.**

Source: Virginia Commission on Youth Graphic of Virginia Office of Comprehensive Services for At-Risk Children and Families data, based on 4th Quarter FY 05, 2006.

E. CONSEQUENCES OF OUT-OF-STATE PLACEMENTS AND SURVEY OF LOCAL CSA COORDINATORS

Virginia's children are placed out-of-state only when their needs exceed the services that can be provided within the home, community and/or Commonwealth. When a child is placed outside of the home and/or community environment, there are many consequences associated with placement. These consequences are more evident when children are placed out-of-state.

In 2005, the Commission conducted a telephone survey of 21 local CSA coordinators. The goal of the survey was to identify key issues and themes in relation to children who have been placed out-of-state for treatment. CSA coordinators were asked questions about the reasons why children in their localities were being placed out-of-state for treatment, the length of time that these children have been out-of-state, and any medical diagnosis that would further explain the out-of-state placement.

The CSA coordinators who were contacted represent each region within the Commonwealth, including rural, urban and suburban areas. Some of the localities contacted include Albemarle, Alleghany, Arlington, Chesterfield, Mecklenburg, Norfolk and Spotsylvania. The individuals contacted were asked to identify common areas of concerns in providing services for those children.

The results of the telephone survey noted numerous issues regarding Virginia's capacity to meet the needs of troubled and at-risk youth and adolescents.

- Many of the children who are being served in out-of-state residential facilities were previously served in in-state facilities;
- There is a lack of facilities in Virginia that serve intense-need children;
- There is a lack of facilities in Virginia that serve children diagnosed with mental retardation;
- There is a lack of facilities in Virginia that offer in-depth assessments;
- There is a lack of facilities in Virginia that employ best practices;
- Facilities in Virginia can refuse to treat a child due to the severity of the child's problems and because of the child's severe behaviors; and
- There is a lack of facilities in Virginia that are for females, particularly for females with severe behaviors and sex offenders.

The 2005 telephone survey responses also noted several observations regarding intense treatment needs:

- Children who are being placed out-of-state frequently require constant supervision;
- Case workers exhaust all other placement options prior to sending these children out-of-state and after multiple in-state placements have proven unsuccessful;
- If the child shows improvement, case workers attempt to bring the child back to Virginia into appropriate community-based "step-down" treatments;
- The child's treatment needs may escalate so as to warrant more restrictive and intense treatment settings; and
- Treatment programs in other states may be better designed to meet the service needs of these children.

Additionally, the survey responses noted several funding concerns:

- The rates for many of these out-of-state placements are competitive when compared with programs that currently exist in Virginia;
- Many Virginia programs do not accept Medicaid. This is particularly true for facilities that serve children with more intense service needs;
- Some out-of-state facilities are becoming enrolled in Virginia Medicaid in order to treat these children;
- Mandated children (both foster care and special education cases) obtain services whereas non-mandated children frequently go without, based on the localities' resources;
- In some localities, non-custodial foster care is seen as a way to obtain services for children; however, this is not always utilized appropriately; and
- Twenty percent of the children who are placed out-of-state receive 80 percent of the funding from localities.

Lastly, the 2005 survey recognized two issues related to agency turf:

- Some agencies hold the idea that children belong to a single agency; and
- Agencies within a locality do not always know and/or share information about available services within or outside of the community. This lack of information-sharing is damaging.

The drawbacks to placing children out-of-state for residential treatment which were cited included:

- The distance of the child from his/her family and community;
- Restrictive nature of residential placements;
- Decline of family functioning as a byproduct of placement;
- Economic and psychological costs to families;
- Expense of placements to the Commonwealth;
- Reliance upon such placements due to lack of available treatment programs in the Commonwealth; and
- Adequacy of ICPC in determining the number of children being placed out-of-state.

F. CONCERNS WITH RESIDENTIAL TREATMENT

Residential treatment is a very restrictive form of care and has many questions regarding its effectiveness. Next to inpatient hospitalization, it is the most restrictive form of care.[21] These centers are designed to handle more serious emotional disturbed (SED) children. Some of the treatment types include psychoanalytic, psychoeducational, behavioral management, group therapies, medication management and peer-cultural.

The effectiveness of residential treatment is questionable. These concerns include:

- Criteria for admission;
- Costliness of residential treatment services;
- Risk of treatment, including failing to teach the behaviors needed to return to the community and home;
- Possibility of trauma from being separated from family members;
- Family abandonment and/or difficulty returning to the family;
- Staff of residential treatment facilities victimizing the children; and
- Learning other behaviors from daily and intense exposure to other SED children. Such behaviors include antisocial and bizarre behaviors.[22]

Additionally, the consequences for failing to meet the needs of troubled or at-risk youth are very high. According to studies on mental health disorders among children, untreated mental illness leads to an increase in other disorders.[23]

- Untreated mental disorders have the potential of leading to increased contact with the juvenile justice system. Nationwide, approximately 66 percent of males and 75 percent of females in the juvenile justice system have at least one mental disorder;
- Untreated mental disorders can lead to substance abuse. Nationwide, approximately 43 percent of children who receive mental health services also suffer from substance abuse; and

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[21] U.S. Department of Health and Human Services, *Mental Health: A Report of the Surgeon General--Children and Mental Health, Chapter 3*, 1999. [Online]. Available: http://www.surgeongeneral.gov/library/mentalhealth/pdfs/c3.pdf. [April 2006].

[22] U.S. Department of Health and Human Services, 1999.

[23] Judge David L. Bazelon Center for Mental Health Law, *Facts on Children's Mental Health*, 2005. [Online] Available: http://www.bazelon.org/issues/children/factsheets/children-fact%20sheet%20final.pdf. [April 2006].

- Children who suffer from mental disorders are at a greater risk of suicide. Nationwide, approximately 90 percent of suicides among children are committed by youth and adolescents who suffer from mental disorders.[24]

There is also a significant cost factor in placing children out-of-state for treatment. In Fiscal Year 2004, $12,942,183 was spent on out-of-state placements. This represents over 45 percent of the total CSA expenditures for that year. The average cost of serving a child out-of-state is $69,582. Out of the total number of children served out-of-state, 47 placements cost over $100,000. The most expensive out-of-state case in Fiscal Year 2004 was $250,381. Table 4 details CSA expenditures from 1994 to 2005.

Table 4

Out-of-State Placements
CSA Expenditure Summary
Program Years 1994-2005

Year	Expenditures	Unduplicated Census	Unit Cost
1994	$104,012,539	$10,214	$10,236
1995	$125,648,063	$12,028	$10,446
1996	$143,998,432	$13,235	$10,880
1997	$156,899,217	$14,282	$10,986
1998	$174,446,501	$14,359	$12,150
1999	$196,772,741	$14,680	$13,404
2000	$204,670,798	$14,757	$13,869
2001	$195,533,986	$14,700	$13,302
2002	$227,813,290	$14,889	$15,301
2003	$235,516,055	$15,564	$15,132
2004	$259,342,292	$14,590	$17,774
2005*	$273,055,037	$16,269	$16,784

*Estimated due to one locality's not reporting

Source: Virginia Commission on Youth Graphic of Virginia Office of Comprehensive Services for At-Risk Children and Families data, 1994-2004, 2006.

G. OUT-OF-STATE PLACEMENT STRATEGIES IN OTHER STATES

The practice of placing troubled and at-risk youth and adolescents in out-of-state residential treatment facilities has not been researched extensively. Only a few states, including Virginia, have conducted research on out-of-state placements. The research that has been conducted analyzes the impact and cost associated with placing at-risk children in out-of-state residential facilities.

[24] Judge David L. Bazelon Center for Mental Health Law, 2005.

In 2004, 31 states had regulations on out-of-state placements. These states included Alabama, Arizona, California, Delaware, Florida, Georgia, Iowa, Illinois, Indiana, Kansas, Massachusetts, Maryland, Maine, Minnesota, Mississippi, Missouri, Montana, North Carolina, North Dakota, New Hampshire, New Jersey, New York, Oregon, Rhode Island, South Carolina, Texas, Virginia, Vermont, Washington, West Virginia and Wyoming.[25] During the same year, only 12 states had policies/guidance on out-of-state placements. These states included Arizona, Hawaii, Illinois, Indiana, Kansas, Minnesota, Mississippi, North Carolina, New Mexico, Ohio and Pennsylvania, as well as the Virgin Islands.[26]

Over the past decade, a small number of states have established state-level strategies to address the number of children who are placed out-of-state for residential treatment. In the 1990s, Vermont established a plan to increase the effectiveness of the state's System of Care approach.[27] This plan was aimed at preventive care by providing the necessary intensive levels of care to children prior to family disturbance. The plan also provided crisis outreach and home-based services. Through this approach, Vermont reduced the number of children being placed out-of-county by 73 percent and out-of-state by 100 percent.[28]

Four states—Alaska, Connecticut, New York and West Virginia—have conducted extensive research on out-of-state placements. The common themes among these studies are:

- Coordination of the delivery of state services among various state agencies;
- Impacts on youth who are placed out-of-state and on their families; and
- The lack of oversight afforded by out-of-state placements.

Each state's research is outlined briefly in the following paragraphs, detailing information from their respective reporting documents.

Alaska - Bring the Kids Home Project

In January 2006, the Alaska Department of Health and Social Services initiated a project targeted towards out-of-state placements for residential care. The project, Bring the Kids Home (BTKH), is aimed at returning children who have been placed in out-of-state residential facilities back into in-state residential facilities or community-based care.

As stated within the report, the long-term goals of BTKH are to:

- Build/develop and sustain the community-based and residential capacity to serve children with all intensities of need within the service delivery system in Alaska;
- Develop an integrated, seamless service system in Alaska that will allow children and youth to be served in the most culturally competent, least restrictive setting, as close as possible to home as determined to be safe and appropriate; and

[25] National Association of State Directors of Special Education, Inc., *Non-Public Placements: State Policies and Procedures*. 2004. [Online]. Available: http://www.nasdse.org/publications/non_public.pdf. [March 2006].
[26] National Association of State Directors of Special Education, Inc., 2004.
[27] Center for Mental Health, *Overcoming Barriers to Serving Our Children in the Community: Making the Olmstead Decision Work with Children with Mental Health Needs and Their Families*, 2002. [Online]. Available: http://www.olmsteadcommunity.org/documents/Barriers2.pdf. [March 2006].
[28] Center for Mental Health, 2002.

- Significantly reduce the existing numbers of children and youth in out-of-state care and ensure that the future use of out-of-state facilities is kept to a minimum.

Prior to initiating BTKH, Alaska experienced a tremendous increase in out-of-placement of children. Between 1998 and 2004, out-of-state placements in Residential Psychiatric Treatment Center (RPTC) care increased by approximately 800 percent. Nearly 350 to 400 children were being served out-of-state at any given time. Of the total number of custody children, 49 percent were Alaska native children. Of the total number of non-custody children, 22 percent were Alaska native children.

In regards to the financial impact to Alaska, out-of-state placement costs are significantly higher than in-state placements. Between 1998 and 2003, "Medicaid expenditures for in-state RPTC care increased 400 percent, from $3 to $12 million." During the same time period, "Medicaid expenditures for out-of-state RPTC care increased more than ten-fold, from $3 to $31 million." Since initiating BTKH, Medicaid expenditures for out-of-state RPTC care have increased by 1.1 percent. This is the smallest annual increase since 1998.

Source: State of Alaska Department of Health and Social Services Division of Behavioral Health, and the Alaska Mental Health Trust Authority, *Bring the Kids Home Annual Report*, 2005. [Online]. Available: http://www.hss.state.ak.us/dbh/ resources/pdf/BTKH_05_Annual_Report.pdf. [March 2006];
Source: State of Alaska Department of Health and Social Services, *Bringing--and Keeping--the Kids Home: Fact Sheet*, 2006. [Online]. Available: http://www.hss.state.ak.us/dbh/resources/pdf/BTKH_fact_sheet.pdf. [March 2006].

Connecticut – System of Care for Children With Special Health Care Needs

In 2001, the Connecticut Office of the Child Advocate published a report on the state's System of Care that is offered to children with special health care needs. This report results from multiple complaints to the Office about children with special health care needs being placed into inappropriate institutional settings. These institutional settings are both in-state and out-of-state residential facilities.

At that time of this report, there were approximately 450 children residing in out-of-state residential treatment facilities. These children were placed as far away as Georgia and Tennessee. Some of these children were placed in out-of-state residential facilities because their health care needs required a higher level of expertise from specialized facilities. However, some of these children were placed in out-of-state residential facilities simply because of the lack of health care alternatives within Connecticut.

The report identifies numerous problems with out-of-state placement, including:

- Discharge and permanency planning for children placed in out-of-state settings is extremely difficult;
- There is no effective oversight to ensure face-to-face contact or facilitation of family visitation;
- Children in out-of-state facilities often have no sense of belonging to anyone, no personal relationships; and
- If reunification with the family is not feasible, long-term institutionalization often becomes the permanent plan.

Since the publication of this report, the Office has decided to cease all out-of-state placements of children.

Source: State of Connecticut Office of the Child Advocate, *Connecticut's Services for Children with Special Health Care Needs*, 2001. [Online]. Available: http://www.ct.gov/oca/lib/oca/cshcn_final_may_2001.doc. [March 2006].

New York – Interagency Work Group on Out-of-State Residential Placements

In 2003, the Governor of New York created the Interagency Work Group on Out-of-State Residential Placements. This group was formed through the Council on Children and Families. The purpose of the group was to determine state and local reasons why youth were placed out of state for residential treatment. These placements include both education and social services placements.

The Work Group was charged to:

- Explore changes to the mechanisms by which the State oversees such placements;
- Determine whether out-of-state placement serve the best interest of the child;
- If policies and procedures need to be developed to minimize the need for such placements.

The overall consensus of the Work Group is that "each New York child should receive the most appropriate community based services that will support a child's ability to remain in his or her own home or to be placed in the least restrictive setting that will address his or her individual needs."

At the time of this report, there were approximately 1,400 children in out-of-state residential facilities. From 1998 to 2004, the number of out-of-state placements:

- Increased from 490 to 1,007 for the educational system; and
- Increased from 222 to 355 from the social service system.

The study concludes that there are five main concerns with placing children out-of-state for residential treatment.

- The quality of care that a New York child receives when he or she is in an out-of-state residential facility. Currently, New York State agencies have limited control and only limited oversight or resource capacity to monitor an out-of-state residential institution;
- The economic impact and job losses that result from exporting dollars and jobs to other states. The combined tuition and maintenance costs for some children are greater than $200 thousand per year, and some out-of-state institutions receive payments in excess of $7 million annually;
- It is estimated that New York pays $200 million annually to out-of-state residential facilities where New York youth are placed;
- The aggressive marketing efforts of out-of-state providers to local departments of social services, Local Educational Agencies, parents and parent organizations may be inappropriately influencing the local decision-making processes; and
- The geographic and regional disparities in service delivery and placement patterns.

Source: State of New York Council on Children and Families, *Report to the Governor: Interagency Out-of-State Residential Placement Work Group*, 2005. [Online] Available: http://www.ccf.state.ny.us/ finaloosgov.pdf. [March 2006].

West Virginia - Strategic Plan

In 2004, the West Virginia Department of Health and Human Resources Bureau of Children and Families developed a strategic plan to reduce the dependence on out-of-state placement of youth. In 2005, the Department submitted an update on the progress of specific plans and time frames in regards to reducing out-of-state placement reliance.

The goal of the report is to establish measures that will reduce the number of children residing in out-of-state residential facilities from 11 percent to 3 percent by 2006, while simultaneously ensuring that families and children receive most appropriate and cost effective services. At the time of the original report, 11 percent of the total number of children who required special care resided in out-of-state residential facilities.

There are three initiatives that stemmed from the strategic plan.

- Comprehensive Assessment and Planning System - The system focuses on the safety and risk issues of children who are placed in out-of-state residential facilities;
- Socially Necessary Services - The services are interventions that are necessary to improve the relationships and social functioning of the children who are placed in out-of-state residential facilities. This includes retrospective quality reviews and availability of services; and
- Community Based Team - This team is targeted towards strengthening the reunification process for the child, family and community. "The team provides for the collaboration of local community based providers who are willing to work together for the best interest of the children and their families."

The strategic plan also called for a reinvestment of funds. The allocations that are currently used for out-of-state and out-of-home treatment should be reinvested into services that provide support, prevention, intervention and treatment.

Source: West Virginia Department of Health and Human Resources Bureau for Children and Families. *Strategic Plan: Reduction of Dependence on Out-of-State Placement of Youth*, 2004;
Source: West Virginia Department of Health and Human Resources Bureau for Children and Families. *Strategic Plan: Reduction of Dependence on Out-of-State Placement of Youth*, Update, 2005.

VIII. Findings and Recommendations

A. VIRGINIA DEPARTMENT OF SOCIAL SERVICES

Findings

The Commission requested a copy of the most current Interstate Compact for the Placement of Children (ICPC) regulations and training guidelines from the Virginia Department of Social Services. The copy the Commission received was last revised July 1983, prior to the implementation of the Comprehensive Services Act (CSA) in Virginia. These guidelines do not include DSS' plan to promulgate regulations for ICPC.

Recommendation 1

Request that the Department of Social Services update its policy manual for the Interstate Compact for the Placement of Children by June 30, 2006.

Findings

According to findings from an ICPC programmatic assessment of the Commonwealth, training for ICPC staff is inadequate. The assessment found that:

- *There is no formal ICPC training plan;*
- *Training requires an inordinate amount of staff effort;*
- *Training is not standardized;*
- *Staff does not regularly attend the American Public Human Services Association conferences. This organization provides participants and members with up-to-date information on ICPC; and*
- *Funding for training is unavailable.*

Additionally, the assessment determined that training for local DSS staff is also inadequate.

- *Local office staff have not receive formal ICPC training in two years;*
- *The one-to-one training and technical assistance requires tremendous staff effort and resources; and*
- *One-on-one training approach leads to varied interpretation and understanding of information.*

Recommendation 2

Request the Department of Social Services, in conjunction with the Virginia Institute for Social Services Training Activities, to develop a training manual for the Interstate Compact for the Placement of Children (ICPC) progress. All local social services workers in the areas of foster care and adoption and their supervisors should be trained on the ICPC progress. This training should be ongoing and shall be included in the training of all new social services case workers in the areas of foster care and adoption.

Findings

The Virginia Department of Social Services was unable to respond to a request by the Commission on Youth for basic data on Virginia children placed out-of-state, their needs and costs, as well as what out-of-state children were placed in Virginia for treatment. Local departments of social services enter data through OASIS which currently supports foster care, adoption and child protective services. OASIS is a comprehensive system documenting the day-to-day activities performed by child welfare workers. In addition to the OASIS system, DSS' ICPC Unit and the Adoption Unit of DSS collects data through the ARRIS database for those children being placed out of state or out of the country. The ARRIS database is not available for local child welfare workers.

According to the United States Office of the Inspector General, only 27 states out of the 52 Compact states were able to report on the number of children who were placed through ICPC in 1997. This included reporting on the number of adoption, foster care, and residential placements. The states that were not able to report on the number of children placed into or out of the state through ICPC due to the poor quality and inconsistency of the tracking system. The tracking system either had differing standards among the states and/or ineffective tracking techniques.

Recommendation 3

Request the Department of Social Services to monitor the placement of children served by the Interstate Compact for the Placement of Children (ICPC) through an automated reporting and tracking system. This will include information on children served by ICPC, including those referred by other agencies. The Department of Social Services, in developing this system, will determine whether this system should be linked to the OASIS system, as well as other existing data systems. The Department of Social Services shall report on these activities to the Commission on Youth prior to the 2007 General Assembly Session.

Recommendation 4

Request the Department of Social Services to report annually to the General Assembly about the number of Virginia's children being served in out-of-state placements, including those being served in residential facilities. The report shall include information regarding the number of children receiving services in out-of-state residential treatment centers, the reasons these children are being placed out of the Commonwealth and the cost.

Findings

According to findings from an ICPC programmatic assessment of the Commonwealth:

- *A true "round robin" approach to case assignment does not exist;*
- *Program specialists differ in their area of expertise and are, therefore, targeted to receive certain types of cases;*
- *Part-time program specialists have an equal change of getting a case as full-time staff. However, part-time staff are unable to address cases on a timely basis due to shorter work schedules;*
- *The "round robin" approach to case assignment does not result in equitable distribution of work. Simply counting cases does not accurately reflect the level of effort involved in a given case;*
- *There is no system currently in place that can accurately measure workload and productivity;*
- *Staff report being overworked. Staff indicated that productivity is achieved at a cost to workers (i.e. staff do not have time to take breaks and staff often eats lunch at their desk);*
- *A backlog of cases exists that specialists do not have time to address;*
- *A staff backup plan does not exist; and*
- *A contingency plan is needed that addresses the process for work distribution when staff is absent, on leave or resign. In the absence of such a plan, cases continue to be assigned to individuals, even when they are out. Workload piles up in such situations and cases become backlogged.*

Recommendation 5

Request that the Department of Social Services review the state's Interstate Compact for the Placement of Children (ICPC) system, including its management, staffing, caseloads, paper and electronic process, tracking systems and databases to develop a more efficient, accountable ICPC system for all those who participate in the ICPC process. Further, the Department of Social Services shall ensure that Virginia is in compliance with all state and federal laws and

regulations. The Department of Social Services shall report on these activities to the Commission on Youth prior to the 2007 General Assembly Session.

B. OFFICE OF THE COMPREHENSIVE SERVICES FOR AT-RISK CHILDREN AND FAMILIES

Recommendation 6

Request the Secretary of Health and Human Resources, in conjunction with the State Executive Council (SEC), to investigate the feasibility of utilizing a unique child identifier across all child-serving agencies. Request the SEC to coordinate with the data workgroup to evaluate the need to modify the reasons for service fields so that they are more helpful for ascertaining the reasons for service for program development. A report on these activities shall be made to the Commission on Youth prior to the 2007 General Assembly Session.

Findings

In 2002, the Commission conducted a study on the CSA service fee directory. During the course of this study, it became apparent that the CSA Service Fee Directory is not widely used. Two primary reasons seem are that 1) local FAPT members are aware of the services offered by providers in their locality; and 2) the information contained in the Directory is inaccurate. Related to the first reason, in the event a known provider cannot meet a child's needs, the person working to find a placement will contact colleagues in other localities seeking their recommendation for potential placement. The benefit behind such action is that not all providers are of the same quality or are not appropriate for every child or situation. This type of information cannot be gained from consulting the Directory.

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

Recommendation 7

Request that the Office of Comprehensive Services for At-Risk Children and Families (OCS) to improve the information available in and revise the system through which provider information is placed in the Service Fee Directory. Request that OCS update the Directory and request that locality-specific, service-specific and licensing information be included.

Recommendation 8

Request the State Executive Council to coordinate with the data workgroup to evaluate the need to modify the reasons for service fields so that they are more helpful for ascertaining the reasons for service for program development.

IX. Acknowledgments

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Appendix A

CODE OF VIRGINIA
SECTIONS RELATED TO
THE COMPREHENSIVE SERVICES ACT FOR AT-RISK CHILDREN
AND THE INTERSTATE COMPACT ON THE PLACEMENT OF CHILDREN

Sections on the Comprehensive Services Act for At-Risk Children

§ 2.2-212. *Agencies for which responsible.* (Effective July 1, 2006)

The position of Secretary of Health and Human Resources (the Secretary) is created. The Secretary of Health and Human Resources shall be responsible to the Governor for the following agencies: Department of Health, Department for the Blind and Vision Impaired, Department of Health Professions, Department for the Aging, Department of Mental Health, Mental Retardation and Substance Abuse Services, Department of Rehabilitative Services, Department of Social Services, Department of Medical Assistance Services, Advisory Council on the Future of Nursing in Virginia, Child Day-Care Council, Virginia Department for the Deaf and Hard-of-Hearing, and the Office of Comprehensive Services for Youth and At-Risk Youth and Families. The Governor may, by executive order, assign any other state executive agency to the Secretary of Health and Human Resources, or reassign any agency listed above to another Secretary.

Unless the Governor expressly reserves such power to himself, the Secretary shall (i) coordinate the work of state agencies to implement the long-term care policy of the Commonwealth and (ii) serve as the lead Secretary for the Comprehensive Services Act for At-Risk Youth and Families, working with the Secretary of Education and the Secretary of Public Safety to facilitate interagency service development and implementation, communication and cooperation.

(1976, c. 729, §§ 2.1-51.13, 2.1-51.14, 2.1-51.15; 1978, c. 635; 1982, cc. 345, 459; 1983, c. 20; 1984, cc. 720, 781; 1985, cc. 447, 448; 1987, cc. 219, 698; 1988, cc. 646, 765; 1989, cc. 614, 695; 1990, c. 458; 1991, c. 563; 1994, c. 755; 1996, cc. 492, 902; 1998, c. 793; 2000, c. 937; 2001, cc. 577, 777, 844; 2004, cc. 14, 142.)

§ 2.2-2648. *State Executive Council for Comprehensive Services for At-Risk Youth and Families; membership; meetings; powers and duties.*

A. The State Executive Council for Comprehensive Services for At-Risk Youth and Families (the Council) is established as a supervisory council, within the meaning of § 2.2-2100, in the executive branch of state government.

B. The Council shall consist of one member of the House of Delegates to be appointed by the Speaker of the House and one member of the Senate to be appointed by the Senate Committee on Rules; the Commissioners of Health, of Mental Health, Mental Retardation and Substance Abuse Services, and of Social Services; the Superintendent of Public Instruction; the Executive Secretary of the Virginia Supreme Court; the Director of the Department of Juvenile Justice; the Director of the Department of Medical Assistance Services; the chairman of the state and local advisory team established pursuant to § 2.2-5202; two local government representatives to include a member of a county board of supervisors or a city council and a county administrator or city manager, to be appointed by the Governor; a private provider representative from a facility that maintains membership in an association of providers for children's or family services and receives funding as authorized by the Comprehensive Services Act (§ 2.2-5200 et seq.), to be appointed by the Governor, who may appoint from nominees

recommended by the Virginia Coalition of Private Provider Associations; and a parent representative. The parent representative shall be appointed by the Governor for a term not to exceed three years and shall not be an employee of any public or private program that serves children and families. Appointments of legislative members shall be for terms coincident with their terms of office. Legislative members shall not be included for the purposes of constituting a quorum.

C. The Council shall be chaired by the Secretary of Health and Human Resources or a designated deputy who shall be responsible for convening the council. The Council shall meet, at a minimum, quarterly, to oversee the administration of this article and make such decisions as may be necessary to carry out its purposes. Legislative members shall receive compensation as provided in § 30-19.12 and nonlegislative citizen members shall receive compensation for their services as provided in §§ 2.2-2813 and 2.2-2825.

D. The Council shall have the following powers and duties:

1. Hire and supervise a director of the Office of Comprehensive Services for At-Risk Youth and Families;

2. Appoint the members of the state and local advisory team in accordance with the requirements of § 2.2-5201;

3. Provide for the establishment of interagency programmatic and fiscal policies developed by the Office of Comprehensive Services for At-Risk Youth and Families, which support the purposes of the Comprehensive Services Act (§ 2.2-5200 et seq.), through the promulgation of regulations by the participating state boards or by administrative action, as appropriate;

4. Provide for a public participation process for programmatic and fiscal guidelines and dispute resolution procedures developed for administrative actions that support the purposes of the Comprehensive Services Act (§ 2.2-5200 et seq.). The public participation process shall include, at a minimum, 60 days of public comment and the distribution of these guidelines and procedures to all interested parties;

5. Oversee the administration of and consult with the Virginia Municipal League and the Virginia Association of Counties about state policies governing the use, distribution and monitoring of moneys in the state pool of funds and the state trust fund;

6. Provide for the administration of necessary functions that support the work of the Office of Comprehensive Services for At-Risk Youth and Families;

7. Review and take appropriate action on issues brought before it by the Office of Comprehensive Services for At-Risk Youth and Families, Community Policy and Management Teams (CPMTs), local governments, providers and parents;

8. Advise the Governor and appropriate Cabinet Secretaries on proposed policy and operational changes that facilitate interagency service development and implementation, communication and cooperation;

9. Provide administrative support and fiscal incentives for the establishment and operation of local comprehensive service systems;

10. Oversee coordination of early intervention programs to promote comprehensive, coordinated service delivery, local interagency program management, and co-location of programs and services in communities. Early intervention programs include state programs under the administrative control of the state executive council member agencies;

11. Oversee the development and implementation of a mandatory uniform assessment instrument and process to be used by all localities to identify levels of risk of Comprehensive Services Act (CSA) youth;

12. Oversee the development and implementation of uniform guidelines to include initial intake and screening assessment, development and implementation of a plan of care, service monitoring and periodic follow-up, and the formal review of the status of the youth and the family;

13. Oversee the development and implementation of uniform guidelines for documentation for CSA-funded services;

14. Review and approve a request by a CPMT to establish a collaborative, multidisciplinary team process for referral and reviews of children and families pursuant to § 2.2-5209;

15. Oversee the development and implementation of mandatory uniform guidelines for utilization management; each locality receiving funds for activities under the Comprehensive Services Act shall have a locally determined utilization management plan following the guidelines or use of a process approved by the Council for utilization management, covering all CSA-funded services;

16. Oversee the development, implementation, and collection of uniform data collection standards, and the development of outcome measures; including, but not limited to, expenditures, number of youth served in specific CSA activities, length of stay for residents in core licensed residential facilities, and proportion of youth placed in treatment settings suggested by a uniform assessment instrument for CSA-funded services;

17. Establish and oversee the operation of an informal review and negotiation process with the Director of the Office of Comprehensive Services and a formal dispute resolution procedure before the State Executive Council, which include formal notice and an appeals process, should the Director or Council find, upon a formal written finding, that a CPMT failed to comply with any provision of this Act. "Formal notice" means the Director or Council provides a letter of notification, which communicates the Director's or the Council's finding, explains the effect of the finding, and describes the appeal process, to the chief administrative officer of the local government with a copy to the chair of the CPMT. The dispute resolution procedure shall also include provisions for remediation by the CPMT that shall include a plan of correction recommended by the Council and submitted to the CPMT. If the Council denies reimbursement from the state pool of funds, the Council and the locality shall develop a plan of repayment;

18. Deny state funding to a locality where the CPMT fails to provide services that comply with the Comprehensive Services Act (§ 2.2-5200 et seq.), in accordance with subdivision 17; and

19. Biennially publish and disseminate to members of the General Assembly and community policy and management teams a state progress report on comprehensive services to children, youth and families and a plan for such services for the next succeeding biennium. The state plan shall:

a. Provide a fiscal profile of current and previous years' federal and state expenditures for a comprehensive service system for children, youth and families;

b. Incorporate information and recommendations from local comprehensive service systems with responsibility for planning and delivering services to children, youth and families;

c. Identify and establish goals for comprehensive services and the estimated costs of implementing these goals, report progress toward previously identified goals and establish priorities for the coming biennium; and

d. Include such other information or recommendations as may be necessary and appropriate for the improvement and coordinated development of the state's comprehensive services system.

(1992, cc. 837, 880, § 2.1-746; 1995, c. 800; 1996, c. 1024; 1998, c. 622; 1999, c. 669; 2000, cc. 900, 937; 2001, c. 844; 2002, c. 410; 2003, cc. 483, 498; 2004, c. 836; 2005, c. 930.)

§ 2.2-2649. *Office of Comprehensive Services for At-Risk Youth and Families established; powers and duties.*

A. The Office of Comprehensive Services for At-Risk Youth and Families is hereby established to serve as the administrative entity of the Council and to ensure that the decisions of the council are implemented. The director shall be hired by and subject to the direction and supervision of the Council pursuant to § 2.2-2648.

B. The director of the Office of Comprehensive Services for At-Risk Youth and Families shall:

1. Develop and recommend to the state executive council programs and fiscal policies that promote and support cooperation and collaboration in the provision of services to troubled and at-risk youths and their families at the state and local levels;

2. Develop and recommend to the Council state interagency policies governing the use, distribution and monitoring of moneys in the state pool of funds and the state trust fund;

3. Develop and provide for the consistent oversight for program administration and compliance with state policies and procedures;

4. Provide for training and technical assistance to localities in the provision of efficient and effective services that are responsive to the strengths and needs of troubled and at-risk youths and their families;

5. Serve as liaison to the participating state agencies that administratively support the Office and that provide other necessary services;

6. Provide an informal review and negotiation process pursuant to subdivision D 17 of § 2.2-2648;

7. Implement, in collaboration with participating state agencies, policies, guidelines and procedures adopted by the State Executive Council;

8. Consult regularly with the Virginia Municipal League and the Virginia Association of Counties about implementation and operation of the Comprehensive Services Act (§ 2.2-5200 et seq.);

9. Hire appropriate staff as approved by the Council; and

10. Perform such other duties as may be assigned by the State Executive Council.

C. The director of the Office of Comprehensive Services, in order to provide support and assistance to the Comprehensive Policy and Management Teams (CPMTs) and Family Assessment and Planning Teams (FAPTs) established pursuant to the Comprehensive Services Act for At-Risk Youth and Families (§ 2.2-5200 et seq.), shall:

1. Develop and maintain a web-based statewide automated database, with support from the Department of Information Technology or its successor agency, of the authorized vendors of the Comprehensive Services Act (CSA) services to include verification of a vendor's licensure status, a listing of each discrete CSA service offered by the vendor, and the discrete CSA service's rate determined in accordance with § 2.2-5214; and

2. Develop, in consultation with the Department of General Services, CPMTs, and vendors, a standardized purchase of services contract, which in addition to general contract provisions when utilizing state pool funds will enable localities to specify the discrete service or services they are purchasing for the specified client, the required reporting of the client's service data, including types and numbers of disabilities, mental health and mental retardation diagnoses, or delinquent behaviors for which the purchased services are intended to address, the expected outcomes resulting from these services and the performance timeframes mutually agreed to when the services are purchased.

(2000, c. 937, § 2.1-746.1; 2001, c. 844; 2002, c. 410; 2003, c. 485.)

§ 2.2-5200. *Intent and purpose; definitions.*

A. It is the intention of this law to create a collaborative system of services and funding that is child-centered, family-focused and community-based when addressing the strengths and needs of troubled and at-risk youths and their families in the Commonwealth.

This law shall be interpreted and construed so as to effectuate the following purposes:

1. Ensure that services and funding are consistent with the Commonwealth's policies of preserving families and providing appropriate services in the least restrictive environment, while protecting the welfare of children and maintaining the safety of the public;

2. Identify and intervene early with young children and their families who are at risk of developing emotional or behavioral problems, or both, due to environmental, physical or psychological stress;

3. Design and provide services that are responsive to the unique and diverse strengths and needs of troubled youths and families;

4. Increase interagency collaboration and family involvement in service delivery and management;

5. Encourage a public and private partnership in the delivery of services to troubled and at-risk youths and their families; and

6. Provide communities flexibility in the use of funds and to authorize communities to make decisions and be accountable for providing services in concert with these purposes.

B. As used in this chapter, unless the context requires a different meaning:

"CSA" means the Comprehensive Services Act.

"Council" means the State Executive Council for Comprehensive Services for At-Risk Youth and Families created pursuant to § 2.2-2648.

(1992, cc. 837, 880, § 2.1-745; 2001, c. 844.)

§ 2.2-5201. *State and local advisory team; appointment; membership.*

The state and local advisory team is established to better serve the needs of troubled and at-risk youths and their families by advising the Council by managing cooperative efforts at the state level and providing support to community efforts. The team shall be appointed by and be responsible to the Council. The team shall include one representative from each of the following state agencies: the Department of Health, Department of Juvenile Justice, Department of Social Services, Department of Mental Health, Mental Retardation and Substance Abuse Services, the Department of Medical Assistance Services, and the Department of Education. The team shall also include a parent representative who is not an employee of any public or private program which serves children and families; a representative of a private organization or association of providers for children's or family services; a local Comprehensive Services Act coordinator or program manager; a juvenile and domestic relations district court judge; and one member from each of five different geographical areas of the Commonwealth and who serves on and is representative of the different participants of community policy and management teams. The nonstate agency members shall serve staggered terms of not more than three years, such terms to be determined by the Council.

The team shall annually elect a chairman from among the local government representatives who shall be responsible for convening the team. The team shall develop and adopt bylaws to govern its operations that shall be subject to approval by the Council. Any person serving on such team who does not represent a public agency shall file a statement of economic interests as set out in § 2.2-3117 of the State and Local Government Conflict of Interests Act (§ 2.2-3100 et seq.). Persons representing public agencies shall file such statements if required to do so pursuant to the State and Local Government Conflict of Interests Act.

(1992, cc. 837, 880, § 2.1-747; 2000, c. 937; 2001, c. 844; 2003, c. 499; 2004, c. 836.)

§ 16.1-286. *Cost of maintenance; approval of placement; semiannual review.*

A. When the court determines that the behavior of a child within its jurisdiction is such that it cannot be dealt with in the child's own locality or with the resources of his locality, the judge shall refer the child to the locality's family assessment and planning team for assessment and a recommendation for services. Based on this recommendation, the court may take custody and place the child, pursuant to the provisions of subdivision 5 of § 16.1-278.4 or 13 b of § 16.1-278.8, in a private or locally operated public facility, or nonresidential program with funding in accordance with the Comprehensive Services Act for At-Risk Youth and Families (§ 2.2-5200 et seq.). No child shall be placed outside the Commonwealth by a court without first complying with the appropriate provisions of Chapter 11 (§ 63.2-1100 et seq.) of Title 63.2 or with regulations of the State Board of Social Services relating to resident children placed out of the Commonwealth.

The Board shall establish a per diem allowance to cover the cost of such placements. This allowance may be drawn from funds allocated through the state pool of funds to the community policy and management team of the locality where the child resides as such residence is determined by the court. The cost, however, shall not exceed that amount which would be incurred if the services required by the child were provided in a juvenile facility operated by the Department of Juvenile Justice. However, when the court determines after an investigation and a hearing that the child's parent or other person legally obligated to provide support is financially able to contribute to support of the child, the court may order that the parent or other legally obligated person pay, pursuant to § 16.1-290. If the parent or other obligated person willfully fails or refuses to pay such sum, the court may proceed against him for contempt. Alternatively, the court, after reasonable notice to the obligor, may enter an order adjudicating that the obligor is delinquent and such order shall have the effect of a civil judgment when duly docketed in the manner prescribed for the docketing of other judgments for money provided.

B. The court service unit of the locality which made the placement shall be responsible for monitoring and supervising all children placed pursuant to this section. The court shall receive and review, at least semiannually, recommendations concerning the continued care of each child in such placements.

(Code 1950, § 16.1-181.1; 1976, c. 464; 1977, c. 559; 1978, c. 310; 1982, c. 166; 1987, c. 667; 1989, c. 733; 1991, c. 534; 1992, cc. 732, 837, 880; 1995, cc. 696, 699; 1997, c. 347; 1999, c. 669; 2003, c. 579.)

§ 63.2-410. *State pool of funds under the Comprehensive Services Act.*

The General Assembly and the governing body of each county and city shall appropriate such sum or sums of money for use by the community policy and management teams through the state pool of funds established in Chapter 52 (§ 2.2-5200 et seq.) of Title 2.2 as shall be sufficient to provide basic foster care services for children who are identified as being at risk, as determined by policy developed by the Board, or who are under the custody and control of the local board. The local governing body of each county and city shall appropriate such sums of money as necessary for the purchase of such other essential social services to children and adults under such conditions as may be prescribed by the Board in accordance with federally reimbursed public assistance and social service programs.

(Code 1950, § 63-72.1; 1966, c. 593; 1968, cc. 466, 578, § 63.1-55; 1973, c. 122; 1977, c. 634; 1982, c. 171; 1984, c. 781; 1986, c. 281; 1992, cc. 837, 880; 2002, c. 747.)

Sections on the Interstate Compact on the Placement of Children

§ 22.1-101.1. *Increase of funds for certain nonresident students; how increase computed and paid; billing of out-of-state placing agencies or persons.*

A. To the extent such funds are appropriated by the General Assembly, a school division shall be reimbursed for the cost of educating a child who is not a child with disabilities and who is not a resident of such school division under the following conditions:

1. When such child has been placed in foster care or other custodial care within the geographical boundaries of the school division by a Virginia agency, whether state or local, which is authorized under the laws of this Commonwealth to place children;

2. When such child has been placed within the geographical boundaries of the school division in an orphanage or children's home which exercises legal guardianship rights; or

3. When such child, who is a resident of Virginia, has been placed, not solely for school purposes, in a child-caring institution or group home licensed under the provisions of Chapter 17 (§ 63.2-1700 et seq.) of Title 63.2 which is located within the geographical boundaries of the school division.

B. To the extent such funds are appropriated by the General Assembly, a school division shall be reimbursed for the cost of educating a child with disabilities who is not a resident of such school division under the following conditions:

1. When the child with disabilities has been placed in foster care or other custodial care within the geographical boundaries of the school division by a Virginia agency, whether state or local, which is authorized under the laws of this Commonwealth to place children;

2. When such child with disabilities has been placed within the geographical boundaries of the school division in an orphanage or children's home which exercises legal guardianship rights; or

3. When such child with disabilities, who is a resident of Virginia, has been placed, not solely for school purposes, in a child-caring institution or group home licensed under the provisions of Chapter 17 (§ 63.2-1700 et seq.) of Title 63.2 which is located within the geographical boundaries of the school division.

C. Each school division shall keep an accurate record of the number of days which any child, identified in subsection A or B above, was enrolled in its public schools, the required local expenditure per child, the handicapping condition, if applicable, the placing agency or person and the jurisdiction from which the child was sent. Each school division shall certify this information to the Board of Education by July 1 following the end of the school year in order to receive proper reimbursement. No school division shall charge tuition to any such child.

D. When a child who is not a resident of Virginia, whether disabled or not, has been placed by an out-of-state agency or a person who is the resident of another state in foster care or other custodial care or in a child-caring institution or group home licensed under the provisions of Chapter 17 (§ 63.2-1700 et seq.) of Title 63.2 located within the geographical boundaries of the school division, the school division shall not be reimbursed for the cost of educating such child from funds appropriated by the General Assembly. The school division in which such child has been enrolled shall bill the sending agency or person for the cost of the education of such child as provided in subsection C of § 22.1-5.

The costs of the support and maintenance of the child shall include the cost of the education provided by the school division; therefore, the sending agency or person shall have the financial responsibility for the educational costs for the child pursuant to Article V of the Interstate Compact on the Placement of Children as set forth in Chapters 10 (§ 63.2-1000 et seq.) and 11 (§ 63.2-1100 et seq.) of Title 63.2. Upon receiving the bill for the educational costs from the school division, the sending agency or person shall reimburse the billing school division for providing the education of the child. Pursuant to Article III of the Interstate Compact on the Placement of Children, no sending agency or person shall send, bring, or cause to be sent or brought into this Commonwealth any child for placement unless the sending agency or person has complied with this section by honoring the financial responsibility for the educational cost as billed by a local school division.

(1988, c. 101; 1992, cc. 837, 880; 1994, c. 854.)

§ 22.1-218.1. *Duty to process placements through the Interstate Compact on the Placement of Children.*

In order to protect the interests of the Commonwealth and local governments and provide for the safety and welfare of children with disabilities, all placements of children with disabilities facilitated by a school division in an out-of-state special education facility shall be processed through the Interstate Compact on the Placement of Children as provided in Chapters 10 (§ 63.2-1000 et seq.) and 11 (§ 63.2-1100 et seq.) of Title 63.2.

(1983, c. 376; 1994, c. 854.)

§ 63.2-1000. *Interstate Compact on the Placement of Children; form of compact.*

The Governor of Virginia is hereby authorized and requested to execute, on behalf of the Commonwealth of Virginia, with any other state or states legally joining therein, a compact which shall be in form substantially as follows:

The contracting states solemnly agree that:

ARTICLE I. Purpose and Policy.

It is the purpose and policy of the party states to cooperate with each other in the interstate placement of children to the end that:

(a) Each child requiring placement shall receive the maximum opportunity to be placed in a suitable environment and with persons or institutions having appropriate qualifications and facilities to provide a necessary and desirable degree and type of care.

(b) The appropriate authorities in a state where a child is to be placed may have full opportunity to ascertain the circumstances of the proposed placement, thereby promoting full compliance with applicable requirements for the protection of the child.

(c) The proper authorities of the state from which the placement is made may obtain the most complete information on the basis of which to evaluate a projected placement before it is made.

(d) Appropriate jurisdictional arrangements for the care of children will be promoted.

ARTICLE II. Definitions.

As used in this compact:

(a) "Child" means a person who, by reason of minority, is legally subject to parental, guardianship or similar control.

(b) "Sending agency" means a party state, officer or employee thereof; a subdivision of a party state, or officer or employee thereof; a court of a party state; a person, corporation, association, charitable agency or other entity which sends, brings, or causes to be sent or brought any child to another party state.

(c) "Receiving state" means the state to which a child is sent, brought, or caused to be sent or brought, whether by public authorities or private persons or agencies, and whether for placement with state or local public authorities or for placement with private agencies or persons.

(d) "Placement" means the arrangement for the care of a child in a family free or boarding home or in a child-caring agency or institution but does not include any institution caring for the mentally ill, mentally defective or epileptic or any institution primarily educational in character, and any hospital or other medical facility.

ARTICLE III. Conditions for Placement.

(a) No sending agency shall send, bring, or cause to be sent or brought into any other party state any child for placement in foster care or as a preliminary to a possible adoption unless the sending agency shall comply with each and every requirement set forth in this article and with the applicable laws of the receiving state governing the placement of children therein.

(b) Prior to sending, bringing or causing any child to be sent or brought into a receiving state for placement in foster care or as a preliminary to a possible adoption, the sending agency shall furnish the appropriate public authorities in the receiving state written notice of the intention to send, bring, or place the child in the receiving state. The notice shall contain:

(1) The name, date and place of birth of the child.

(2) The identity and address or addresses of the parents or legal guardian.

(3) The name and address of the person, agency or institution to or with which the sending agency proposes to send, bring, or place the child.

(4) A full statement of the reasons for such proposed action and evidence of the authority pursuant to which the placement is proposed to be made.

(c) Any public officer or agency in a receiving state which is in receipt of a notice pursuant to paragraph (b) of this article may request of the sending agency, or any other appropriate officer or agency of or in the sending agency's state, and shall be entitled to receive therefrom, such supporting or additional information as it may deem necessary under the circumstances to carry out the purpose and policy of this compact.

(d) The child shall not be sent, brought or caused to be sent or brought into the receiving state until the appropriate public authorities in the receiving state shall notify the sending agency, in writing, to the effect that the proposed placement does not appear to be contrary to the interests of the child.

ARTICLE IV. Penalty for Illegal Placement.

The sending, bringing, or causing to be sent or brought into any receiving state of a child in violation of the terms of this compact shall constitute a violation of the laws respecting the placement of children of both the state in which the sending agency is located or from which it sends or brings the child and of the receiving state. Such violation may be punished or subjected to penalty in either jurisdiction in accordance with its laws. In addition to liability for any such punishment or penalty, any such violation shall constitute full and sufficient grounds for the suspension or revocation of any license, permit, or other legal authorization held by the sending agency which empowers or allows it to place, or care for children.

ARTICLE V. Retention of Jurisdiction.

(a) The sending agency shall retain jurisdiction over the child sufficient to determine all matters in relation to the custody, supervision, care, treatment and disposition of the child which it would have had if the child had remained in the sending agency's state, until the child is adopted, reaches majority, becomes self-supporting or is discharged with the concurrence of the appropriate authority in the receiving state. Such jurisdiction shall also include the power to effect or cause the return of the child or its transfer to another location and custody pursuant to law. The sending agency shall continue to have financial responsibility for support and maintenance of the child during the period of the placement. Nothing contained herein shall defeat a claim of jurisdiction by a receiving state sufficient to deal with an act of delinquency or crime committed therein.

(b) When the sending agency is a public agency, it may enter into an agreement with an authorized public or private agency in the receiving state providing for the performance of one or more services in respect of such cases by the latter as agent for the sending agency.

(c) Nothing in this compact shall be construed to prevent a private charitable agency authorized to place children in the receiving state from performing services or acting as agent in that state for a private charitable agency of the sending state; nor to prevent the agency in the receiving state from discharging financial responsibility for the support and maintenance of a child who has been placed on behalf of the sending agency without relieving the responsibility set forth in paragraph (a) hereof.

ARTICLE VI. Institutional Care of Delinquent Children.

A child adjudicated delinquent may be placed in an institution in another party jurisdiction pursuant to this compact but no such placement shall be made unless the child is given a court hearing on notice to the parent or guardian with opportunity to be heard, prior to his being sent to such other party jurisdiction for institutional care and the court finds that:

1. Equivalent facilities for the child are not available in the sending agency's jurisdiction; and

2. Institutional care in the other jurisdiction is in the best interest of the child and will not produce undue hardship.

ARTICLE VII. Compact Administrator.

The executive head of each jurisdiction party to this compact shall designate an officer who shall be general coordinator of activities under this compact in his jurisdiction and who, acting jointly with like officers of other party jurisdictions, shall have the power to promulgate rules and regulations to carry out more effectively the terms and provisions of this compact.

ARTICLE VIII. Limitations.

This compact shall not apply to:

(a) The sending or bringing of a child into a receiving state by his parent, step-parent, grandparent, adult brother or sister, adult uncle or aunt, or his guardian and leaving the child with any such relative or nonagency guardian in the receiving state.

(b) Any placement, sending or bringing of a child into a receiving state pursuant to any other interstate compact to which both the state from which the child is sent or brought and the receiving state are party, or to any other agreement between said states which has the force of law.

ARTICLE IX. Enactment and Withdrawal.

This compact shall be open to joinder by any state, territory or possession of the United States, the District of Columbia, the Commonwealth of Puerto Rico, and, with the consent of Congress, the Government of Canada or any province thereof. It shall become effective with respect to any such jurisdiction when such jurisdiction has enacted the same into law. Withdrawal from this compact shall be by the enactment of a statute repealing the same, but shall not take effect until two years after the effective date of such statute and until written notice of the withdrawal has been given by the withdrawing state to the Governor of each other party jurisdiction. Withdrawal of a party state shall not affect the rights, duties and obligations under this compact of any sending agency therein with respect to a placement made prior to the effective date of withdrawal.

ARTICLE X. Construction and Severability.

The provisions of this compact shall be liberally construed to effectuate the purposes thereof. The provisions of this compact shall be severable and if any phrase, clause, sentence or provision of this compact is declared to be contrary to the constitution of any party state or of the United States or the applicability thereof to any government, agency, person or circumstance is held invalid, the validity of the remainder of this compact and the applicability thereof to any government, agency, person or circumstance shall not be affected thereby. If this compact shall be held contrary to the constitution of any state party thereto, the compact shall remain in full force and effect as to the remaining states and in full force and effect as to the state affected as to all severable matters.

(1975, c. 406, § 63.1-219.2; 2002, c. 747.)

§ 63.2-1104. *Children from other states and countries.*

A. Any child-placing agency or court that brings or sends, or causes to be brought or sent, a nonresident child into Virginia for the purpose of an interstate placement shall comply with the regulations and procedures adopted by the Board for the administration of the Interstate Compact on the Placement of Children (§ 63.2-1000 et seq.) regardless of whether the state from which the child is sent is a party to the compact. The agency shall also comply with all the regulations of the Board relating to nonresident children so brought or sent into the Commonwealth. Intercountry placements made by licensed child-placing agencies, courts, or other entities are subject to regulations prescribed by the Board.

B. The Board is authorized to adopt regulations for the bringing or sending of such children into the Commonwealth by child-placing agencies or courts for the purpose of an interstate placement, and for the care, maintenance, supervision and control of all children so brought or sent into the Commonwealth until they have been adopted, attained their majority, or have been otherwise lawfully discharged or released, as are reasonably conducive to the welfare of such children and as comply with the provisions of the Interstate Compact on the Placement of Children (§ 63.2-1000 et seq.).

(Code 1950, § 63-245; 1968, c. 578, § 63.1-207; 1975, c. 406; 1977, c. 645; 1980, c. 40; 1981, c. 75; 2002, c. 747.)

§ 63.2-1105. *Children placed out of Commonwealth.*

A. Any child-placing agency, licensed pursuant to Subtitle IV (§ 63.2-1700 et seq.), local board or court that takes or sends, or causes to be taken or sent, any resident child out of the Commonwealth for the purpose of an interstate or intercountry placement shall comply with the appropriate provisions of the Interstate Compact on the Placement of Children (§ 63.2-1000 et seq.) or shall first obtain the consent of the Commissioner, given in accordance with regulations of the Board relating to resident children so taken or sent out of the Commonwealth.

B. The Board is authorized to adopt regulations for the placement of children out of the Commonwealth by licensed child-placing agencies, local boards or courts as are reasonably conducive to the welfare of such children and as comply with the Interstate Compact on the Placement of Children (§ 63.2-1000 et seq.). Provided, however, notwithstanding the provisions of subdivision (d) of Article II of the compact that exclude from the definition of "placement" those institutions that care for the

mentally ill, mentally defective or epileptic or any institution primarily educational in character and any hospital or other medical facility, the Board shall prescribe procedures and regulations to govern such placements out of the Commonwealth by licensed child-placing agencies, local boards or courts.

(Code 1950, § 63-73; 1952, c. 409; 1960, c. 331; 1968, cc. 466, 578, § 63.1-56; 1975, cc. 248, 406; 1977, cc. 559, 562, 634, 645, § 63.1-207.1; 1980, c. 40; 1978, c. 734; 1981, c. 75; 1984, c. 734; 1986, c. 281; 1991, c. 34; 1994, c. 865; 1999, c. 889; 2002, c. 747.)

§ 63.2-1240. *Court issuing order deemed sending agency under Interstate Compact on Placement of Children.*

When a petitioner moves outside the Commonwealth after the entry of an interlocutory order of adoption but prior to the entry of a final order of adoption and the child was not placed by a child-placing agency, the circuit court issuing the interlocutory order shall be deemed the sending agency for the purposes of the Interstate Compact on the Placement of Children authorized pursuant to the provisions of § 63.2-1000.

(1978, c. 733, § 63.1-226.1, § 63.1-219.47; 2000, c. 830; 2002, c. 747.)

Synopses of 39 Studies Related to the Delivery of Mental Health Services to Youth and Adolescents in Virginia 1988-2006

Researched and Synopsized by the Virginia Commission on Youth, 2006

Studies Included:

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

2. Council on Community Services for Youth & Families, *Improving Care for Troubled and At-Risk Youth and Their Families*, 1991.

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

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

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

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

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

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

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

10. Research and Evaluation Center of the Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services, *Comprehensive Services Act Implementation Assessment – FY94*, 1995.

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

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

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

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

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

16. Hays-Smith, Melissa, *Continuum of Care for Children and Adolescents: A Presentation to HJR 225 by the Child and Family Services Task Force of the Virginia Association of Community Services Boards (VACSB)*, 1999.

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

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

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

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

21. Joint Legislative Audit and Review Commission, *Report to the General Assembly,* 2001.

22. Virginia Commission of Youth, *Youth Suicide Prevention Plan*, 2001.

23. Virginia Secretary of Health and Human Resources, *Report of the Secretary of Health and Human Resources: A Plan for Improving Services and Containing Costs in the Treatment and Care of Children Under the CSA for At-Risk Youth and Families*, 2002.

24. Virginia Commission on Youth, *Youth with Emotional Disturbance Requiring Out-of-Home Treatment*, 2002.

25. Joint Commission on Behavioral Health Care, Virginia State Crime Commission and the Virginia Commission on Youth, *Studying Treatment Options for Offenders Who Have Mental Illness or Substance Abuse Disorders*, 2002.

26. Child and Adolescent Special Populations Workgroup of the Department's Restructuring Policy Advisory Committee, *Final Report and Recommendations to the Commissioner of the Department of Mental Health, Mental Retardation and Substance Abuse Services and the Restructuring Policy Advisory Committee*, 2004.

27. Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services, *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*, 2004.

28. Office of Comprehensive Services, *A Report on the Progress of Increasing Medicaid Utilization for CSA Services*, 2004.

29. State Executive Council Workgroup, *The Relinquishment of Custody for the Purpose of Assessing Behavioral Health Treatment*, 2004.

30. Virginia Commission on Youth, *Dissemination of the Collection of Evidence-based Treatment Modalities for Children and Adolescents with Mental Health Treatment Needs*, 2004; *Collection of Evidence-based Treatment Modalities for Children and Adolescents with Mental Health Treatment Needs, 2nd Edition*, 2005.

31. Office of Comprehensive Services, *Report on the Utilization, Length of Stay and Expenditures in Residential Care by Locality for Children Served Through the CSA*, 2005.

32. State Executive Council, *Biennial Report*, December 2005.

33. Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services, *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*, 2005.

34. State Executive Council Workgroup, Final Report: *The Relinquishment of Custody for the Purpose of Assessing Behavioral Health Treatment*, 2005.

35. Virginia Department of Medical Assistance Services, *Reimbursement of Educational Services within the Medicaid Residential Treatment Rate*, 2005.

36. Virginia Joint Commission on Health Care, *Report on Mental Health Needs and Treatment of Young Minority Adults,* 2006.

37. Office of Comprehensive Services, *Service Area Plan*, 2006.

38. Office of Comprehensive Services, *Agency Strategic Plan*, 2006.

39. Virginia Department of Medical Assistance Services, *Annual Report on CSA*, 2006.

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

Key Remarks by Beth A. Stroul, M.Ed., Keynote Speaker

- The Report of the Joint Commission of the Mental Health of Children (1969) and the President's Commission on Mental Health (1978) found that millions of children and youth were not receiving needed health services;
- Jane Knitzer, in *Unclaimed Children* (1982), reported that there are approximately three million severely emotionally disturbed youth in the U.S. and that two-thirds of these children do not receive the services needed. Knitzer also asserted that 40-60 percent of the children placed in hospitals are hospitalized primarily because of the lack of alternatives;
- In 1987, the Office of Technology Assessment of the U.S. Congress reported that, despite the tragic nature of children's mental health problems and increasing knowledge of how to prevent and treat these problems, the care available to children does not reflect this knowledge; and
- Presentation of a System of Care for severe emotionally disturbed (SED) youth:
  - *Core values*: Child-centered and community-based;
  - *Principles*: Comprehensive array of services; least restrictive setting; family orientation; service integration; case management; and smooth transitions; and
  - *Dimensions of service*: Mental health services; social services; educational services; health services; vocational services; recreational services; and operational services.

Recurring Issues throughout the Conference

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

Commonalties of the Model Programs

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

Interagency Funding

Consortium of child mental health:

- Funding of last resort; and
- The result of the forum was a memorandum of agreement by the Secretariats and department heads and an interagency budget initiative for FY88-90. The agreement created criteria for eligibility for funding and an interagency funds pool to help localities meet the needs of SED children.

Regional Work Sessions

Common problems identified:

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

- Lack of client/family involvement;
- Lack of community-based programs; and
- Lack of transitional services.

2. **Council on Community Services for Youth & Families, *Improving Care for Troubled and At-Risk Youth and Their Families*, 1991.**

Introduction

This report sets forth the plan for what is now known as the Comprehensive Services Act for At Risk Youth and Families (CSA). The report includes:

- Preliminary findings from the evaluation of the demonstration projects;
- A long-range plan for phasing in community-based nonresidential services across Virginia;
- An interagency plan for redirecting current funds and identifying new revenue sources for funding community-based services, including consideration of Medicaid; and
- Any proposed legislation necessary for implementation.

Findings

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

A Long-Range Plan for Phasing in Community–based Nonresidential Services across Virginia

- Characteristics of the proposed system:
  - Early identification and intervention;
  - More flexible funds;
  - More community control and flexibility;
  - More funds managed at local level;
  - Expanded costs to invest in proposed system; and
  - More options to serve youth and families:
    - Tailored services to meet strengths and needs of youth and family;
    - Family support and community services balanced with secure and intensive treatment placements; and
    - More family involvement in service decisions.
- Local governments should consolidate the multiple interagency teams into one structure;
- Local governments should appoint a collaborative team at the policy and management level that has the decision-making authority on interagency funding and policy issues. This team would establish one or more family assessment and planning teams which would assess the strengths and needs of the troubled youth and their families and identify and arrange for the provision of services; and
- Consolidate several state-level interagency teams into one structure to better coordinate program and fiscal policies, support community efforts and reduce the duplication and fragmentation of state requirements across agencies.

An Interagency Plan for Redirecting Current Funds and Identifying New Revenue Sources for Funding Community-based Services

Existing funding structure at the time of the report:

- Sixteen funding streams across four agencies;
- Required local match varies from zero to 50 percent (one ranges up to 80 percent, based on community's ability to pay);
- Localities have no financial interest in 46 percent of the total dollars they spend, which leaves little incentive to consider cost-effectiveness;
- Costs for services depend on which agency pays; and

- Distribution of current resources across the state is based on historical expenditure patterns of accessing certain funding streams and not necessarily reflective of the community's need or ability to pay.

- Recommended structure:
  - Create a state pool in which nine funds are consolidated, from which public or private services across four child-serving agencies can be purchased;
  - Authority and accountability for spending the funds would be at a community level;
  - Communities would be required to match the allocation of state pool funds based on their ability to pay, with local shares capped at 45 percent;
  - Under this plan, all localities would receive additional or the same amount of state dollars, with no locality receiving a reduction in state funds. Proposed formula was considered revenue neutral to local governments;
  - Recognize the need to fund foster care and special education services at sum sufficient levels;
  - Establish a trust fund in which at least 25 percent of the funds must be used for early intervention services and would increase incrementally to 40 percent by the year 2000. These funds would be used to develop:
    - Early intervention services for young children at risk;
    - Community services for troubled youth who can appropriately and effectively be served in the home and/or community; and
    - Grants would be available to communities at 100 percent state funding for at least two years in order to develop, stabilize and evaluate the services, at which time the community would assume the local match required under the state pool funding formula.
  - Potential revenue sources:
    - Medicaid reimbursement;
    - Pending federal legislation and funding; and
    - An interagency plan for redirecting current funds and identifying new revenue sources for funding community-based services, including consideration of Medicaid.
  - Training and technical assistance would be provided at the state and community levels to support the new system.; and
  - Virginia would institute methods for evaluating the effectiveness of services, analyzing the costs, and providing management reports to decision-makers at both the state and community levels.

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

Introduction

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

Findings

- National Statistics:
  - Twelve percent of America's 63 million children and adolescents experience mental health problems. Five percent of these children and adolescents experience severe and persistent mental health problems;
  - Approximately three million of America's children and adolescents are seriously emotionally disturbed;
  - Demographics indicate that 30 percent of monies for mental health services should be allocated for children. Children's services receive approximately 10 percent of mental health resources; and

  - One of three children in need of mental health services actually receives the needed services.
- If appropriate treatment options are not available in the community, the child may be sent away from home to residential treatment, sometimes out-of-state;
- Recent reports in Virginia by DSS and DMHMRSAS suggest that Virginia is effectively treating a small portion of these children, adolescents and their families;
- Approximately 74,500 youth are estimated to be SED, if national prevalence rates are applied to Virginia;
- While a residential placement may be able to address the child's needs within the context of its program, successfully transitioning the child back to his home and community too often proves to be difficult, if not impossible;
- It is easier for service providers to demand change from the child rather than to implement changes in the environment/systems that produced, or added to, the child's difficulties;
- This study collected data on the number of invisible children in Virginia. For purposes of the study, invisible children were characterized by:
  - A defined mental health problem that can be diagnosed under *DSM III-R* and/or problems in personality development and social functioning which have been exhibited over at least one year's time;
  - Problems which are significantly disabling based upon the social functioning of most children;
  - Service needs that require significant intervention by more than one agency;
  - Residence in:
    - An out-of-state facility;
    - A correctional learning facility;
    - A state or private psychiatric hospital;
    - A 24-hour private residential facility;
    - An approved foster care setting;
    - A mental health group home;
    - A correctional group home;
    - A public residential school; or
    - A facility where distance causes disconnectedness from family/community resources.

- The study adopted the following guiding principles:
  - Treatment and care should be through a comprehensive array of services which are community-based and family-focused;
  - Collaboration in all planning, funding, and implementation strategies;
  - Early identification and intervention;
  - Use of a case manager for each child;
  - Recognition of the special needs of families with children with multiple impairments;
  - The needs of the child and family should dictate the types and mix of services provided with families as full participants in service planning and delivery.
  - Effective advocacy and protection of rights of emotionally disturbed children;
  - Services for children and their families should be available throughout the state to avoid the need for institutional care because of lack of services;
  - Emotionally disturbed children should receive services within the least restrictive, most normalizing environment that is clinically appropriate; and
  - Services should be provided without regard to race, religion, etc. and sensitivity to cultural differences.

<u>Data Collection on the Number of Invisible Children</u>

Data reflects the funding of differing types of residential or hospital placements; and

- Data is not an unduplicated count of children because each agency tracks the children differently.

<u>Recommendations</u>

- Redirect or develop flexible policies for existing funding streams so that these funds can be used to serve children in their homes and/or communities. Funding for which a child is eligible should follow the child into less restrictive alternatives;
- Develop new funding initiatives for community-based services;

- Establish an interagency data tracking system with which data and costs regarding an individual child could be tracked, unduplicated, across agencies; and
- The joint board liaison committee should undertake a review of the *Code* to make recommendations to each of the child-serving agencies with regard to policies and administrative functions that would encourage gate keeping, joint service planning for individual children, joint agency budget planning for children's services, and resolution of issues such as confidentiality and which agency is responsible to do what.

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

Introduction

The Virginia General Assembly mandated the Department of Planning and Budget (DPB) to conduct a study of children's residential services. The four agencies included in this study were DSS, DOC, VDOE and DMHMRSAS.

Major Objectives of the Study

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

Terms

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

Finding

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

Children in Residential Care

- DPB compiled an interagency database by merging 14 files containing demographic, placement and cost information. The data concluded:
  - There were actually 4,993 children in residential care in FY88. This number is an unduplicated count derived from an interagency database of 14,000 child entries;
  - Children in residential care averaged two placements during FY88. This number is underreported because DPB generally did not include those where the length of stay was less than 30 days;
  - More than 80 percent of the children included in a survey of local agencies had received residential or other services from two or more child-serving agencies; and
  - In FY88, six percent of the children in residential care (303 children) were placed outside Virginia.

Expenditures for Residential Care

- Virginia spent a total of $93.6 million in federal, state, local and other funds for children in residential care during FY88:
  - $52.4 million (74 percent) was for governmental residential programs; and
  - $18 million was for residential services purchased for individual children.
- Expenditures per child averaged $19,000 annually, although a significant number of children were in care for less than the full year; and

- The study found that state funds allocated to children's residential services during FY88-89 were substantial and increased sharply. Significant increases in the state share of costs of residential care could be expected to continue through FY90-92.

Service Delivery

The study team conducted extensive interviews with state and local agency staff, judges, providers, advocates and parents. The teams concluded:

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

Funding and Administration

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

Recommendations

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

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

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

Introduction

This report lays the foundation for the development of CSA. The report provides a model for developing local systems of service and care for children at risk of becoming troubled or children who are emotionally disturbed, behaviorally disordered and abused and neglected. This report includes the following:

- Comprehensive service model to define the most effective alternative for providing services to at-risk youth (graphic display and narrative);
- List of core values for the System of Care;
- List of guiding principles for the System of Care; and
- List of service components and their individual definitions and roles within the service model.

Findings

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

Comprehensive Service Model

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

Core Values of Care

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

Guiding Principles for the System of Care

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

- Have access to a comprehensive array of services;
- Receive individualized services guided by an individualized service plan;
- Receive services within the least restrictive and most normative environment appropriate;
- Be treated with the full involvement of their families in planning, delivery and evaluation of services;
- Receive services that are integrated and inter-disciplinary to assure collaborative case management;
- Be provided with case management so that they can move through the system of services in accordance with their changing needs;

- Be identified and treated early in order to enhance the likelihood of positive outcomes; and
- Be ensured of smooth transitions to the adult service system as they reach maturity.

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

Major Goals

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

Accomplishments

- A variety of needs assessment and planning activities were undertaken during the CASSP project:
  - *The First Lady's Forum on Child Mental Health* (1987);
  - *The Invisible Children Project* (1989);
  - *The Mental Health Plan 1990-1992* (1989);
  - *Child and Adolescent Psychiatric Hospital Units Staffing Study* (1989);
  - *Study of Children's Residential Services* (1990);
  - *The Council on Community Services for Youth and Families* (1991);
  - *The Mental Health Plan 1992-1994 and implementation Progress Report* (1991); and
  - *Needs Assessment for the Interagency Trust Fund* (1992).
- Several legislative, regulatory, policy and budgetary changes which support movement toward community-based care have been accomplished in Virginia over the period of the CASSP grant.
  - *Minor's treatment laws*: Laws have been developed over the past two years to govern the inpatient hospitalization of children in public and private sector facilities. The laws altered admission processes for children by developing specific admission criteria. Voluntary admissions of minors to state psychiatric facilities increased to 45 percent of total admissions.
  - *CSBs budgets and planning*: For the first time in Virginia, specific guidance was given by DMHMRSAS to CSBs on priorities for child and adolescent services. This was the first step in DMHMRSAS moving towards a foundation of specific services available across Virginia for SED youth.
  - *State board policy*: The State Board of DMHMRSAS adopted a policy to specifically target SED youth and their families. This policy made a clear statement to the state as a whole about DMHMRSAS' priorities for services and serves as a guideline for all new Department initiatives.
  - *Community Medicaid Initiative:* New changes added coverage for case management, in-home crisis and long-term interventions, day treatment and education programs and summer therapeutic programs.

Introduction

In 1990, the Governor of Virginia and Virginia General Assembly appropriated more than $2 million to establish youth and family projects in order to demonstrate how to improve services and control costs. Under the direction of the three Cabinet Secretaries of Health and Human Resources (SHHR), Education, and Public Safety, the Council on Community Services for Youth and Families redirected and pooled existing funds to supplement the initial interagency appropriation. They also awarded $3.4 million to five communities to establish and conduct demonstration projects during FY90-92. The sites selected were Lynchburg/Bedford, Richmond, Roanoke, Norfolk and the Rappahannock area. The Commonwealth Institute for Child and Family Studies was awarded a contract to evaluate the demonstration projects.

Findings

- Although specific outcomes were difficult to assess in the short time frame available for the evaluation, some changes were apparent in the follow-up data on youth and families:
  - Youth in the demonstration projects were significantly less likely to be placed in a residential setting following their identification for demonstration project services; and
  - Youth in the demonstration projects were significantly more likely to have received advocacy, case management, financial assistance, in-home services and transportation services.
- Interviews were conducted with approximately 50 local personnel on two separate occasions and survey responses were obtained from over 450 respondents in the five demonstration project sites.
  - Localities reported that interagency assessment teams were central to their projects. In all cases, the teams had been expanded either in number or in frequency which they met;
  - Representatives from all localities expressed the opinion that the demonstration project resulted in a more positive and enthusiastic approach to the work of interagency teams;
  - The availability of more resources, particularly the availability of a greater number of local service alternatives, was stressed as one of the major positive outcomes already felt by local personnel;
  - These changes were seen as improvements in interagency functioning, but many respondents also expressed concern that the increased staff time required to devote to community assessment teams and the staffing of cases presented a considerable drain on already limited staff time.
- Personnel at the five localities were asked about their perceptions of interagency communications and collaboration. Their perceptions of change were assessed in three areas:
  - Overall perceptions of the local service system:
    - An improvement in the local service system was perceived by the personnel in two localities; worsening in another and no change in the other two.
  - Opinions regarding the relationships among agencies:
    - A worsening of interagency collaboration was perceived by the personnel in all five localities.
  - Perceptions of the service system along specific dimensions (e.g., goals, leadership, coordination, and interdisciplinary function):
    - A minor but statistically insignificant improvement was perceived across the five localities in terms of their perception of change in specific aspects of the service system. However, statistically significant improvements were noted by personnel in two localities.
- The perceptions of consumers who responded to a satisfaction questionnaire were consistently positive. They indicated:
  - They would recommend the services they received to friends in similar need;
  - They would seek the same services again if the need arose; and
  - The services they received helped them deal more effectively with their problems.
- Available data suggested that, on average, the use of residential care changed very little.

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

Introduction

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

- Rappahannock Area Development Commission (RADCO) Planning District, comprised of the City of Fredericksburg and Caroline, King George, Spotsylvania and Stafford counties;
- Cities of Lynchburg and Bedford and Bedford County;
- City of Norfolk;
- City of Richmond; and
- City of Roanoke.

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

- Intensive probation services;
- Therapeutic respite care;
- Parent and student aide programs;
- Day treatment programs;
- After school programs;
- Therapeutic summer programs;
- Pre-school prevention programs; and
- Transition classroom.

Findings

- The typical youth who are served by the demonstration projects might be:
  - Black or white male, 11.9 years old;
  - Experiencing a number of problems, including aggressive behavior, defiance, oppositional behavior, concentration problems, lying and hyperactivity;
  - Failed at least one grade in school;
  - Placed out of the home at least once within the 12 months preceding intake;
  - Impoverished (38 percent live in households with incomes of less than $10,000); and
  - Have parents who are divorced (28 percent), separated (11 percent) or widowed or single (24 percent).
- What evidence is there of increased identification and intervention with younger children at risk of developing emotional and behavioral problems?
  - There has been a documented increase in each locality in the number and types of services.
- How have the communities' capacities for providing community-based alternatives to residential services changed through the demonstration projects?
  - There has been a notable increase in the number and types of services available to meet the needs of families with serious emotional and behavioral disturbances;
  - Increases occurred across all categories of service;
  - The trend toward the development of new and more specialized services appeared to have continued into the second year of the demonstration projects;
  - The number of gaps in services has not decreased due to increase in demand, even with the increase in number and scope of services;
  - Reported gaps increased from 74 in 1992 to 84 in 1993; and
  - Reasons for continued existence of gaps include: (1) a continuing lack of resources, especially funds and staff and (2) the continued presence of barriers to the receipt of services, particularly in the area of insurance requirements and private provider admissions criteria.
- How have local child-serving agencies cooperated and collaborated in the planning and provision of services to youth with serious emotional and behavioral problems?
  - Staff across all five agencies collaborated with each other at the local level in new and more specialized ways from 1992-1993;
  - More time and staff have been devoted to interagency meetings than during first year of project implementation; and
  - Staff reported a high degree of satisfaction with the level and intensity of interagency collaboration efforts, although concerned about the time and energy required to make this approach work.
- How satisfied are the youth, families and service providers with the services being received through the project?
  - Families report a highly positive perception of the extent to which the services they have received have met their needs;
  - There was an increase in the number of families reporting being very satisfied with their child's progress overall;
  - There was a decline in the degree of difficulty experiences by families trying to access services; and
  - Service providers indicated satisfaction with demonstration projects.

- To what extent has the use of residential services changed as indicated by the number of youth placed out of the home and the expenditures for these services?
  - It is premature to make conclusive statements about the role of demonstration projects in controlling residential placements and costs; and
  - Statewide data available on youth residential placements and their associated costs are limited with regard to their level of detail and their comparability across state agencies.
- To what extent have the youth served changed as the result of services received through the demonstration projects?
  - Projects appear to have a positive impact; and
  - There is ample evidence that a child-centered, family-focused, community-based approach to service troubled youth is a notable improvement over more traditional methods.

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

Introduction

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

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

Recommendations

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

9. **Research and Evaluation Center of the Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services, *Comprehensive Services Act Implementation Assessment – FY94*, 1995.**

Introduction

This is a report on the implementation of CSA during its initial year of operation (FY93). Data was collected and findings reviewed in relation to seven implementation issues: youth served, expenditure of state pool funds, local administrative costs, team functioning/interagency collaboration, family participation, public-private partnership and goal achievement.

Findings and Recommendation on Youth Served

Findings:

- The report notes that the information received is limited in its reliability and depth. Data was collected by hand, with many opportunities for misinterpretation of term by local staff and errors in recording and calculations at all levels. Automated data management system is available but used by only 35 percent of the localities.
- About 8,000 youths served through CSA pooled funds during first year;
- Majority (around 60 percent) were white, male and between the ages 13-17;
- Most (91 percent) were mandated (entitled to services through federal or state mandates);
- Of all CSA youth served who were mandated, 57 percent were in private residential care (includes foster care children);
- About 66 percent of all youth served through CSA pooled funds were placed outside their homes (includes foster care children); and
- About 83 percent of all youth received services provided by the private sector.

Recommendation:

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

Findings and Recommendations for Expenditure of State Pool Funds

Findings:

- Total spent on CSA services in FY94 was $103,251,744. Of this amount, 61 percent came from state allocations and the remaining 39 percent was provided by local governments;
- Of the total amount expended, 11 percent was supplemental (the initial allocation was insufficient to meet the service needs of the mandated population);
- The finding reinforced conventional knowledge that privately provided out-of-home care is the most expensive type of service for troubled youths. This type of service was provided for 57 percent of mandated CSA youth in FY94, yet it consumed 76 percent of the total pooled funds spent on the mandated population;
- Non-residential public services averaged $2,342 per mandated child per year. These services are typically community-based and operated by local government agencies; and
- One of the unresolved issues related to CSA funding mechanisms included the continuation of the long-standing problem of inadequate funding for non-mandated youth.
- At the August 18, 1994 meeting of the State Management Team (SMT), a focus group was conducted. A top priority among the critical issues was to address the struggle between the mandated and non-mandated children. The group focused particularly on:
  - The adequacy of funding for non-mandated youth continues to be a major concern. A problem exists in the very use of the terms mandated and non-mandated. The distinction is artificial for the actual needs among the two groups are often identical;
  - The juvenile justice population has been long underserved. Now that 286 funds are no longer available, judges are frustrated with the lack of alternatives for the youth they see. Today's court cases often present more serious and more complex child and family circumstances than we encountered in past years. These situations may require costly remedies, yet services for mandated youth are given higher priority;
  - The availability of children's services is directly affected by the degree to which local funds are allocated for these services. Children who are non-mandated are especially vulnerable because, under CSA regulations, services for this population are more likely to require new local funding than services for mandated children (286 funds required no local match). In

attempts to conserve limited funds, decisions by local governments may have detrimental effects on certain at-risk youth and their families;
- Some SMT members suggested that this problem may be resolved by 100 percent state funding of services to severely emotionally and behaviorally disturbed youth and their families. At a minimum, there should be a funding mechanism that does not in effect penalize localities which choose to serve their non-mandated youth. SMT should strive to develop means by which all eligible children would experience equal access to services;
- The issue of differing philosophies for dealing with youthful offenders was raised. There is a debate at both the local and state levels which can be characterized as punishment vs. treatment. This debate is relevant for CSA because placements in juvenile correctional centers are fully funded by the state, while alternative community-based services require local funds. Even though for some youthful offenders, community-based services are less costly and more effective, these youth may be placed in state correctional centers in order to preserve local funds; and
- SMT members acknowledged that there will never be enough state funds for all needed services for at-risk youth and families and that other sources of funding must be pursued, including family contributions and Medicaid.

Recommendations:

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

Findings and Recommendations on Local Administrative Costs

Findings:

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

Recommendations:

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

Findings and Recommendations on Team Functioning/Interagency Collaboration

Finding:

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

Recommendations:

- Four recommendations were made. The most relevant was to identify specific problems CSA teams may encounter with local courts and aggressively seek solutions.

Findings and Recommendation on Family Participation

Findings:

- Overall findings were positive;
- Parent representatives had positively contributed to the process; and
- The majority of parents of the youth served attended the Family Assessment and Planning Teams (FAPTs) teams, participated in the meetings and adequately represented the views of the youth's family.

Recommendation:

- Continue to monitor the capacity of the FAPTs to engage parents of troubled youth in service planning and implementation.

Findings and Recommendations on Public-Private Partnership

Findings:

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

Recommendations:

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

Findings and Recommendations on Goal Achievement

Findings:

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

Recommendations:

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

Additional Findings

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

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

Introduction

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

Background:

- Four of the nine funding streams merged for the purposes of creating the CSA state pool of funds had previously provided services for non-mandated youth. These accounted for 12 percent of the total pool. These streams were:
  - Department of Youth and Family Services (DYFS) 286 funds;
  - DYFS 239 funds;
  - State Interagency Consortium on Child Mental Health; and
  - State Hospital Private Bed Purchase funds.
- To ensure that the sum sufficiency requirements for special education and foster care services did not prevent funds from being spent on non-mandated youth, SEC created a protection level policy. This allowed localities to protect a portion of their allocation for youth in the juvenile justice system. This protection system provides localities with the opportunity to apply for supplemental funds in the event that youth requiring foster care or special education services became known to the locality after they

had created their allocation plan. Decision-making regarding the use of the protection level and the expenditure of funds rests with the locality; and

- In FY94, localities could protect an amount up to their actual 286 and 239 expenditures in 1993. In FY95, this protection level was increased in an effort to expand the services provided to non-mandated youth. The protection level was expanded to apply to those localities that did not have youths served under the 286 funds prior to CSA. The protection level statewide was approximately 12 percent of the total pool, reflecting the proportion of non-mandated youths in the original pool.

Findings

- The FY95 year-to-date figures reveal that the expenditures in a sizeable number of localities will not equal their protection level. This indicates that a large number of localities are not using the protection provided by SEC to assure that some non-mandated youth in their locality receive services;
- A comparison of FY94 and FY95 expenditures to date for non-mandated youth indicates a decreasing reliance on residential services and on private services. This suggests that community efforts to build their capacity to provide alternatives to residential services and to private services are beginning to be realized;
- The approaches used by SEC to assure that localities have funds available to serve non-mandated youth have had mixed success. Although expenditures for non-mandated youth exceed the amount spent in FY92, the proportion of funds spent on these youth has decreased statewide;
- Any approach to resolve the funding issues must address both types of spending patterns in order to create improvements on a statewide basis; and
- Analysis has revealed two distinct spending patterns exhibited by localities:
  - *Want More*: Localities that spend (or nearly spend) their protection level and want more funds to serve youth; and
  - *Don't Spend*: Localities that have not accessed or have minimally accessed their protection level.

Approaches for Both *Wants More* and *Don't Spend*

- Broaden access to supplemental fund. Access for non-mandated youth would be based on obligation of 100 percent of the protection level. To mitigate the impact of increasing access to supplemental funds, the cap on local match rate would be removed for supplemental funds for mandated and non-mandated youth. Those localities with actual local match rates higher than 45 percent would be required to use their actual match rate.
  - This approach would move CSA toward de-categorization of youth at the level of requesting supplemental funds; however, this may add to the cost of the pool and exacerbates the debate regarding the allocation formula and the local match level.
- Expand utilization of the trust fund for non-mandated youth. Three potential approaches have been discussed, which are to (1) change the criteria for the trust fund to focus solely on non-mandated youth, (2) change the trust fund match rate or step down for community services grants and (3) increase the available funds.
  - This would increase services for non-mandated youth; however, this is a limited source of funds and only a limited number of youth would be impacted, based on the small amount of funds available.
- Allow local Community Policy and Management Teams (CPMTs) to use Virginia Juvenile Community Crime Control Act (VJCCCA) funds as local match for youth who are before the juvenile court.
  - This would increase the pool for juveniles before the court, and would maximize two funding streams that, for some localities, have relatively small funds available. However, this may violate the intent and administration requirements of the VJCCCA and, unless there is a requirement that local services cannot be reduced, this may result in a reduction of services. In addition, the use of the two state funding streams to match each other moves away from state-local partnership for services.
- Allow CPMTs to use CSA funds for match for non-CSA grants. Grants could be federal, state, local government or private with a match requirement that would not preclude the use of pool funds.
  - This increases the pool without additional pressure on state pool of funds; however, this may increase administrative requirements and decrease the state's ability to manage the pool efficiently.

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

Approaches for *Wants More*

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

Approaches for *Don't Spend*

- Lower the local match rate if the locality has used 100 percent of the protection level for non-mandated youth.
  - This provides an incentive for localities to spend their protection level; however, the administrative burden on localities to determine when and how the protection level is "used" may not be worth the potential benefit. In addition, there is a potential for increasing access of state pool dollars and creating a deficit.
- Increase the match rate for mandated youth if the locality has not used 100 percent of its protection level for non-mandated youth.
  - This once again provides an incentive for localities to spend their protection level; however, localities may perceive this as an under-funded state mandate on localities. Furthermore, this

increases state control over local decision-making, contrary to the intention of CSA. It also may produce creative efforts to get around the consequences.

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

Introduction

The purpose of this report is to study and evaluate the effectiveness, efficiency and adequacy of state funding for CSA. The report is based on the experiences of Virginia's counties and cities during the 1st year of implementation (FY93). The three major objectives of this report:

- Provide preliminary data on local administrative costs of implementing CSA during FY94;
- Provide preliminary data on the adequacy of CSA pooled service funds for FY94; and
- Examine the interrelatedness of various planning processes for services to mandated children.

Findings

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

12. **Joint Legislative Audit and Review Commission, *Review of the Comprehensive Services Act*, 1998.**

Findings

- Despite the emphasis the statute places on serving children with serious emotional and behavioral problems, almost half of the at-risk children who received treatment services through CSA in FY95 either had no risk or no recent history of risk for serious behaviors such as those which pose a danger to themselves or others. While the majority of these represent local attempts to provide early intervention services, others may indicate a misuse of the CSA;
- In a number of localities, CSA staff either misclassified some children or manipulated the system to establish eligibility for youths under the mandated service provisions of the statute.
  - To circumvent those aspects of the program eligibility criteria that are regarded as too restrictive, CSA staff admitted that they manipulate the system and establish eligibility for children who do not meet the requirements of certain provisions of the statute; and

- In other localities that have provided funding only for children who are mandated by state statute, CSA staff are misclassifying non-mandated children to ensure that they will receive services.

- In terms of the placement of children in treatment programs, approximately 70 percent of the children who are approved for services were initially provided treatment in a community-based setting. Most of the remaining children received treatment in residential group homes. However, when these placement decisions were examined based on the risk of the child, in about half of the cases the treatment setting could not be justified;
- More than 70 percent of the parents and grandparents of children who received services through CSA indicate that the program has helped to stabilize their child's behavior in the community, at home or at school; and
- State officials should be encouraged to pursue the use of Medicaid funds to offset some of the cost of CSA to both the state and localities. This effort could generate an estimated $41 million in CSA savings ($25.9 million – State; $15.4 million – local).

Recommendations

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

Overview of CSA

- Multiple funding streams were consolidated into one pool of funds;
- CSA was organized on principles of local service coordination among agencies, greater local flexibility to design treatment plans, and a more extensive use of community based services;
- Using this pool of funds, human service agencies in the localities are now required to form a multi-agency team to plan and implement a coordinated assistance plan for those children whose treatment needs are beyond the capacity of any one agency;
- One of the basic purposes of the program is to stabilize the child through the provision of services in the least restrictive environment, preferably the child's home or community;
- For CSA eligibility criteria, staff must determine whether a child referred to CSA has a qualifying behavior or emotional problem that:
  - Persisted over a significant period of time or is of such a critical nature that intervention is warranted or is significantly disabling;
  - Present in several community settings;
  - Requires services or resources that are unavailable or inaccessible, or that is beyond the normal agency services or requires coordinated interventions by at least two agencies; and
  - Places the child in an imminent risk of entering residential care and require services or resources that are beyond normal agency services or routine collaborative processes across agencies.
- Mandated youth are youth who would have been served by one of the categorical funds because of existing service mandates. This includes special education students eligible for private tuition assistance, children in foster homes or children who are at risk of being placed in foster home placement. This group has priority over other youth when localities make plans to spend CSA funds. Because of the sum sufficient requirement for mandated populations, the state and local fiscal implications for service to this group are significant;
- Non-mandated youth are primarily juvenile offenders and children with mental health problems, but not covered by sum-sufficient language and are only served at the discretion of individual localities;
- The most frequently funded CSA service in FY96 was foster care (43 percent); and

- Total CSA expenditures have risen more than 62 percent in the program's first three years of operation.

Participants Served through CSA

- Most beneficiaries are mandated recipients who come from highly dysfunctional families. Nine out of ten youth served entered the program as a mandated case;
- Most of the participants are 13-17 years old;
- More than 40 percent of the sample displayed symptoms of conduct disorder. This was especially prevalent in the non-mandated group (65 percent);
- Risk profile for CSA participants was examined through the Childhood Severity of Psychiatric Illness (CSPI). It incorporates three dimensions:
  - Nature and severity of child's symptoms of psychopathology;
  - Risks identified for children; and
  - Capacity of caregivers to manage the child in the community.
- Half of the children entering CSA had two lowest levels of risk for serious behavior: no risk or a history of risk;
- A higher proportion of the non-mandated youth posed greater risks for criminal behavior; and
- Proportion of mismatched services is high. The use of a multi-agency team improves the likelihood that a child with recent or acute risks received the services needed.

Local Implementation and Monitoring of CSA

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

Recommendation

The Virginia General Assembly may wish to amend the *Code* to require that non-mandated cases, where children have displayed acute or recent risk, be afforded sum sufficient funding. In order to access sum sufficient funding for these cases, local CSA multi-agency teams should be required to make these risk determinations through a uniform assessment process. This recommendation is contingent on the Virginia General Assembly's approval of Medicaid as an alternative funding source for CSA.

Use of Medicaid Funding

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

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

Introduction

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

- The number of children meeting the acute and severe risk criteria;
- The type of services these children would need; and
- The costs of providing these services.

Data Collection

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

Findings

- The total number of children assessed to be at acute or severe levels of risk is 20,661.
  - The report notes that a significant proportion of the children seen through court service units (53.3 percent) or CSBs (69.3 percent) were assessed as having displayed no risk behaviors.
- In all risk categories, the most frequently recommended treatment options are wraparound services (45.5 percent) and intensive in-home services (16.9 percent).
- Two cost estimates to provide services to these children were made:
  - *Empirical Model Estimate:* $120,779,235, of which the State's share is $76,694,815, with the average locality's share at $44,084,420; and
  - *Theoretical Model Estimate:* $305,530,851 of which the State's share is estimated at $194,012,090. Local costs would average $111,518,761.
- Other potential sources of funding for children who are assessed at acute and severe levels of risk, but not currently mandated for service through CSA were not a focus in this study.
- There are a number of ways that local government and service providers go about procuring services for children. Indeed, some non-mandated children may be receiving such services already. These include:
  - Services through the VJCCCA, which provides funding for community-based intervention services for children/youth involved with the juvenile justice system;
  - Children in locally-operated programs such as detention, outreach detention, group homes and community services boards;
  - Children whose primary risk factors are aggressive or threatening behaviors and who come to the attention of the juvenile justice system would likely be managed through juvenile court sanction and supervision;
  - CSBs may provide services to children based on several funding strategies available to local communities. Options may include fee-for-service, Medicaid-funded mental health services and special local or state-funded initiatives;
  - Non-mandated children may receive services through CSA. Approximately 1,705 children were served during the FY98, at a cost of roughly $9.5 million;
  - Children may receive services through private insurance, although indications are that such funding is often exhausted before the need for services ends or covers only a limited range of the services needed;
  - The Children's Medical Security Insurance Plan (CMSIP); and
  - Effective January 1, 2000, Medicaid funds will support residential treatment services for children meeting specific eligibility criteria.
- Service capacity was not addressed by this study.

Recommendations

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

14. Department of Education and the Disability Commission, *Educational Needs of Emotionally Disturbed Students with Visual and Hearing Impairments*, 1999.

Introduction

This report was conducted in response to Senate Joint Resolution (SJR) 193, requesting VDOE and the Disability Commission to study the educational needs of emotionally disturbed students with visual and hearing impairments. Specifically, the resolution called for the study to:

- Determine the number of students with emotional disturbances who have visual/hearing impairments;
- Identify and review the educational programs available for such students in Virginia;
- Determine the need for instructional staff and the qualifications required to teach such students;
- Evaluate the educational needs of such students over the next five, ten and fifteen years; and
- Recommend the changes and alternatives necessary to ensure the availability of quality special education programs for these students.

For the purposes of the study, emotionally disturbed students included those hearing or visually impaired students who have been formally classified as such by their school divisions following an evaluation from school psychologists or other trained personnel. The study also included those students who have demonstrated consistent behavior disorders in school but have not been classified as emotionally disturbed, because their physical disability prevented the use of standard testing protocols. The services that provide support for emotional development and behavior disorder are included on Individualized Education Plans (IEPs) required for all special education students.

Findings

- Virginia does not operate state programs for emotionally disturbed blind or deaf children;
- Local school divisions and communities frequently have difficulty providing the services that adequately serve students with these combinations of disabilities, and thereby rely on residential services;
- Students with severe hearing problems or deafness who are emotionally disturbed require services that aid in closing the gap that exists between the students' use of American Sign Language as a way of communicating and the hearing and speaking ability of the students' parents, teachers and counselors;
- Most school psychologists, counselors, social workers, providers of guidance and counseling services are not fluent in sign language, making it difficult for them to work with deaf children;
- The hiring of an interpreter for use in a counseling session is effective only if the interpreter is available when counseling is needed;
- VDOE reported that, in 1996-97, 83 percent of interpreters working in local divisions failed to meet DOE's requirements for interpreters. This is problematic because an individual who has minimal but lowly developed interpretation skills may be assigned to interpret in a course that requires highly developed skills due to the nature of the course material and the vocabulary (middle and secondary courses). It can also be problematic because they may be asked to interpret during the developmental years that reading and language skills are acquired (early grades). In either case, the student may not receive enough quality interpretation to acquire the content and skills needed to successfully learn the Standards of Learning (SOLs);
- Services for students who are blind and emotionally disturbed are not needed. Treatment via oral communication can be effective in addressing their emotional needs;
- At the time of the study there were five regional programs in Virginia for mental health services for deaf, hard-of-hearing and deaf-blind children. Providers had an estimated ratio of one staff person to 6,781 children and adults with disabilities;
- There are presently no residential services in Virginia for the student who is deaf and has an emotional disturbance or behavioral disorder;

- The Virginia School for the Deaf and Blind in Staunton (VSDB-S) returns from three to six students to their home communities annually. A survey of school divisions suggests a demand for residential and day treatment services for 77 students statewide. Students for whom these services are unavailable are either served with a patchwork of community-based services, which have been judged ineffective in meeting students needs according to a local school division survey or they are served in out-of-state residential facilities. The cost of these out-of-state facilities exceeds $157,000 per student per year and is borne by the student's local school division; and
- The study also examined programs for deaf students with emotional disturbance in other states to identify state of the art programming, likely outcomes of such programs, staffing patterns, and funding issues. Two programs were examined closely:
  - The Pennsylvania School for the Deaf; and
  - The Learning Center for Deaf Children in Massachusetts.

Recommendations

- The study recommended that the Massachusetts program be used as a model for implementation in Virginia and that it should be adopted at VSDB-S;
- Creation of a program on the campus of the residential school for the deaf and blind places the program within an existing deaf community and among educators and residential specialists who have experience working with deaf students. This placement prevents the common isolation that deaf persons frequently experience in their schools and communities;
- The program should be developed for in-state purposes with an approximate caseload of 10 students each year and low teacher-student and dorm staff-student ratios. The children should be grouped by age ranges of 6-12 and 12-18. The program should operate seven days a week, as compared to the current VSDB-S programs which operate five days a week;
- This program would be a residential initiative separate from the current program and placement at the facility would enable students to step-down to a less restrictive treatment setting and to interact with other students who are deaf;
- The program could focus either on managing student behavior or providing therapeutic programs. While therapeutic programs are generally believed to be more effective, they are also more costly;
- The per student costs were estimated at $93,000 per year based upon the enrollment of 10 students; and
- The study recommended that the tuition be a shared state-local responsibility. Additional funding sources mentioned included CSA, DMAS and Medicaid.

15. **Hays-Smith, Melissa, *Continuum of Care for Children and Adolescents: A Presentation to HJR 225 by the Child and Family Services Task Force of the Virginia Association of Community Services Boards (VACSB)*, 1999.**

Introduction

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

Services discussed

- Family support services:
  - More recognized in mental retardation field;
  - Necessary for all children with serious emotional disorders and/or chemical dependence; and
  - Includes community services, such as parenting classes and support groups.
- Crisis intervention services:
  - Needed for children in psychiatric crisis and demonstrating self-injurious behavior; and
  - Includes specialized assessments and knowledge of community resources to provide intensive, short-term counseling and case management to children and families.
- Case management:
  - This service has been a frustration to providers in the state for many years because of the lack of ways to deliver it properly;
  - Need for it was highlighted by implementation of CSA;

  - Only case management designed to work with seriously mentally ill or mentally retarded is Medicaid reimbursable; and
  - Two types addressed:
    - *Targeted*: Non-intensive, follow-along case management. It involves assessment, monitoring, education, advocacy and service linkages; and
    - *Family-focused:* Delivered intensely to five to 15 families, working with the family as a unit.
- Outpatient services
  - Access to this service needs to be greater and available in more non-mental health settings, such as schools or school-based health clinics;
  - Includes psychiatric services and medication management specialized for children, as well as individual, group and family psychotherapy; and
  - Not readily available across the state.
- Intensive Community-Based Treatment
  - Wide range of services with different focuses that take place in different settings;
  - Requires flexibility in delivery and is not reimbursable by Medicaid;
  - Includes in-home therapy, intensive in-home services, therapeutic day treatment, therapeutic preschool and intensive outpatient services; and
  - Therapeutic day treatment is an important tool. It is a less restrictive alternative to hospitalization or residential treatment and can be used to provide a transition from or back to the community. It is particularly successful in natural settings such as schools, after-school programs and community centers or park programs.
- Specialized vocational programs
  - Often not available to adolescents with special needs because behavior problems can eliminate training opportunities;
  - Can be center-based or can involve the presence of support staff in community jobs; and
  - Would be classified as non-mandated services under CSA, which does not insure funding.
- Community-based residential services
  - These are over-relied-upon due to the absence of other components of the system of care;
  - This setting is not a normal setting for social and emotional growth and is not the place for children to spend large periods in their development;
  - Necessary component of the complete continuum of care;
  - Communities have difficulty funding this service, particularly when use is inconsistent and high costly;
  - CSA can fund some of them through fees, but resources are not available to establish and maintain residential services beyond what costs are covered by fees; and
  - Includes crisis stabilization units, substance abuse residential treatment, therapeutic foster care, community group homes and programs for independent living skills.

16. **Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services, *Keeping Our Kids at Home Project: A Study of the Feasibility, Efficacy, and Cost-Effectiveness of Expanding the Project Statewide*, 1999.**

Introduction

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

Findings:

- KOKAH has reduced BRCS state facility bed days used from 2,459 in FY95 to 1,096 in FY99. This is a reduction of 55 percent;
- In comparison to other CSBs, BRCS has the eighth highest utilization of state child and adolescent impatient facilities;
- The cost of care is lowest for children and adolescents diverted to community-based services;

- Thirty-five CSBs are within a 50-mile radius of a private psychiatric hospital that serves children and/or adolescents. There appears to be moderate community-based service capacity upon which to develop additional hospital diversion pilots; and
- Over 55 percent of CSBs provide five or more foundation community-based services to children and adolescents. The extent of child-specific diversion and step-down services is unknown. There appears to be moderate community-based service capacity upon which to develop additional hospital diversion pilots.

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

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

Introduction

This is a position paper in which the Child and Family Services Council discussed the need for Virginia to collaborate with community services boards and advocacy groups to plan comprehensively and provide the necessary funds so that community systems of care can be actualized immediately.

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

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

- Virginia must begin to plan services for children and adolescents and should include in its comprehensive planning families, advocates, community service providers (public and private) and DMHMRSAS.

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

Introduction

The 1998 session of the Virginia General Assembly directed the Joint Subcommittee to examine the impact of a carve-out of Medicaid-financed mental health, mental retardation and substance abuse services from any managed care contracts negotiated with health maintenance organizations and the feasibility of contracting out the administration of all Medicaid-covered mental health, mental retardation and substance abuse services to DMHMRSAS.

Findings

- Virginia's State Plan includes:
  - *Required services*: Outpatient services, including:
    - Psychiatric services and psychological testing if provided by a medical doctor; and
    - Inpatient services in a general hospital and inpatient psychiatric hospital services for individuals under 21 years of age as part of EPSDT.
  - *Optional services*: Inpatient services provided to persons with mental retardation in:
    - An intermediate care facility;
    - Mental hospital services for persons 65 and over;
    - Outpatient services (which includes psychiatric services and psychological testing when provided by a licensed clinical psychologist or mental health clinic);
    - Mental health and mental retardation community rehabilitation services; and
    - Mental retardation home-based and community-based waiver services.

    It covers substance abuse treatment only for pregnant and postpartum women (partial hospitalization and residential services and only one occurrence during a lifetime) and for children if treatment is part of their EPSDT;
  - *Carve-out treatments*: This is from the Medicaid Medallion II managed care program (pay on a fee-for-service basis and are not included in the capitation rates paid to HMO contractors). Services include:
    - Rehabilitation services (day treatment/partial hospitalization, psychosocial rehabilitation, crisis intervention, intensive community treatment, crisis stabilization and mental health support);
    - Targeted mental health and MR case management;
    - Residential and day support substance abuse treatment for pregnant and postpartum women; and
    - Intensive in-home and therapeutic day treatment for children and adolescent services in the EPSDT program (private providers may deliver these services, but initial access is through CSBs).
- Virginia has adopted a more restrictive Medicaid income eligibility criterion than most states. Less than 70 percent of people who live in poverty are eligible for Medicaid. Virginia ranks 43 among the states on this measure;
- VACSB's survey indicated that 40 to 55 percent of clinically eligible persons who are seriously mentally ill do not qualify for Medicaid. For many individuals, the income threshold is too low to qualify. Even if the individuals qualified, recipients face a disincentive to work because they risk losing their eligibility;
- DMAS reported that not all community services are available statewide and lack of statewide access places Virginia out of compliance with Health Care Financing Administration requirements. Examples include:
  - Only three CSB's offer day treatment/partial hospitalization for mentally ill;
  - Ten offer day treatment for children and adolescents;
  - Two provide residential substance abuse treatment for pregnant women; and
  - Three offer crisis supervision or stabilization for people with MR.

- In response, CSBs say that restrictive Medicaid criteria and limited funding have affected statewide service accessibility. Because of complex funding and administrative structure, CSBs must decide whether to provide services and how much Medicaid match they can afford without jeopardizing services to Medicaid ineligible consumers;
- Virginia's criteria:
  - Virginia applies more restrictive income and resource criteria to Medicaid eligibility for people with disabilities;
  - One of 11 states to adopt 209(b) of the Social Security Amendment of 1972. This amendment allows states to use eligibility criteria that were in place before the Supplemental Security Income (SSI) was established;
  - Under this option, Virginia is required to allow SSI recipients with incomes in excess of the eligibility criteria to spend down their income to a level that they would qualify them for Medicaid;
  - Virginia's program must also allow SSI recipients to exclude the value of their home or contiguous property; however, Virginia restricts the value of contiguous property that can be excluded to $5,000.
- Children's services:
  - DMAS presented data that showed:
    - Only 10 CSBs provide day treatment;
    - Three provide partial hospitalization;
    - Two provide crisis stabilization; and
    - Five provide intensive community treatment.
  - Virginia's EPSDT program does not include a formal mental health screening, although any health professional can refer for services;
  - Report by the Bazelon Center indicates that many Medicaid-eligible children are going without the care they need because adequate assessments of their mental health have not been made;
  - Child and Family Services Task Force of VACSB reported that the full continuum of care necessary for the successful treatment of children and adolescents is not available because of rigid Medicaid definitions or inflexible service delivery requirements; and
  - CSBs should function as care coordinators and as the single point of entry into the services system. Care coordination is the central service function of CSBs in a managed system of care and it would be provided exclusively by the CSBs and behavioral health authorities. HJR 240 recommended that CSBs and behavioral health authorities be local care coordinators and not the primary or only providers of services.
- Current needs:
  - There is a dire lack of case management, either targeted or family-focused intensive, for children and their families, as some feel has been highlighted by the implementation of CSA;
  - Access to outpatient services;
  - Intensive community-based treatment;
  - Specialized vocational programs; and
  - Community-based residential.
- There is a perception that consensus, unanimity and agreement on definitions are lacking among the public and the private sectors regarding children's services;
- The Joint Subcommittee noted that, on occasion, block grants have been given for services, and some CSBs have chosen not to use those funds for children's services, instead using those funds for other programs or populations;
- Performance and Outcomes Measurement System (POMS):
  - Prior to this study, DMHMRSAS had launched an initiative to develop, test, refine and implement a system for measuring provider performance and consumer outcomes;
  - Separate sets of performance and outcomes measures and data have been developed for each of five program areas:
    - Adult mental health;
    - Child mental health;
    - State hospital;
    - Substance abuse;
    - Substance abuse prevention; and

    - Mental retardation measures still under development.
  - Measures are designed to reflect different priorities and the unique characteristics of the population;
  - Addresses various issues, including access to services, quality and appropriateness of services, human rights, consumer and family involvement, consumer satisfaction and consumer outcomes; and
  - Statewide implementation is to begin July 1, 2001 and be completed October 1, 2001.
- CSA:
  - It is anticipated that at least portions of some public facilities will be available for alternative uses as patients are discharged;
  - Admissions to mental health facilities have declined steadily over the years, down from 9,880 in 1984 to a projected 3,685 in 2000 (62.7 percent reduction in adult admissions, 3.9 percent annual average rate of reduction);
  - These facilities have a total of 427 buildings, of which 131 are currently occupied (46 are scheduled for demolition pending availability of capital outlay funding and 36 buildings have been declared surplus);
  - In 1999, SJR 478 was passed requesting this Joint Subcommittee to establish a special task force to examine whether the buildings could be converted to use for the provision of services to at-risk youth and families under the CSA;
  - The Chair of SEC, supported by Office of Comprehensive Services (OCS), shall examine the potential for use of the underutilized state property under the control of DMHMRSAS to determine whether the use of this property, leased to vendors, would reduce the cost of services in the provision under CSA. Every attempt should be made to locate these treatment facilities, if deemed feasible, in an appropriate geographic distribution across the state that allows all children and families to have reasonable access to services.

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

Introduction

The purpose of this study is to examine the expenditures and funding levels of CSA and make recommendations to establish the appropriate funding levels. The report also seeks ways to add fiscal prudence and stabilize the program. Additionally, the report provides an excellent background of CSA, including history, organizational structure, process and populations served.

Findings and Recommendations

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

20. Joint Legislative Audit and Review Commission, *Report to the General Assembly*, 2001.

Introduction

In 1998, the Joint Legislative Audit and Review Commission (JLARC) submitted an extensive report to the Virginia General Assembly on CSA. This report detailed CSA findings and recommendations, as well

as an overview of CSA, local implementation and the utilization of Medicaid funds. The report also addressed the following areas:

- Areas in which functions of state agencies are duplicative, overlap, fail to accomplish legislative objectives or for any other reason should be redefined or redistributed;
- Ways in which agencies may operate more economically and efficiently; and
- Ways in which agencies can provide better services to the state and people.

Every biennium, JLARC conducts a systemic follow-up of all of its studies. JLARC re-examined CSA within this 2001 report.

General Assembly Actions

- Statutorily recognized OCS as the administrative arm of SEC and established powers and duties for SEC;
- Restructured a layer of the state management team into the State and Local Advisory Team (SLAT);
- Increased the membership of SEC to include the Director of DMAS and more local representatives;
- Designated the Commissioner of DMHMRSAS as the permanent chair of SEC;
- Implemented a uniform assessment instrument and process to be used by all localities to identify the levels of risk of CSA youth;
- Implemented uniform standards for case management, documentation and data collection for CSA-funded services;
- Implemented utilization review for all providers of CSA-funded services;
- Specified that all CSA youth and families requiring treatment services must be assessed by FAPTs in order to be eligible for CSA funds;
- Allowed SEC to deny CSA funds to localities that fail to comply with federal and state requirements pertaining to the provision of special education services; and
- Provided $4.25 million (per year of the biennium, through the FY00 Appropriation Act) to be used exclusively for children and adolescents who are not mandated for services under CSA and who are identified and assessed through FAPTs and approved by CPMTs.

Actions Taken by Various Agencies

OCS, SEC, and DMAS reported taking the following actions in relation to JLARC's 1998 recommendations:

- Informational meetings and CSA training sessions have been conducted throughout the state to support uniform assessment approach;
- Per a study recommendation, SEC has examined data needs and reporting requirements for a system of performance standards for CSA. Such a system would be used statewide to evaluate local decisions regarding levels of care and participant outcomes. OCS has made revisions to fiscal reporting forms to help facilitate such a system;
- A study concern was the varying level of compliance with statutory CSA requirements by localities receiving supplemental funding. OCS reports that it has placed a priority on this finding by assigning a full-time compliance officer and a full-time statistician to monitor activities and provide data analysis; and
- To develop the necessary criteria for the CSA-Medicaid link, DMAS organized workgroups to provide input to the agency. OCS and DMAS have kept localities aware of developments through newsletters and training.

22. Virginia Commission of Youth, *Youth Suicide Prevention Plan*, 2001.

Introduction

The 2000 Virginia General Assembly directed the Virginia Commission on Youth (COY), with the assistance of the Virginia Department of Health (VDH) and DMHMRSAS, to develop a comprehensive youth suicide prevention plan. The study resolution recognized suicide as the third leading cause of death among adolescents and also recognized the significant increase in the rate of suicide among Virginia youth ages ten to 19 since 1975.

In developing goals for the Youth Suicide Prevention Plan, COY reviewed the authorizing legislation and the most recent Virginia studies related to suicide in Virginia. The following goals for the Plan were drafted, presented and approved by the Commission in June 2000:

- Prevent suicidal behavior among youth in Virginia;
- Reduce the impact of suicide and suicidal behavior on individuals, families and communities; and
- Improve access to and availability of appropriate prevention services for vulnerable individuals and groups of youth.

The following activities were undertaken:

- Coordination with DMHMRSAS, VDOE and the State Child Fatality Review Team (SCFRT);
- Review of suicide prevention plans from other states;
- Review of literature, including existing data, reports and research;
- Convening of stakeholders' group;
- Determination of components of youth suicide prevention plan;
- Development of a plan in cooperation with designated state agencies and stakeholders; and
- Recommendation of policy, legislative and/or budget initiatives.

Findings

- Consistent with the recommendations of VDH's Study of Suicide in Virginia, COY recommends that VDH take responsibility for developing, implementing and monitoring a coordinated suicide prevention strategy. VDOE and DMHMRSAS should partner with VDH in the development and implementation of some specific components, but statewide coordination by one agency is critical;
- Youth suicide is a complex problem; therefore, efforts must be designed to provide for broad-based dissemination of information to all citizens of Virginia. This information includes:
  - Prevalence and causes of suicide;
  - Need to talk to youth about suicide; and
  - Services / supports available for youth and families.

  Community-wide education programs reach families, students, youth in the workforce, hard-to-reach youth in other sectors and media personnel. Research has shown that youth facing depression and other difficult times are unlikely to contact a mental health professional. Rather, friends, family and teachers are most likely those who are in positions to observe the youth's despair and to respond. This, and the fact that early intervention with depressed youth is essential, compels the organization of public awareness campaigns which address the warning signs and appropriate approaches for helping. As a result of increased knowledge, skills and interest, suicidal youth are more likely to be recognized and assisted in seeking appropriate mental health care;
- Suicide contagion is a major concern among service providers and policy makers. Suicide acts following another's suicide have been linked with reporting practices in which the completed suicide was glorified or romanticized. Since media reports may affect the incidence of youth suicide, state and local policy makers should work together to influence media reporting practices regarding youth. Responsible reporting of suicide can have several direct benefits. Community efforts to address the problem can be strengthened by news coverage that describes the help and support available, as well as provides information about how to access assistance. It can also explain how to identify persons at-risk for suicide or presents information about risk factors;
- School-based suicide prevention strategies involve a coordinated effort, reaching all levels of school staff. The purpose of school-based education efforts is to provide instructional content that parallels the community-wide public education campaign, so that youth, parents, teachers and other adults are sensitized simultaneously to the issues and concerns, and to the knowledge and skills for preventing youth suicide. School-based programs are an effective method of disseminating information about suicide to large segments of the youth population;
- Gatekeeper Training is designed to teach youth and significant adults specific strategies for recognizing and responding to suicide-risk youth and connecting them with persons capable of providing crisis intervention and support services. Gatekeeper Training is designed to prepare a broad spectrum of community members throughout Virginia to serve the protective functions of identifying and responding to youth with a high potential for suicide. Gatekeepers are trusted individuals who routinely have significant contact with youth and who are likely to observe high-risk behaviors. These Gatekeepers include:
  - Health care providers;
  - School personnel;
  - Clergy;
  - Youth service workers; and

- Law enforcement and court service personnel.

Gatekeepers do not replace professional mental health care providers, but are, more often, natural helpers in a youth's social network. Gatekeeper Training is a process by which these frontline persons acquire the skills necessary to accurately screen and refer high-risk youth;

- Youth suicide prevention is necessarily linked to mental health and emotional well-being. While it is recognized that youth in crisis and at-risk of suicide need immediate access to crisis intervention services, research also shows that early intervention and prevention services help to avoid the onset of crisis. Comprehensive mental health services for children, adolescents and their families include prevention, early identification and intervention, screening and evaluation, and a continuum of both non-residential and residential treatment services. A critical component of an effective system is an appropriate balance between more restrictive and less restrictive services. To reduce suicidal behaviors and prevent suicide, high-risk youth, their friends and family members need immediate, 24-hour access to crisis intervention. Local crisis centers should be supported in their efforts to expand their service capacity, particularly in the implementation of 24-hour crisis hotlines;
- Skill-building support groups are designed to provide a safe, comfortable environment in which vulnerable youths can learn and practice life skills to increase resiliency, strengthen protective factors and reduce risk factors. The target population for these groups is made up of youth who have been identified as being at-risk for suicide through screening, self-referral or referral by parents, gatekeepers and/or mental health professionals. Increasing the availability of prevention and early intervention services for depressed youth are priority goals of the youth suicide prevention plan. Providing school-linked mental health services will help to ensure that youth who need these services have access to them. Lack of social support, particularly family support, has been shown to increase the risk of youth suicide. Family support should include education about ways to support youth as well as teaching skills for family members. Youth should be served within the context of their families. A family-systems approach to mental health services will increase opportunities for successful prevention and intervention;
- If professionals are to work effectively with youth at-risk for suicide, continuing training opportunities must be provided to support these professionals. Expected outcomes of clinician training include:
  - Increased knowledge of the interpersonal and intrapersonal dynamics of youth at high-risk for suicide, psychosocial indicators of suicide and necessary supports for these youth;
  - Increased skill in the assessment of youth at-risk;
  - Increased skill in individual therapeutic methods for youth at-risk and their families; and
  - Prevention of worsening condition of youth and decreased risk and incidence of suicide.
- Currently, Virginia has no system for monitoring suicide attempts among youth. A suicide attempt data system will provide a comprehensive surveillance instrument for understanding suicide attempters who are present in Virginia hospitals. Monitoring suicide attempts in Virginia is necessary to better understand the occurrence of attempts by youth in the Commonwealth. Data gathered will help planning of activities and evaluation of the success of suicide prevention activities; and
- Both process and outcome evaluation of all components of Virginia's plan are critical to ensuring its success. VDH may wish to contract with a university partner to conduct certain aspects of the comprehensive evaluation.

Recommendations

- Amend the *Code* to designate VDH as the lead agency for youth suicide prevention in Virginia and require reporting to the Governor and General Assembly on the status of suicide prevention initiatives;
- Increase funding for VDH and DMHMRSAS for their development and/or adoption of materials and dissemination of youth suicide prevention information throughout Virginia;
- VDH should make available to media professionals throughout Virginia information about the responsible reporting of suicide (including specific guidelines developed by the U.S. Centers for Disease Control and Prevention) in order to reduce the risk of subsequent suicides;
- VDOE should revise the Suicide Prevention Guidelines to include criteria for follow-up with parents of students expressing suicidal intentions after initial contact is made;
- VDH and DMHMRSAS should develop and deliver Gatekeeper Training to designated audiences throughout Virginia;

- The Board of Health Professions and all state agencies responsible for licensing or certification of youth-serving personnel should require suicide prevention education as a requirement for licensure or certification;
- DMHMRSAS should continue to develop and implement the plan to provide comprehensive mental health services for children, adolescents and their families;
- DMHMRSAS and VDH should increase the capacity of local communities to provide community-based crisis intervention and support services for children, adolescents and their families;
- DMHMRSAS should continue to expand the availability of comprehensive mental health services for children and youth at-risk for suicide, particularly helping localities to offer skill-building and support groups, school-linked mental health services and family support / survivor services;
- DMHMRSAS and VDH, in cooperation with university medical centers, health science centers and professional organizations should develop, implement and evaluate curriculum and training plans to increase the knowledge and skills of clinicians and others who work with youth at-risk for suicide and their families;
- VDH should design and implement an adolescent suicide attempt data collection system to determine the magnitude of the problem, as well as the following characteristics of youth who attempt suicide: demographics, service access and behavioral characteristics;
- VDH should improve the system for reporting external cause of injury (e-codes) by providing training to designated reporters and by requiring e-code reporting for emergency room admission in selected sites around Virginia;
- VDH should coordinate comprehensive evaluation of all aspects of the suicide prevention program; and
- The General Assembly should appropriate funds to VDH, DMHMRSAS and VDOE to implement the youth suicide prevention initiatives described in this plan.

23. Virginia Secretary of Health and Human Resources, *Report of the Secretary of Health and Human Resources: A Plan for Improving Services and Containing Costs in the Treatment and Care of Children Under the CSA for At-Risk Youth and Families*, 2002.

Introduction

The 2002 Virginia General Assembly directed the SHHR to develop and implement a plan for improving services and containing costs in the treatment and care of children served through the CSA. The mandate was a result of concerns about the total general fund cost of the program and the average rate at which these costs had been increasing (approximately 10 percent per year). Additionally, the Virginia General Assembly had increasing concerns with the problems which existed with the state and local management of the program.

The plan addressed the following findings:
- Methods for evaluating and monitoring the quality, appropriateness and outcomes of care;
- Strategies for increasing federal reimbursements for the program;
- Assessment and development of negotiated statewide contracts for services purchased by state and local agencies;
- Revised allocation methodologies, reimbursement procedures and cost-sharing formulas for localities;
- Coordinated collection of information among state agencies;
- A review of the program's organization and management structure; and
- Projected caseloads, service needs and costs.

The Secretary developed a steering committee to study CSA. The committee was divided into task groups. The groups examined relevant CSA policies for their issue area and made recommendations to the steering committee.

Findings and Recommendations on Revision of Allocation Methodologies, Reimbursement Procedures and Cost Sharing Formulas for Localities

Findings:
- Each locality receives an initial base allocation that has been found to account for only 55 percent of annualized costs. Additional funds are available through a supplemental funding process that requires local governments to demonstrate that their request for more funding is based upon an increase in

the number of mandated children or that treatment costs have increased due to the service needs of the children. Because base allocations are often not sufficient to serve their mandated populations, many localities must request supplemental funds each year and present additional data to OCS to justify the request.

Near Term Recommendations:

- Freeze supplemental funding at the FY03 level and place any new dollars appropriated into the base allocation; and
- Separate child-specific data from the supplemental process, with the understanding that the data collection will be addressed in some manner to increase the quantity of data provided to the state.

Long Term Recommendations:

- Complete a systemic study of the allocation formula and consider creating an efficiency incentive related to the base allocation; and
- Consider elimination of the local match for Medicaid cases.

Findings and Recommendations on State Organization and Structure of CSA

Findings:

- State-level management of CSA is predicated on the concept of inter-agency cooperation and local control. As a result, no one agency is responsible for the program's administration. Instead, CSA policy development, program management and oversight responsibilities are vested in multiple agencies. Studies have shown that the benefits of this novel approach to management appear to be offset by the lack of attention given to the basic elements of program management. As the program has grown in size and complexity, this management structure does not appear to have yielded the stewardship needed to ensure the proper management of the program.

Near Term Recommendation:

- Develop a legislative package on state structure to include the following changes:
  - SEC to be chaired by SHHR or a designated deputy;
  - SLAT to be chaired by a local government representative and to advise SEC on state agency policy and impact on localities; and
  - Dispute resolution through SHHR and the Governor.

Findings and Recommendations on Strategies to Increase Collection of Federal Reimbursements

Findings:

- Funding for CSA is a state-local partnership. In FY01, the local share averaged 37 percent. Since the inception of the program, CSA has been defined as the final funding source and is to be used only after other resources (programmatic and fiscal) are explored. Use of other funding sources saves both state and local dollars. While many localities place considerable importance on locating alternative funding sources, others do not. In 1998, the Virginia General Assembly directed that two additional services (treatment foster care and residential psychiatric services) to become Medicaid reimbursable. Still, since the addition of those services, Medicaid utilization patterns have been significantly below the level that was originally predicted. In view of the potential cost savings at the state and local levels, more work is needed toward a greater use of federal funding sources to replace state and/or local funding.

Near Term Recommendations:

- Expand the scope of Medicaid coverage. Consideration will be given to additional levels of residential treatment, expansion of case management, elimination of the limit on Intensive In-Home Services accompanied by required review and reauthorization and reassessment of the current definition of family for Intensive In-Home Services. Additionally, Family Access to Medical Insurance Security (FAMIS) will be examined as an alternative funding source for some children normally served in CSA;
- Determine what barriers exist to impede local use of Title IV-E and determine whether the scope of use can be expanded further; and
- Continue and expand training for state and local agencies related to the use of EPSDT, Medicaid and Title IV-E.

Long Term Recommendation:

- Examine the feasibility of requiring CSA service providers to become Medicaid certified as a condition of participating in CSA.

Findings and Recommendations for Managing, Evaluating and Monitoring Care in CSA

Findings:

- Studies conducted during the early years of CSA indicated the many localities were not implementing CSA according to legislative intent. Further, there was no uniformity in the assessment process for children and only a small number of localities had formal utilization review programs. Since that time, CSA has required localities to use a uniform assessment instrument and participate in a UM process. Nonetheless, questions have surfaced about the degree and extent to which localities are using the state's uniform assessment instrument.

Near Term Recommendations:

- OCS will facilitate the provision of additional utilization management training for localities, as well as training to support the proper use of the Child and Adolescent Functional Assessment Scale (CAFAS) assessment instrument;
- Localities should continue using CAFAS uniform assessment instrument but with eight versus five scales. This will require revision on the Levels of Need Chart, which contains guidelines for services/treatment; and
- A designee of SHHR will conduct an evaluation of the alternatives to CAFAS uniform assessment instrument currently used in CSA. It will include CSPI assessment instrument.

Findings and Recommendations for Managing Care as an Option for CSA

Findings:

- A significant amount of interest has been expressed in the concept of managed care as a basis for curbing CSA expenditure growth. In the strictest sense, a statewide CSA managed care program would vest a third party (typically a private corporation) with the authority needed to manage the provision of mental health services to children in the program. With this arrangement, it is theorized that the sometimes wide and unexplained variations that occur in CSA expenditures can be reduced through greater control and management of the treatment planning and service delivery process for children. Nevertheless, there are a number of concerns and questions about the appropriateness of the managed care model for CSA.

Long Term Recommendation:

- A designee of SHHR will lead a study of options existing in managed care technologies which are appropriate to Virginia's System of Care to assist with the management of CSA.

Findings and Recommendations on Assessment and Development of Negotiated Statewide Contracts for Services Purchased by State and Local Agencies:

Findings:

- Currently, the *Code* requires that the rates paid for services purchased shall be determined by competition of the market place and by a process sufficiently flexible to ensure FAPTs and providers can meet the needs of individual children and families referred to them. However, the ability of local CSA programs to negotiate the best rates possible for the services they purchase is impeded by bundled service rates. Moreover, both the service providers and local officials agree that the contracting process would be significantly improved if the state adopted standard contract language.

Near Term Recommendations:

- Development of a standardized contract (by a diverse stakeholder group lead by the OCS) to be used statewide with allowance for addendums by individual localities; and
- Provision for unbundling of services. This is to be done in conjunction with efforts to develop standardized contracting.

Long Term Recommendation:

- On-going enhancement of Service Fee Directory (an electronic directory developed to assist providers in sharing information regarding services and fees) to enable localities to become informed purchasers of service. The directory is currently located on the CSA website.

Findings and Recommendations on Coordinating the Collection of Information among State Agencies

Findings:

- There has been on-going concern about the limited amount of data available on children served through CSA. There is no consistency around the types of data that are automated. Further, the absence of unique identifiers for CSA cases and the lack of compatibility across the various legacy

systems make data sharing an expensive and technologically challenging proposition. Additionally, the lack of available data has complicated the task of projecting caseloads, service needs and costs for the program.

Near Term Recommendation:

- Develop interim data reporting to expand quantity of data collected by OCS. The expectation will be that data currently collected only on children involved in supplemental funding requests will now be submitted on all CSA children on a point-in-time basis. It is anticipated that reporting requirements will be combined to reduce state and local administrative burden. This project will be lead by OCS in collaboration with technical experts and local governments.

Long Term Recommendation:

- SHHR will take the lead in efforts to further explore and resolve findings related to the establishment of an automated information system containing data on all children who receive CSA services. This will be an expansion of the project involving state agency Management Information Systems (MIS) directors and related to coordinated collection of information among state agencies.

Findings and Recommendations on the Projections of Caseloads, Service Needs and Costs

Findings:

- While projections of caseload and costs have been accurate over the years, there has been a lack of sufficient advanced integrated data to justify an increased initial appropriation. The range and type of program information collected from localities are quite narrow. This greatly limits the prospect of successful forecasting. The only reliable data available from CSA payment records cannot support more sophisticated statistical forecasting. The only data available for projecting expenditures is the record of aggregate annual expenditures and overall growth rates.

Long Term Recommendation:

- All work on forecasting should be held in abeyance until CSA information management needs are appropriately addressed. The chair of the task group that considered projections of caseloads, service needs and costs will be asked to serve as a resource to the group considering technical processes. In turn, DPB will be kept apprised of changes as they occur and be prepared to begin taking advantage of increased forecasting capabilities, particularly as improved data becomes available through the project discussed above, in conjunction with the six year financial plan.

24. Virginia Commission on Youth, *Youth with Emotional Disturbance Requiring Out-of-Home Treatment*, 2002.

Introduction

The 2000 Virginia General Assembly directed COY to conduct a two-year study on children and youth with serious emotional disturbance requiring out-of-home placement (SED-OH). The resolution directed COY to develop and implement a methodology for accurately determining the number of children who were determined to be SED-OH.

For the first year of the study, COY was directed to:

- Describe the population;
- Describe the state and local services available in Virginia;
- Analyze funding sources; and
- Assess the unmet needs.

For the second year of the study, COY was directed to assess the service capacity for SED-OH youth. An advisory group was established to assist COY in this process.

Findings

- There are 23 hospitals in Virginia that operate adolescent acute psychiatric beds, including two state facilities. These facilities report that there are 461 beds available to adolescents. However, this number is misleading because not all hospitals reserve beds for adolescent use. Some hospitals swing their beds to serve any age group, including children and adults. While these hospitals can serve children and adolescents, only one or two adolescents may be admitted in a year. The result is fewer acute psychiatric beds for adolescents than is officially reported. Clinicians' accounts of difficulties in finding available beds in acute care facilities and documentation of a five-day period in which attempts by the Commonwealth Center for Children and Adolescents to assist in the placement of 35 children in any psychiatric hospital facility failed is additional evidence of this inadequacy;

- Obtaining and then maintaining an accurate count of the number of acute psychiatric adolescent beds is very difficult. Simply accessing DMHMRSAS licensure data does not provide an accurate picture because it contains the number of beds licensed for the facility and not the number of beds that are actually staffed to receive patients. Furthermore, licensure data does not specify how many of the licensed beds are for children and adolescents. The number of pediatric psychiatric beds, licensed and staffed, is not contained in any one known database. Contributing to the difficulty in documenting the number of beds is the reliance on Certificates of Need (CON) (which authorize a certain number of inpatient, acute care beds) to ascertain the supply of acute care beds. The number of beds licensed under CON remains the official record, while hospitals may be using these beds for residential treatment or another purpose. The licensure of residential treatment beds does not require CON; instead they are licensed through Core requirements. A facility may change, without notice, the use of their beds from acute care to residential;
- Residential services can be difficult to find in Virginia for juveniles with mental health treatment needs who exhibit aggressive or difficult to manage behaviors. A number of factors can contribute to their reluctance to accept these juveniles, including:
  - Concern for the safety of the juvenile, other residents and treatment staff; and
  - Difficulty in hiring staff willing to work with this difficult population.

  There is a need for residential, short-term crisis stabilization centers. A juvenile may be placed in such a center when placement outside the juvenile's home is needed but at a level in between those offered by hospitalization and therapeutic foster care or other less intensive environments. These facilities would prevent hospitalization and allow the youth to remain in the community. Currently, when there are no other placements available for emergency cases, a psychiatric bed is typically purchased for the juvenile. Although it is recognized that this is a more expensive and restrictive placement, alternatives are not readily available. Many of these placements occur in facilities that are a great distance from the community, increasing the costs of travel for transitional staff and making incorporation of the family into treatment programs extremely difficult. Sex offender treatment services are extremely difficult to obtain throughout Virginia. Only two residential facilities operate in Virginia that specializes in sex offender treatment and those are in the Tidewater area. Less restrictive residential placements that assist in transitioning sex offenders back into the community are badly needed. Community services for sex offenders include evaluation services, relapse prevention and counseling; however, they are not readily available statewide. Also difficult to find are residential facilities that will accept children and adolescents who have multiple disabilities including a dual diagnosis of serious emotional disturbance with mental retardation, hearing impairment or substance abuse. In order to receive treatment services, these children and adolescents often must be sent to residential facilities outside of Virginia;
- Many of the mental health treatment needs of children and adolescents can be managed in non-residential, community settings. As the number of residential placements decreased, there was an expectation that resources would be shifted to support the development and maintenance of community based programs. DMHMRSAS' FY00 utilization report shows that all 40 CSBs provided emergency and case management services as required by law. All 40 also provided outpatient services to at least one or more children ages 0-17. However for other services, the following were reported: Of the 40 CSBs, only:
  - Thirty provided intensive in-home services;
  - Eleven provided therapeutic day treatment;
  - Three provided early intervention;
  - Two provided highly intensive services;
  - Two provided intensive services;
  - One provided family support; and
  - Zero provided prevention services.

  Each of these services is an element in a coordinated system of care. Where coordinated systems of care have been implemented and evaluations conducted, it has been found that they typically:
  - Reduce rates of re-institutionalization after discharge from residential settings; and
  - Reduce out-of-state placements of children and improve other individual outcomes, such as child behavior and parental satisfaction with services.

  All of these outcomes could result in a reduction of the fiscal and human costs associated with the limited system currently in place. As in any coordinated system, if one component is weak or

missing, pressure and stress are felt by the other components and, in some cases, their efforts are ineffective;

- Allocation of money for the purchase of services and the employment of additional mental health professionals is insignificant if there are not enough qualified persons to fill existing and new positions. Fifty Virginia localities have been designated as Mental Health Professional Shortage Areas. There are three programs available to Virginia psychiatrists seeking financial assistance in return for a commitment to serve in an underserved area or a state or local government facility. The three programs are:
  - Virginia Physicians Loan Repayment Program;
  - National Health Service Corp (NHSC)-Virginia Loan Repayment Program; and
  - Gilmore Fellows Program.
- The 2000-2002 biennium budget includes $500,000 each year for the recruitment and retention of psychiatrists in medically underserved areas;
- There is a shortage of fully qualified teachers for children with emotional disturbance. There was a 79 percent increase in the number of students with emotional disturbance from 1988 to 1998. In the same period, there was a 34 percent increase in the number of qualified teachers still needed for these children. Many private, special education schools use teachers who are conditionally or provisionally licensed and often cannot provide competitive compensation. Retention of qualified teachers for students with emotional disturbance is problematic for psychiatric hospital connected day and residential programs since they operate year-round;
- The CSA Service Fee Directory was established so that providers' services and fees could be visible to all and localities could use this directory to select a provider. The directory is not widely used by localities to select a provider. Instead, the directory is primarily used to ensure that a provider is eligible to receive CSA funds. Responsibility for updating information in the directory is with the providers. This study found that the directory contains inaccurate information. Members of FAPTs use personal knowledge of and experience with providers when making placement decisions. As an alternative to the statewide directory, some localities have developed their own local directories. One of the theoretical goals behind the creation of the Directory was that the publication of fees would increase competition among providers thereby driving down fees charged for services. The negotiation of fees and contracts draws on already limited resources due to its time-consuming and heavily administrative nature. Additional resources, including staff and funding to support the staff, are needed to effectively negotiate contracts. The size of a locality and the number of children needing services also directly affects a locality's ability to realistically negotiate fees;
- As a result of data collection in 2000, COY found that of SED children on whom information was collected, 32.7 percent reported no funds for the child and 31.7 percent reported no funds for service as the specific case factors for why services were recommended but not received. (Percentages are not mutually exclusive.) It is likely that the children were considered non-mandated under CSA and other local funds were not available. Out of a desire to help a child, parents, professionals and judges may use less desirable means in order to secure mental health services for the child, including:
  - Legal actions against school systems; and
  - Relinquishment of custody through foster care.

  As reported by JLARC in its 1998 review of CSA, many localities are containing costs under CSA by refusing to serve children who are not mandated under current law. JLARC further noted that:
  - In most cases, however, the emotional and behavioral problems of children who are considered non-mandated are similar, and in some cases, greater than those of children for whom services are mandated...; and in terms of criminal behavior, a higher proportion of non-mandated youth posed greater risks.

  Once a juvenile is within the juvenile justice system, many communities lack sufficient capacity to treat juvenile offenders with mental health treatment needs while in local detention homes and when they are released from a state juvenile correctional center or a local detention home. DJJ reports that juveniles may be kept in secure detention while waiting for needed services, such as substance abuse treatment or mental health counseling. Although the number of mandated youth has grown and the amount of money spent on mandated youth has more than doubled since its inception in 1994, the amount of money spent for non-mandated youth has decreased. Given the significant increase in mandated youth, it is unlikely that the number of non-mandated youth or their service needs have decreased. However, the cap on the state appropriation for non-mandated youth has

remained unchanged since the Act's inception. Additionally, the level of resources committed to non-mandated youth exemplified by Virginia can also be seen in the number of localities who spend little or no money on non-mandated youth:

- During FY00, 46 of 132 localities (35 percent) spent zero dollars on non-mandated youth; and
- Nineteen of the 132 (14 percent) spent less than $5000 on non-mandated youth.

Furthermore, it is unlikely that the amount spent on non-mandated youth is indicative of the number of non-mandated youth present in those communities;

- In DPB's 2000 Review of the Budget for CSA, it was noted that the use of Medicaid should be maximized to realize general fund savings for state and local governments. Pursuant to SJR 441, JLARC is to conduct an evaluation of the development, management, utilization and funding of health and mental health services provided through DMAS. It is to include a comparison with other states of Virginia's provision of Medicaid-funded health and mental health services, such as child health, long-term care services and waivers and mental health services. JLARC's report will be submitted to the Governor and the 2003 General Assembly session;
- On August 1, 2001, Virginia transitioned from CMSIP to FAMIS. FAMIS uses the Key Advantage Plan, available to state employees, as the benchmark for covered services. Also available to FAMIS participants are enhanced services, such as continued well-child care from ages six through 18 and physical therapy, occupational therapy, speech language pathology and skilled nursing services for special education students. Eligible children covered under employer plans can receive supplemental benefits as needed to be equivalent to those available through the comprehensive health care benefits package under FAMIS. FAMIS covers children up to 200 percent of the Federal Poverty Level. As of June 11, 2001, there were 32,526 children in Virginia enrolled in CMSIP (now FAMIS) out of the estimated 65,000 eligible for participation;
- Early intervention services are intended to improve functioning or change behavior in those people identified as beginning to experience problems, symptoms or behaviors which, without intervention, are likely to result in the need for treatment. Early intervention appears to have its greatest impact at the earliest ages. Early intervention efforts can reduce the social costs of future criminal activity. Programs, such as home visits, parent training, specialized preschools and graduation incentives, have been found to significantly reduce long-term costs related to crime and victimization. Research also indicates that health care utilization is higher for children with psychosocial problems. This suggests that the costs of timely and appropriate mental health care for young children may be offset by decreased general health care costs. Virginia has recognized the importance of early intervention, including in CSA, since one of the fundamental precepts behind it was the importance of early identification and treatment of children in order to enhance the likelihood of positive outcomes. However, an example of Virginia's failure to support early intervention for mental health services can be seen in the following:
  - In FY98, only 1,274 CSB consumers were served with early intervention services related to mental health, reflecting only .01% of the unduplicated, total number of consumers (119,438) who received mental health services.

  EPSDT has not been fully utilized to conduct mental health screenings and to provide the services necessary to treat an identified condition. DMAS is taking steps to emphasize and promote the use of EPSDT for the identification and treatment of mental health treatment needs through the implementation of Bright Futures. Information and training related to the EPSDT for physicians and mental health providers is planned; and
- Virginia and its localities spend a substantial amount of money each year to provide mental health and substance abuse treatment services to children and adolescents. However, information on the effectiveness of services is not available. OCS has developed a utilization management process through which the appropriate level of service for the child can be determined. However, within this particular level of service, there can be several treatment and placement options. Local human service professionals would appreciate assistance to determine the most appropriate treatment and/or provider given the problems and disorders of the child, thereby improving outcomes. As identified within JLARC's review of CSA, linking program and participant outcomes could provide a meaningful tool to assess whether providers are producing the type of results required given the nature of the children they receive.

Recommendations

- Direct DMHMRSAS to identify and create opportunities for public-private partnerships and the incentives necessary to establish and maintain an adequate supply of acute care psychiatric beds for children and adolescents, while acknowledging the Commonwealth's responsibility to serve this population;
- Direct the Virginia Health Information to provide the number of licensed and staffed acute care psychiatric beds and residential treatment beds for children and adolescents in public and private facilities, as well as the actual demand for these beds, to the General Assembly by December 1, 2002;
- Direct DMHMRSAS and DJJ, where appropriate, to identify and create opportunities for public-private partnerships and the necessary incentives to establish and maintain an adequate supply of residential beds for the treatment of juveniles with mental health treatment needs, including those who are mentally retarded, aggressive or sex offenders and those juveniles who need short-term crisis stabilization short of psychiatric hospitalization;
- Amend the *Code* to specify that the services available will be provided to adults, children and adolescents rather than to persons;
- Support and endorse the concept of KOKAH or other similar models in which an array of community-based services is emphasized. Support the continuation of existing funding levels for the KOKAH model implemented by BRCS;
- Amend and continue in the current biennium budget and in the 2002-2004 budget the current biennium language that requires DMHMRSAS, DJJ and DMAS, in cooperation with the OCS, CSBs and Court Service Units to develop an integrated policy and plan, including the necessary legislation and budget amendments, to provide and improve access by children, including juvenile offenders, to mental health, substance abuse and mental retardation services. Require the Departments to report on the plan to the Senate Committee on Finance and House Committee on Appropriations by June 30, 2002;
- Direct VDH to expand the Virginia Physicians Loan Repayment Program to include more psychiatrists, including child psychiatrists, and appropriate additional funds to support such an expansion, including support for VDH staff to administer the program;
- Appropriate $50,000 for and direct VDH to pursue the expansion of the NHSC-Virginia Loan Repayment Program to include mental health professionals. Financial support should include support for VDH staff to administer the program;
- Request that VDH explore the expanded use of telepsychiatry for underserved areas;
- Direct VDH to expand the Virginia Physicians Loan Repayment Program to include other types of mental health professionals beyond psychiatrists, including doctoral clinical psychologist, clinical social worker, or psychiatric nurse specialist. The Virginia Department of Health Professions should also ensure that one dollar be set aside from the state license fees of each of the participants in order to provide continued financial support for the program. Financial support should include support for VDH staff to administer the program;
- Continue the current funding level for recruitment and retention of psychiatrists under the Gilmore Fellows Program, in which psychiatry residents are paid a stipend to work in under served areas with a portion designated for the recruitment and retention of child psychiatrists;
- Direct VDOE to expand the Virginia Teaching Scholarship Loan Program to enable more teachers seeking an emotional disturbance endorsement to receive funding. Financial support should include support for VDOE staff to administer the program;
- Request SEC to improve the information available in and revise the system through which provider information is placed in the Directory, including the procedures by which the information is updated and verified, and make information about this process available to the public by July 1, 2002;
- Request that DJJ provide information to localities on opportunities for using VJCCCA funds that address mental health treatment services, including the provision of intensive individual and family treatment, and structured day treatment and structured residential programs;
- Request that DJJ, DMHMRSAS and the Department of Criminal Justice Services (DCJS) examine opportunities to leverage non-general fund sources of funding to meet the need for mental health and substance abuse assessment and treatment services of juveniles, including those within local detention homes;

- Direct JLARC to conduct a study that identifies viable incentives that encourage localities to enhance or maintain levels of funding for non-mandated children;
- Support the current level of funding that was appropriated for non-mandated children and adolescents in the 2000-2002 biennium through Budget Item 325B;
- COY shall monitor JLARC's study of DMAS and request that particular attention be given to Virginia's Medicaid provisions related to mental health services for children and adolescents;
- Direct DMAS to continue outreach efforts to enroll a greater number of children eligible for participation in Medicaid or FAMIS and report annually to COY by December 1;
- Request DMAS to continue their efforts to provide information to physicians and mental health providers about the comprehensive picture of services available through EPSDT. DMAS shall inform COY of its progress prior to the 2003 Session of the General Assembly;
- Request DMAS, together with VDOE, to provide information and training, including information on available services, to school nurses, school counselors and school social workers. DMAS shall inform COY of its progress prior to the 2003 Session of the General Assembly;
- Request DMAS to encourage physicians to make referrals to mental health providers, when appropriate, so that a full assessment of the child's mental health treatment needs can be made. DMAS shall inform COY of its progress prior to the 2003 Session of the General Assembly; and
- Direct COY to coordinate the collection and dissemination of empirically-based information that would identify the treatment modalities and practices recognized as effective for the treatment of children, including juvenile offenders with mental health treatment needs, symptoms and disorders. An Advisory Committee comprised of state and local representatives from DMHMRSAS, DSS, DMAS, DJJ, VDOE, VDH, OCS, private providers and parent representatives should assist in and guide this effort. Upon completion, client specific information on the types of services utilized for certain conditions and behaviors in Virginia should be collected. This information should be shared with entities involved in efforts to develop a policy and plan for children's improved access to mental health services as required under current biennium language. The results of the study shall be used to:
  - Plan future services and resources within Virginia for SED children or children at risk of SED;
  - Identify effective models that could be replicated; and
  - Identify effective means to transfer technology regarding effective programs, such as education, training and program development to public and private providers.

25. Joint Commission on Behavioral Health Care, Virginia State Crime Commission and the Virginia Commission on Youth, *Studying Treatment Options for Offenders Who Have Mental Illness or Substance Abuse Disorders*, 2002.

Introduction

The 2001 Virginia General Assembly directed the Joint Commission on Behavioral Health Care, Virginia State Crime Commission and COY to examine treatment options for offenders who have mental illness or substance abuse disorders. The report examined mental health and substance abuse services delivered to and needed by adult and juvenile offenders at the state and local levels. The commissions were directed to review the:

- Incidence of mental illness and substance abuse among offenders;
- Current system for delivering mental health and substance abuse services, including assessment, treatment, post-release and follow-up;
- Model treatment programs for offenders;
- Costs and benefits of private versus public delivery of treatment services;
- Need for specialized training of local law enforcement and court personnel; and
- Funding, sources of funding and legislation required to ensure adequate assessment and treatment services.

Findings

- Formal state and local interagency collaboration, which is necessary to plan integrated, comprehensive service delivery systems for adult offenders with mental illness, is not available in all communities. Interagency responsibilities for serving adult offenders with mental illness in local jails and local pre-trial service and community-based probation programs often are not clearly defined. Moreover, a consensus does not appear to exist as to whether the responsibility for the provision of services lays with the criminal justice or the mental health treatment systems. The Interagency Drug Offender Screening and Assessment and the Substance Abuse Reduction Effort (SABRE) initiatives

have promoted interagency cooperation toward improving the integration of substance abuse identification and treatment within the criminal justice system. However, similar statewide initiatives have not been targeted to offenders with mental illness;

- Many communities lack sufficient capacity to treat offenders with mental illness and substance abuse disorders while they are incarcerated and when they are released from state correctional facilities and local or regional jails. Lack of a comprehensive and systemic approach to funding these services has resulted in inequitable access to care across Virginia. DOC indicated that additional clinical support is needed in Probation and Parole districts. Forty-two (73.7 percent) of the local and regional jails that responded to a survey from this committee indicated problems dealing with persons who require acute psychiatric care:
  - Nineteen respondents indicated problems accessing hospital beds, because inmates did not meet the criteria for admission, hospital beds were not available, or the time to process the admission was burdensome; and
  - Nine respondents indicated lack of space and staff to house inmates with mental illness.

  Community services boards that responded to a survey by the DMHMRSAS indicated that their expenses for mental health and substance abuse services provided or contracted for in jails is approximately six million dollars per year. CSBs estimated that the cost of meeting the unmet need for mental health and substance abuse services in local jails is approximately $34 million per year.
- Fifty localities in Virginia have been designated as Mental Health Professional Shortage Areas. The 2000-2002 biennium budget includes $500,000 each year for the recruitment and retention of psychiatrists in medically underserved areas. Eleven residents are currently enrolled in the program; six will graduate in 2002.
- Virginia has not developed clinical guidelines for local and regional jails to ensure an adequate level of mental health services. Uniform screening and assessments for mental illness are not available in many local jails. Eighty percent of the jails that responded to the committee's questionnaire indicated that standardized screening instruments were used for mental health, but only 42.2 percent use standardized assessment instruments. Almost 70 percent use standardized screening instruments for substance abuse, but only 41.2 percent use standardized assessment instruments. In many cases, local inmates lack access to adequate mental health and substance abuse treatment services, including psychiatrists, acute psychiatric inpatient beds and atypical antipsychotic medications. Discharge plans are not routinely developed and oversight responsibilities are not routinely assigned when offenders with mental illness or substance abuse disorders are released from local jails. Of those jails responding to the committee's survey, 40 percent indicated that no discharge plans are developed when the inmate is released;
- Cross training in balancing therapeutic goals with security needs and public safety is needed for law enforcement, judges, jail staff, and community treatment staff. The concept of training specific law-enforcement officers to interact with suspects who have mental illness began in Memphis, Tennessee, and has since been replicated in other communities, including Albuquerque, New Mexico, and Roanoke County, Virginia. The Virginia Police Chiefs Foundation recently developed an intensive four-day training seminar for police officers on crisis intervention with persons with mental illness;
- No comprehensive mechanism exists to systematically collect complete and accurate data on treatment services provided to and needed by adult offenders, or to evaluate the effectiveness of the services;
- Nine community services boards receive funds totaling $1,119,692 from a combination of sources in fiscal year 2002 to provide intensive substance abuse treatment services in local jails. Although these programs are patterned after a national model for offender-based therapeutic communities, evaluation data are not available to determine the success of the programs in Virginia jails. The programs are located in Petersburg, Roanoke County, Roanoke City, Virginia Beach, Norfolk, Fairfax, Hampton, Martinsville, and Middle Peninsula-Northern Neck areas. The sources of funds are:
  - DMHMRSAS: $225,000 (GF); and
  - DCJS: $194,692 (GF) and 700,000 (NGF).

  State agencies and treatment providers need better ways of sharing best practices information with each other.
- More formal interagency commitment and collaboration are needed to plan integrated, comprehensive services delivery systems for juvenile offenders with mental illness. Moreover, interagency responsibilities for serving juvenile offenders with mental illness in local detention homes

or through the services of CSA are not clearly defined. Local CPMTs serve as the financing and coordinating effort for CSA; however, no one agency takes responsibility for the juvenile offender's mental health needs. Juvenile felons, certain misdemeanants and first-time drug offenders are required to undergo a substance abuse screening and, if necessary, a follow-up assessment, to identify an offender's substance abuse problems and treatment needs. The Interagency Drug Offender program promotes coordination and cooperation toward improving the integration of substance abuse identification and treatment within the criminal justice system. However, similar initiatives have not been implemented for offenders with mental illness;

- Due to limited access to mental health and substance abuse services, juveniles are more apt now to be involved with the juvenile justice system than ever before. Some families may turn to the juvenile justice system as a last resort with the hope that their child will be able to access the needed services. Such limited access can be attributed to the absence of services or the lack of sufficient funding to provide access. DJJ believes it is adequately staffed to provide sex offender and mental health services in state facilities. However, additional funding and staff are needed to provide substance abuse treatment to a population where approximately 70 percent of 1,100 youths in care need substance abuse treatment. On the local level, juvenile offenders are most likely to fall in the non-mandated category of CSA. While total CSA expenditures have increased from $105 million in 1994 (first year of CSA) to $205 million in 2000, the amount spent on the non-mandated population, which includes juvenile justice and mental health, has remained about the same, decreasing from $10 million in 1994 to $9.96 million in 2000. COY, through its Study of Children and Youth with Serious Emotional Disturbance Requiring Out-of-Home Placement (HJR 119), is continuing to examine the needs of non-mandated youth, which are often greater than the needs of mandated children. However, the availability of funding provides little relief if the needed service is unavailable. Gaps in the full continuum of care place stress upon existing services and reduce the success of the services. The KOKAH project ($360,000 in 2000-2002) has demonstrated success in reducing state inpatient hospitalization; however, the project has recognized a need for a broader array of community-based diversion and step-down services and standards for hospital utilization rates;
- Once a juvenile is within the juvenile justice system, many communities lack sufficient capacity to treat juvenile offenders with mental health needs while they are in local detention homes and when they are released from a state juvenile correctional center or a local detention home. DJJ reports that juveniles may be kept in secure detention while waiting for needed services, such as substance abuse treatment or mental health counseling;
- An adequate number of acute care psychiatric beds are not available for children and adolescents in Virginia. Almost 69 percent of the detention homes that responded to the committee's questionnaire indicated problems handling juveniles who require acute psychiatric care.
- Fifty localities in Virginia have been designated as Mental Health Professional Shortage Areas. The 2000-2002 biennium budget includes $500,000 each year for the recruitment and retention of psychiatrists in medically underserved areas.
- Neither local detention homes nor court service unit intake officers conduct uniform screenings and assessments for mental illness. Of the detention homes that responded to the committee's questionnaire, only 37.5 percent indicated that a standardized mental health assessment instrument is used. DJJ regulations require that staff at each secure detention facility shall ascertain the resident's need for a mental health assessment and, if staff determines that a mental health assessment is needed, it shall take place within 24 hours of such determination. However, regulations do not give the detention homes basic guidelines for conducting screenings or assessments. Further, uniform clinical guidelines for mental health treatment services to be provided in Virginia detention homes do not exist for pre-dispositional detention. In addition, discharge plans are not routinely developed and oversight responsibilities are not routinely assigned when juvenile offenders with mental illness or substance abuse disorders are released from detention homes. Of the Court Service Units that responded to the committee's questionnaire:
  - Forty-one percent indicated that juveniles wait 11 to 30 days for their first mental health appointment; and
  - Forty-nine percent indicated that juveniles wait from 31 to 60 days for a first appointment;

  Of the detention homes that responded to the questionnaire:
  - Thirty-five percent indicated that juveniles wait 11 to 30 days for a first mental heath appointment; and

  - Thirty-six percent responded unknown when asked about the wait time for a first appointment.
- Law enforcement, judges, detention home staff, court services unit staff and community treatment staff should receive training in balancing therapeutic goals with security needs and public safety; and
- Virginia and its localities spend a substantial amount of money each year to provide mental health and substance abuse treatment services to children and adolescents. OCS has developed a utilization management process through which the appropriate level of service for the child can be determined. However, within this particular level of service, several treatment and placement options are available. Additional information designed to assist human service professionals determine whether a particular treatment and/or provider is appropriate, given the problems and disorders of the child, would result in better outcomes. As identified within JLARC's Review CSA, linking program and participant outcomes could provide a meaningful tool to assess whether providers are producing the type of results required given the nature of the children they receive.

Recommendations

- Establish an interagency work group under the leadership of the committee to develop a screening-assessment-treatment model for offender groups with mental health needs. The workgroup should identify or develop:
  - Consensus concerning the statutory assignment of responsibility for providing treatment services to offenders with mental illness or substance abuse disorders;
  - A regional planning process to foster state and local interagency collaboration;
  - A defined continuum of care;
  - Model memoranda of agreement that detail responsibilities of the treatment provider and the purchasing agency and provisions for exchange of information, cross training for staff, confidentiality and payment terms; and
  - A framework to pilot the memoranda and evaluate the results.

  The membership of the committee should be expanded to include the Cabinet Secretaries of Health and Human Resources and Public Safety as ex officio members. The work group should consist of the following entities:
  - DCJS;
  - DOC;
  - DMHMRSAS;
  - DSS;
  - VACSB;
  - Community Criminal Justice Boards (CCJB);
  - Virginia Sheriffs' Association (VSA); and
  - Regional Jails Association (VARJ).
- Request that the Office of the Executive Secretary of the Supreme Court work with DCJS, DOC, DMHMRSAS, VACSB, CCJB, VSA and VARJ to examine the feasibility of designing and implementing a model court order that addresses mental health services;
- By budget amendment, direct DCJS, in collaboration DOC, DMHMRSAS, VACSB, CCJB, VSA and VARJ to identify the unmet need for mental health and substance abuse treatment services for offenders and develop a comprehensive plan, including the necessary resources and funding sources, for covering the increasing costs of providing existing services and to fill service gaps;
- By budget amendment, direct the Commissioner of DMHMRSAS, in consultation with DOC, VACSB, VSA and VARJ to make recommendations to this committee concerning access to psychiatric care for jail inmates, including the availability of inpatient beds, judicially-ordered treatment and atypical antipsychotic medications. The recommendations should include consideration for use of existing state facilities (DOC and DMHMRSAS) and designated sections of regional jails;
- By budget amendment, direct the DCJS, DMAS, DOC and DMHMRSAS to examine opportunities to leverage non-general funds to meet the unmet need for services;
- Direct DMAS, in conjunction with DOC and DJJ, to examine ways to provide immediate access to Medicaid for eligible offenders when they are released from prisons or jails;
- Direct DOC and DMHMRSAS to recommend ways to ensure the appropriate management of medications for offenders when they are released from state correctional facilities, including development of a memorandum of agreement to ensure the continuity of care;
- Continue the current funding level ($500,000 each year) for recruitment and retention of psychiatrists;

- Request that DMHMRSAS explore the expanded use of telepsychiatry for underserved areas;
- By budget amendment, direct the State Board of Corrections and the State Mental Health, Mental Retardation and Substance Abuse Services Board, in consultation with VSA, VARJ and VACSB, to develop:
  - Minimum guidelines for the provision of mental health and substance abuse treatment services in local and regional jails that reflect an adequate continuum of services, including the availability of atypical antipsychotic medications; and
  - A plan, including the necessary fiscal and staff resources, for meeting the guidelines. The State Board of Corrections and the State Mental Health, Mental Retardation and Substance Abuse Services Board shall report it findings and recommendations to this committee by September 30, 2002.
- Request that DMHMRSAS, in conjunction with the Office of the Executive Secretary of the Supreme Court and the DCJS, develop and make recommendations for implementing a curriculum for cross training law enforcement officers, judges, jail staff and community treatment staff in security and treatment, including philosophy, confidentiality, judicially ordered treatment, medication management, records management and treatment and security services reference guides;
- Request that the Secretary of Public Safety, in conjunction with the Cabinet Secretaries of Health and Human Resources and Administration, develop a plan, including the estimated cost, for the collection of data on treatment services provided to and needed by state responsible offenders and for the evaluation of the effectiveness of treatment services;
- Continue the funding for intensive substance abuse treatment services for the next biennium and direct DMHMRSAS to issue a Request-for-Proposals to conduct a comprehensive process and outcome evaluation of therapeutic communities in local jails;
- Request that DMHMRSAS, in consultation with federal, state and local experts, explore ways to communicate best practice information among treatment providers;
- Establish an interagency work group under the leadership of this committee to develop a screening-assessment-treatment model for juvenile offender groups with mental health needs. The workgroup should identify or develop:
  - Consensus concerning the statutory assignment of responsibility for providing mental health treatment services to juvenile offenders in local and regional detention homes or under the supervision of Court Service Units;
  - A regional planning process to foster state/local interagency collaboration;
  - A defined continuum of care;
  - Model memoranda of agreement that detail responsibilities of the treatment provider and the purchasing agency and provisions for exchange of information, cross training for staff, confidentiality and payment terms; and
  - A framework to pilot the memoranda and evaluate the results.

  The work group should consist of the following entities:
  - DJJ;
  - DMHMRSAS;
  - DSS;
  - VACSB;
  - OCS; and
  - Virginia Council of Juvenile Detention Homes.
- Direct DMHMRSAS and DJJ, where appropriate, to identify and create opportunities for public-private partnerships and the necessary incentives to establish and maintain an adequate supply of residential beds for the treatment of juveniles with mental health treatment needs, including those who are mentally retarded, aggressive, or sex offenders and those juveniles who need short-term crisis stabilization short of psychiatric hospitalization;
- Support and endorse the concept of KOKAH or other similar models in which an array of community-based services is emphasized. Support the continuation of existing funding levels for the KOKAH model implemented by BRCS;
- Amend in the current biennium budget and continue in the 2002-2004 budget the language that requires DMHMRSAS, DJJ and DMAS, in cooperation with the OCS, CSBs and Court Service Units to develop an integrated policy and plan, including the necessary legislation and budget amendments, to provide and improve access by children, including juvenile offenders, to mental health, substance abuse and mental retardation services. Require the Departments to report on the

plan to the Senate Committee on Finance and House Committee on Appropriations by June 30, 2002;

- Request that DJJ provide information to localities on opportunities for using VJCCCA funds that address mental health treatment services, including the provision of intensive individual and family treatment, and structured day treatment and structured residential programs as authorized in the *Code*;
- Request that DJJ, DMHMRSAS and DCJS examine opportunities to leverage non-general fund sources of funding to meet the need for mental health and substance abuse assessment and treatment services accessible to juveniles in local detention homes.
- Request the Commissioner of DMHMRSAS to work with the private sector to develop and maintain a daily updated, web-based database of licensed and available acute psychiatric beds for children and adolescents;
- Direct Virginia Health Information to provide the number of licensed and staffed acute care psychiatric beds and residential treatment beds for children and adolescents in public and private facilities, as well as the actual demand and trend data for these beds, to the General Assembly by December 1, 2002;
- Direct DMHMRSAS to identify and create opportunities for public-private partnerships and the incentives necessary to establish and maintain an adequate supply of acute care psychiatric beds for children and adolescents, while acknowledging Virginia's responsibility to serve this population;
- Direct DMHMRSAS to ensure an adequate supply of acute psychiatric beds for children and adolescents;
- Continue the current funding level for recruitment and retention of psychiatrists under the Gilmore Fellows Program, in which psychiatry residents are paid a stipend to work in underserved areas with a portion designated for the recruitment and retention of child psychiatrists;
- Appropriate $50,000 for and direct VDH to pursue the expansion of the NHSC-Virginia Loan Repayment Program to include mental health professionals (as defined by NHSC). Financial support should include support for VDH staff to administer the program;
- Request that VDH explore the expanded use of telepsychiatry for underserved areas;
- Request that DJJ design and implement a uniform mental health screening instrument and interview process for juveniles identified by probation officers as needing a mental health screening. For those juveniles identified as needing a mental health assessment, the assessment should be conducted by a qualified individual;
- Request that DJJ and DMHMRSAS develop a process of identifying and communicating to families information about mental health and substance abuse resources available in the community;
- Direct the Board of Juvenile Justice, in conjunction with the State Mental Health, Mental Retardation and Substance Abuse Services Board to develop:
  - Minimum guidelines for including mental health screening and assessments in pre-dispositional investigations;
  - Minimum guidelines for the provision of mental health services and substance abuse services including uniform screening and assessment in local detention homes;
  - A standard discharge plan that includes mental health and substance abuse services if needed; and
  - A plan, including the necessary fiscal and staff resources for meeting the standards.
- Request that DMHMRSAS, in conjunction with DCJS, DJJ and the Office of the Executive Secretary of the Supreme Court of Virginia, develop a curriculum and make recommendations for its implementation to train law-enforcement officers, judges, detention staff and court service unit staff in security and treatment, including confidentiality, records management protocols, and treatment and security reference guides;
- Request that the Cabinet Secretaries of Health and Human Resources and Public Safety develop a plan, including the estimated cost, for the collection of data on treatment services provided to and needed by state responsible offenders and for the evaluation of the effectiveness of treatment services;
- Direct COY to coordinate the collection and dissemination of empirically-based information that would identify the treatment modalities and practices recognized as effective for the treatment of children, including juvenile offenders, with mental health treatment needs, symptoms and disorders. An Advisory Committee comprised of state and local representatives from DMHMRSAS, DSS, DMAS, DJJ, VDOE, VDH, OCS, private providers and parent representatives should assist in and guide this

effort. Upon completion, client-specific information on the types of services utilized for certain conditions and behaviors in Virginia should be collected. This information should be shared with entities involved in efforts to develop a policy and plan for children's improved access to mental health services as required under current biennium language. The results of the study shall be used to plan future services and resources within the Commonwealth for children with serious emotional disturbance or at risk of serious emotional disturbance; to identify effective models that could be replicated; and to identify effective means to transfer technology regarding effective programs, such as education, training and program development to public and private providers; and

- Continue the Joint Committee Studying the Needs of Offenders with Mental Illness and Substance Abuse Disorders, with the addition of the Cabinet Secretaries of Health and Human Resources and Public Safety as ex officio members, to oversee implementation of its recommendations and to conduct further research into diversion programs that will prevent persons with mental illness and substance abuse disorders from entering the criminal justice system in the first place.

26. Child and Adolescent Special Populations Workgroup of the Department's Restructuring Policy Advisory Committee, *Final Report and Recommendations to the Commissioner of the Department of Mental Health, Mental Retardation and Substance Abuse Services and the Restructuring Policy Advisory Committee*, 2004.

Introduction

In June 2003, the Commissioner of DMHMRSAS formed the Child and Adolescent Special Populations Workgroup. The workgroup studied Virginia's service delivery system in two ways:

- Strengths and weaknesses of the current service delivery system; and
- Formulation of short and long term recommendations and priorities to improve the current service delivery system.

Through the development of subcommittees, the workgroup addressed the following findings more extensively:

- Juvenile justice;
- Substance abuse;
- Prevention and early intervention;
- Mental retardation; and
- Demonstration project models.

Each subcommittee listed above developed findings and recommendations that were presented to the full workgroup. Some of the recommendations were adopted by the full workgroup and some were not adopted.

Methodology of Study

- Examined best-practices and exemplary service delivery systems within Virginia and across the country;
- Analyzed common elements that existed within successful systems;
- Examined inpatient beds for public children and adolescents; and
- Analyzed current funding streams for system.

Needs of Children and Their Families

- 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;
- There will 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.

Strengths of Current System

- The CSA system has required collaboration and coordination for nearly ten years at local and state levels;
- CSA's values include many of the values of the System of Care model;
- DMHMRSAS has a state board policy reflecting the values of the System of Care model developed in 1986;
- 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 (OCFS) within DMHMRSAS;
- Strong working relationship between DMAS and DMHMRSAS;
- Evidence-based and promising programs are in place in a few areas; and
- COY has developed a website on evidence-based treatments for behavioral health disorders.

Weaknesses of Current System

Inadequate funding of behavioral health services for youth and their families;

- Children's services are fragmented across the state;
- The state legal code does not require the provision of behavioral health services for children and their families, which results in discontinuity in priorities across state agencies and localities;
- State agencies continue to be fragmented in their approaches to strengthen delivery of services to children and their families;
- Service provision is inconsistent and diverse across the 40 CSBs;
- The children's System of Care in Virginia does not have a clear and consistent vision, identity and set of priorities;
- Poor coordination among state and local agencies causes confusion for families, overlapping services and increased cost to taxpayers;
- CSA does not sufficiently fund the needs of children with behavioral health disorders;
- Funding streams are not coordinated or sufficient;
- Children with behavioral health disorders who are involved in the juvenile justice system are not adequately served;
- Most youth with substance abuse disorders are not adequately served because substance abuse services are not sufficiently funded;
- DMHMRSAS services are not integrated with each other system wide;
- Although specific components of a comprehensive community-based System of Care have been identified, the extent of implementation varies significantly from community to community;
- There is insufficient funding for capacity building for community-based services;
- There is a lack of certified child psychiatrists and other child-trained professionals at many CSBs;
- There is a lack of consensus among service providers regarding how, which and at what levels children's behavioral health services should be delivered;
- Children and families who receive behavioral health services funded by different funding streams receive different or no services; and
- Services for children with mental retardation and severe behavioral disorders are insufficient.

Recommendations

- Public inpatient beds for children and adolescents were significantly reduced in the 1990s. There is no further need for bed reduction; and
- DMHMRSAS should adopt the System of Care model developed by the Georgetown University's Technical Assistance Center for Children's Mental Health and adopted by the Substance Abuse and Mental Health Services Administration (SAMHSA).

Recommendations for Funding Priorities

- Four System of Care demonstration projects outlined ($2.5 million);
- Parent/Youth Involvement Network ($500,000 for the first year – $1 million for second year);

- Behavioral health services provided by CSBs in detention centers during and after detention stay ($3.5 million); and
- All resources in Virginia need to be maximized to build the capacity for behavioral health services that include a comprehensive continuum of prevention, early intervention and intensive therapeutic services:
  - Increase Medicaid rates for day treatment services to $150 per day;
  - 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);
  - Conduct a rate study to expand community-based services in the state plan to include intensive case management level system in CSBs, parenting education, respite services and behavioral aides;
  - MST and FFT capacity building ($2.5 million to include training and statewide licensure and to oversee and fund local MST/FFT services); and
  - Training priorities are:
    - Systems of Care ($500,000 for five regional and one state training); and
    - Fund slots for university training of child psychiatry fellows and child psychology interns with payback provisions ($60,000 per fellow and $26,000 per intern).

Recommendations Related to Increased Funding

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

System of Care Recommendations

- DMHMRSAS will recommend to SEC and the Virginia General Assembly possible *Code* and regulatory changes and budget initiatives to support the revision and expansion of state and local systems of care;
- 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;
- State agencies should continuously blend and braid funding sources to meet the needs of children and adolescents with mental health, mental retardation and substance abuse problems and their families; and
- DMHMRSAS will support and expand its OCFS to assure that children's behavioral health services are prioritized and include all service entities related to children and their families.

Recommendations Not Related to Funding

- Encourage partnerships and collaborations among parents, providers and other stakeholders in regards to children with behavioral health problems and their families;
- 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;
- 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 a one care plan;
- Promote integration of services across mental health, mental retardation and substance abuse disabilities by establishing policies that require service providers to conduct a single comprehensive intake addressing the areas of mental health, mental retardation and substance abuse and developing a unified services plan and record;
- Continue the dissemination of the COY's *Collection*;
- Seek grant funding to enhance child and adolescent behavioral health services by establishing matching fund capacity through private foundations/corporations;

- Strengthen university/community partnerships to enhance child and adolescent behavioral health services; and
- Encourage DMAS to suspend rather than terminate Medicaid benefits while children and adolescents are in a public institution, including state hospitals, juvenile detention centers (JDCs), juvenile correctional facilities and jails.

27. **Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services, *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*, 2004.**

Introduction:

In June 2003, DMHMRSAS submitted a report to the Chairmen of the Senate Finance and House Appropriations Committees. The report satisfied the legislative intent of the budget language and delineates the recommendations to improve access to mental health, mental retardation and substance abuse services for children and their families. The report includes eight recommendations that address the unmet service needs, funding, infrastructure and system findings and recommendations for improvement. The report also includes analysis of the CSA and recommendations related to systems improvement to address unmet needs in rural communities.

The report identifies the status of the eight recommendations made in June 2003 and makes recommendations for the next state fiscal year.

Progress Report on Previous Recommendations

Recommendations:

- DMHMRSAS should initiate a budget request to fund an integrated continuum of mental health, mental retardation and substance abuse services for children, adolescents and their families. The budget initiative shall give consideration to the varying geographic needs in Virginia, filling identified gaps, addressing co-occurring disorders and the needs of special populations such as children with early development needs, juvenile offenders and adolescents in need of transitional services into the adult services system;
- DMHMRSAS should initiate a budget request to build an infrastructure of children and adolescents and their families at the community services boards with a determined number of dedicated integrated case managers and mental health clinicians for CSBs; and
- DMHMRSAS, in conjunction with CSBs, should request a dedicated pool of flexible funds to be used specifically for program start-up and program development, allocated in a manner that maximizes flexibility in program design and promotes achieving specific outcomes for children, adolescents and their families with mental health, mental retardation and substance abuse needs.

Status of Recommendations:

- These three recommendations are addressed together. Recommendations that addressed budget requests were to be submitted by DMHMRSAS to the Virginia General Assembly for funding. DMHMRSAS initially developed four budget proposals to increase capacity for children and adolescents in the community. The outcome of the Governor's biennium proposed budget included $2 million to provide mental health services to children and adolescents by addressing the services needs and building capacity in the community. These funds were approved by the 2004 Virginia General Assembly. The intent of this appropriation is to finance non-mandated CSA to build community capacity for the behavioral health needs of children's services. Funds will be allocated to CSBs.

Recommendation:

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

Status of Recommendation:

- In 2003, a workgroup of select state staff various agencies were organized to review the Bright Futures materials and to develop a curriculum for the training and education of staff across agencies.

Georgetown University's National Technical Assistance Center for Children Mental Health provided technical assistance staff to this workgroup to assist in developing a Virginia-specific curriculum. The curriculum will be adopted by DMHMRSAS and used statewide for training case managers and other entry-level staff who work with children.

Recommendation:

- DMHMRSAS, in conjunction with CSBs, should establish a cooperative agreement with a state university to evaluate the efficiency of such programs that are based on terms established by DMHMRSAS.

Status of Recommendation:

- No action has been taken on this recommendation. In conjunction with CSBs, meetings will be planned to implement this recommendation in 2005.

Recommendation:

- DMHMRSAS should continue to support the integrated OCFS into the Division of Community Support Services. OCFS shall provide leadership for child and family issues on a statewide basis through coordination of services delivery and integration of disability service systems, with the goal of improving access to mental health, mental retardation and substance abuse services for children, adolescents and families.

Status of Recommendation:

- This was a significant recommendation of the 2003 report that DMHMRSAS has successfully implemented. OCFS was established in April 2004. OCFS provides leadership and direction in developing a seamless System of Care that integrates services across disciplines. This involves partnering with stakeholders working to improve services for children, developing policies that promote children and family services, addressing gaps in existing services, developing new services using evidence-based practices and expanding existing evidence-based models, increasing family involvement on committees, councils, taskforces, addressing children's issues and increasing family involvement.

Recommendation:

- DMHMRSAS and OCFS should organize and support a state advisory committee composed of families of children with mental health, mental retardation and substance abuse services, children's services representatives of state agencies that are systems of care, representatives of service program organizations, private providers and advocacy organizations.

Status of Recommendation:

- DMHMRSAS will establish an advisory group that is responsible for promoting services for children and support activities that improve services to children. Representatives from groups representing children's interests will be invited to participate on this advisory group.

Recommendation:

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

Status of Recommendation:

- No action was taken on this recommendation during FY03. DMHMRSAS has several contracts with organizations to provide family support services to parents of children with mental health and mental retardation disabilities. In 2004, DMHMRSAS plans to assess existing resources available to parent organizations to determine how best to build and link the network of families with children who require or receive mental health, mental retardation and substance abuse services.

Recommendation:

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

Status of Recommendation:

- DMHMRSAS expects to continue publishing relevant information about mental health, mental retardation and substance abuse services and links to educational resources and supports for families and providers on its website. Additional activities planned for 2004-2005 include

strengthening partnerships with universities to explore training for child and adolescent service providers, professional development for clinicians trained in child and adolescent mental health and to explore developing interactive web-based curriculum to meet the training needs of diverse regions statewide.

Recommendations for 2005

- DMHMRSAS should resubmit a budget request to fund an integrated continuum of mental health, mental retardation and substance abuse services for children, adolescents and their families based on evidence-based 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;
- DMHMRSAS should resubmit a budget request to fund a determined number of dedicated integrated case managers for children and families in all CSBs;
- DMHMRSAS should continue to explore existing resources within state and federal funds to provide statewide training on mental health, mental retardation and substance abuse services and integrated case management as it relates to the recommended continuum of mental health, mental retardation and substance abuse services for children, adolescents and their families. All agencies within the Secretariats of Health and Human Resources, Education, and Public Safety shall cooperate in the planning and funding of the training;
- DMHMRSAS, in conjunction with CSBs, should resubmit the request for a dedicated pool of flexible funds to be used specifically for program start-ups and program development. Funds should be allocated in a manner that maximizes flexibility in program design and promotes achieving specific outcomes for children, adolescents and their families with mental health, mental retardation and substance abuse needs;
- DMHMRSAS should continue to build the infrastructure of the new OCFS to be an integrated organizational unit of DMHMRSAS. This organizational unit should be involved at all levels in seeking state and federal funding and developing policy for children and family services. OCFS should provide leadership for child and family issues on a statewide basis through coordination of services delivery and integration of disability service systems with the goal of improving access to mental health, mental retardation and substance abuse services for children, adolescents and families in Virginia;
- DMHMRSAS should complete formalizing the state advisory committee for child and family services to support activities of the organizational unit. This should include identifying members, establishing bylaws, meeting schedules and setting agendas;
- DMHMRSAS should seek ways to build and link the network of parents who have children and adolescents with mental health, mental retardation and substance abuse service needs through collaborative effort with other child serving agencies and organizations to develop and implement a statewide parent/family network and advocacy program;
- DMHMRSAS should create, publish and fund an interactive website to be used as a resource for children, adolescents and families to enable improved access to mental health, mental retardation and substance abuse services, providers, educational resources and supports;
- DMHMRSAS shall review the policies and procedures within 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's services agencies in the provision of services to children, adolescents and their families;
- DMHMRSAS should provide training and technical assistance on the development of systems of care for children in Virginia to CSBs and other interested parties;
- DMHMRSAS should work with CSBs to provide cross-training on children's issues; and
- DMHMRSAS should review all state board policies related to prevention, mental health, mental retardation and substance abuse services and make recommendations to improve integrated services for children, adolescents and their families.

28. **Office of Comprehensive Services, *A Report on the Progress of Increasing Medicaid Utilization for CSA Services*, 2004.**

Introduction

OCS is required by law to submit a progress report. This report includes an update in the increased use of Medicaid for CSA. The report also provides details about Medicaid expenditures at the local level.

Strategies to Increase the Utilization of Medicaid

- DMAS was invited and now actively participates in OCS Technical Assistance and Training Group (TAG). TAG represents a collaborative group of state and local CSA stakeholders charged with identifying and resolving specific CSA training needs;
- In conjunction with DMAS Memorandum of Understanding (MOU) with OCS, DMAS has agreed to provide training for local CSA teams and providers on proper utilization of Medicaid for treatment foster care and residential services. The training includes, but is not limited to, claims processing, utilization review and prior authorization of all services related to Medicaid coverage. CSA coordinators and providers are invited to attend these sessions;
- DMAS staff is available for consultation and assistance in answering questions regarding provider enrollment, services provision and billing inquiries;
- DMAS is an active participant with CSA groups charged to identify provider issues and resolution;
- DMAS is a member of SLAT. SLAT, established within the *Code,* is charged with managing cooperative efforts at the state level and providing support to community efforts;
- In the fall of 2004, DMAS notified current Medicaid, FAMIS Plus and FAMIS enrollees under the age of 21 of EPSDT. The goal of EPSDT is to assure that health problems are diagnosed and treated as early as possible;
- The 2004 Appropriations Act contains language requiring DMAS to amend the state plan for Medicaid assistance to include reimbursement for required tuition payments for children receiving Medicaid-eligible residential services, provided such educational services are part of the (child's) treatment plan by July 1, 2005. Currently, DMAS is developing the cost impact of this initiative;
- Effective July 1, 2004, two new Medicaid community-based residential treatment services were initiated. As this service just began, meaningful results are not available at this time (through the August 2004 Medicaid billing report, a total of $20 thousand has been reimbursed). This service is budgeted at $10.9 million in FY05;
- DMAS frequently attends and makes presentations to CSA coordinator groups; and
- In November 2004, DMAS will announce changes to the Community Mental Health Rehabilitative Services Manual that will make easier assess to current services.

29. **State Executive Council Workgroup, *The Relinquishment of Custody for the Purpose of Assessing Behavioral Health Treatment*, 2004.**

Introduction

The 2004 Virginia General Assembly directed SEC for CSA to investigate the reasons why parents relinquish custody of their children solely for the purpose of obtaining the necessary and appropriate mental health services. SEC established a workgroup to study this issue. The initial report from 2004 concluded that issues relating to the problem of custody relinquishment were too complex. The workgroup studied the problem for another year and presented final conclusions in 2005.

Areas of Focus

- The extent to which custody relinquishment for the purpose of obtaining behavioral health treatment occurs and the related impacts on children, families and communities;
- The causes, factors, policies, procedures and practices relating to custody relinquishment; and
- The existing or available best practices or model programs that offer access to services without requiring custody relinquishment (except where necessary and appropriate).

Findings:

- For a significant number of families, the only way to access resources for behavioral health treatment services for their children is to relinquish custody;
- Relinquishing custody under these circumstances has myriad of negative consequences, sometimes severe and devastating, for families and their children and communities;

- Relinquishing custody solely for this purpose uses Virginia's child-serving systems in unintended, inappropriate and inefficient ways;
- Virginia laws, policies and practices that govern custody relinquishment are primarily designed for purposes other than addressing children's treatment needs and, as such, can be experienced as adversarial by parents;
- Limited availability, lack of funding or inadequate insurance coverage for behavioral health treatment service are primary reasons families relinquish custody in order to obtain these services;
- Virginia's child-serving system, comprised of multiple state and local agencies, is fragmented both programmatically and in its funding streams. This complex fragmentation poses significant challenges for families and the professionals who serve them;
- Extreme variability exists across localities in Virginia and within localities themselves regarding the consistent application of policies and practices, service availability and resources;
- Virginia lacks a strong, organized family advocacy network. Such networks have proven in other states to be effective resources in helping families of children with serious emotional disturbances navigate the complex public and private systems of children's services. These networks have also successfully advocated for system improvement;
- In the short term, changes in the *Code*, regulation, policy and practice to the current System of Care for children will improve access to behavioral health services and reduce some of the negative effects of custody relinquishment for some families; and
- In the long term, transforming and adequately funding the System of Care for children and families, building on CSA will significantly improve access to behavioral health services and eliminate the need for relinquishment of custody.

Recommendations

Recommendations on system reform:

- Develop a system to include all state-level child services by coordinating at the secretarial level. This will include the response of the Program Improvement Plan (PIP) to the federal Child and Family Services Review;
- Examine the use of private insurance funds to prevent additional hospitalization costs. Study the role of the State Corporation Commission (SCC) and Bureau of Insurance to mental health treatment for children;
- DSS will develop a system to track the number of custody relinquishment cases;
- Study alternate models that reduce or eliminate categorical allocations, minimize fragmentation and encourage cost containment strategies; and
- Support the development of a continuum of mental health and substance abuse treatment services for youth. This will be outcome-based and accessible.

Recommendations on funding expansion and existing resource efficiency:

- Examine other funding streams to match CSA funding;
- Examine the effects of non-mandated funding levels of CSA;
- Examine the option of developing and funding community based service infrastructure and program start-up;
- Expand funding for behavioral health services for youth; and
- Examine various funding streams under Medicaid and Virginia's Children Health Insurance Programs (CHIP).

Recommendations on policy and Code changes:

- Each child-serving agency should examine all applicable policies, procedures and practices;
- DSS will collaborate with other partners to guide localities on policies and procedures for voluntary placement;
- DSS will recommend changes and revisions to the *Code* and departmental policies;
- Promote prevention and early intervention. Examine the use of less restrictive community-based services with CSA match rates; and
- Advocate for changes at the federal government level.

Recommendations on service improvement and program development:

- Continue examining best-practices that address custody relinquishment;

- All agencies on SEC will develop and execute technical assistance and training for localities; and
- DMHMRSAS will collaborate with other child-serving partners to develop and execute a resource and advocacy program for parents and families.

30. Virginia Commission on Youth, *Dissemination of the Collection of Evidence-based Treatment Modalities for Children and Adolescents with Mental Health Treatment Needs*, 2004; *Collection of Evidence-based Treatment Modalities for Children and Adolescents with Mental Health Treatment Needs, 2nd Edition*, 2005.

Introduction

In 2002, the Virginia General Assembly directed COY to coordinate the collection of empirically-based information to identify the treatments recognized as effective for the treatment of children, including juvenile offenders, with mental health treatment needs, symptoms and disorders. The initiative originated from recommendations made to the 2002 Virginia General Assembly by COY as part of a two-year study of *Children and Youth with Serious Emotional Disturbance Requiring Out-of-Home Placement* and by the Joint Committee studying Treatment Options for Offenders with Mental Illness or Substance Abuse Disorders.

In 2003, the Virginia General Assembly passed a resolution which required COY to update the report biennially. This resolution was passed to ensure that the information remained current and that it reached the intended audience. The resolution also required COY to disseminate the report through web technologies. The Cabinet Secretaries of Health and Human Resources, Education, and Public Safety, along with the Advisory Group and various state and local agencies, were requested to assist COY in updating the report.

The *2nd Edition* is the first biennial update. This report summarizes current research on mental health treatment that has been proven to be effective in treating children and adolescents. It is intended to serve a broad readership: educators, service providers, parents, caregivers and others seeking information on evidence-based mental health treatments for youth.

Areas of Focus

- Role of family in treatment programs;
- Evidence-based treatments;
- Key components of successful treatment programs;
- Mental retardation;
- Pervasive development disorders;
- Adjustment disorders;
- Behavior disorders;
- Maladaptive behaviors;
- Tourette's disorder;
- Anxiety disorders;
- Mood disorders;
- Schizophrenia;
- Co-occurrence of substance abuse and mental illness;
- Youth suicide;
- School-based mental health services;
- Juvenile offenders; and
- Antidepressants and the Risk of Suicidal Behavior.

Findings on the Role of the Family in Treatment Programs

- The involvement of family members in child and adolescent services is crucial to successful treatment outcomes;
- The effectiveness of services for children and adolescents is believed to hinge less on the particular type of treatment provided than on the participation of the family in planning, implementing and evaluating the services;
- Research indicates that, for children with serious mental health problems, the more the family participates in planning services, the more likely the family members are to feel that their child's needs are being met (Koren et al., 1997);

- Family participation promotes an increased focus on families, the provision of services in natural settings, a greater awareness of cultural sensitivity and a community-based System of Care;
- Additional research is necessary to determine the factors that contribute to early termination of treatment; and
- Researchers have identified six broad roles that families should play in the treatment process. The six roles of families include (Friesen & Stephens, 1998):
  - Contributors to the environment;
  - Recipients of service;
  - Partners in the treatment process;
  - Service providers;
  - Advocates; and
  - Evaluators and researchers.

Findings on Evidence-based Treatments

- Evidence-based treatments are interventions for which there is consistent scientific evidence showing that they improve client outcomes (National Association of State Mental Health Program Directors Research Institute, Inc. Center for Evidence-based Practices, 2000);
- It is imperative that treatments for mental health disorders be examined, based on clinical research, in order to ascertain whether the treatments are effective;
- Evidence-based treatments must be consistent with characteristics of evidence-based guidelines developed by the National Institute of Mental Health (NIMH):
  - At least two control group design studies or a large series of single-case design studies;
  - Minimum of two investigators;
  - Use of a treatment manual;
  - Uniform therapist training and adherence;
  - True clinical samples of youth;
  - Tests of clinical significance of outcomes applies;
  - Both functioning and symptom outcomes reviewed; and
  - Long-term outcomes beyond termination.
- Benefits of evidence-based treatment include, but are not limited to:
  - Allows patients, clinicians and families to see the difference between alternative treatment decisions and to ascertain the best treatment approach that will facilitate successful outcomes (Donald, 2002);
  - Informs clinical and policy decisions about numerous faces and aspects of healthcare;
  - Provides data and fair, scientifically rigorous method of evaluating treatment options;
  - Assists in developing clearer and more concise working practices, as well as establishing treatment guidelines and practices;
  - Promotes effective use of resources, while simultaneously allowing for improvements in clinician's knowledge base (Fonagy, 2000); and
  - Encourages key players in the medial industry to come together in the decision-making process. This can ultimately reduce conflict and even potentially reduce litigation.
- Limitations of evidence-based treatment include but are not limited to:
  - The rapid emergence of data regarding evidence-based treatments has made it difficult for clinicians to both access and disseminate (Burns et al., 1999);
  - Evidence may be preliminary, rather that well-established, thus the treatments may be so new that their long-term effects are not yet known; and
  - The study process for particular treatment interventions can be long and painstaking, whereas policy decisions need to be made almost immediately.
- Issues for consideration:
  - Differences between science and practice;
  - Understanding the target audience;
  - The impact of culture;
  - Individual information processing; and
  - Organizational change.

Findings on the Key Components of Successful Treatment Programs

Three guiding principles that should provide the foundation for any treatment program:

- *Integrated programming*:
  - Guiding principles call for services to be integrated, with linkages between the child-serving agencies and programs that allow for collaborative planning, development and implementation of services;
  - Research continues to support the idea that the mental health needs of children and adolescents are best served within the context of a System of Care in which multiple service providers work together in an organized, collaborative way; and
  - The System of Care approach encourages agencies to provide services that are child-centered and family-focused, community-based and culturally competent.
- *Engagement of families in treatment efforts*:
  - Service providers and researchers have increasingly come to realize the important role that families play in mental health treatment services for children; and
  - According to the President's New Freedom Commission on Mental Health, local, state and federal officials must engage families to participate in planning and evaluating treatment and support services (2003). Direct participation of consumers and families in developing a range of community-based, recovery-oriented treatment and support services is important.
- *Culturally competent service delivery:*
  - The culture has been found to influence many aspects of mental illness. Patients from specific cultures may express and manifest their symptoms in different way and may differ in their styles of coping, their family and community supports, and their willingness to seek and continue with treatment;
  - Research has shown that tailoring interventions to the cultural traditions of the family improves outcomes effectiveness; and
  - Cultural competency involves addressing several aspects (Saldana, 2001):
    - Acculturalation;
    - Poverty;
    - Language;
    - Transportation, housing and childcare;
    - Reading ability/educational background;
    - Beliefs; and
    - Physical characteristics.

Findings on Mental Retardation

- Mental retardation is not a single, isolated disorder but a condition affecting individuals who are limited in mental functioning to a level that affects many aspects of life, including basic skills such as communication, taking care of personal needs and social interaction;
- There are numerous causes for mental retardation. Those most frequently cited include external factors, such as infections, trauma, toxins, premature births and delivery problems.
- The most common comorbids are:
  - General medical conditions, including seizure disorders and motor handicaps;
  - Pervasive developmental disorders;
  - Attention Deficit Disorders (ADD and ADHD);
  - Conduct disorders;
  - Behavior disorders;
  - Mood disorders;
  - Anxiety disorders;
  - Post-traumatic Stress Disorder (PTSD); and
  - Schizophrenia.
- The treatment of children with mental retardation is based on two guiding principles (Szymanski and King, 1999):
  - *Normalization*: Requires that children with mental retardation live under patterns and conditions of everyday life that are as close as possible to mainstream society; and
  - *Community-based care*: The treatment and integration of mentally retarded children within the community to the maximum extent possible.
- The primary goal is prevention, including developmental and educational services; and

- Other treatments include:
  - Individual therapy;
  - Family therapy;
  - Group therapy;
  - Behavior modification:
  - Social skills training
  - Cognitive therapy; and
  - Pharmacological treatment.

Findings on Pervasive Development Disorders

- Pervasive Development Disorders (PDDs) describes disorders arising during the first years of life which disrupt various development processes (National Dissemination Center for Children with Disabilities, 2001);
- Symptoms of PDD includes (National Institute of Neurological Disorders and Stroke, 2001):
  - Communication problems;
  - Difficulty relating to people, objects and events;
  - Unusual play with toys and other objects;
  - Difficulty with changes in routine or familiar surroundings; and
  - Repetitive body movements or behavior patterns.
- Types of PDD includes (National Institute of Neurological Disorders and Stroke, 2001 and Autism Society of America, 2002):
  - *Autistic*: Impairment in social interaction, communication and imaginative play prior to age three years;
  - *Asperger's*: Impairment in social interactions and the presence of restricted interests and activities, with no clinically significant general delay in language and testing in the range of average to above average intelligence;
  - *Rett's*: A progressive disorder which, to date, has occurred only in girls. It is characterized by a period of normal development and then low of previously acquired skills, loss of purposeful use of the hands, replaced with repetitive hand movements beginning at the age of 1-4 years;
  - *Childhood Disintegrative Disorder*: Characterized by normal development for at least the first two years, significant loss of previously acquired skills; and
  - *PDD not otherwise specified (PDDNOS):* May be made when a child does not meet the criteria for a specific diagnosis, but there is a severe and pervasive impairment in specified behaviors.
- Incidence of PDD (Autistic Children's Activity Program, 2002):
  - One in 1,000 individuals diagnosed the classic autism;
  - One in 500 individuals within the autism spectrum, including PDDs; and
  - One in 200 individuals within the autism spectrum, including PDD and Asperger's.
- Prevalence of Autism (Autism Society of America, 2002):
  - Autism affects an estimated one in 250 births;
  - It is estimated that as many as 1.5 million American today have a form of autism; and
  - Autism is growing at a rate of 10-17 percent a year.

Findings on Adjustment Disorders

- Adjustment disorders are a behavioral or emotional reaction to an outside stressor and, accordingly, there is no single trigger between the stressor and the child's reaction to it (The Medical Center Online, 2002);
- Six types of adjustment disorders (*Diagnostic and Statistical Manual, 4th Edition*):
  - Adjustment disorder with depressed mood: Symptoms are that of a minor depression;
  - Adjustment disorder with anxious mood: Symptoms of anxiety are dominant;
  - Adjustment disorder with mixed anxiety and depressed mood: Symptoms are a combination of depression and anxiety;
  - Adjustment disorder with disturbance of conduct: Symptoms are demonstrated in behaviors that break societal norms or violate the rights of others;

- Adjustment disorder with mixed disturbance of emotions and conduct: Symptoms include combined affective and behavioral characteristics with mixed emotional features and with disturbance of conduct; and
- Adjustment disorder not otherwise specified: This residual diagnosis is used when a maladaptive reaction that is not classified under other adjustment disorders but occurs in response to stress.

- Characteristics of adjustment disorders (The Medical Center Online, 2002):
  - Occurs equally in males and females;
  - Stressors and symptoms may vary based on cultural influences;
  - The characteristics in children differ from those in adults;
  - Adolescent symptoms are more behavioral; and
  - Adult symptoms are more depressive.

Findings on Behavior Disorders (Attention Deficit Hyperactivity Disorder)

- Facts about Attention Deficit Hyperactivity Disorder (ADHD):
  - ADHD affects an estimated 4.1 percent of youth ages 9 to 17 in a six-month period;
  - About two to three times more boys than girls have ADHD;
  - Children with untreated ADHD have higher than normal rates of injury;
  - ADHD often co-occurs with other problems, such as depressive and anxiety disorders, conduct disorder, drug abuse or antisocial behavior;
  - Symptoms of ADHD usually become evident in preschool or early elementary years;
  - The disorder frequently persists into adolescence and into adulthood; and
  - Treatment may be required throughout life.
- Three subtypes of ADHD:
  - *Predominately hyperactive-impulsive type*: Exists when the child or adolescent does not show significant inattention;
  - *Predominately inattentive type*: Sometimes referred to as ADD, it is based on the child's not showing significant hyperactive-impulsive behavior; and
  - *Combined type*: Display of both hyperactive-impulse and inattentive symptoms.
- There is no treatment available to cure this disorder, but many treatments are available that effectively assist with its management. Education of family and school staff about ADHD and its management is the leading form of treatment; and
- Treatment requires behavioral, psychological and education components.

Findings on Behavior Disorders (Oppositional Defiant and Conduct Disorders)

- Children who are diagnosed with oppositional defiant disorder (ODD) and conduct disorder (CD) exhibits behaviors that are significantly disruptive to the point where the child may impair functioning;
- Disruptive disorders are complex and may lead to long-term adverse consequences affecting academic performance, as well as difficulties in social and emotional development. Children with ODD and CD are also at high risk for criminality and antisocial personality disorders in adulthood;
- ODD is considered a mental disorder where the child exhibits noncompliance toward authority figures. It is characterized by two different sets of problems: aggressiveness and a tendency to purposefully bother and irritate others;
- CD is considered a mental disorder where the child exhibits persistent and critical patterns of misbehavior. CD behaviors include aggression towards people or animals, destruction of property, deceitfulness, theft or serious violation of rules;
- Facts about ODD:
  - Reported to affect between 2 to 16 percent of children;
  - More common in boys than in girls before puberty; and
  - After puberty, the rates in both genders are equal.
- Facts about CD:
  - Approximately six percent of children have CD;
  - More common in boys than in girls (4:1 ratio);
  - Believed to be more prevalent in urban than in rural settings;
  - Children with CD often have other psychiatric problems;
  - The prevalence of CD has increased over recent decades; and

- Aggressive behavior is the reason for one-third to one-half of the referrals made to child and adolescent mental health services.

Findings on Maladaptive Behaviors

- Maladaptive behaviors include:
  - Sexual offending;
  - Eating disorders;
  - Juvenile firesetting; and
  - Self-injury.
- Sexual behaviors:
  - Sexual offense behavior is not a disorder per se, but is rather a behavioral problem that may be closely linked to other disorders;
  - Juveniles who perpetrate sexual offenses are defined as those who commit any sexual act against the victim's will, without consent or in an aggressive, exploitive or threatening manner;
  - Common characteristics includes:
    - High rates of learning disabilities and academic dysfunction;
    - The presence of other behavioral problems and CDs; and
    - Difficulties with impulse control and judgment.
  - Treatment includes:
    - Multisystemic therapy (MST);
    - Group therapy;
    - Residential sexual offender treatment;
    - Community-based programming;
    - Virginia's sexual offender treatment program; and
    - Psychopharmacological treatments.
- Eating disorders:
  - Eating disorders are a significant problem among children and adolescents;
  - Of the millions of Americans who are diagnosed annually with an eating disorder, an estimated 90 percent are adolescents and young women;
  - Characteristics of eating disorders:
    - *Anorexia nervosa*: A disorder characterized by a distorted body image that causes individuals to see themselves as overweight even when they are dangerously thin;
    - *Bulimia nervosa*: A pattern of behavior in which the individual eats excessive quantities of food and then purges the body by using laxative, enemas or diuretics, vomiting and/or exercising; and
    - *Binge eating disorder*: A disorder in which individuals experience frequent episodes of out-of-control eating.
  - Evidence-based treatments for anorexia nervosa:
    - Nutritional rehabilitation;
    - Family psychotherapy;
    - Inpatient behavioral programs; and
    - Pharmacological treatments.
  - Evidence-based treatments for bulimia nervosa:
    - Cognitive behavioral psychotherapy;
    - Pharmacological treatments;
    - Combined treatments; and
    - Group psychotherapy.
  - Evidence-based treatments for binge eating disorder:
    - Little research exists on effective treatment strategies.
- Juvenile firesetting:
  - Juvenile firesetting are typically defined as children or adolescents who engage in firesetting.
  - More than 40,000 arson incidents in the U.S. each year are attributable to juvenile arsons;
  - Children under 18 years of age account for 55 percent of the arrests for arson in the U.S. Nearly half of these are children ages 15 or less. Five percent of those arrested are under age 10; and

- An estimated 300 deaths, 2,000 injuries and $300 million in property damage in the U.S. result annually from fires set by youth.
- Currently, specific information is not available about juvenile firesetting; however, most attention to firesetting has been included within broader categories of delinquency and aggression in children; and
- It is believed that juvenile firesetting, much like other forms of delinquency and aggression in juveniles, can be explained as examples of problem behaviors.

- Self injury:
  - Self-injury (SI), also called self-mutilation or cutting, is a highly stigmatized emotional disorder:
  - Approximately one percent of Americans suffer from SI;
  - It is estimated that, out of every 200 females between the ages of 13 and 19, at least one will engage in SI;
  - Risk factors of SI include:
    - Being a member of an at-risk group;
    - Inability to cope with increased psychological/physiological tension in a healthy manner;
    - Feelings of depression, rejection, isolation, self-hatred, separation anxiety, guilt and depersonalization;
    - Command hallucinations;
    - Need for sensory stimuli; and
    - Dysfunctional family.
  - Treatment includes:
    - Cognitive behavioral therapy;
    - Behavioral modification;
    - Addictions model;
    - Pharmacological treatment;
    - Hospitalization; and
    - Family involvement.

Findings on Tourette's Disorders

- Tourette's disorder is an inherited neurological disorder characterized by repeated involuntary motor and vocal tics;
- A tic is a sudden, quick, recurrent, nonrhythmic motor movement or vocalization;
- In patients diagnosed with Tourette's disorders, sudden, explosive outbursts of behavior are reported in approximately 25 percent of patients, but occurring more frequently in children than adult;
- Tourette's disorder is a rare disorder that is found more commonly in males;
- An evaluation of the child's family history, along with general observation of the symptoms, is the most common method for diagnosing Tourette's disorder;
- Facts about Tourette's disorder:
  - Forty percent of children and adolescents who have Tourette's disorder also have attention problems;
  - Thirty percent have academic difficulties;
  - Approximately 50 percent of children with Tourette's disorder meet criteria for ADHD; and
  - There is no standard treatment.

Findings on Anxiety Disorders

- Anxiety disorders are those disorders that cause children to feel frightened, distressed and uneasy for no apparent reason;
- Anxiety disorders are one of the most common mental health problems that children encounter;
- In children between the ages of six to 17, anxiety disorders occur in as many as six to eight percent of the population;
- Children with anxiety disorders have a strong risk factor for anxiety disorders in adulthood;
- Characteristics of anxiety disorders include:
  - Overt behavioral responses;
  - Physiological responses; and
  - Subjective responses.

- Types of anxiety disorders:
  - Separation Anxiety Disorder (SAD);
  - Obsessive-compulsive Disorder (OCD);
  - Post-traumatic Stress Disorder (PTSD);
  - Phobias; and
  - Generalized Anxiety Disorder.
- Evidence-based treatments:
  - Cognitive behavioral therapy (CBT);
  - Behavioral therapy;
  - CBT and family intervention;
  - CBT and group interventions;
  - Systematic desensitization; and
  - Modeling.

Findings on Mood Disorders

- Facts on mood disorders:
  - Ten to 15 percent of all children and adolescents will experience some symptoms of depression;
  - Seven to 14 percent of children will experience an episode of major depression before the age of 15;
  - Twenty to 30 percent of adult bipolar patients report having their first episode before the age of 20; and
  - Out of 100,000 adolescents, 2,000 to 3,000 adolescents will have mood disorders. Of this number, eight to 100 will commit suicide.
- Types of mood disorders:
  - Major depressive disorder: Characterized by one or more major depressive episodes, lasting from seven to nine months on average. Depressed children exhibit symptoms of sadness, disinterest and are critical of themselves;
  - Dysthymia: This disorder is a less severe type of depression but still involves long-term, chronic symptoms that are not disabling, but keeps a child from functioning well or from feeling good; and
  - Bipolar disorder: Referred to manic-depressive illness, it is characterized by shifts of mood with severe highs (mania) and extreme lows (depression).
- Risk factors include:
  - Stress;
  - Cigarette smoking;
  - A loss of a parents or loved one;
  - Break-up of a romantic relationship;
  - Attention, conduct or learning disorders;
  - Chronic illnesses, such as diabetes;
  - Abuse or neglect; and
  - Other trauma, including natural disasters.
- Treatment considerations:
  - Mood disorders and suicide in children;
  - Recurrence of mood disorders;
  - Prognosis of mood disorders in treatment; and
  - Development of other mood disorders.

Findings on Schizophrenia

- Schizophrenia is a neurodevelopment disorder associated with deficits in cognition, affect and social functioning;
- Children with schizophrenia have extreme difficulty managing daily activities and exhibit the same symptoms as adults;
- Symptoms include:
  - Hallucinations;
  - Delusions;
  - Social withdrawal;

  - Lack of emotions;
  - Loss of social skills; and
  - Loss of the ability to care for themselves.
- Facts about Schizophrenia:
  - Schizophrenia is rare in children, affecting about one in 40,000, compared to one in 100 in adults;
  - The average age of onset is 18 in men and 25 in women;
  - Schizophrenia ranks among the top 10 causes of disability in developed countries worldwide;
  - Children with schizophrenia may also share some symptoms with---and be mistaken for---children who suffer from autism or other PDDs, which affect about one in 500 children ;
  - Approximately one third of those with schizophrenia will attempt suicide;
  - Ten percent will actually complete suicide;
  - Those considered high risk include those with a history of depression, those with a recent hospital discharge and those with a chronic course of the disorder; and
  - Males under age 30 are especially susceptible.
- Subtypes of Schizophrenia:
  - *Paranoid*: Paranoid delusions, frequent auditory hallucinations and affect not flat;
  - *Catatonic*: Motoric immobility and excessive purposeless motor activity and maintenance of a rigid echolalia;
  - *Disorganized*: Disorganized speech, disorganized behavior and flat or inappropriate affect, but not catatonic;
  - *Undifferentiated*: Delusion, hallucinations, disorganized speech, catatonic behavior, negative symptoms but the criteria are not met for the Paranoid, Disorganized or Catatonic types; and
  - *Residual*: Met criteria for schizophrenia, now resolved.

Findings on Co-occurrence of Substance Abuse and Mental Illness

- Children and adolescents may be involved with substances in a variety of ways, including experimentation. Children who experiment with substances at a young age are more likely to use other drugs later in life;
- Nine percent of adolescent females and 20 percent of adolescent males meet the adult diagnostic criteria for an alcohol use disorder;
- Among adolescents and young adults with a substance abuse disorder, 41 to 65 percent also have a mental health disorder;
- The lifetime co-occurrence of mental and addictive disorders has been estimated at approximately 50 percent;
- Although research has not conclusively established the relationship between substance abuse and mental health disorders, there are four theories behind this relationship:
  - One disorder directly causes the other;
  - The substance abuse is an attempt to self-medicate;
  - The two disorders develop independently, but have a significant impact on each other; and
  - The development of both disorders is related to the existence of an independent external factor.
- There are certain risk factors that increase the possibility of a child being dually-diagnosed:
  - *Family influence*: Possibly the most significant, it includes various risk factors, such as genetic predispositions, parental psychopathology, parental substance abuse and the availability of substances;
  - *Social development and peer influences*: A child who is highly susceptible to peer pressure and negative influences is at a greater risk of developing a substance abuse problem; and
  - *Childhood conduct problems*: More than half of adolescents with substance abuse problems also experience conduct problems.
- Most prevalent treatment methods:
  - *CBT*: The goal is the identification and modification of maladaptive thinking patterns to reduce negative thoughts, feelings and behavior;
  - *Group therapy*: Provides friendship, socialization and support to youth who are recovering from co-occurring disorders. The discussion is intended to remind adolescents of negative consequences of substance use and benefits of abstinence and to provide advice and encouragement regarding treatment and recovery from mental disorders;

- *Behavioral therapy*: The goal is to allow the youth and the treatment provider to identify specific problems and area of deficit and to work on improving these behaviors;
- *Skill development*: Provides assistance in developing needed skills and functions that were passed by while the child was struggling with the untreated disorders;
- *Family therapy*: The goal is to provide education, improve communication and functioning among family members and to re-establish parental influence through parent management training;
- *MST*: The goal is to address serious antisocial behavior in children and adolescents who abuse substances;
- *Individual psychotherapy*: Individual counseling that is often incorporated into the child or adolescent's treatment plan;
- *Pharmacotherapy*: Children who are most often prescribed medication are those with depression and mood disorders, ADHD, severe aggressive behavior and anxiety disorders; and
- *Medical detoxification*: The goal is to treat any withdrawal effects by substituting a legal drug for an illicit one during prolonged periods of abstinence.

Findings on Youth Suicide

- Suicide is the third leading care of death for individuals 15 to 24 years old and the sixth leading cause of death for individuals 5 to 14 years old;
- In 2003, the suicide rate among:
  - Children aged 10 to 14 was 1.5/100,000 or 300 deaths among 19,895,072 children in this age group;
  - Adolescents aged 15 to 19 was 8.2/100,000 or 1,621 deaths among 19,882,596 adolescents in this age group; and
  - Young people aged 20 to 24 was 12.8/100,000 or 2,373 deaths among 18,484,615 people in this age group.
- In Virginia, suicide is:
  - The third leading cause of death for ages 10 to 24;
  - The second leading cause of death for ages 25 to 34;
  - The fourth leading cause of death for ages 35 to 54;
  - In almost all age groups, Virginia's suicide rates are slightly higher than the national average;
  - One teenager a week, two adults each day and one older adult every three days are lost to suicide;
  - There is an estimated 25 suicide attempts for every death by suicide; and
  - In 2000, the total cost for hospitalizations due to suicide attempts in Virginia was over $25 million.

Findings on School-based Mental Health Services

- School-based health centers have increasingly become a key provider of health services for children and adolescents;
- Implementation issues of school-based health services:
  - Integration of mental health professional into the school environment;
  - Creation of a System of Care within the school environment;
  - Engagement of families in educational planning and services;
  - Consistent program implementation;
  - Other environmental and community factors, such as collaboration between community-based mental health systems and school systems; and
  - Use of medication in school setting.
- The establishment of new school-based initiatives may require administrators and policymakers to be creative in their pursuits of additional funding and resources within the community;
- Sources of funding may include private health insurance plans, traditional school health funds, EPSDT, Medicaid, CSA and other local, state and federal resources;
- Recommendations from the President's New Freedom Commission on Mental Health for improving school-based mental health programs:
  - Collaboration between schools and parents, local providers and local agencies to support screening, assessment and early intervention;

- Ensuring that mental health services are part of school health centers;
- Provision of federal funding for health, mental health and education programs;
- Implementation of empirically supported prevention and early intervention approaches at the school district, local school, classroom and individual student levels; and
- Creating a state-level structure for school-based mental health services to provide consistent state-level leadership and collaboration between education, general health and mental health systems.

Findings on Juvenile Offenders

- There is a high prevalence of mental health needs among juvenile offenders. Unfortunately, an increasing number of youth with mental health disorders continue to enter and remain involved in the juvenile justice system;
- It is estimated that 50 to 75 percent of incarcerated young offenders nationwide have a diagnosable mental health disorder. Moreover, while there are highly successful treatment methods which can rebuild families and provide intensive mental health services to youth offenders with mental health problems, their availability is rare;
- Children at-risk for institutional placement are placed according to the primary type of dysfunction they evidence, with behaviorally-disordered children becoming incarcerated and emotionally-disordered children placed into the state mental health system;
- Youth within the juvenile justice system are at high risk for psychiatric conditions that may be contributed to the risk of offending or which may interfere with rehabilitation;
- Juvenile courts can have a positive mental health orientation and provide a foundation to build a stronger system of care collaboration and the establishment evidence-based practices in the juvenile justice system;
- There are nine components of effective treatment for juvenile offenders:
  - Highly structured, intensive programs focusing on changing specific behaviors;
  - Development of basic social skills;
  - Individual counseling that directly addresses behavior, attitudes and perceptions;
  - Sensitivity to a youth's race, culture, gender and sexual orientation;
  - Family member involvement in the treatment and rehabilitation of children;
  - Community-based, rather than institution-based treatment;
  - Services, support and supervision that wrap around a child and family in an individualized way;
  - Recognition that youth think and feel differently than adults, especially under stress; and
  - Strong aftercare treatment.
- Evidence-based approaches include:
  - *Wraparound:* Entails treating children with serious emotional problems and developing individualized, child-centered, family-focused, community-based and culturally competent services;
  - *Integrated Systems of Care*: Involve collaboration across a number of agencies, with the goal of developing coordinated plans for family-centered services and building upon youth and family strengths;
  - *MST*: Provides an integrative, cost effective, family-based treatment with focus on improving psychosocial functioning for youth and families so that the need for out-of-home placements is reduced or eliminated. Behavioral problems of children and adolescents are maintained through problematic interactions within or between one or more of these systems;
  - *Functional Family Therapy (FFT):* Family-based prevention and intervention program that combines and integrates established clinical therapy, empirically supported principles and extensive clinical experience;
  - *CBT:* An excessively instructive approach that involves teaching youth about the thought-behavior link and working with them to modify their thinking patterns in a way that will lead to more adaptive behavior in challenging situations; and
  - *Multidimensional Treatment Foster Care:* Recruits, trains and supervises foster families to provide youth with close supervision, fair and consistent limits and consequences and a supportive relationship with an adult.

Findings on Antidepressants and the Risk of Suicidal Behavior

- Facts on antidepressants and the risk of suicidal behavior:
  - Overall, child antidepressant use increase by 9.2 percent each year from 1998 to 2002;
  - Antidepressant prescriptions are increasing faster for girls than for boys;
  - Serotonin-specific reuptake inhibitors are more commonly prescribed for child patients than other antidepressants; and
  - Data shows doctors prescribe antidepressants more frequently for depression than for anxiety disorders.
  - In a study by the Injury Control Research Center at Harvard School of Public Health, 11 percent of 123 youth suicide completers and 21 percent of 2,674 adults who died by suicide tested positive for the presence of an antidepressant; and
  - There is a need to further study use of antidepressants in children and adolescents.

31. Office of Comprehensive Services, *Report on the Utilization, Length of Stay and Expenditures in Residential Care by Locality for Children Served Through the CSA,* 2005.

Introduction

The 2005 Virginia General Assembly passed a budget line item within the Appropriations Act that required every locality to submit information on the utilization of residential facilities for treatment of children and length of stay in such facilities. The information is required to be submitted to OCS.

Report Methodology

Localities collected statistical data from the CSA data set. CSA data set contains quarterly data on demographic, service and placement information on approximately 15,000 children served by CSA. Localities used fourth quarter data for this report.

The collected data is separated into three schedules within the submitted report:

- Schedule one details the total number of children who at some point in FY04 resided in a residential setting;
- Schedule two details residential placements by three residential service options (foster care, special education or non-mandated residential services); and
- Schedule three compares residential expenditures to total pool fund expenditures on a local basis.

Statewide Summary

- One out of four CSA children received residential services. On average, children stayed in residential care for nine months;
- Over $133 million in CSA state and local pool funds were spent on children in residential care. The average local match was 37 percent and the average state share was 63 percent;
- Approximately $95.6 million was spent on secure residential treatment facilities and campus style residential programs; $35.8 million was spent on group homes; and $1.7 million was spent on psychiatric hospitals;
- There are multiple reasons why a community may have a relatively higher percentage of children placed in residential care than other communities:
  - CSA caseload for the community may be small, thus one or two children in residential care comprise a larger percentage of the total caseload than communities with more children;
  - Some smaller communities report that it is not economically feasible to develop specialized services locally for a small number of children;
  - Some communities report having access to a broader array of services locally or regionally, thus the children served through CSA are the ones requiring more intensive services; and
  - A residential care provider may be effectively serving the children in that community; and
- Many localities report the inability to effectively serve some CSA children in the community. Localities reported needing:
  - Community-based services to prevent placements of children in more restrictive settings outside of their communities than necessary;
  - Private and public providers who are willing to develop specialized, wraparound services tailored to meet the needs of difficult children and their families;

- Start-up funds across several communities to provide sufficient economies of scale to develop services;
- Expertise in conducting assessments, developing creative service plans and providing care coordination for children with serious emotional and/or behavioral problems and their families to effectively serve them in the community; and
- Clinical expertise to assess the necessity, appropriateness and effectiveness of continued placement in residential care and to assist with discharge planning to reduce length of stay.

32. State Executive Council, *Biennial Report*, December 2005.

Introduction

SEC is mandated to publish a report biennially. SEC is to report on Virginia's progress in providing comprehensive services to children, youth and families. The report also details a plan for providing comprehensive services over the next biennium.

Major Objectives of Report

- Provide a fiscal profile of expenditures for comprehensive service system. The profile includes current and past federal and state funding;
- Provide information on local comprehensive service systems. This also includes recommendations from local service delivery;
- Identify and establish goals for providing comprehensive services to children, youth and families. Goals will include estimated costs for implementation, establishing priorities for next biennium and report on past biennium goals and accomplishments; and
- Provide additional information on improving Virginia's comprehensive services system.

CSA Priorities and Progress in Virginia

- Allocation methodologies, reimbursement procedures and cost sharing formulas for localities;
- CSA state organization and structure;
- Strategies for increasing collection of federal reimbursement;
- Managing, evaluating and monitoring care in CSA;
- Managed care as an option for CSA;
- Negotiated statewide contracts for services purchased by state and local agencies;
- Coordinated collection of information among state agencies; and
- Projections of caseloads, service needs and costs.

Strategic Goals for Directing Service Delivery System for CSA in Virginia

- To develop policies that improve access to care for all at-risk and troubled youth and their families;
- To promote open communication, ownership and active participation among all CSA participants. This includes parents and their children, local and state decision-makers and government and private agencies;
- To maximize and efficiently utilize all available local, state, federal and private funding streams that are aligned with and complementary to CSA principles;
- To develop and implement a quality improvement program that uses customer feedback, client outcomes and program and fiscal data to improve the operation and management of CSA, OCS and SEC; and
- To develop program efficiencies and support that minimize CSA administrative processing and expenses at all levels.

Accomplishments and Improvements of CSA Service Delivery System

- *State organization*: SEC was restructured to include the SHHR as chairperson and two members of the Virginia General Assembly as members. An executive director was hired for OCS;
- *Program*: Recommendations for CSA system reform were provided to the Virginia General Assembly within a SEC's workgroup report. A new contract was negotiated for improving the utilization of management review of residential placements for CSA children. There was an increase in collaboration with CSA associations and providers at state and local levels;
- *Training, technical assistance and best practices*:
  - Additional technical assistance, peer consultation, best practices and CSA tool are being offered to local CSA providers. Other technical assistance will be provided to local CSA providers. This includes strength-based assessments, establishing goals and collaboration among teams; and

- SEC collaborated with various stakeholders to develop a model utilization management plan, individual family services plan and a standard provider contract. These plans included best practices.

- *Financing:* Several measures were taken to streamline, simplify and maximize funding for CSA:
  - DMAS added two levels of step-down care to residential coverage and treatment foster care case management;
  - DSS worked to allow localities to claim particular expenditures that were not previously allowed;
  - Grant announcements for localities are posted on the website of OCS;
  - New state general funds that were allocated by CSA are now given to the base allocations instead of being set aside to support supplemental requests; and
  - OCS made the process of requesting supplemental funds more streamlined; and
- *Management information*: New data sets were established to make the management of information more detailed and user-friendly. This includes providing demographic, service and expenditure information on all children under CSA service delivery systems, extending data reporting dates, enabling localities to access the statewide data set information, using a web based application to communicate all reporting information and implementing a system to allow localities to request increases electronically. Additionally, licensing information was added to the CSA web-based service fee directory.

33. **Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services, *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*, 2005.**

Introduction

Over the past several years, the Virginia 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, the 2003 Virginia General Assembly created the Child and Family Behavioral Health Policy and Planning Committee. The committee was directed to 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 committee is also charged with examining funding restrictions of CSA 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.

Funding Recommendations

- *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;
- *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; and
- *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 Virginia.

Non-Funding Recommendations

- Adopt children's behavioral health services as a very high priority. DMHMRSAS needs to emphasize through policy that children's behavioral health policies, plans and services are of the highest priority;
- Use CSA funding flexibly and creatively to develop additional services. SEC should authorize and encourage communities to use CSA funds more flexibly and creatively, including developing pilot projects to serve children with behavioral health needs more effectively at the same or lower cost;

- Suspend rather than end Medicaid benefits when youth enter juvenile justice facilities. DMAS should suspend rather than end Medicaid benefits when youth enter detention and prison facilities;
- Develop standards for case management. DMHMRSAS should develop case management standards for CSBs throughout Virginia;
- Coordinate and lead children's behavioral health services planning with other state agencies. DMHMRSAS is only one state agency among several including DMAS, DJJ, DSS, VDOE, OCS, VDH and DRS that play a role in the welfare of children in Virginia. DMHMRSAS should coordinate and lead the planning for children with behavioral health needs;
- Provide guidance to local offices to maximize children's behavioral health funding. DMHMRSAS should develop guidance document to help local offices maximize third party funding for children's behavioral health services;
- Expand the membership on the Child and Family Services Behavioral Health Policy and Planning Committee. The Virginia General Assembly should add DSS, VDOE, 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 FY07-08 biennium budget language reauthorizing the Committee;
- Make prevention activities a central focus. DMHMRSAS 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 health problems, but also to save money. Funding prevention services when children are young will reduce the cost of services to the state as they age; and
- 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 will 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.

34. State Executive Council Workgroup, Final Report: *The Relinquishment of Custody for the Purpose of Assessing Behavioral Health Treatment*, 2005.

Introduction

The 2004 Virginia General Assembly directed that SEC for CSA to investigate the reasons why parents relinquish custody of their children solely for the purpose of obtaining the necessary and appropriate mental health services. SEC established a workgroup to study this issue. The initial report from 2004 concluded that issues relating to the problem of custody relinquishment were too complex. The workgroup studied the problem for another year and presented final conclusions in 2005.

Finding

The problem results from inadequate access to and availability of prevention, early intervention and intensive mental health and substance abuse treatment services for children and adolescents.

Recommendations

- Recommend a legislative proposal to establish the Commonwealth's intent of providing behavioral health services without requiring custody relinquishment;
- Establish a task force to review the *Code* and make recommendations on necessary changes in order to make non-custodial agreements less adversarial;
- Remove the requirement of a criminal background check for parents with children who are under non-custodial foster care agreements. Amendments will be made to the *Code*;
- Revise the *Code* and interpret policies to ensure that youth receive adequate and necessary behavioral health treatment services; and
- Increase community service access by expanding the number of demonstration projections that implement System of Care models that focus on evidence-based practices and incorporate the use of diversion protocols.

Funding Recommendations

- Increase funding and fiscal incentives to encourage the development of community services statewide for mandated and non-mandated children;
- Increase funding for serving non-mandated children through the various state child-serving agencies;
- Provide access for local start-up funds to develop community services that prevent or return children from out-of-community placements; and
- Incorporate the use of diversion protocols as community-based services are expanded in communities.

35. Virginia Department of Medical Assistance Services, *Reimbursement of Educational Services within the Medicaid Residential Treatment Rate*, 2005.

Introduction

In 2004, the Virginia General Assembly directed the DMAS to modify the State Plan for Medical Assistance to include reimbursement for required tuition payments in the agency's reimbursement methodology for Medicaid-eligible residential services. DMAS was further directed to report on the regulatory changes necessary to implement this methodological change and any fiscal impact associated with this new approach.

In response, this study addressed two concerns:

- The utilization of federal funds for educational services that serve to relieve some fiscal stress at the local level; and
- The inclusion of educational services as a Medicaid-covered service. This would allow more children who are in need of educational services and residential treatment to access these services by a determination of medical eligibility rather than through local decision-making. These outcomes might vary from locality to locality.

Findings

- Under the current State Plan, Medicaid does not cover educational costs for recipients in residential care, regardless of CSA status;
- DMAS received guidance from the Centers for Medicare and Medicaid Services that the federal regulations make an exception for individuals under age 21 receiving inpatient psychiatric services as prescribed in an active treatment plan;
- Medicaid coverage of educational services already provided as part of the CSA residential treatment plan would result in a savings to the Commonwealth of roughly the existing cost. Payment through Medicaid would generate a 50 percent federal match, which would allow Virginia to reduce state and local expenditures for the existing recipients;
- Coverage of educational services would most likely result in some added cost relative to current spending overall. This would allow existing non-CSA children to have coverage for educational services; and
- DMAS projected an estimated 16 percent shift from CSA to non-CSA status as a result from general fund savings ($1.3 million). $6.4 million savings to CSA and $5.1 million cost to DMAS. This is based on the current known count of recipients of these services.

Recommendations

- Develop implementing regulations. Regulations and the State Plan would need to be modified to provide Medicaid coverage for educational services;
- Modify DMAS claims processing systems. It might be necessary to develop two sets of per diems for residential treatment providers. One would be for educational services and another would be without educational services; and
- Implement a timeline.

36. Virginia Joint Commission on Health Care, *Report on Mental Health Needs and Treatment of Young Minority Adults*, 2006.

Introduction:

The 2004 Virginia General Assembly directed the Joint Commission on Health Care to study the mental health needs and treatment of young minority adults in Virginia. The Commission developed a workgroup

to study this issue from 2004 to 2005. The workgroup concluded that the study will require one to two more years to address adequately the study issues.

Areas of Focus

- Estimate the number of mentally disabled young adults by gender, age and racial and ethnic classification by geographic regions in Virginia;
- Identify the prevailing mental health and emotional disorders and their etiology among minority young adults [and]...the mental health needs of minority citizens, particularly minority young adults in Virginia;
- Determine the number of racial and ethnic minority person who receive mental health treatment...and the facilities providing such care;
- Ascertain whether mental health providers are trained to provide culturally competent mental health treatment and the level of need for such treatment in Virginia; and
- Review federal and state laws and regulations...and identify the...extent to which medical records information may be disclosed to parents and family members to assist them in obtaining health, social services and mental health treatment for mentally disabled young adults. Recommend ways to provide information to allow family members to obtain services and treatment without resorting to involuntary commitment.

37. Office of Comprehensive Services, *Service Area Plan*, 2006.

Introduction

The Service Area Plan provides localities with resources, technical assistance and tools to effectively maintain a system of funding services for children who have emotional and behavioral problems and their families. The plan forecasts, budgets, reimburses and monitors funds that local governments use to purchase services for children and families under CSA.

Services Provided within Service Area

- Reimburse local government with the state's share of eligible services for children and families;
- Reimburse DMAS for eligible expenditures made by the Department on behalf of CSA;
- Maintain local government performance measures;
- Assist CPMTs to ensure that services and funding are consistent with the Commonwealth's policies of preserving families and providing appropriate services in the least restrictive environment;
- Provide communities with technical assistance on ways to control costs, the use of alternative funding sources, utilization management, administrative and fiscal issues;
- Provide support for uniform CSA assessment and reporting requirements; and
- Provide local government administrative funding opportunities.

Factors Impacting Service Area

- *Foster care PIP:* Increased responsibilities for serving foster care children will impact CSA. More than half of all CSA referrals come from local DSS (57 percent);
- *Medicaid:* The reliance on the increased use of Medicaid funding has been a major focus in the effort to reduce the increase in CSA costs. Since 2000, when Medicaid funding was incorporated into CSA, over $290 million in services have benefited from CSA. With discussions at the federal level focusing on limiting federal Medicaid costs, any policy changes that would reduce Medicaid reimbursement for CSA services will increase state and local CSA costs. Furthermore, FY05 actual levels for CSA Medicaid expenditures ($74M) fell significantly below budget projections ($100M). Because services required by CSA youth and families that cannot be funded by Medicaid must be paid for with CSA pool funds, should this shortfall continue or expand, additional CSA general funds will be required;
- *Title IV-E funding:* The loss in Virginia's ability to utilize certain federal Title IV-E funding could negatively impact CSA financially. DSS and the federal government are discussing the disallowance of certain Title IV-E federal reimbursement claims. The local services funded through this funding source have benefited CSA, offsetting state pool costs. Should the use of some of these funds be disallowed or limited, demand for CSA funds will increase; and
- *Availability of community services*: Due to the lack of an array of community services, many localities are not able to serve some children with emotional and behavioral problems in the most appropriate and effective ways. This often results in more restrictive care and higher costs. In FY04, more than one out of four CSA children (27 percent) received residential services, accounting for 47 percent of

all of CSA's pool expenditures. Without increasing access to less restrictive and less costly community services, CSA's costs will continue to increase.

Challenges

Local administrative funds have not increased since 2000. Currently, $1.6 million in state general funds are available for local governments to administer CSA. This level of administrative funding for a mandated program represents not even one percent of the $256 million in state and federal funds appropriated for CSA. In FY05, 95 of 131 localities, or almost 73 percent, received less than $10,375 in state funds to administer CSA. It is difficult with this level of financial support for localities to effectively administer this major human services program. The local administrative allocations are formula-based, as specified in the Appropriations Act, ranging from $12,500 to $50,000 inclusive of state funds and required local match.

Objectives

- Minimize the length of time when CSA child-specific dataset demographic and expenditure information is submitted to the state office after the end of the quarter;
- Maximize the number of CSA-funded youth served in community and family-based settings; and
- Ensure that resources are used efficiently and programs are managed effectively.

38. Office of Comprehensive Services, *Agency Strategic Plan*, 2006.

Introduction

OCS is charged with creating a collaborative system of services and funding that is child-centered, family-focused and community-based when addressing the strengths and needs of troubled and at-risk youths and their families in Virginia. This report provides customer trends and coverage on CSA services.

Findings

- In FY04, a total of 14,590 children received CSA services, consistent with the average of 14,825 children served annually during the prior six years, from 1998 to 2003;
- Baseline data is available for the first time on child demographics, services and funding through the new CSA dataset. OCS is now tracking trends and changes over time in children served;
- While the CSA population is varied, teenage males from high density localities are the typical recipient of CSA-funded services;
- Almost half of all CSA children had a mental health diagnosis and more than a third were on psychotropic medication;
- Multiple problems led children into CSA services: 39 percent due to parental neglect, physical abuse and caregiver incapacity; 17 percent for special education issues; 16 percent for behavioral problems; and eight percent for emotional problems;
- Three out of every ten new children coming into CSA had serious problems;
- More than one out of four children (27 percent) received residential services, accounting for 47 percent of expenditures;
- After five months of services, some improvement was observed in the functioning level of children;
- The lack of community-based services, including Medicaid providers for these services, has increased demand for pool fund dollars;
- There has been an increased demand for technical assistance and training from localities on consistent state policy guidance and best practices for implementing CSA; and
- There are increasing administrative demands on local governments for CSA.

Productivity

- In FY04, a total of 14,590 children received CSA services, which is consistent with the average of 14,825 children served annually during the prior six years from 1998 to 2003;
- Most CSA referrals come from local DSS (57 percent) and the schools (21 percent), since foster care and special education children represent mandated populations required by federal law to receive sum sufficient funding for needed services. Fewer referrals come from Court Service Units (8 percent) and from CSBs (5 percent);
- Baseline data is available for the first time on child demographics, services and funding due to implementation of a new CSA dataset. Historically, child-specific data was not available to assist the state and localities in tracking progress, identifying trends and making decisions;

- While the CSA population was varied in FY04, teenage males from high density localities were the typical recipient of CSA-funded services. Almost half of all CSA children had a mental health diagnosis and more than a third were on psychotropic medication. Multiple problems led children into CSA services: 39 percent due to parental neglect, physical abuse and caregiver incapacity; 17 percent for special education issues; 16 percent for behavioral problems; and 8 percent for emotional problems. Three out of every ten new children coming into CSA had serious problems;
- More than one out of four children (27 percent) received residential services, which accounts for approximately 47 percent of expenditures. 41 percent of all days purchased for children were for community-based care; 37 percent were for specialized care; and 22 percent were for residential care. Average per child spending during FY04 by service type was:
  - *Out-of-state placements*: $63,821;
  - *Restrictive care:* $32,816, including residential treatment facility, group home and hospital;
  - *Specialized care:* $16,615, including special education day placement and services, specialized foster care and therapeutic foster care; and
  - *Community care*: $4,153, including community-based interventions, counseling and independent living.
- The average annual rate of increase in total expenditures (state, local and Medicaid) during the past five years has been 10.3 percent. This is lower than the average annual rate of 11.8 percent during the preceding four years (1996 through 1999) prior to the introduction of Medicaid. This is also an improvement in expenditure growth prior to the creation of CSA. JLARC reported in 1998 that state and local program costs grew by 22 percent annually from FY89 to FY93 (except for one year from FY91 to FY92); and
- To date, over $268 million in CSA-connected services has been funded since the introduction of Medicaid. During FY04, localities screened 74 percent of cases for Medicaid and 59 percent for Title IV-E funds.

39. **Virginia Department of Medical Assistance Services, *Annual Report on CSA*, 2006.**
Report is pending.

Virginia Department of Social Services
http://www.dss.virginia.gov/pub/pdf/interstateguide.pdf

VIRGINIA'S GUIDE TO THE INTERSTATE COMPACT ON THE PLACEMENT OF CHILDREN

The ICPC (Interstate Compact on the Placement of Children) is the best means we have to ensure protection and services to children who are placed across state lines for foster care, residential treatment, or adoption. The ICPC, a uniform law that has been enacted by all fifty states, the District of Columbia and the Virgin Islands, establishes orderly procedures for the interstate placement of children and fixes responsibilities for those involved in placing the child.

WHY IS A COMPACT NEEDED?

Children placed out of the state need to be assured of the same protections and services that would be provided if they had remained in their home states. They must also be assured of a return to their original jurisdictions should placements prove not to be in their best interests or should the need for out-of-state services cease.

Both the great variety of circumstances which makes interstate placement of children necessary and the types of protections needed offer compelling reasons for a mechanism which regulates those placements. An interstate compact- a contract among the states that enact it- is one such mechanism. Under a compact, the jurisdictional, administrative, and human rights obligations of all the parties in an interstate placement can be protected.

HOW THE ICPC CAME ABOUT

The need for a compact to regulate the interstate movement of children was recognized in the 1950's. At that time, a group of East Coast social service administrators joined informally to study the problems of children moved out of state for foster care, residential treatment, and adoption. Among the problems they identified was the failure of importation and exportation statutes enacted by individual states to provide protection for children. They recognized that a state's jurisdiction ends at its borders and that a state can only compel an out-of-state agency or individual to discharge its obligations toward a child through a compact. The administrators were also concerned that a state to which a child was sent did not have to provide supportive services even though it might agree to do so as a courtesy. Without a compact, the reality was that all too frequently children were placed in unstudied, unlicensed, at risk environments and that no services were provided to protect these children or to promote permanency for them.

In response to these and other problems, the Interstate Compact on the Placement of Children (ICPC) was drafted, and in 1960 New York was the first state to enact it.

WHAT THE ICPC DOES

The ICPC law contains ten articles. They define the types of placements and placers subject to the law; the procedures to be followed in making an interstate placement; and

the specific protections, services, and requirements brought by enactment of the law. In Virginia, the text of the ICPC is found in the ***Code of Virginia*, 63.2-1000.** The implementation of the ICPC is found in the ***Code of Virginia*, 63.2-1100 through 63.2-1105.** (Web site link for ICPC law is at www.dss.state.va.us/family/interstate. Click on "ICPC External Link." See "Code of Virginia, Title 63.2, Chapters 10 and 11.")

The major provisions of the law are highlighted below.

Types of Placements Covered

The ICPC applies to four types of situations in which children may be sent to other states:

- Placements preliminary to an adoption.
- Placements into foster care, including foster homes, group homes, residential treatment facilities, and institutions.
- Placements with parents and relatives when a parent or relative is not making the placement.
- Placements of adjudicated delinquents in institutions in other states.

Who Must Use the ICPC?

The ICPC clearly spells out who must use the Compact when they "send, bring, or cause a child to be sent or brought" to another party state. These persons and agencies, called "sending agencies," are the following:

- A state party to the ICPC, or any officer or employee of the party state.
- A subdivision, such as a county or a city, or any officer or employee of the subdivision.
- A court of the party state.
- Any person (including parents and relatives in some instances), corporation, association, or charitable agency of a party state.

There are some placements of children into other states that are not subject to the ICPC. These exemptions are specified in the ICPC law. The ICPC does not include placements made into medical and mental facilities or in boarding schools or "any institution primarily educational in character" (see ICPC Article II (d) and ICPC Regulation No.4). (ICPC regulations are at the end of this guide.) ICPC Article VIII (a) also specifically excludes from Compact coverage the placement of a child made by a parent, stepparent, grandparent, adult brother or sister, adult uncle or aunt, or the child's non-agency guardian. This exclusion *only* applies when one of these close relatives places the child with another close relative enumerated in Article VIII. Because there are risks and penalties associated with making a placement in violation of the ICPC, the Virginia Interstate Placement Office is available to provide assistance in determining whether or not a child's proposed placement will need to be made through the Compact.

Safeguards Offered by the ICPC

In order to safeguard both the child and the parties involved in the child's placement, the ICPC:

- Provides the "sending agency" the opportunity to obtain home studies, licensing verification, or an evaluation of the proposed placement.
- Allows the prospective receiving state to obtain information sufficient to ensure that the placement is not "contrary to the interests of the child" and that its applicable laws and policies have been followed before it approves the placement.
- Guarantees the child legal and financial protection by fixing these responsibilities with the sending agency or individual.
- Ensures that the sending agency or individual does not lose jurisdiction over the child once the child moves to the receiving state.
- Provides the sending agency the opportunity to obtain supervision and regular reports on the child's adjustment and progress in placement.

These basic safeguards are routinely available when the child, the person, or responsible agency and the placement are all in a single state or jurisdiction. When the placement involves two states or jurisdictions, however, these safeguards are available only through the ICPC.

PROCEDURES FOR MAKING ICPC PLACEMENTS

When a state enacts the ICPC, it becomes law, just as any other legislation passed by a state legislature. When Virginia enacted the ICPC it agreed to follow uniform procedures when it makes or accepts interstate placements of children. As of 1990, every state, the District of Columbia and the Virgin Islands have all statutorily committed to the same requirements and procedures. Since the ICPC is also a contract among the party states as well as a statute in each of them, it must be interpreted and implemented uniformly by all of them.

Administering the ICPC

Each state appoints a Compact Administrator and one or more Deputy Compact Administrators who oversee or perform the day-to-day tasks associated with the administration of the ICPC. In every state, the Interstate Placement office and personnel are located in an office that is part of the department of public welfare or the state's equivalent agency. In Virginia, the ICPC is administered by the **Department of Social Services, 7 N. Eighth Street, Richmond, VA, 23219, Telephone: (800) 552-3431** . (See web site link for VA ICPC general information, Code, forms, publications at www.dss.state.va.us/family/interstate.) The Compact Administrator is designated to serve as the central clearing point for all referrals for interstate placements. The Administrator and his/her deputies are authorized to conduct the necessary investigation of the proposed placement and to determine whether or not the placement is contrary to the child's interests.

After the placement is approved and the child is moved into the state, the Compact Administrator is responsible for overseeing the placement as long as it continues.

[NOTE: The term "Compact Administrator" is used to designate both the person appointed pursuant to Article VII of the ICPC and those persons to whom the responsibility for day-to-day operation of the ICPC has been administratively designated.]

Recognizing a Placement Covered by the ICPC

Although the ICPC law is short, it may be confusing to persons unfamiliar with it. If you are considering placing a child into another state, the placement may be subject to the ICPC in the following general circumstances:

- If the state in which you (or your agency) reside and the state to which the child is to be sent (or from which the child is to be brought) are both party to the ICPC; and
- If you are not related to the child (or are not the child's non-agency guardian) or, if you are related, and you are sending the child to live with someone other than a close relative or non-agency guardian named in ICPC Article VIII(a) of the Compact; and
- If you are sending, bringing, or causing the child to be brought or sent into a party state, whether or not you have custody of the child, and without regard to the present location of the child (the child could even be in a foreign country); and
- If you are placing the child with someone or some agency other than a medical facility, a boarding school, or a mental health or mental retardation facility.

If the circumstances of the proposed placement fit into those described above, you should proceed according to the requirements of the ICPC. If you have any questions about whether or not the ICPC applies to your proposed placement plans or about how to comply, you may contact the ICPC office for advice.

Processing Referrals for Interstate Placements

When an interstate placement is being considered, the ICPC requires that the sending agency or individual provide written notice of the proposed placement to the Compact Administrator in the receiving state and request the receiving state's written permission to proceed prior to making the placement. This notice and supporting documents must first be submitted to the Interstate Compact office in the sending state to review for compliance with placement laws in the sending state.

This written notice is made on a standardized form ICPC-100A, "Interstate Compact Placement Request," available from all party states. This form serves as the formal contract between the sending agency and the receiving state. In Virginia, ICPC forms are available from the Virginia Interstate Compact office or your local social services agency. Forms are available at www.dss.state.va.us/family/interstate_form or at

www.dss.state.va.us/form/index. Scroll to "Foster Care." Scroll to Interstate Compact Form 100A and Form 100B.)

The precise documents required to complete an interstate placement request are dictated by the specific circumstances of the placement and the placement laws in the sending and receiving states. At a minimum, the request packet should include the child's social history; supplementary medical, psychological and educational information that will give a complete picture of the child's placement needs; court order(s) regarding the child's legal status; and a description of the placement plan for the child. In Virginia, an evaluation or home study of the proposed placement must be current- within one year- and conducted by a local social service agency or private child-placing agency licensed in Virginia.

The sending state's Interstate Compact Administrator then forwards the completed form ICPC-100A and supportive documentation to the prospective receiving state's Interstate Compact Administrator.

Upon receiving notice of the proposed placement from the Interstate Compact office in the sending state, the Interstate Compact Administrator in the receiving state will review the packet for compliance with the placement laws of the receiving state. The receiving state's Interstate Compact Administrator forwards the supportive documents to an appropriate party in the receiving state for further action. The "appropriate party" will usually be a local public agency, a private child placing agency, or the residential facility that is being asked to accept the child. The "action" needed on any particular request will vary depending upon the nature of the proposed placement, but may include a study of the prospective adoptive or foster family, confirmation of licensure, or a review by the facility to determine whether or not its program will meet the child's needs.

After the local agency has completed the necessary work, it prepares a report that includes a recommendation on whether or not the placement should be made. This report is returned to the Interstate Compact Administrator in the receiving state for review. If the local agency's recommendation is favorable and the Interstate Compact Administrator determines that all requirements of the receiving state's laws have been met, the placement will be approved. If, however, the local agency recommends against the placement or the Interstate Compact Administrator determines that the placement cannot lawfully be completed, the placement will be denied unless the problems can be remedied. In either case, the Interstate Compact Administrator notifies the sending state's Interstate Compact office and forwards copies for the sending agency.

Recommended Time Needed to Process Requests

Six weeks- 30 working days- is the recommended processing time from the date the receiving state's Interstate Compact Office receives the notice of the proposed placement until the date that the placement is approved or denied. However, referrals may take longer to process because of incomplete information or other work demands placed upon

the local agency in the receiving state or upon the Interstate Compact office. The Virginia Interstate Compact Office takes administrative action on cases in the order in which they are received. The office's goal is to respond to correspondence same day to within three business days of receipt. In the event of a child-related emergency, however, the Virginia Interstate Office will reassign priority to the case, and respond by the fastest means of communication.

Experience, especially in recent years, has shown that delays in the completion of home studies by the receiving state's local agencies are a significant problem across the nation. Sometimes the receiving state does not complete the home studies for many months. As a result, ICPC Regulation No.7, Priority Placement, was enacted in 1996 with the aim of achieving parity of treatment in fact for interstate and intrastate cases. It is also the objective to assure priority handling for hardship cases and for cases that have already suffered delay. (See Regulation 7 at the end of this guide or, see ICPC regulations at the VA ICPC web site link at www.dss.state.va.us/family/interstate_pub).

Making Arrangements for Child Placement

When the request to place a child has been approved by the receiving state, the sending agency and receiving parties work together to arrange the details of the actual placement. Final agreements (discussed at the time of referral) are entered into regarding payment for the child's care, the type of monitoring of the placement, and the frequency of supervisory reports to be provided to the sending agency.

After all plans and agreements have been completed, the child is moved to the receiving state. The sending agency notifies the receiving state of the placement by using form ICPC-100B. "Interstate Compact Report: Child Placement Status." (See web site link for VA ICPC forms at www.dss.state.va.us/family/interstate_form or at www.dss.state.va.us/form/index. Scroll to "Foster Care." See Interstate Form 100A or 100B)

The Sending Agency's Responsibilities

While the child remains in the out-of-state placement, the sending agency retains legal and financial responsibility for the child. This means that the sending agency has both the authority and the responsibility to determine all matters in relation to the "custody, supervision, care, treatment, and disposition of the child", just as the sending agency would have "if the child had remained in the home state." (See ICPC law, Article V(a) at www.dss.state.va.us/family/icpclinks. Click on "ICPC External Link." See "Code of Virginia, Title 63.2, Chapter 10, Interstate Compact on the Placement of Children.")

The sending agency's responsibilities for the child continue until it legally terminates the interstate placement. Legal termination of an interstate placement may only occur when the child is returned to the home state, the child is legally adopted, the child reaches the

age of majority or becomes self-supporting, or for other reasons with the prior concurrence of the receiving state's Compact Administrator. (ICPC law, Article V (a)).

The sending agency must notify the receiving state's Compact Administrator of any change in the child's status, again using the ICPC-100B. Changes of status may include a termination of the interstate placement, a change in the placement of the child in the receiving state, or the completion of an approved transfer of legal custody.

PENALTIES FOR ILLEGAL PLACEMENTS

Interstate placements made in violation of the law constitute a violation of the "laws respecting the placement of children of both the state in which the sending agency is located or from which it sends or brings the child and of the receiving state" (ICPC law, Article IV). Violators are subject to punishment or penalties in both jurisdictions in accordance with their laws. Legal imposition of penalties has been rare, but since 1980 there have been several court decisions in which children placed illegally were ordered returned to the sending state. Some of these cases have involved the dissolution of adoptive placements. Since Virginia agencies are required to inform the Court as to whether or not an interstate placement for the purpose of adoption has been made in compliance with the ICPC and since the requirements of the ICPC can be met in most cases, the wisest course of action is compliance.

RELATED COMPACTS

Three other compacts regulate certain types of interstate placements of children:

The **ICAMA Interstate Compact on Adoption and Medical Assistance)** ensures that adoptive parents of children with special needs receive the services and benefits provided for in their adoption assistance agreement, particularly medical assistance in interstate cases. It facilitates the delivery of benefits and services when families move during the continuance of the adoption assistance agreement or in cases when the child is initially placed for adoption across state lines. The Compact was developed in response to the mandate of the Adoption Assistance and Child Welfare Act of 1980 that directs states to protect the interstate interests of adopted children with special needs. ICAMA has been enacted by most states. Virginia is a member state. In Virginia, the text of the ICAMA is found in the ***Code of Virginia*, 63.2-1401 through 63.2-1405. The Department of Social Services administers the ICAMA in Virginia. For more information on the Virginia ICAMA, call (804) 692-1274 or 692-1279.**

The **ICJ (Interstate Compact on Juveniles)** permits interstate supervision of adjudicated delinquents on probation or parole and provides for the placement of certain juvenile delinquents in out-of-state public institutions. his Compact also authorizes the return of juvenile escapees and absconders to their home states, and is used to arrange the return of non-delinquent runaways to their homes. All 50 states and other jurisdictions, except

for Puerto Rico and the Virgin Islands, have enacted this Compact. In Virginia, the text of the Compact is found in the ***Code of Virginia*, 16.1-323 to 16.1-330. The Virginia ICJ is administered by the Department of Juvenile Justice. For more information on the Virginia ICJ, call (804) 692-0167.**

The **ICMH (Interstate Compact on Mental Health)** permits the transfer of mentally ill and mentally retarded children and adults from a public institution in one state to a public institution in another state. It may also be used to secure publicly provided aftercare services in another state. A patient transferred through this Compact becomes the full responsibility of the receiving state. The ICMH has been enacted by most states and jurisdictions. While Virginia is not formally a member of the ICMH, we participate in the transfer of patients into and out of the Commonwealth. In Virginia, the related Code of Virginia section is 37.1-91, Disposition of nonresidents. For additional information, contact the **Virginia Department of Mental Health, Mental Retardation & Substance Abuse Services at (804) 786-0040.**

ADDITIONAL INFORMATION:

For more information on the ICPC contact:

ICPC Secretariat
Interstate Compact on the Placement of Children
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This document has been adapted from the "Guide to the Interstate Compact on the Placement of Children 2002," prepared by the Secretariat to the AAICPC (Association of Administrators of the Interstate Compact on the Placement of Children).

Regulation No. 0.01

Forms

1. To promote efficiency in processing placements pursuant to the Interstate Compact on the Placement of Children (ICPC) and to facilitate communication among sending agencies, states and other concerned persons, the forms promulgated by the compact administrators, acting jointly, shall be used by all sending agencies, sending and receiving states, and others participating in the arranging, making, processing and supervision of placements.

2. ICPC forms shall be uniform as to format and substance, and each state shall make available a reference to where its forms may be obtained by the public.

3. The mandatory forms currently in effect are described below. These forms shall be reproduced in sufficient supply by each of the states to meet its needs and the needs of persons and agencies required to use them. Forms referenced in the preceding sentence, above, currently in effect are the following:

ICPC-100A "Interstate Compact Placement Request;"
ICPC-100B "Interstate Compact Report on Child's Placement Status;"
ICPC-100C "Quarterly Statistical Report: Placements Into An ICPC State;"
ICPC-100D "Quarterly Statistical Report: Placements Out Of An ICPC State;" and
ICPC-101 "Sending State's Priority Home Study Request."

4. Form ICPC-102 "Receiving State's Priority Home Study Request" is an optional form that is available for use.

5. Words and phrases used in this regulation have the same meanings as in the Compact, unless the context clearly requires another meaning.

6. This regulation is adopted pursuant to Article VII of the Interstate Compact on the Placement of Children by action of the Association of Administrators of the Interstate Compact on the Placement of Children at its annual meeting of April 29 through May 2, 2001; the regulation, as amended, was approved May 2, 2001 and is effective as of July 2, 2001.

(See web site link for VA ICPC Form 100A and Form 100B at www.dss.state.va.us/family/interstate_form and at www.dss.state.va.us/form/index. Scroll to "Foster Care." See Interstate Forms.)

Regulation No. 1

Conversion of Intrastate Placement into Interstate Placement; Relocation of Family Units

1. Regulation No. 1 as first effective May 1, 1973, is repealed and is replaced by the following:

2. A placement initially intrastate in character becomes an interstate placement subject to the Interstate Compact on the Placement of Children (ICPC) if the child's principal place of abode is moved to another state.

3. If the child is to be sent or brought to the receiving state more than forty-five (45) days in the future, the normal procedures of ICPC for an interstate placement shall be initiated. However, the ICPC-100A and the information accompanying it shall make it specific and clear that the relocation of a family unit is involved and that the family home is not yet in the receiving state. As much information as reasonably possible shall be given to the receiving state concerning the location and character of the intended family home in the receiving state.

4. (a) In any instance where the decision to relocate into another state is not made until forty-five (45) days or less before the date on which it is intended to send or bring the child to the receiving state, an ICPC-100A and its supporting documentation shall be prepared immediately upon the making of the decision, processed promptly by the sending agency's state compact administrator and transmitted to the receiving state compact administrator. The sending agency's state compact administrator shall request that the receiving state provide prompt handling of the case with due regard for the desired time for the child to be sent or brought to the receiving state.

(b) The documentation provided with a request for prompt handling shall include:

(1) A form ICPC-100A fully completed.

(2) A copy of the court order pursuant to which the sending agency has authority to place the child or, if authority does not derive from a court order, a statement of the basis on which the sending agency has authority to place the child.

(3) A case history for the child.

(4) In any instance where the sending state has required licensure, certification or approval, a copy of the most recent license, certificate or approval of the qualification of the custodian(s) and/or their home showing the status of the custodian(s), as qualified custodian(s).

(5) A copy of the most recent home study of the custodian(s) and any updates thereof.

(6) A copy of the child's permanency plan and any supplements to that plan.

(7) An explanation of the current status of the child's Title IV-E eligibility under the Federal Social Security Act.

(c) Requests for prompt handling shall be as provided in paragraph 4 (a) hereof. Some or all documents may be communicated by express mail or any other recognized method for expedited communication. The receiving state shall recognize and give effect to any such expedited transmission of an ICPC-100A and/or supporting documentation, provided that it is legible and appears to be a complete representation of the original. However, the receiving state may request and shall be entitled to receive originals or duly certified copies if it considers them necessary for a legally sufficient record under its laws.

(d) In an instance where a custodian(s) holds a current license, certificate or approval from the sending state evidencing qualification as a foster parent or other custodian, the receiving state shall give effect to such license, certificate or approval as sufficient to support a determination of qualification pursuant to Article III (d) of ICPC, unless the receiving state compact administrator has substantial evidence to the contrary. This provision applies to a case which meets the description set forth in paragraph 4 (b) of this regulation.

(e) The receiving state may decline to provide a favorable determination pursuant to Article III (d) of ICPC if its compact administrator finds that the child's needs cannot be met under the circumstances of the proposed relocation, or until it has the documentation identified in subparagraph (b) hereof.

(f) If necessary or helpful to meet time requirements, the receiving state may communicate its determination pursuant to Article III (d) to the sending agency and the sending agency's state compact administrator by "FAX" or other means of facsimile transmission. However, this may not be done before the receiving state compact administrator has actually recorded the determination on the ICPC-100A. The written notice (the completed ICPC-100A) shall be mailed or otherwise sent promptly to meet Article III (d) written notice requirements.

5. If submitted by a custodian(s), a receiving state shall recognize and give effect to evidence that the custodian(s) have satisfactorily completed required training for foster parents or other parent training. Such recognition and effect shall be given if:

(a) the training program is shown to be substantially equivalent to training offered for the same purpose in the receiving state; and

(b) the evidence submitted is in the form of an official certificate or other document identifying the training.

6. Nothing in this regulation shall be construed to alter the obligation of a receiving state to supervise and report on the placement; nor to alter the requirement that the custodian(s) comply with the licensing and other applicable laws of the receiving state after arrival therein.

7. A favorable determination made by a receiving state pursuant to Article 3 d) of the ICPC and this regulation means that the receiving state is making such determination on the basis of the best evidence available to it in accordance with the requirements of paragraph 4 b) of this regulation and does not relieve any custodian or other entity of the obligation to comply with the laws of the receiving state as promptly after arrival in the receiving state of the child as possible. If it is subsequently determined that the placement in the receiving state appears to be contrary to the interest of the child, the sending agency shall return the child or make an alternative placement as provided in Article 5(a) of the ICPC.

8. Within thirty (30) days of being notified by the sending state or by the custodian(s) that the custodian(s) and the child have arrived in the receiving state, the appropriate personnel of the receiving state shall make an initial contact with the custodian(s) to ascertain conditions and progress toward compliance with applicable laws and requirements of the receiving state.

9. Words and phrases used in this regulation have the same meanings as in the Compact, unless the context clearly requires another meaning.

10.This regulation is adopted pursuant to Article VII of the Interstate Compact on the Placement of Children by action of the Association of Administrators of the Interstate Compact on the Placement of Children at its annual meeting of April 1999.

Regulation No. 2 Repealed

This regulation, adopted May 25, 1977, relating to certain programs in which children could be placed in family homes to permit their attendance at local public schools was repealed by action taken at the annual meeting of the Association of Administrators of the Interstate Compact on the Placement of Children, April 1999.

Regulation No. 3

Placements with Parents, Relatives, Non-agency Guardians, and Non-family Settings

The following regulation, adopted by the Association of Administrators of the Interstate Compact on the Placement of Children, is declared to be in effect on and after July 2, 2001.

1. "Placement" as defined in Article II(d) includes the arrangement for the care of a child in the home of his parent, other relative, or non-agency guardian in a receiving state when the sending agency is any entity other than a parent, relative, guardian or non-agency guardian making the arrangement for care as a plan exempt under Article VIII (a) of the Compact.

2. "Conditions for Placement" as established by Article III apply to any placement as defined in Article II (d) and Regulations adopted by action of the Association of Administrators of the Interstate Compact on the Placement of Children.

3. The terms "guardian" and "non-agency guardian" have the same meanings as set forth in Regulation No. 10 of the Regulations for the Interstate Compact on the Placement of Children (ICPC).

4. The term "family free or boarding home" as used in Article II (d) of ICPC means the home of a relative or unrelated individual whether or not the placement recipient receives compensation for care or maintenance of the child, foster care payments, or any other payments or reimbursements on account of the child's being in the home of the placement recipient.

5. The term "foster care" as used in Article III of ICPC, except as modified in this paragraph, means care of a child on a 24-hour a day basis away from the home of the child's parent(s). Such care may be by a relative of the child, by a non-related individual, by a group home, or by a residential facility or any other entity. In addition, if 24-hour a day care is provided by the child's parent(s) by reason of a court-ordered placement (and not by virtue of the parent-child relationship), the care is foster care.

6. (a) Pursuant to Article VIII (a), this Compact does not apply to the sending or bringing of a child into a receiving state by the child's parent, stepparent, grandparent, adult brother or sister, adult uncle or aunt, or the child's guardian and leaving the child with any such relative or non-agency guardian in the receiving state, provided that such person who brings, sends, or causes a child to be sent or brought to a receiving state is a person whose full legal right to plan for the child: (1) has been established by law at a time

prior to initiation of the placement arrangement, and (2) has not been voluntarily terminated, or diminished or severed by the action or order of any court.

(b)The Compact does not apply whenever a court transfers the child to a non-custodial parent with respect to whom the court does not have evidence before it that such parent is unfit, does not seek such evidence, and does not retain jurisdiction over the child after the court transfers the child.

7. Placement of a child requires compliance with the Compact if such placement is with either of the following:

(a) any relative, person, or entity not identified in Article VIII of the Compact; or

(b) any entity not included in the definition of placement as specified in Article II (d) of the Compact.

8. If a court or other competent authority invokes the Compact, the court or other competent authority is obligated to comply with Article V (Retention of Jurisdiction) of the Compact.

9. Words and phrases used in this regulation have the same meanings as in the Compact, unless the context clearly requires another meaning.

10. This regulation is adopted pursuant to Article VII of the Interstate Compact on the Placement of Children by action of the Association of Administrators of the Interstate Compact on the Placement of Children at its annual meeting of April 29 through May 2, 2001; the regulation, as amended, was approved on May 2, 2001 and is effective as of July 2, 2001.

Regulation No. 4

Residential Placement

The following regulation was adopted by the Association of Administrators of the Interstate Compact on the Placement of Children on April 20, 1983, was readopted in 1999, was amended in 2001, and is declared to be effective, as amended, as of July 2, 2001.

1. In determining whether the sending or bringing of a child to another state is exempt from the provisions of the Interstate Compact on the Placement of Children by reason of the exemption for various classes of institutions in Article II (d), the following concepts and terms shall have the following meanings:

(a) "Primarily educational institution" means an institution which operates one or more programs that can be offered in satisfaction of compulsory school attendance laws, in which the primary purpose of accepting children is to meet their educational needs; and which does not do one or more of the following:

(1) accept responsibility for children during the entire year;

(2) provide or hold itself out as providing child care constituting nurture sufficient to substitute for parental supervision and control or foster care;

(3) provide any other services to children, except for those customarily regarded as extracurricular or cocurricular school activities, pupil support services, and those services necessary to make it possible for the children to be maintained on a residential basis in the aforementioned school program or programs.

(b) "Hospital or other medical facility" means an institution for the acutely ill which discharges its patients when they are no longer acutely ill, which does not provide or hold itself out as providing child care in substitution for parental care or foster care, and in which a child is placed for the primary purpose of treating an acute medical problem.

(c) "Institution for the mentally ill or mentally defective" minors means a facility which is responsible for treatment of acute conditions, both psychiatric and medical, as well as such custodial care as is necessary for the treatment of such acute conditions of the minors who are either voluntarily committed or involuntarily committed by a court of competent jurisdiction to reside in it. Developmentally disabled has the same meaning as the phrase "mentally defective."

(d) Treatment for a chronic mental or behavioral condition, as described in this regulation, that is 24-hour care away from the child's parental home is foster care as such term is used in Article III of ICPC.

2. (a) Admission for treatment of an acute condition includes the treatment and care of minors who are mentally ill or developmentally disabled and who require stabilization of such condition for short-term treatment. Such short term treatment is exempt from the Interstate Compact on the Placement of Children.

(b) Placement for treatment of a chronic condition includes the treatment and care of minors who may be mentally ill, emotionally ill, or developmentally disabled and require treatment beyond what was required for stabilization of the underlying acute condition. Treatment modalities for chronic conditions may include psychotherapy and psychopharmacology.

(c) Any placement of a minor for treatment of that minor's chronic mental or behavioral condition into a facility having treatment programs for acute and chronic conditions must be made pursuant to the Interstate Compact on the Placement of Children. The Interstate Compact on the Placement of Children becomes applicable once

the minor is placed for treatment of a chronic condition regardless of whether that child was originally placed in the same facility for treatment of an acute condition.

(d) A minor may be accepted into a residential treatment center without first having been in that facility for the treatment of an acute condition. An interstate placement of a minor into such a facility must be made pursuant to the Interstate Compact on the Placement of Children.

3. An institution for the mentally ill or developmentally disabled may accept a child for treatment and care without complying with ICPC, if the treatment and care and other services are entirely out-patient in character.

4. The type of funding source or sources used to defray the costs of treatment or other services does not determine whether the Interstate Compact on the Placement of Children applies. Such determination is made on a case-by-case basis.

5. The type of license, if any, held by an institution is evidence of its character, but does not determine the need for compliance with ICPC. Whether an institution is either generally exempt from the need to comply with the Interstate Compact on the Placement of Children or exempt in a particular instance is to be determined by the services it actually provides or offers to provide. In making any such determinations, the criteria set forth in this regulation shall be applied.

6. Words and phrases used in this regulation have the same meanings as in the Compact, unless the context clearly requires another meaning.

7. This regulation was amended pursuant to Article VII of the Interstate Compact on the Placement of Children by action of the Association of Administrators of the Interstate Compact on the Placement of Children at its annual meeting of April 29 through May 2, 2001; such amendment was approved on May 2, 2001 and is effective as of July 2, 2001.

Regulation No. 5

Central State Compact Office

Regulation No. 5 ("Central State Compact Office"), as first effective April 1982, is amended to read as follows:

1. It shall be the responsibility of each state party to the Interstate Compact on the Placement of Children to establish a procedure by which all Compact referrals from and to the state shall be made through a central state compact office. The Compact Office shall also be a resource for inquiries into requirements for placements into the state for children who come under the purview of this Compact.

2. The Association of Administrators of the Interstate Compact on the Placement of Children deems certain appointments of officers who are general coordinators of activities under the Compact in the party states to have been made by the executive heads of states in each instance wherein such an appointment is made by a state official who has authority delegated by the executive head of the state to make such an appointment. Delegated authority to make the appointments described above in this paragraph will be sufficient if it is either: specifically described in the applicable state's documents that establish or control the appointment or employment of the state's officers or employees; a responsibility of the official who has the delegated authority that is customary and accepted in the applicable state; or consistent with the personnel policies or practices of the applicable state. Any general coordinator of activities under the Compact who is or was appointed in compliance with this paragraph is deemed to be appointed by the executive head of the applicable jurisdiction regardless of whether the appointment preceded or followed the adoption of this paragraph.

3. Words and phrases used in this regulation have the same meanings as in the Compact, unless the context clearly requires another meaning.

4. This regulation was first effective on April 20, 1982; was amended as of April 1999; and is amended by the Compact Administrators, acting jointly and pursuant to Article VII of the Interstate Compact on the Placement of Children, at their annual meeting of April 2002, with such amendments effective after June 27, 2002.

Regulation No. 6

Permission to Place Child; Time Limitations, Reapplication

The following regulation, originally adopted in 1991 by the Association of Administrators of the Interstate Compact on the Placement of Children, is amended in 2001 and declared to be in effect, as amended, on and after July 2, 2001.

1. Permission to place a child given pursuant to Article III (d) of the Interstate Compact on the Placement of Children shall be valid and sufficient to authorize the making of the placement identified in the written document ICPC-100A, by which the permission is given for a period of six (6) months commencing on the date when the receiving state compact administrator or his duly authorized representative signs the aforesaid ICPC-100A.

2. If the placement authorized to be made as described in Paragraph 1. of this Regulation is not made within the six (6) months allowed therein, the sending agency may reapply. Upon such reapplication, the receiving state may require the updating of documents submitted on the previous application, but shall not require a new home study unless the laws of the receiving state provide that the previously submitted home study is too old to be currently valid.

3. If a foster care license, institutional license or other license, permit or certificate held by the proposed placement recipient is still valid and in force, or if the proposed placement recipient continues to hold an appropriate license, permit or certificate, the receiving state shall not require that a new license, permit or certificate be obtained in order to qualify the proposed placement recipient to receive the child in placement.

4. Upon a reapplication by the sending agency, the receiving state shall determine whether the needs or condition of the child have changed since it initially authorized the placement to be made. The receiving state may deny the placement if it finds that the proposed placement is contrary to the interests of the child.

5. Words and phrases used in this regulation have the same meanings as in the Compact, unless the context clearly requires another meaning.

6. This regulation was readopted pursuant to Article VII of the Interstate Compact on the Placement of Children by action of the Association of Administrators of the Interstate Compact on the Placement of Children at its annual meeting of April 1999; it is amended pursuant to Article VII of the Interstate Compact on the Placement of Children by action of the Association of Administrators of the Interstate Compact on the Placement of Children at its annual meeting of April 29 through May 2, 2001, was approved May 2, 2001, and is effective in such amended form as of July 2, 2001.

Regulation No. 7
Priority Placement

The following regulation adopted by the Association of Administrators of the Interstate Compact on the Placement of Children is declared to be in effect on and after July 2, 2001.

1. Words and phrases used in this regulation shall have the same meanings as those ascribed to them in the Interstate Compact on the Placement of Children (ICPC). A word or phrase not appearing in ICPC shall have the meaning ascribed to it by special definition in this regulation or, where not so defined, the meaning properly ascribed to it in common usage.

2. This regulation shall not apply to any case in the sending state wherein:

(a) the request for placement of the child is for licensed or approved foster family care or adoption; or

(b) the child is already in the receiving state in violation of ICPC.

3. Whenever a court, upon request, or on its own motion, or where court approval is required, determines that a proposed priority placement of a child from one state into

another state is necessary, the court shall make and sign an order embodying that finding. The court shall send its order to the Sending Agency within two (2) business days. The order shall include the name, address, telephone number, and if available, the FAX number, of the judge and the court. The court shall have the sending agency transmit, within three (3) business days, the signed court order, a completed Form 100A ("Request for Placement") and supporting documentation pursuant to ICPC Article III, to the sending state Compact Administrator. Within a time not to exceed two (2) business days after receipt of the ICPC priority placement request, the sending state Compact Administrator shall transmit the priority request and its accompanying documentation to the receiving state Compact Administrator together with a notice that the request for placement is entitled to priority processing.

4. The court order, ICPC-100A, and supporting documentation referred to in Paragraph Three (3) hereof shall be transmitted to the receiving state Compact Administrator by overnight mail together with a cover notice calling attention to the priority status of the request for placement. The receiving state Compact Administrator shall make his or her determination pursuant to Article III (d) of ICPC as soon as practicable but no later then twenty (20) business days from the date the overnight mailing was received and forthwith shall send the completed 100-A by FAX to the sending state Compact Administrator.

5. (a) If the receiving state Compact Administrator fails to complete action as the receiving state prescribed in Paragraph Four (4) hereof within the time period allowed, the receiving state shall be deemed to be out of compliance with ICPC. If there appears to be a lack of compliance, the court, which made the priority order, may so inform an appropriate court in the receiving state, provide that court with copies of relevant documentation in the case, and request assistance. Within its jurisdiction and authority, the requested court may render such assistance, including the making of appropriate orders, for the purpose of obtaining compliance with this Regulation and ICPC.

(b) The foregoing shall not apply if:

(1) within two (2) business days of receipt of the ICPC priority placement request, the sending state Compact Administrator determines that the ICPC request documentation is substantially insufficient, specifies that additional information is needed, and requests the additional documentation from the sending agency. The request shall be made by FAX, or by telephone if FAX is not available, or

(2) within two (2) business days of receipt of the ICPC priority placement request, the receiving state Compact Administrator notifies the sending state Compact Administrator that further information is necessary. Such notice shall specifically detail the information needed. For a case in which this subparagraph applies, the twenty (20) business day period for the receiving state Compact Administrator to complete action shall be calculated from the date of the receipt by the receiving state Compact Administrator of the information requested.

(c) Where the sending state court is not itself the sending agency, it is the responsibility of the sending agency to keep the court, which issued the priority order, informed of the status of the priority request.

6. A court order finding entitlement to a priority placement shall not be valid unless it contains an express finding that one or more of the following circumstances applies to the particular case and sets forth the facts on which the court bases its finding:

(a) the proposed placement recipient is a relative belonging to a class of persons who, under Article VIII (a) of ICPC could receive a child from another person belonging to such a class, without complying with ICPC and; (1) the child is under two (2) years of age; or (2) the child is in an emergency shelter; or (3) the court finds that the child has spent a substantial amount of time in the home of the proposed placement recipient.

(b) the receiving state Compact Administrator has a properly completed ICPC-100A and supporting documentation for over thirty (30) business days, but the sending agency has not received a notice pursuant to Article III (d) of ICPC determining whether the child may or may not be placed.

7. Time periods in this regulation may be modified with a written agreement between the court which made the priority order, the sending agency, the receiving state Compact Administrator, and the sending state Compact Administrator. Any such modification shall apply only to the single case to which it is addressed.

8. To fulfill its obligations under ICPC, a state and its local agencies must process interstate cases no less quickly than intrastate cases and give no less attention to interstate hardship cases than to intrastate hardship cases. If in doing so, a receiving state Compact Administrator finds that extraordinary circumstances make it impossible for it and its local agencies to comply with the time requirements set forth in this regulation, it may be excused from strict compliance therewith. However, the receiving state Compact Administrator shall, within two (2) business days of ascertaining inability to comply, notify the sending state Compact Administrator via FAX of the inability to comply and shall set forth the date on or before which it will complete action. The notice shall contain a full identification and explanation of the extraordinary circumstances which are delaying compliance.

9. Unless otherwise required or allowed by this regulation, all transmittals of documents or other written materials shall be by overnight express mail carrier service.

10. This regulation as first effective October 1, 1996, and readopted pursuant to Article VII of the Interstate Compact on the Placement of Children by action of the Association of Administrators of the Interstate Compact on the Placement of Children at its annual meeting of April 1999, is amended pursuant to Article VII of the Interstate Compact on the Placement of Children by action of the Association of Administrators of the Interstate Compact on the Placement of Children at its annual meeting of April 29 through May 2,

4. If the child's stay is intended to be for no longer than thirty (30) days and if the purpose is as described in Paragraph 2, it will be presumed that the circumstances constitute a visit rather than a placement.

5. A stay or proposed stay of longer than thirty (30) days is a placement or proposed placement, except that a stay of longer duration may be considered a visit if it begins and ends within the period of a child's vacation from school as ascertained from the academic calendar of the school. A visit may not be extended or renewed in a manner which causes or will cause it to exceed thirty (30) days or the school vacation period, as the case may be. If a stay does not from the outset have an express terminal date, or if its duration is not clear from the circumstances, it shall be considered a placement or proposed placement and not a visit.

6. A request for a home study or supervision made by the person or agency which sends or proposes to send a child on a visit and that is pending at the time that the visit is proposed will establish a rebuttable presumption that the intent of the stay or proposed stay is not a visit.

7. A visit as defined in this regulation is not subject to the Interstate Compact on the Placement of Children.

8. Words and phrases used in this regulation have the same meanings as in the Compact, unless the context clearly requires another meaning.

9. This regulation was first adopted as a resolution effective April 26, 1983; was promulgated as a regulation as of April 1999; and is amended by the Compact Administrators, acting jointly and pursuant to Article VII of the Interstate Compact on the Placement of Children, at their annual meeting of April 2002, with such amendments effective after June 27, 2002.

Regulation No. 10

Guardians

Regulation No. 10 ("Guardians"), as first adopted in 1999, is amended to read as follows:

1. Guardian Defined.

As used in the Interstate Compact on the Placement of Children (ICPC) and in this Regulation:

2001; the regulation, as amended, was approved on May 2, 2001 and is effective as of July 2, 2001.

Regulation No. 8

Change of Placement Purpose

1. An ICPC-100B should be prepared and sent in accordance with its accompanying instructions whenever there is a change of purpose in an existing placement, e.g., from foster care to preadoption even though the placement recipient remains the same. However, when a receiving state requests a new ICPC-100A in such a case, it should be provided by the sending agency and transmitted in accordance with usual procedures for processing of ICPC-100As.

2. Words and phrases used in this regulation have the same meanings as in the Compact, unless the context clearly requires another meaning.

3. This regulation as first effective April 30, 1997, is readopted pursuant to Article VII of the Interstate Compact on the Placement of Children by action of the Association of Administrators of the Interstate Compact on the Placement of Children at its annual meeting in April 1999.

Regulation No. 9

Definition of a Visit

Regulation No. 9 ("Definition of a Visit"), as first adopted in 1999, is amended to read as follows:

1. A visit is not a placement within the meaning of the Interstate Compact on the Placement of Children (ICPC). Visits and placements are distinguished on the basis of purpose, duration, and the intention of the person or agency with responsibility for planning for the child as to the child's place of abode.

2. The purpose of a visit is to provide the child with a social or cultural experience of short duration, such as a stay in a camp or with a friend or relative who has not assumed legal responsibility for providing child care services.

3. It is understood that a visit for twenty-four (24) hours or longer will necessarily involve the provision of some services in the nature of child care by the person or persons with whom the child is staying. The provision of these services will not, of itself, alter the character of the stay as a visit.

appointment shall be construed as a request that the sending agency and the receiving state concur in the discontinuance of the application of ICPC to the placement. Upon concurrence of the sending and receiving states, the sending agency and an appropriate court of the sending state shall close the ICPC aspects of the case and the jurisdiction of the sending agency pursuant to Article V (a) of ICPC shall be dismissed.

5. Guardian Appointed by Parent.

If the statutes of a jurisdiction so provide, a parent who is chronically ill or near death may appoint a guardian for his or her children, which guardianship shall take effect on the death or mental incapacitation of the parent. A nonagency guardian so appointed shall be deemed a nonagency guardian as that term is used in Article VIII (a) of ICPC, provided that such nonagency guardian has all of the powers and responsibilities that a parent would have by virtue of an unrestricted parent-child relationship. A placement with a nonagency guardian as described in this paragraph shall be effective for the purposes of ICPC without court appointment or confirmation unless the statute pursuant to which it is made otherwise provides and if there is compliance with procedures required by the statute. However, the parent must be physically present in the jurisdiction having the statute at the time that he or she makes the appointment or expressly submits to the jurisdiction of the appointing court.

6. Other Definitions of Guardianship Unaffected.

The definitions of "guardian" and "nonagency guardian" contained in this regulation shall not be construed to affect the meaning or applicability of any other definitions of "guardian" or "nonagency guardian" when employed for purposes or to circumstances not having a bearing on placements proposed to be made or made pursuant to ICPC.

7. Words and phrases used in this regulation have the same meanings as in the Compact, unless the context clearly requires another meaning.

8. This regulation was first promulgated in April 1999; it is amended by the Compact Administrators, acting jointly and pursuant to Article VII of the Interstate Compact on the Placement of Children, at their annual meeting of April 2002, with such amendments effective after June 27, 2002.

(a) "Guardian" means a public or private agency, organization or institution which holds a valid and effective permanent appointment from a court of competent jurisdiction to have custody and control of a child, to plan for the child, and to do all other things for or on behalf of a child which a parent would have authority and responsibility for doing by virtue of an unrestricted parent-child relationship. An appointment is permanent for the purposes of this paragraph if the appointment would allow the guardianship to endure until the child's age of majority without any court review, subsequent to the appointment, of the care that the guardian provides or the status of other permanency planning which the guardian has a professional obligation to carry out. Guardian also means an individual who is a non-agency guardian as defined in subparagraph (b) hereof.

(b) "Nonagency guardian" means an individual holding a currently valid appointment from a court of competent jurisdiction to have all of the authority and responsibility of a guardian as defined in subparagraph (a) hereof.

2. Prospective Adoptive Parents Not Guardians.

An individual with whom a child is placed as a preliminary to a possible adoption cannot be considered a non-agency guardian of the child, for the purpose of determining applicability of ICPC to the placement, unless the individual would qualify as a lawful recipient of a placement of the child without having to comply with ICPC as provided in Article VIII (a) thereof.

3. Effect of Guardianship on ICPC Placements.

(a) An interstate placement of a child with a nonagency guardian, whose appointment to the guardianship existed prior to consideration of the making of the placement, is not subject to ICPC if the sending agency is the child's parent, stepparent, grandparent, adult brother or sister, or adult uncle or aunt.

(b) An appropriate court of the sending agency's state must continue its jurisdiction over a non-exempt placement until applicability of ICPC to the placement is terminated in accordance with Article V (a) of ICPC.

4. Permanency Status of Guardianship.

(a) A state agency may pursue a guardianship to achieve a permanent placement for a child in the child welfare system, as required by federal or state law. In the case of a child who is already placed in a receiving state in compliance with ICPC, appointment of the placement recipient as guardian by the sending state court is grounds to terminate the applicability of the ICPC when the sending and receiving state compact administrators concur on the termination pursuant to Article V (a). In such an instance, the court which appointed the guardian may continue its jurisdiction if it is maintainable under another applicable law.

(b) If, subsequent to the making of an interstate placement pursuant to ICPC, a court of the receiving state appoints a non-agency guardian for the child, such

REV. 8/2001

COMMONWEALTH OF VIRGINIA
INTERSTATE COMPACT ON THE PLACEMENT OF CHILDREN REQUEST

Please type

Appendix D

TO: **FROM:**

SECTION I – IDENTIFYING DATA

Notice is given of intent to place - Name of Child:

Social Security Number:

ICWA Eligible ☐ Yes ☐ No

Sex:

Date of Birth

Title IV-E determination ☐ Yes ☐ No ☐ Pending

Ethnicity: Hispanic Origin: ☐ Yes ☐ No ☐ Unable to determine/unknown

Race:
☐ American Indian or Alaskan Native
☐ Asian
☐ Native Hawaiian/ Other Pacific Islander
☐ Black or African American
☐ White

Name of Mother:

Name of Father:

Name of Agency or Person Responsible for Planning for Child:

Phone:

Address:

Name of Agency or Person Financially Responsible for Child:

Phone:

Address:

SECTION II - PLACEMENT INFORMATION

Name of Person(s) or Facility Child is to be placed with:

Soc Sec # (optional):
Soc Sec # (optional):

Address:

Phone:

Type of Care Requested:

☐ Foster Family Home
☐ Group Home Care
☐ Child Caring Institution
☐ Residential Treatment Center
☐ Institutional Care-Article VI, Adjudicated Delinquent
☐ Parent
☐ Relative (Not Parent)
Relationship: _____
☐ Other: _____

☐ ADOPTION
☐ IV-E Subsidy
☐ Non IV-E Subsidy
To Be Finalized In:
☐ Sending State
☐ Receiving State

Current Legal Status of Child:

☐ Sending Agency Custody/Guardianship
☐ Parent Relative Custody/Guardianship
☐ Court Jurisdiction Only
☐ Protective Supervision
☐ Parental Rights Terminated-Right to Place for Adoption
☐ Unaccompanied Refugee Minor
☐ Other:

SECTION III – SERVICES REQUESTED

Initial Report Requested (if applicable):

☐ Parent Home Study
☐ Relative Home Study
☐ Adoptive Home Study
☐ Foster Home Study

Supervisory Services Requested:

☐ Request Receiving State to Arrange Supervision
☐ Another Agency Agreed to Supervise
☐ Sending Agency to Supervise

Supervisory Reports Requested:

☐ Quarterly
☐ Semi-Annually
☐ Upon Request
☐ Other:

Name and Address of Supervising Agency in Receiving State:

Enclosed: ☐ Child's Social History ☐ Court Order ☐ Financial/Medical Plan ☐ Other Enclosures
☐ Home Study of Placement Resource ☐ ICWA Enclosure ☐ IV-E Eligibility Documentation

Signature of Sending Agency or Person:

Date:

Signature of Sending State Compact Administrator, Deputy or Alternate:

Date:

SECTION IV - ACTION BY RECEIVING STATE PURSUANT TO ARTICLE III(d) of ICPC

☐ Placement may be made ☐ Placement shall not be made

REMARKS:

Signature of Receiving State Compact Administrator, Deputy or Alternate:

Date:

DISTRIBUTION (Complete six (6) copies):

032-02-042/2

- Sending Agency retains a (1) copy and forwards completed original plus four (4) copies to:
- Sending Compact Administrator, DCA, or alternate retains a (1) copy and forwards completed original and three (3) copies to:
- Receiving Agency Compact Administrator, DCA, or alternate who indicates action (Section IV) a[illegible]rwards a (1) copy to receiving agency and the completed original and one (1) copy to sending Compact Administrator, DCA, or alternate within 30 days.
- Sending Compact Administrator, DCA, or alternate retains a completed copy and forwards the co[illegible]ted original to the sending agency.

ICPC 100B
REV. 8/2001
Appendix E

One form per child
Please type

COMMONWEALTH OF VIRGINIA
INTERSTATE COMPACT ON THE PLACEMENT OF CHILDREN
REPORT ON CHILD'S PLACEMENT STATUS

TO: **FROM:**

SECTION I - IDENTIFYING INFORMATION

Child's Name: _____ Birthdate: _____

Mother's Name: _____ Father's Name: _____

SECTION II - PLACEMENT STATUS

☐ Initial Placement of Child in Receiving State **Date Child Placed in Receiving State:** _____

Name of Resource: _____

Address: _____

Type of Care: _____

☐ Placement Change Effective Date of Change: _____

Name of Resource: _____

Address: _____

Type of Care: _____

SECTION III – COMPACT PLACEMENT TERMINATION

☐ Adoption Finalized ☐ In Sending State ☐ In Receiving State ☐ Court Order Attached

☐ Child Reached Majority/Legally Emancipated

☐ Legal Custody Returned to Parent(s) ☐ Court Order Attached

☐ Legal Custody Given to Relative ☐ Court Order Attached

Name: _____ Relationship: _____

☐ Treatment Completed

☐ Sending State's Jurisdiction Terminated with the Concurrence of the Receiving State

☐ Unilateral Termination

☐ Child Returned to Sending State

☐ Child Has Moved to Another State

☐ Proposed Placement Request Withdrawn

Name of Placement Resource: _____

☐ Approved Resource Will Not Be Used for Placement

Name of Approved Placement : _____

☐ Other (Specify): _____

Date of Termination: _____

SECTION IV – SIGNATURES

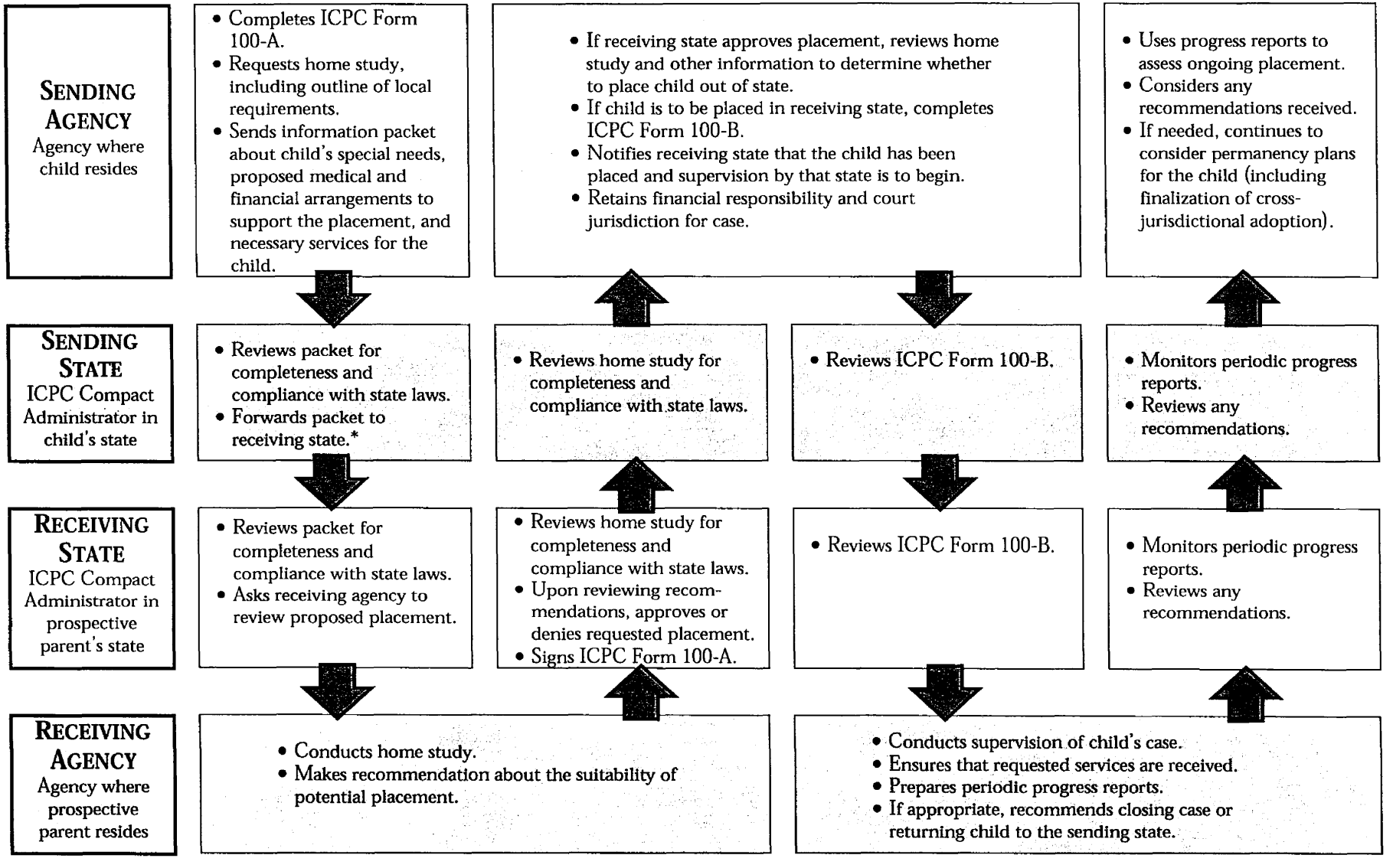
Person/Agency Supplying Information: Date:

Compact Administrator, Deputy or Alternate: Date:

DISTRIBUTION (Complete four (4) copies of this form):
- Sending Agency retains a (1) copy and forwards completed original plus three (3) copies to:
- Sending Compact Administrator, DCA, or alternate retains one (1) copy and forwards two (2) copies to:
- Receiving Agency Compact Administrator, DCA, or alternate retains one (1) copy and forwards one (1) copy to the receiving agency

032-02-210 /2

The ICPC Process to Place a Foster Child Out of State:
A Flowchart of Stakeholders' Responsibilities



** Note: In a few states, responsibility for contacting the receiving state has been delegated to the sending agency. In those locations, the ICPC state compact administrator receives copies of documents but does not forward them.*

Adapted from the GAO's November 1999 report,
HHS Could Better Facilitate the Interjurisdictional Adoption Process

VOLUME VII
SECTION III

TABLE OF CONTENTS

- Guarantee the child legal and financial protection by fixing these responsibilities with the sending agency or party.

- Ensure that the sending agency or party does not lose jurisdiction over the child once the child moves to the receiving state.

- Provide the sending agency the opportunity to obtain supervision and regular reports on the child's adjustment and progress in the placement.

1. TYPES OF PLACEMENTS AND REQUESTS COVERED BY THIS CHAPTER:

   a. Placements preliminary to adoption

   b. Placements into foster care, including foster homes, group homes, residential treatment facilities and institutions, and independent living settings

   c. Placements with parents and relatives when a party other than a parent or exempt relative is making the placement

   d. Placements of adjudicated delinquents in institutions in other states

   e. Placements facilitated by courts for children found to be abused, neglected, or in need of services

   f. Requests for home evaluations which may or may not be expected to result in a placement.

2. TYPES OF PLACEMENTS AND REQUESTS NOT COVERED BY THIS CHAPTER:

   a. Placements in which the child is both sent and received by one of the following relatives:

      1) Parent
      2) Step-parent
      3) Grandparent
      4) Adult brother or sister
      5) Adult uncle or aunt
      6) Non-agency guardian

b. Requests for custody investigations in divorce cases.

c. Requests for transfer of custody from one relative to another when both parties are in agreement.

d. Protective service referrals.

e. Visits out of state lasting 30 days or less.

3. STEPS REQUIRED FOR PLACING VIRGINIA CHILDREN WITH FAMILIES IN OTHER STATES:

a. The sending agency sends the Virginia ICPC Office the following:

1) The Interstate Compact Application Request to Place a Child (ICPC-100A),

2) Social information on the child with assistance on the ICPC-101: Outline for Child's Summary, in triplicate,

3) Background information on the family with whom the child is to be placed for foster home or adoptive placement,

4) Medical and psychological reports on the child, and

5) School reports on the child.

b. ICPC Office reviews and sends material to the Interstate Office in the receiving state for forwarding to the appropriate local agency.

c. The local agency in the receiving state completes and sends back to its Interstate Office the following:

1) Evaluation of the family with whom the child is to be placed,

2) Any additional information indicated in the request,

3) Recommendation as to the suitability of the proposed placement, and

4) Agreement to provide supervision as requested.

d. The Interstate Office in the receiving state determines the suitability of the proposed placement and indicates approval or denial by completing the ICPC-100A's. The evaluation and ICPC-100A's are returned to the Virginia ICPC Office.

e. The Virginia ICPC Office forwards the evaluation and ICPC-100A's to the sending agency.

1) When approval to place is granted, arrangements are to be made directly with the local agency for travel, placement of the child and supervision. The sending agency submits ICPC-100B, Report of Placement Status of Child, indicating date placement was made.

2) The law prohibits placement when approval is denied.

f. Adoptive placements are required to have three supervisory visits within six months. Placements with relatives or foster parents are supervised as needed and reports filed on a quarterly basis.

g. Supervisory reports are sent by the local agency in the receiving state to its Interstate Office for forwarding to the Virginia ICPC Office and then to the sending agency.

h. Reports of changes in the child's placement status, such as change of address, termination of placement or transfer of custody, are reported by local agencies on the ICPC-100B

i. Termination occurs when an adoption is finalized or when the Interstate Office in the receiving state agrees to the sending agency's termination or transfer of custody.

j. Until lawful termination occurs, the sending agency is required by Article V of the Compact to retain jurisdiction over any child placed out of state ". . . sufficient to determine all matters in relation to the custody, supervision, care, treatment and disposition of the child which it would have had if the child had remained in the sending agency's state . . .".

4. STEPS REQUIRED FOR PLACING CHILDREN FROM OTHER STATES WITH VIRGINIA FAMILIES

a. Interstate Office in the sending state forwards the ICPC-100A's and social summary information to the Virginia ICPC Office.

b. Virginia ICPC Office reviews material and forwards request to the appropriate local agency (now the "receiving agency").

c. Upon notification from the Virginia ICPC Office that the necessary forms have been received, the receiving agency should complete and submit in triplicate to the Virginia ICPC Office the following:

1) Evaluation of the family with whom the child is to be placed,

2) Any additional information indicated in the request,

3) Recommendation as to the suitability of the proposed placement,

4) Agreement to provide supervision as requested.

d. The Virginia ICPC Office approves or denies the proposed placement on the ICPC-100A's, and forwards copies to the receiving agency and the Interstate Office in the sending state.

e. If the Virginia ICPC approves the placement, the sending agency will make travel and placement plans directly with the receiving agency.

f. The receiving agency is responsible for regular supervisory contacts with the child and family. Supervisory reports are to be submitted in triplicate to the Virginia ICPC Office for forwarding to the sending state.

g. The receiving agency must continue supervision until the adoption is finalized or the sending agency has obtained Virginia's ICPC permission to terminate its jurisdiction over the child.

5. OUT-OF-STATE RESIDENTIAL PLACEMENTS

An agency must have the Commissioner's approval to place a child in a residential facility outside Virginia. The agency must document that:

- the placement is in the child's best interests,
- no appropriate placement is available in Virginia, and
- no appropriate placement is available outside Virginia that is closer to the child's community.

The documentation is to be developed by contacting all apparently appropriate in-state facilities, both public and private, prior to requesting approval to place a child out-of-state.

a. Time Frames for Requesting Commissioner's Approval

1) The sending agency must request approval 30 days prior to the anticipated date of placement (see 5.d. below).

2) The sending agency will be notified of the Commissioner's decision within a week after the request is received.

b. Facilities Which Require Commissioner's Approval

1) Group homes
2) Treatment centers
3) Child caring institutions
4) Boarding schools
5) Maternity homes
6) Hospitals and medical facilities

c. Steps to be Taken Prior to Requesting Commissioner's Approval

1) The sending agency must consult with other local agencies to see if the child's needs can be met by outpatient or day services. Agencies which should be consulted are Corrections, Mental Health and Mental Retardation, Vocational Rehabilitation and the child's school division.

If the child has been receiving special education services, a copy of the IEP (Individual Educational Program) should be obtained. If an eligibility determination for special education has not been done, a request for one should be made, if appropriate.

2) The agency should consult resource directories and VACIS for appropriate in-state facilities.

3) A telephone call should be made to the ICPC Office for additional suggestions.

d. Steps for Requesting Commissioner's Approval

1) The Child Profile form must be used to document the lack of appropriate in-state facilities. Written requests should be made to any seemingly appropriate in-state facility asking that the child be considered for admission.

2) A proposed out-of-state placement may be justified when the facility is geographically closer to the child's community than similar in-state facilities. When this is the case:

a) documenting the lack of appropriate in-state facilities is not required, and

b) the placement must be shown to be in the child's best interests because it allows the child to have ongoing contact with his family and/or community.

3) The sending agency must send a social summary, ICPC-100A's, and results of any diagnostic evaluations and recommendations to the Virginia ICPC Office. These reports should include the following:

a) Physical examination

b) Psychological testing

c) Psychiatric testing, when indicated

d) IEP or educational evaluation

e) A written statement from the local MH/MR agency indicating that admission to a state MH/MR facility is not appropriate.

4) The sending agency will be notified of the Commissioner's decision within a week after receiving the material listed above.

5) If the Commissioner approves the placement request, the sending agency must contact the Purchase of Services Unit, Virginia Department of Social Services, to see if the out-of-state facility meets criteria for payment. The agency may then apply for the child's admission.

6) Pertinent material and ICPC-100A's will be sent to the receiving state by the Virginia ICPC Office. The child cannot be placed until approved ICPC-100A's are returned by the receiving state.

e. Responsibilities of the Sending Agency After ICPC Approval

1) Arranging admission date and travel to the out-of-state facility.

2) Obtaining a written service plan from the facility within 30 days of the child's admission. This plan must describe the facility's treatment goals for the child and the estimated completion time for the goals. A copy of the plan must be submitted to the Virginia ICPC Office.

3) Securing quarterly progress reports from the facility and sending these reports to the Virginia ICPC Office.

4) Visiting the child in the facility on a semi-annual basis and notifying the Virginia ICPC Office of visit dates.

5) Notifying the Virginia ICPC Office of any changes in the child's placement status by submitting the ICPC-100B.

f. Failure to comply with Items c., d. and e. of this category precludes reimbursement from State and/or federal funds for the cost of placement.

6. OUT-OF-STATE INDEPENDENT LIVING PLACEMENTS

Independent living placements include:

- Facilities which develop skills needed to live without daily, substitute parental supervision, and

- Placements of children 16 years of age or older into college, vocational training programs or employment, apartment or boarding home settings.

Out-of-state independent living placements require the Commissioner's approval. Time frames as stated for Residential Placements apply to independent living placements.

a. Steps for Requesting Commissioner's Approval for Independent Living Placements

1) Social summary and other information must document the need for the proposed placement. The sending agency must send this documentation and ICPC-100A's to the Virginia ICPC Office.

2) The sending agency will be notified of the Commissioner's decision within a week after receiving the request.

3) If the request is approved by the Commissioner, the ICPC Office will forward necessary material to the receiving state. The child cannot be placed until approved ICPC-100A's are returned by the receiving state.

b. Responsibilities of the Sending Agency After ICPC Approval

1) Arranging travel to the out-of-state independent living placement.

2) Obtaining written progress reports from the placement program. If the program does not provide supervision, the sending agency is responsible for preparing progress reports. Reports are to be sent to the Virginia ICPC Office on a semi-annual basis.

3) Visiting the child in the program on a semi-annual basis and notifying the Virginia ICPC Office of visit dates.

4) Notifying the Virginia ICPC Office of changes in the child's placement status by submitting the ICPC-100B.

7. INTERCOUNTRY PLACEMENTS

The Immigration and Naturalization Service relies on a state's provisions in accordance with its child welfare laws prior to a United States citizen's bringing of any foreign child into such state. Such provisions are intended to ensure that foreign children entering the United States are provided the same rights and protections as children born in the United States.

a. Intercountry Placements are Initiated When:

1) A United States based agency having offices in a foreign country wishes to place a child in its custody into a Virginia home.

2) The child is in the custody of an agency located in another country or child's placement is initiated by a court in another country.

3) A licensed child placing agency in Virginia wishes to place a child in its custody in a home outside the United States.

b. Steps for Completing Intercountry Placements When the Child is in the Custody of U. S. Based Agency Having Offices in a Foreign Country

1) After receiving an application from prospective adoptive parents residing in Virginia, the United States based agency requests a home study of the family.

2) The request is made through the Virginia Interstate Compact Office (ICPC), Department of Social Services, and forwarded to:

a) the Virginia Social Services agency in whose jurisdiction the family lives, or

b) a private licensed child placing agency of the family's choosing.

3) The public or private agency evaluates the family and sends a home study and recommendation to the Virginia ICPC Office for forwarding to the child placing agency.

4) If the public or private agency recommends approval of the home, the child placing agency selects a child for the family. The child placing agency forwards all social and medical information about the child to the ICPC Office.

5) The ICPC Office sends information on the child to the public or private agency who will have the responsibility for presenting the information to the family.

6) The ICPC Office requests the child placing agency to submit the "Interstate Compact Application Request to Place a Child" (ICPC-100A) when the family agrees to accept the child.

7) Responsibilities of the public or private agency when the child arrives in Virginia include:

a) Making supervisory visits as required in accordance with adoption statute (Section 63.1-229, Code of Virginia).

b) Sending reports of supervisory visits to the ICPC Office.

8) The placing agency may give consent for the child to be adopted when:

a) Six months have elapsed since the placement was made,

b) The family expresses willingness to proceed with adoption, and

c) Supervisory reports from the public or private agency indicate that the relationship between the parent(s) and the child is firmly established.

c. Steps for Completing Intercountry Placements When a Child is in the Custody of a Foreign Agency or When Placement is Initiated by a Foreign Court

1) A home study is completed by a licensed placing agency or such foreign agencies or persons so authorized by the ICPC Office.

2) The home study and recommendation are sent in triplicate to the ICPC Office.

3) A narrative summary on the child along with a certified translation are sent in triplicate to the ICPC Office. This summary is to include:

a) Background information on the child,

b) Current medical information on the child, and

c) Information on the natural parents.

4) Copies of documents along with certified translations regarding termination of both parents' parental rights are to be obtained and forwarded to the ICPC Office.

5) Documentation along with certified translation describing the foreign agency's authority to place is forwarded to the ICPC Office and must indicate that:

a) The agency is licensed to receive or place children for adoption; or,

b) The agency is authorized to receive and place children for adoption according to the laws of the country.

6) Certified translations of all court documents regarding the child's custody and authorization to leave the foreign country are forwarded to the ICPC Office.

7) A statement of financial responsibility is submitted to the ICPC Office and is to include:

a) Name of the child for whom approval is being sought

b) Name and address of the person or agency responsible for cost of care of the child should the placement disrupt.

8) When the required documentation is received, the ICPC Office issues the Commissioner's consent to the placement.

9) The Virginia ICPC Office submits a copy of the Commissioner's consent to the Immigration and Naturalization Service indicating that Virginia's pre-adoptive requirements have been met.

10) When the child is placed with the family, the Virginia ICPC Office is notified by:

a) the Virginia agency providing services and

b) the family with whom the child is placed.

d. Filing the Petition to Adopt

1) When the child-placing agency consents to the adoption, the family files a petition to adopt.

2) The Virginia ICPC Office is responsible for:

a) notifying the respective agencies that a petition has been filed, and

b) transferring the record to the Adoption Reports Section for completion of the adoption in accordance with Chapter 11 of the Code of Virginia.

e. Birth Certificates for Foreign-Born Children

The Virginia State Registrar of Vital Records in the State Health Department will establish a Virginia birth certificate for a child born in a foreign country upon receipt of the following:

1) A request from the adoptive family that a certificate be established,

2) A report of Adoption (VS-21) to be provided by the petitioners' attorney or the petitioners when acting in their own behalf, and

3) The established Bureau of Vital Records fee.

f. Placements of Children in the Custody of a Licensed Virginia Agency Into Another Country

This type of placement is handled on an individual basis according to:

1) The procedures outlined on pages 3-5, "STEPS REQUIRED FOR PLACING VIRGINIA CHILDREN WITH FAMILIES IN OTHER STATES," and

2) The rules and regulations of the country involved.

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF WELFARE

INTERSTATE COMPACT APPLICATION CHILD PLACEMENT REQUEST

ICPC – 100A

NAME AND ADDRESS OF COMPACT ADMINISTRATOR FOR RECEIVING STATE

TO:

FROM: NAME AND ADDRESS OF COMPACT ADMINISTRATOR FOR SENDING STATE

SECTION I SENDING DATA

APPROVAL IS REQUESTED FOR THE PLACEMENT OF CHILD'S NAME | BIRTHDATE

MOTHER'S NAME | FATHER'S NAME

NAME OF AGENCY OR PERSON RESPONSIBLE FOR PLANNING FOR CHILD | NAME OF AGENCY OR PERSON FINANCIALLY RESPONSIBLE FOR CHILD

ADDRESS | ADDRESS

CITY STATE ZIP | CITY STATE ZIP

TELEPHONE NUMBER | TELEPHONE NUMBER

SECTION II PROPOSED PLACEMENT

NAME OF PERSON CHILD IS TO BE PLACED WITH

TYPE OF CARE
- ☐ FOSTER FAMILY CARE
- ☐ GROUP HOME CARE
- ☐ RESIDENTIAL TREATMENT CENTER
- ☐ INSTITUTIONAL CARE
- ☐ ADOPTION
- ☐ INDEPENDENT LIVING PLACEMENT
- ☐ PLACEMENT WITH RELATIVE

SPECIFY RELATIONSHIP

ADDRESS

CITY STATE ZIP

TELEPHONE NUMBER

ADOPTION TO BE COMPLETED IN
- ☐ SENDING STATE
- ☐ RECEIVING STATE

SECTION III SUPERVISION

- ☐ SENDING AGENCY REQUESTS RECEIVING AGENCY TO ARRANGE SUPERVISION
- ☐ SENDING AGENCY TO SUPERVISE
- ☐ AGENCY IN RECEIVING STATE HAS AGREED TO SUPERVISE

NAME AND ADDRESS OF SUPERVISING AGENCY IN RECEIVING STATE

REPORTS REQUESTED
- ☐ QUARTERLY
- ☐ SEMI-ANNUALLY
- ☐ UPON REQUEST
- ☐ OTHER (SPECIFY)

ENCLOSED
- ☐ SUMMARY FOR CHILD AS SUGGESTED IN COMPACT PROCEDURES
- ☐ SUMMARY OF HOME STUDY AS SUGGESTED IN COMPACT PROCEDURES
- ☐ OTHER ENCLOSURES (SPECIFY)

SIGNATURE OF SENDING AGENCY | TITLE | DATE SIGNED

SIGNATURE OF SENDING STATE COMPACT ADMINISTRATOR OR ALTERNATE | DATE SIGNED

SECTION IV ACTION BY RECEIVING STATE

- ☐ APPROVAL GRANTED
- ☐ APPROVAL DENIED

SIGNATURE OF RECEIVING STATE COMPACT ADMINISTRATOR OR ALTERNATE | DATE SIGNED

REMARKS

Action Completed Sending State Compact Administrator
Copy

INSTRUCTIONS FOR ICPC-100A

The ICPC-100A, Interstate Compact Application Child Placement Request Form, is completed by the sending agency and sent to the Virginia ICPC Office to request evaluation of a proposed placement in another state. Before a lawful interstate placement can be made, the ICPC-100A must be approved and signed by the Compact Office in the receiving state. All items on this form are self-explanatory with the following exceptions:

1. The Virginia Interstate Office completes "TO" and "FROM" sections at top of form.

2. Section I - Identifying Date

   Name, address and telephone number of sending agency is shown as agency responsible for planning and as agency financially responsible for child.

3. Section II - Placement

   Sending agency checks block indicating type of care; type of relationship, if applicable; and indicates where adoption is to be finalized, if adoptive placement is requested.

4. Section III - Supervision

   "Quarterly" report block is to be checked except for adoptive placements.

   Sending agency forwards ICPC-100A (with carbons intact) to the Virginia ICPC Office where signature of "Sending State Compact Administrator" is affixed prior to forwarding to the receiving state.

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF WELFARE

INTERSTATE COMPACT REPORT
CHILD PLACEMENT STATUS

ICPC — 100B

(NAME AND ADDRESS OF COMPACT ADMINISTRATOR)
TO:

(NAME AND ADDRESS OF COMPACT ADMINISTRATOR)
FROM:

CHILD'S NAME | BIRTHDATE

MOTHER'S NAME | FATHER'S NAME

PRESENT PLACEMENT STATUS OF CHILD

- ☐ PLACED WITH | DATE
  - NAME
  - ADDRESS
  - CITY, STATE, ZIP
- ☐ DISCHARGED FROM PLACEMENT WITH | DATE
  - NAME
  - ADDRESS
  - CITY, STATE, ZIP
- ☐ PLACEMENT PLANS CANCELLED | DATE CANCELLED
- ☐ PLACEMENT STATUS CHANGED WHILE IN RECEIVING STATE | DATE OF CHANGE
- ☐ NEW ADDRESS
  - CITY, STATE, ZIP
- TYPE OF CHANGE
- ☐ ADOPTION FINALIZED IN SENDING STATE | DATE FINALIZED
- ☐ ADOPTION FINALIZED IN RECEIVING STATE | DATE FINALIZED
- ☐ LEGAL CUSTODY TRANSFERRED TO: NAME | DATE
- ☐ DISCHARGED TO | DATE
  - NAME OF
  - ADDRESS
  - CITY, STATE, ZIP
  - TELEPHONE NUMBER

TYPE OF CARE

- ☐ FOSTER CARE FAMILY
- ☐ GROUP HOME CARE
- ☐ RESIDENTIAL TREATMENT CENTER
- ☐ INSTITUTIONAL CARE
- ☐ ADOPTION
- ☐ INDEPENDENT LIVING PLACEMENT
- ☐ PLACEMENT WITH RELATIVE (SPECIFY RELATIONSHIP)

SIGNATURE OF REPORTING COMPACT ADMINISTRATOR OR ALTERNATE | DATE SIGNED

REMARKS

033-03-116

RECEIVING COMPACT ADMINISTRATOR

VIRGINIA DEPARTMENT OF WELFARE
CHILD'S PROFILE

Placement Agency _____

Worker's Name _____ Attorney _____ Telephone _____

Child's Name _____ Case Number _____ Age _____ Sex _____

When does child need to be placed? ☐ Immediate ☐ Within _____ Weeks ☐ Within _____ Months

Placement Preference: ☐ Group Home ☐ Placement Facility ☐ Child Caring Institution ☐ Psychiatric Hospital (Medical)
☐ Boarding School

A. What is the child's current living arrangement? _____

How long? _____ Why is replacement necessary? _____

B. Placement History:

1. Please provide the following information about each of the child's previous placements, starting with the most recent first.

Type of Placement	Length	Reason for Replacement

(If more than five previous placements, please submit information on a separate sheet.)

2. Date of first out-of-home placement? _____ Total number? _____

C. What is the child's Permanent Planning Goal? (Check appropriate category)
☐ Return to Parents / Prior Custodians ☐ Adoption ☐ Permanent Foster Care
☐ Continuous Foster Care ☐ Placement with Relative

D. What is the target date for goal achievement? _____

E. What kind of living arrangement should the child be prepared to go into following the proposed placement? _____

Target date? _____

F. Medical:

1. Are there any significant medical problems? _____
If yes, identify: _____

2. Will these problems require specialized medical care or services? _____
If yes, identify: _____

G. Educational:

1. What grade is the child in? _____ Is this the appropriate grade? _____

2. Has the child been excluded from the local school district? _____

H. Does the child require special educational programs? _____
If yes, please appropriate category (categories) below:

☐ TMR ☐ Orthopedic ☐ Emotionally Disturbed
☐ EMR ☐ Learning Disability ☐ Sensory Handicapped
☐ Deaf ☐ Speech Therapy ☐ Multiple (check other appropriate categories)
☐ Blind ☐ Functionally Retarded ☐ Other, identify: _____

The above is based on:
☐ Formal assessment
☐ Assessments by school / professionals
☐ Already in special education program or indicated

I. Are Behavior Related or Emotional Disturbance / Social Maladjustment?

Please check those categories which best describe the child's behavior in order of greatest concern: i.e., put a No. 1 in the box of the category of greatest concern or that presents the greatest problem for the child, a No. 2 in the box for the category of next greatest concern, etc.

☐ Runaway
☐ Occasional
☐ Chronic
☐ Serious Drug Involvement
☐ Depression
☐ Mild
☐ Severe
☐ Self Abusive Behavior
☐ Suicide
☐ Physical
☐ Property Abusive Behavior
☐ Toys
☐ Itself
☐ Others
☐ Physically Assaultive Behavior
☐ Toys
☐ Itself
☐ Others
☐ Suicide
☐ Manipulative Behavior
☐ Serious Risk
☐ Social Maladjustment (Status Offender)
☐ Mild Social Acting Out
☐ Chronic Curfew Violations
☐ Chronic Truancy
☐ Mild Alcohol and / or Drug Abuse
☐ Destructive to Property
☐ Fire Setting
☐ Other Physical Destruction
☐ Delinquent Behavior (Criminal Behavior)
☐ Specify: _____
☐ Frequent and Progressive Use of Secure Custody
☐ Institutionally Behavior
☐ Progressive and Total Use of Set Controls
☐ Moderate and Occasional
☐ Severe and Frequent

The outline below is recommended for providing information to receiving states and agencies when a child's placement out-of-state is under consideration. Not every category of information may be applicable for each child. Adequate background information and a description of the child's current functioning will enable the receiving state to make recommendations regarding the most appropriate placement for the child.

ICPC-101: OUTLINE FOR CHILD'S SUMMARY

1. Identifying data including name, birthdate, and religion.

2. Description of natural family

   a. Background information on natural parents and siblings.

   b. Circumstances leading to child's involvement with sending agency.

   c. Court order granting agency custody or requiring agency supervision.

   d. Description of child's relationships with extended family members, foster family or other substitute caretakers.

3. Termination of parental rights if adoptive placement is requested, include copies of entrustment agreements.

4. Description of child's personal history

   a. Developmental history.

   b. Past and present health problems.

   c. Current social functioning, health and adjustment to current living situation.

   d. School adjustment.

5. Description of any substantiated problems

   a. Recent psychological, medical or psychiatric reports.

   b. School reports indicating learning or behavioral difficulty.

6. Statement summarizing sending agency's assessment of child's needs, agency's goals and plans for child. This statement should clearly indicate why an interstate placement is being requested.

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF WELFARE

INTERSTATE COMPACT APPLICATION
CHILD PLACEMENT REQUEST

ICPC — 100A

NAME AND ADDRESS OF COMPACT ADMINISTRATOR FOR RECEIVING STATE
TO:

FROM: NAME AND ADDRESS OF COMPACT ADMINISTRATOR FOR SENDING STATE

SECTION I IDENTIFYING DATA

APPROVAL IS REQUESTED FOR THE PLACEMENT OF CHILD'S NAME | BIRTHDATE

MOTHER'S NAME | FATHER'S NAME

NAME OF AGENCY OR PERSON RESPONSIBLE FOR PLANNING FOR CHILD | NAME OF AGENCY OR PERSON FINANCIALLY RESPONSIBLE FOR CHILD

ADDRESS | ADDRESS

CITY, STATE, ZIP | CITY, STATE, ZIP

TELEPHONE NUMBER | TELEPHONE NUMBER

SECTION II PLACEMENT

NAME OF PERSON CHILD IS TO BE PLACED WITH

ADDRESS

CITY, STATE, ZIP

TELEPHONE NUMBER

TYPE OF CARE
- ☐ FOSTER FAMILY CARE
- ☐ GROUP HOME CARE
- ☐ RESIDENTIAL TREATMENT CENTER
- ☐ INSTITUTIONAL CARE
- ☐ ADOPTION
- ☐ INDEPENDENT LIVING PLACEMENT
- ☐ PLACEMENT WITH RELATIVE; SPECIFY RELATIONSHIP

ADOPTION TO BE COMPLETED IN
- ☐ SENDING STATE
- ☐ RECEIVING STATE

SECTION III SUPERVISION

- ☐ SENDING AGENCY REQUESTS RECEIVING AGENCY TO ARRANGE SUPERVISION
- ☐ SENDING AGENCY TO SUPERVISE
- ☐ AGENCY IN RECEIVING STATE HAS AGREED TO SUPERVISE

NAME AND ADDRESS OF SUPERVISING AGENCY IN RECEIVING STATE

REPORTS REQUESTED
- ☐ QUARTERLY
- ☐ SEMI-ANNUALLY
- ☐ UPON REQUEST
- ☐ OTHER (SPECIFY):

ENCLOSED
- ☐ SUMMARY FOR CHILD AS SUGGESTED IN COMPACT PROCEDURES
- ☐ SUMMARY OF HOME STUDY AS SUGGESTED IN COMPACT PROCEDURES
- ☐ OTHER ENCLOSURES (SPECIFY):

SIGNATURE OF SENDING AGENCY | TITLE | DATE SIGNED

SIGNATURE OF SENDING STATE COMPACT ADMINISTRATOR OR ALTERNATE | DATE SIGNED

SECTION IV ACTION BY RECEIVING STATE

- ☐ APPROVAL GRANTED
- ☐ APPROVAL DENIED

SIGNATURE OF RECEIVING STATE COMPACT ADMINISTRATOR OR ALTERNATE | DATE SIGNED

REMARKS

Action Copies Distributed: Sending State Compact Administrator Copy.

The Interstate Compact Application Child Placement Request, ICPC-100A is to be completed by the sending agency and sent to the Virginia Compact Administrator in order to request an evaluation of a proposed placement in the receiving state and/or to notify a receiving state of a proposed placement. Before placement can be made, it must be signed as approved by the Compact Administrator of the receiving state.

Instructions for use follow:

NAME AND ADDRESS OF COMPACT ADMINISTRATOR FOR RECEIVING STATE TO:
This will be completed at the Central Office.

NAME AND ADDRESS OF COMPACT ADMINISTRATOR FOR SENDING STATE FROM:
This is to read: William L. Lukhard, Commissioner
State Department of Welfare
Blair Building
8007 Discovery Drive
Richmond, VA 23288

SECTION I-IDENTIFYING DATA

CHILD'S NAME

Show the child's full legal name. According to interstate law, agency code names or numbers are not acceptable.

BIRTHDATE

Show complete date.

MOTHER'S NAME

Show her complete name. If parental rights have been fully terminated, this fact can be noted and no name need appear.

FATHER'S NAME

Show his complete name. If parental rights have been fully terminated, this fact can be noted and no name need appear.

NAME OF AGENCY OR PERSON RESPONSBILE FOR PLANNING FOR CHILD

The name of the sending agency which is making a plan to send the child out-of-state should be shown here with appropriate address and telephone number.

NAME OF AGENCY OR PERSON FINANCIALLY RESPONSIBLE FOR CHILD

The name of the agency which is making the plan is also shown here. If a return to a parent is contemplated but the child is in agency custody, the agency, not the parent, must be shown here. The agency is responsible for removing the child from the receiving state during the period of placement if the need arises.

SECTION II-PLACEMENT

NAME OF PERSON CHILD IS TO BE PLACED WITH

The complete name and address of the person with whom the child is to be placed should be shown here.

TYPE OF CARE

Check appropriate block. If placement is to be with a relative specify the relationship of the relative to the child. One block should be checked to indicate the type of placement into which the child was placed. These types include:

FOSTER CARE FAMILY - Placement with a foster family.

RESIDENTIAL TREATMENT CENTER - Placement in a self-contained setting for thirteen or more youth in which program activities are planned and implemented based upon the treatment needs of the residents.

ADOPTION - Placement for purposes of adoption.

PLACEMENT WITH RELATIVE - Specify the relationship between the youth and relative.

GROUP HOME CARE - Placement in a community-based, home-like dwelling serving up to twelve youths where care is provided by paid staff.

INSTITUTIONAL CARE - Placement in a physically restricting, secure facility, such as a detention center.

INDEPENDENT LIVING PLACEMENT - Placement in an environment independent of daily substitute parental supervision, such as colleges and vocational training programs.

ADOPTION TO BE COMPLETED IN

Show whether adoption is to be completed in the sending state (Virginia) or receiving state. The decision of where to complete the adoption is made by the adoptive family. Information on adoption laws of other states is available upon calling the Interstate Office.

SECTION III-SUPERVISION

One of the three blocks should be checked.

SENDING AGENCY REQUESTS RECEIVING AGENCY TO ARRANGE SUPERVISION

This indicates that Virginia is requesting supervision from the appropriate locality in the receiving State.

SENDING AGENCY TO SUPERVISE

This indicates that the Virginia agency will provide direct supervision of the child. Note: This option is available in Maryland, West Virginia and Washington, D. C. but North Carolina prohibits out-of-state agencies from providing social services in the State of North Carolina.

AGENCY IN RECEIVING STATE HAS AGREED TO SUPERVISE

This indicates that supervision has already been accepted by an agency in the receiving state.

NAME AND ADDRESS OF SUPERVISING AGENCY IN RECEIVING STATE

When "sending agency requests receiving agency to arrange supervision" is indicated this portion should be completed by the receiving state upon approval of the placement.

When "agency is receiving state has agreed to supervise" is indicated, the name and address of the agency which has accepted supervision should be shown.

REPORTS REQUESTED

Indicate how often reports are requested. A minimum of one (1) report after placement is to be requested. In cases where adoption is to be completed in Virginia, "OTHER" may be checked with the specification "three (3) visits per Virginia law." A cover letter should indicate for the receiving state Virginia's specific requirements.

ENCLOSED SUMMARY FOR CHILD AS SUGGESTED IN COMPACT PROCEDURES

This block is to be checked as a summary of the child is required to accompany the ICPC-100A. See p.36, OUTLINE FOR CHILD'S SUMMARY.

SUMMARY OF HOME STUDY AS SUGGESTED IN COMPACT PROCEDURES

In instances of a child moving out-of-state with the foster or adoptive family, a summary in duplicate of the foster or adoptive home study is required and this block is to be checked. In instances of adoptive placements when a home study has already been received by the Virginia agency, a summary in duplicate should be provided and this block check; otherwise, this block may be left blank.

OTHER ENCLOSURES (SPECIFY):

This includes court orders, psychologicals, psychiatric and educational reports or other appropriate documentation.

SIGNATURE OF SENDING AGENCY

The signature of the person responsible for sending the child is required indicating title and date of the signature. This provides a readily identifiable contact with the sending agency.

SIGNATURE OF SENDING STATE COMPACT ADMINSTRATOR OR ALTERNATE

This signature is affixed in the Central Office.

SECTION IV-ACTION BY RECEIVING STATE

This section is to be completed by the receiving state indicating either approval or denial of the request.

DISTRIBUTION OF COPIES

The sending agency keeps the bottom copy, "Preliminary Sending Agency Copy." The sending agency will later receive an "Action Completed: Sending Agency Copy" for its record.

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF WELFARE

INTERSTATE COMPACT REPORT
CHILD PLACEMENT STATUS

ICPC — 1006

NAME AND ADDRESS OF COMPACT ADMINISTRATOR
TO:

NAME AND ADDRESS OF COMPACT ADMINISTRATOR
FROM:

CHILD'S NAME | BIRTHDATE

SENDER'S NAME | AGENCY'S NAME

PRESENT PLACEMENT STATUS OF CHILD

- ☐ PLACED WITH | DATE
  - NAME
  - ADDRESS
  - CITY, STATE, ZIP
- ☐ PLACEMENT PLANS CANCELLED | DATE CANCELLED
- ☐ NEW ADDRESS
  - CITY, STATE, ZIP
- ☐ DISCHARGED FROM PLACEMENT WITH | DATE
  - NAME
  - ADDRESS
  - CITY, STATE, ZIP
- ☐ PLACEMENT STATUS CHANGED WHILE IN RECEIVING STATE | DATE OF CHANGE
  - TYPE OF CHANGE
- ☐ ADOPTION FINALIZED IN SENDING STATE | DATE FINALIZED
- ☐ ADOPTION FINALIZED IN RECEIVING STATE | DATE FINALIZED
- ☐ LEGAL CUSTODY TRANSFERRED TO: NAME | DATE
- ☐ DISCHARGED TO | DATE
  - NAME
  - ADDRESS
  - CITY, STATE, ZIP
  - TELEPHONE NUMBER

TYPE OF CARE

- ☐ FOSTER CARE FAMILY
- ☐ GROUP HOME CARE
- ☐ RESIDENTIAL TREATMENT CENTER
- ☐ INSTITUTIONAL CARE
- ☐ ADOPTION
- ☐ INDEPENDENT LIVING PLACEMENT
- ☐ PLACEMENT WITH RELATIVE (SPECIFY RELATIONSHIP)

SIGNATURE OF REPORTING COMPACT ADMINISTRATOR OR ALTERNATE | DATE SIGNED

REMARKS

RECEIVING COMPACT ADMINISTRATOR

The Interstate Compact Report Child Placement Status, ICPC-100B is to be used to notify the receiving state of the placement status of the child, including date of initial placement and termination of placement. It is to be completed by the local agency and sent to the Compact Administrator for forwarding to the receiving state.

Instructions for use follows:

NAME AND ADDRESS OF COMPACT ADMINISTRATOR TO:

This will be completed at the Central Office.

NAME AND ADDRESS OF COMPACT ADMINISTRATOR FROM:

This is to read: William L. Lukhard, Commissioner
State Department of Welfare
Blair Building
8007 Discovery Drive
Richmond, VA 23288

CHILD'S NAME

Show the child's full legal name.

BIRTHDATE

Show complete date.

MOTHER'S NAME

Show her complete name. If parental rights have been fully terminated, this fact can be noted and no name need appear.

FATHER'S NAME

Show his complete name. If parental rights have been fully terminated, this fact can be noted and no name need appear.

PRESENT PLACEMENT STATUS OF CHILD

One or more of the blocks in this section may be checked as appropriate.

PLACED WITH

This is to be completed to show the date a child is placed out-of-state. Indicate date of placement and name and address of person the child is placed with. This block is applicable when interstate approval has been provided on ICPC-100A and the sending agency is notifying the receiving state that a placement has been made.

DISCHARGE FROM PLACEMENT WITH

This is to be completed when a child leaves a placement in another state. The date the placement ended is to be indicated along with the name and address of whomever the child was subsequently placed with.

PLACEMENT PLANS CANCELLED

This is to be checked when an agency had been contemplating placing a child out-of-state and no longer plans to pursue such a placement possibility.

NEW ADDRESS

This is to be completed when the family with whom the child is placed moves to a new address. (For example, the family moves from the address shown on the ICPC-100A.)

PLACEMENT STATUS CHANGED WHILE RECEIVING STATE

This is to be completed when the status of an out-of-state placement changes. Most often this type of change is one from a foster care placement to an adoptive placement. (For example, the agency terminates the natural parents' rights making adoption a possibility.)

ADOPTION FINALIZED IN SENDING STATE

When a final order of adoption is entered in Virginia, this block is to be checked and the date of final order shown.

ADOPTION FINALIZED IN RECEIVING STATE

This should be shown if the sending agency receives notice directly of the finalization of an adoption in the receiving state.

LEGAL CUSTODY TRANSFERRED TO

When the receiving state's Compact Administrator can recommend, after a favorable period of placement, that legal custody be given or returned to the person with whom the child is placed, the sending agency may be relieved of custody and custody given to the person with whom the child is placed. After this action is taken the agency completes this section and shows the date of transference of custody.

DISCHARGED TO

This is to be completed when the child is discharged from a placement and returned to Virginia. The date of discharge and the name of whom the child is discharged to should be shown.

TYPE OF CARE

One block should be checked to indicate the type of placement to which the child was discharged. These types include:

FOSTER CARE FAMILY - Placement with a foster family.

RESIDENTIAL TREATMENT CENTER - Placement in a self-contained setting for thirteen or more youth in which program activities are planned and implemented based upon the treatment needs of the residents.

ADOPTION - Placement for purposes of adoption.

PLACEMENT WITH RELATIVE - Specify the relationship between the youth and relative.

GROUP HOME CARE - Placement in a community-based, home-like dwelling serving up to twelve youths where care is provided by paid staff.

INSTITUTIONAL CARE - Placement in a physically restricting, secure facility, such as a detention center.

INDEPENDENT LIVING PLACEMENT - Placement in an environment independent of daily substitute parental supervision, such as colleges and vocational training programs.

SIGNATURE OF REPORTING COMPACT ADMINISTRATOR OR ALTERNATE

This signature will be affixed in the Central Office.

DISTRIBUTION OF COPIES

The sending agency keeps for its record the bottom copy, "Sending Agency."

032-02-316

VIRGINIA DEPARTMENT OF WELFARE
CHILD'S PROFILE

Responsible Agency _____

Worker's Name _____ Address _____ Telephone _____

Child's Name _____ Case Number _____ Age _____ Sex _____

When does child need to be placed? ☐ Immediately ☐ Within _____ Weeks ☐ Within _____ Months

Placement Preferences: ☐ Group Home ☐ Treatment Facility ☐ Child Caring Institution ☐ Psychiatric Hospital (Maximal) ☐ Boarding School

A. What is the child's current living arrangement? _____

How long? _____ Why is replacement necessary? _____

B. Placement History

1. Please provide the following information about each of the child's previous placements, starting with the most recent one.

Type of Placement	Length	Reason for Replacement

(If more than five previous placements, attach supplementary sheet.)

2. Date of this most-recent placement? _____ Total number? _____

C. What is the child's Permanent Planning Goal (check appropriate response)

☐ Return to Natural Family ☐ Adoption ☐ Permanent Foster Care
☐ Continued Foster Care - Independence ☐ Continued Foster Care - Preparation

D. What is the target date for goal attainment? _____

E. What kind of living arrangement should the child be prepared to go into following the proposed placement? _____

_____

Target date? _____

F. Medical

1. Are there any significant medical problems? _____

If yes, specify? _____

2. Will these problems require specialized medical care or services? _____

If yes, specify? _____

G. Educational

1. What grade is the child in? _____ Is this the appropriate grade? _____

2. Has the child been suspended from the local school system? _____

H. Does this child require special educational programs? _____

If yes, check appropriate category(categories) below:

☐ EMR ☐ Orthopedic ☐ Emotionally Disturbed
☐ TMR ☐ Learning Disability ☐ Socially Maladjusted
☐ Deaf ☐ Speech Therapy ☐ Multiple (check other appropriate categories)
☐ Blind ☐ Permanently Assistant ☐ Other, specify _____

The above is based on:

☐ Teacher assessment
☐ Recommendation by school/psychologist
☐ Already in special education program as indicated

I. Any Behavior Related to Emotional Disturbance/Social Maladjustment

Please check those categories which best describe the child's behavior in order of greatest concern (i.e., put a No. 1 in the box of the category of greatest concern or that presents the greatest problem for the child, a No. 2 in the box for the category of next greatest concern, etc.

☐ Runaway
☐ Occasional
☐ Chronic
☐ Serious Drug Involvement
☐ Depression
☐ Mild
☐ Severe
☐ Self Abusive Behavior
☐ Sexual
☐ Physical
☐ Physically Abusive Behavior
☐ Peers
☐ Staff
☐ Others
☐ Physically Assaultive Behavior
☐ Peers
☐ Staff
☐ Others
☐ Suicidal
☐ Manipulative Behavior
☐ Serious Risk
☐ Sexual Maladjustment (check Offender)
☐ Mild Sexual Acting Out
☐ Chronic Contact Violations
☐ Chronic Truancy
☐ Mild Alcohol and/or Drug Abuse
☐ Destructive to Property
☐ Fire Setting
☐ Other Physical Destruction
☐ Delinquent Behavior (Criminal Behavior)
☐ Specify? _____
☐ Frequent and Prolonged Loss of Reality Contact
☐ Schizophrenic Behavior
☐ Pronounced and Total Loss of Self Control
☐ Moderate and Occasional
☐ Severe and Frequent

The Child Profile form should be completed to accompany the Social Summary and ICPC-100A for children expected to be placed out-of-state. The use of this form will enable providers to assess the appropriateness of child related problems to residential services currently available in Virginia. In addition, compiling such data will provide needs assessment information upon which services may be developed in accordance with local, regional or statewide gaps in service delivery.

Responsible Agency: Local welfare agency, court, child-placing agency or other sending agency.

Worker's Name: Name of person recommending placement outside of Virginia.

Alternate: Name of person (preferably the worker's supervisor) that may be contacted when the worker cannot be contacted.

Telephone: Phone number of agency worker.

When does child need to be placed? - Estimation of the time frame required for the placement.

Placement Preference - Indicate the type of residential care that would most appropriately meet the needs of the child for whom an out-of-state placement is expected.

A. Child's Current Living Arrangement - Describe the type of location of the residence of the child at the time an out-of-state placement is recommended. Such residences may include "natural family," "foster home," "group home," one of the training schools or mental hospitals, "private institution, hospital," etc.

B. Placement History - (1) Beginning with the most recent placement, indicate the previous placements of this child, length of each along with the reasons that required a change in placement. (2) The date the child was first placed outside the natural family and the total number of placements since that date are to be indicated.

C. Permanent Planning Goal - Check one of the five goals indicated on the form.

D. Target Date of Goal Attainment - Indicate the anticipated date for attaining the desired goal for the child.

E. Living Arrangement Following the Proposed Out-of-State Placement - Indicate the expected placement for the child after completing the residential program and the date that such placement is expected.

F. Medical - Specify any medical problems of the child as well as the services needed for them.

G. Educational - (1) Indicate the current grade the child is in school and whether it is appropriate for the child's age. (2) Indicate whether the local school board has agreed that the educational needs of this child cannot be met in his/her community.

H. Does the Child Require Special Educational Programs - When a special education program is required, indicate with a check next to the appropriate disability among those listed or specify in the space next to "Other" TMR - Trainable Mentally Retarded, EMR - Educable Mentally Retarded. The basis for such diagnosis should also be specified.

I. Behaviors Related to Emotional Disturbance/Social Maladjustment - Indicate in order of severity, the specific behaviors exhibited by the child for whom residential care out-of-state is requested.

J. Problems Related to Developmental Disabilities - Specify among those listed disabilities of the child.

K. Other Handicapping Conditions - Indicate among those listed any other disabilities or problems of the child.

L. Program Considerations - In order of preference, numerically indicate the services important to meet the treatment needs of the child among those services listed.

M. Description of Child - Very briefly describe the child in terms of his/her character strengths.

Resource Availability Section - List all of the day and residential programs in state or justified by closer proximity to the agency to which an application has been made and rejected prior to consideration of a placement outside Virginia.

Recommended Placement Out-of-State - Give the name of the facility, state in which it is located and distance from the agency recommending the placement.

Justification - A statement shall be made which satisfies both legislation and policy requirements to make an exhaustive survey of all in-state programs and others closer than that proposed prior to recommending an out-of-state placement. Additionally, the justification must specify the appropriateness of the proposed placement to meet the needs of the child. This space or accompanying correspondence may be used to specify those other agencies that have been consulted and concur with the proposed placement.

ICPC-101
OUTLINE FOR CHILD'S SUMMARY
(It is recognized that many points will not apply to young infants.)

Name of Agency _____

Date prepared _____

Name of Caseworker _____

A. Identifying data including name, birthdate, race and religion.

B. Natural Family and Reason for Placement in Another State

1. Composition of family and legal status of parents. Indicate each parent's legal relationship to the child and whether parental rights have been legally limited at any time. Indicate problems in family leading to agency or court involvement.

2. Current custody status of child. Include photostatic copy of any court commitment orders.

3. Family History.

a. Mother: Age at delivery, physical appearance, religion, physical and mental health, (discuss in detail if significant for child's placement and future adjustment) general personality, including interests and talents; observation of adequacy of mother's functioning with reasons for this; school and employment history.

b. Father: (Same as for mother).

c. Siblings of child, if any, and significant extended family.

ICPC-101 Outline for Child's Summary (Continued)

d. Termination of parental rights, if applicable.

1) Permanent entrustment agreements by one or both parents and date of agreements. Include photostatic copies.

2) In adoption cases, indicate date of denial or waiver of paternity or affidavit of inability to identify biological father. Include photostatic copies.

3) Divorces or death, verification of dates and conditions. Include photostatic copies, if available.

e. Sequence of court involvement. Indicate briefly the court hearings which have occurred including dates, reasons for hearings, and outcome. Indicate date and reason for hearing for any upcoming court matters.

4. Current involvement or lack of involvement of natural family with child.

a. Indicate plan of services to be provided to the family and progress in this area.

b. Indicate case goals for child.

C. Child's Personality and History

1. Appearance: height, weight, coloring, facial and body characteristics. Be specific about striking or unusual characteristics.

2. Current adjustment: current generalized emotional responses: e.g., crying, contented, demanding, exploring, imitative, passive.

ICPC-101 Outline for Child's Summary (Continued)

3. Child life experience.

   a. A child's significant experience in own home including a description of any incidence of abuse or neglect.

   b. The child's experience out of own home including, subsequent placements, age at placement, child's reaction to separation from parents and the significant events in each placement, the reason for changes in placement and the child's reaction to these changes.

   c. Siblings, if any, and their meaning to child.

4. Present living situation of the child.

5. Interrelationships.

   a. Attitudes of others to child: both natural parents, siblings, both foster parents or house parents, children in the home or institution, caseworker, playmates outside home, teachers.

   b. Attitudes of child to above.

   c. Relationship, if any, with intended foster or adoptive parents in receiving state including frequency and type of previous contacts or, if applicable, reason for lack of previous contact.

D. Development History.

1. Prenatal.

   a. Mother's physical and emotional health during pregnancy.

ICPC-101 Outline for Child's Summary (Continued)

b. Mother's medical care during pregnancy: serology results and treatment, if administered.

2. Details of delivery and neonatal history.

3. Health history.

a. Attach a current medical report.

b. Illnesses and hospitalizations: diagnosis and treatment; age at onset; duration; prognosis.

4. Growth and Development.

a. Feeding: method (scheduled or self-determining), age at weaning, method used for weaning and child's reaction, age when started to feed self, food fads, vomiting, food substitutions.

b. Elimination: regularity of bowel and bladder including problems, treatment or training, attitude of person training the child.

c. Physical development: age at which focused eyes, sat alone, teethed, talked, crawled, walked.

E. Professional observations of development, including any psychological, psychiatric and educational evaluations. Indicate the child's special needs that must be met including handicapping conditions, behavior disorders, problems and special education.

F. Agency's evaluation of child's present needs and type of home or residential placement desired for child. Reason for desired placement in another state. Include any indication of long-range plans for the child.

ICPC-102
OUTLINE FOR SUMMARY OF PROSPECTIVE FOSTER FAMILY

Name of Agency _____

Date prepared _____

Name of Caseworker _____

A. Identifying data including names, ages, sex, religion and occupation of family members.

B. Summary of a agency's experience with the family.

C. Physical and personality description including height, weight, coloring, any special aspects of physical appearance and manner. Briefly describe the personalities of husband and wife.

D. Quality of Marriage

1. Describe the roles of husband and wife in the marriage and their relationship to each other. What are their particular strengths and vulnerabilities?

2. Include verification of marriage, any previous marriages and divorces, evaluation of previous marriage.

E. Background and Interpersonal Relationships

1. Describe family of foster parents briefly, their relationship with own parents and brothers and sisters in childhood and early adult years.

2. Comment on present relationship of the couple to their extended family, friends, and references.

ICPC-102 Outline for Summary of Prospective Foster Family (Continued)

3. Describe the couples' education and employment histories, special interests and abilities, religious and sociocultural identity.

F. Children in the home including development and personality of each child, quality of parent-child relationship and relationship of children to each other. If adopted, how has the family handled adoption with the child?

G. Motivation and Attitudes Toward Foster Care or Adoption

1. Are the parents equally motivated?

2. What do they expect of a child, and how do they visualize their family?

3. Describe the plans to provide for the child including any special needs.

4. What is the attitude of the couple toward illegitimacy and natural parents who surrender children?

5. How do the parents intend to tell a child of his identity and/or his adoption?

H. Health including the results of current physical examinations of all members of the family and any important past health problems.

I. Housing and Financial Situations

1. Brief description of home and plans for accommodating child to be placed.

2. Economic situation of the family, including income, other assets, and financial obligations. Comments on money handling.

3. Agency's evaluation of the family and recommendations on the suitability of the family for the proposed placement of the specific child in the sending state.