An Integrated Policy and Plan to Provide and Improve Access to Mental Health, Mental Retardation and Substance Abuse Services for Children, Adolescents and Their Families (Budget Item 311-E, 2006 Appropriations Act) July 1, 2006- June 30, 2007

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

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

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

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

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Executive Summary

General Assembly Guidance

In 2003 and subsequently, the General Assembly issued Budget Items 329-G, 330-F, and 311-E respectively. These budget items directed the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) to continue the committee with the same budget language related to improving access to services for children and their families across disabilities and requires DMHMRSAS to report the plan to the Chairmen of the Senate Finance and House Appropriations Committees by June 30th of each year. In June 2006, the Department of Mental Health, Mental Retardation and Substance Abuse Services submitted a fourth report, *A Policy and Plan to Provide and Improve Access to Mental Health and Substance Abuse Services to Children, Adolescents and Their Families* to the Chairman of the Senate Finance and House of Appropriations Committees. This report satisfied the legislative intent of the budget language contained in 330-F and delineated recommendations to improve access to mental health, mental retardation and substance abuse services for children and their families. The report included recommendations to address unmet service needs, funding, infrastructure and system issues, as well as recommendations for improvement including analysis of the Comprehensive Services Act (CSA) and recommendations for systems improvement to address unmet needs in rural communities.

The current budget language of the 2006 Appropriations Act, Budget Item 311-E:

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

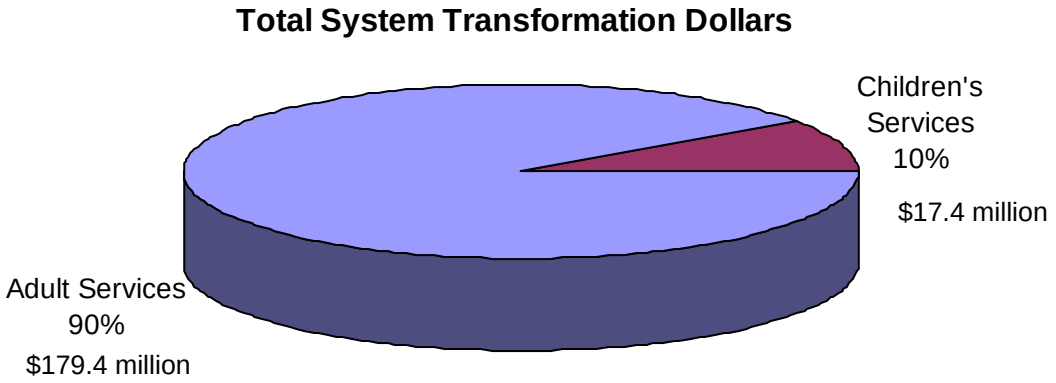
Several studies have been completed in the last five years demonstrating that there is much interest in, and awareness of, the significant problems in the children's behavioral health

services system in Virginia. When one examines Virginia's behavioral health care system, several themes emerge:

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

DMHMRSAS continues its transformation initiative to reform the community behavioral health system by implementing a vision that includes consumer-and family-driven services that promote resilience in children and the highest possible level of participation in community life including school, work, family and other meaningful relationships. Consistent with the budget language contained in the 2006 Appropriations Act, this transformation initiative builds upon the collaboration and coordination process among child-serving agencies and expands the focus into a comprehensive, cross-agency effort that includes Medicaid, juvenile justice, social services, education and the Office of Comprehensive Services. The system of care concept of serving children and their families, the juvenile justice/mental health projects, and system enhancements to align the Part C early intervention system to ensure improved outcomes for children and families are all approaches that effectively support this vision.

Children make up 24% of the population in Virginia, but received only 10% of state behavioral health funds in the transformation initiative, an inequity that undermines the development of needed services for children.



As noted in the 2006 and previous reports:

> "With remarkable consistency, legislative, policy, advisory, and family support groups have called for significant change resulting in better outcomes for children and families. Stable and sufficient funding to implement the system of care concept and to increase community capacity to provide evidence-based practices is a need that has been cited by all stakeholders."

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

In 2006, the Secretary of Health and Human Resources requested that the 330-F committee develop a 10 year strategic plan for children's behavioral health. This report updates the 10 year plan and its goals of: healthy, strong, and stable families; equitable access to services without regard to racial/ethnic status, socioeconomic status and geographic location; and services that are least-restrictive and support healthy child development.

The following are the Child and Family Behavioral Health Policy and Planning Committee's FY 2009 priority recommendations:

Priority Funding Recommendations for FY 2009

1. Increase Service Capacity:

- Fund Intermediate-Level Community-Based Services @ $20.0 million
- Fund 12 System of Care projects @ $3.6 million
- Fund MR Family Support @ $62,500 for each of 40 CSBs @ $2.5 million
- Fund MR waiver slots @ $6.0 million
- Fund Part C Early Intervention for an average increase of 6% per child for the per child annual rate @ $1,730,000
- Fund 3 additional Project LINK programs @ $375,000
- Fund outpatient Substance Abuse services @ $3.0 million
- Fund school-based mental health clinicians in 20 middle schools in five regions @ $1.8 million
- Fund infrastructure in the Department's Office of Child and Family Services (OCFS) to support these initiatives to increase service capacity statewide @ $990,000

2. Increase the Size of the Workforce:

- Fund four new child psychiatry fellowship and two new child psychology internship slots @ $1,036,000 with payback provisions to work in underserved areas in Virginia

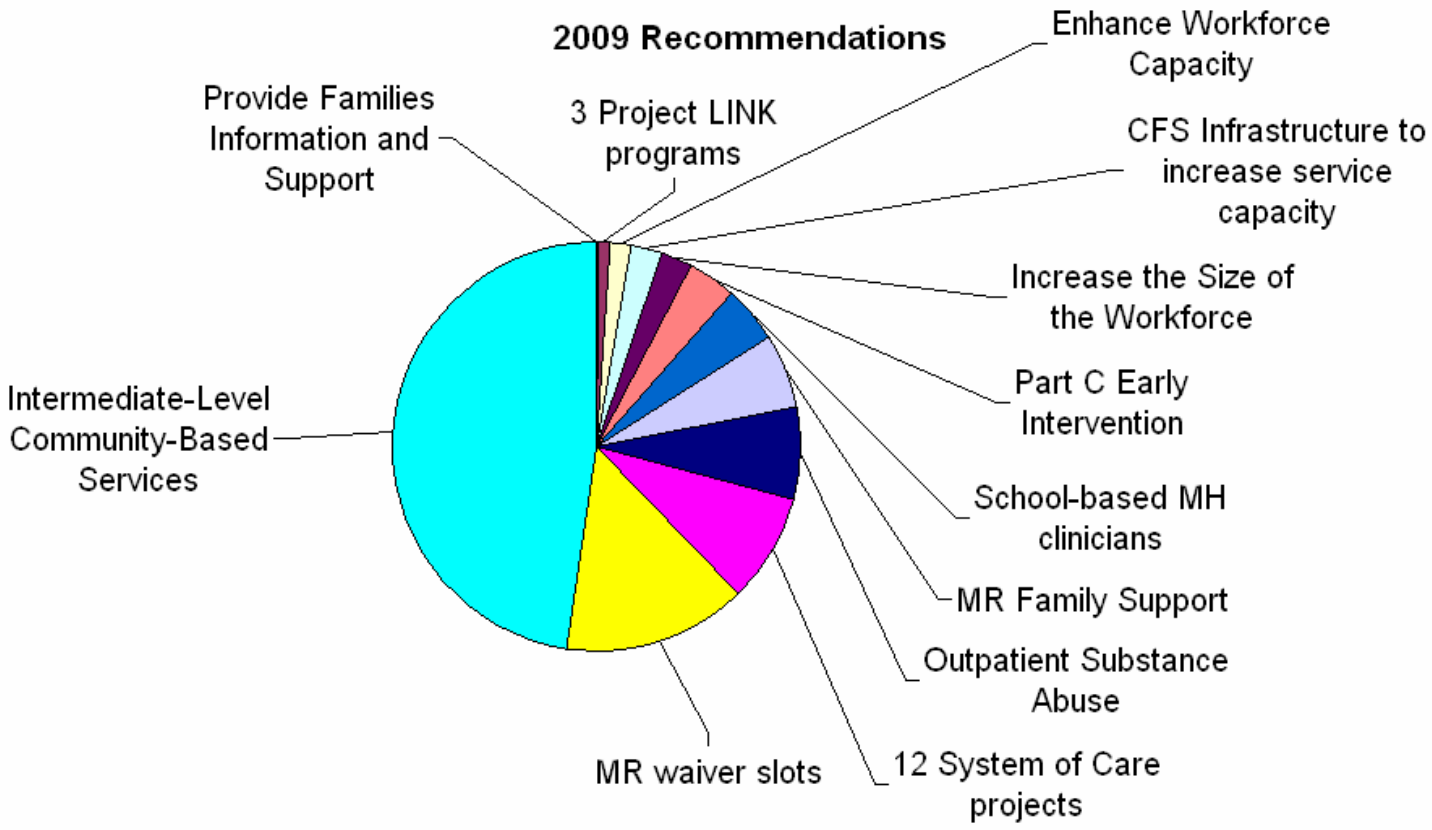
3. Enhance Workforce Capacity:

- Establish three Teaching Centers of Excellence to organize, coordinate and lead the training of clinicians in evidence-based, promising and best practices for children's behavioral health treatment across the Commonwealth @ $700,000

4. Provide Families with Information and Support:

- Fund 1.5 FTE for a Resource/Service Coordinator and administrative support to assist families in accessing needed services for their children and adolescents, educate families about available services, link families with support systems, and educate the public about the needs of children with behavioral health issues @ $100,000

Total cost of funding recommendations: $41,831,000 for FY 2009



2007 CFBHPPC Report

Introduction

The recent tragedy at Virginia Tech in April 2007, pointed out the critical need for people with mental illnesses to obtain treatment services. Following the tragedy, the Richmond Times-Dispatch (May 6, 2007) published an editorial about mental health services in the Commonwealth. The editorial called for three actions: "(1) systematize the process of involuntary commitment; (2) provide a wide range and level of services to ensure treatment without commitment where possible; and (3) improve continuity of care, with particular attention paid to housing."

The editorial's second recommendation is particularly pertinent to this report, because many mental illnesses begin in childhood or adolescence, and because behavioral health services for children and adolescents are insufficient in almost all areas of the Commonwealth. The Surgeon General's Report (1999) stated that only one in five children in need of mental health services receive those services. We must take bold steps to build and strengthen the fractured system of behavioral health services for children and adolescents in Virginia if we hope to positively impact the lives of our future adults.

Since 2002, the General Assembly, through its budget process (budget items 329-G, 330-F, and 311-E), has asked the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) and other agencies to join forces to evaluate and recommend changes to the behavioral health system for children, adolescents, and their families in order to improve access. Annually, in reports like this one, the DMHMRSAS has responded by providing the General Assembly with overviews of the system of care for children, including recommendations for improving the system. Many of the recommendations have not required funding and have been implemented across the system. However, several recommendations forwarded each year do require substantial funding, and some have not been fully addressed to date. This report will outline those specific parts of the system that are currently underfunded and those that are unavailable across the state.

The past five years have seen an increase in interest in children's mental health, mental retardation, and substances abuse services in Virginia. In 2003, as part of its system transformation efforts, the DMHMRSAS initiated a Child and Adolescent Special Populations Workgroup to make recommendations on transforming the system of behavioral health care for children and their families. During the past two years, the General Assembly, JLARC, and the Attorney General's Office have studied the issues of custody relinquishment for mental health treatment, residential treatment services for children, and the availability of private inpatient facilities to serve acute needs of children and adolescents. The 2007 session passed Senate Bill 1332, which allows Community Policy and Management Teams (CPMTs) to use funds for children requiring mental health services who meet specific criteria to prevent them from entering foster care. The session also passed House Joint Resolution 774, which identified the DMHMRSAS as the primary state agency responsible for planning and delivery of mental health services for children and adolescents. It also resolved that "*the Secretary of Health and Human Resources develop for consideration by the Governor Budget recommendations for the 2008-*

2010 Biennial Budget that, if proposed and adopted, would facilitate and fund service delivery for children through the state's mental health, mental retardation, and substance abuse system."

Interestingly, the recommendations coming from each of these initiatives repeatedly and consistently indicate that significant changes must be made to the system of care for children and adolescents in Virginia in order to provide all families with access to needed behavioral health services and supports. For the past five years, every group studying children's services has called for a significant increase in funds to build and improve those services. Some efforts at building a strong system have begun and include:

(1) the DMHMRSAS held a system of care conference in 2005;
(2) the General Assembly funded pilot evidence-based systems of care demonstration projects in four localities (two urban and two rural) across the state;
(3) the General Assembly funded mental health therapist positions to work in 23 detention centers across the state;
(4) the General Assembly funded four child psychiatry fellowship and four child psychology internship positions with payback provisions to work in underserved areas of Virginia;
(5) Department of Social Services (DSS) recently eliminated the need for families to relinquish custody of their children in order to receive mental health care;
(6) Department of Medical Assistance Services (DMAS) was awarded a demonstration grant to help provide community alternatives to psychiatric residential treatment facilities for children. The demonstration grant available over a five year period will assist Virginia in its efforts to adopt strategic approaches for improving quality and work to maintain and improve each child's functional level in the community.
(7) DMAS amended the State Medical Facilities Plan to provide Medicaid funds for substance abuse treatment for adolescents; and
(8) DMHMRSAS and the Commission on Youth are planning a system of care and evidence-based services conference to be held in the fall 2007.

These are important initial steps, but without significant increases in funding across the system, Virginia will continue to provide inadequate and fragmented behavioral health services to children, adolescents, and families. Virginia must develop a wide range of services and supports across the Commonwealth to address current unmet needs. The Commonwealth also must expand the capacity and skills of its public and private workforce necessary to provide the level of services needed for an adequate array of services for Virginia children, adolescents, and their families. In Virginia, historically only 7% of the federal, state and local funding has been directed towards children and adolescents (Landers, 2001), even though they make up 24% of the population and experience behavioral health problems at the same rates as adults

The Unmet Behavioral Health Needs of Virginia's Children

Despite recent gains described in the preceding section, **the Commonwealth's child and adolescent behavioral health system cannot meet the needs of many children and adolescents**. Using 2005 census data and national prevalence estimates, approximately 11% of

children and adolescents have a serious emotional disturbance (SED) and only one in five children and adolescents with a SED obtains treatment.

The primary reason Virginia children and adolescents have difficulty accessing mental health, mental retardation, and substance abuse services is the lack of sufficient amounts and types of services provided by community services boards (CSBs). CSB child and adolescent prevention and treatment services are unavailable in many communities, particularly in rural areas. Of those children and adolescents who do receive services, most receive only the most basic of services, case management and possibly medication management. Very few children receive individual or family therapy. Even fewer receive intermediate-level services, such as day treatment or wraparound services, that would allow them to function successfully in their communities and keep them out of hospitals and residential treatment centers. The unduplicated count of children and adolescents under the age of 18 who received mental health services in 2005 was 26,125 and in 2006, the number increased to 27,114. According to data from the DMHMRSAS Comprehensive Plan for 2008-2012, 1,684 children and adolescents were on waiting lists for specific CSB mental health services, and those children were fortunate enough to be waiting in places where services were available. In addition, there are 1,646 residential beds and 290 acute care beds and 64 state beds that specifically target children and adolescents.

Except for a few scattered communities, waiting lists for CSB services such as outpatient therapy and medication management range from six weeks to six months. According to the DMHMRSAS 2006-2012 Comprehensive State Plan dated December 7, 2005, children and adolescents waited over a month for initial assessments for mental health services and almost three weeks for initial assessments for mental retardation and substance abuse services. Young children waited almost four weeks for infant and toddler Early Intervention services. Adolescents waited just over three weeks for substance abuse treatment services. Children and adolescents waited 12 weeks for highly intensive residential, six weeks for family support, almost two weeks for supportive residential, and one week for intensive residential services. Children and adolescents waited almost seven weeks for intensive in-home services and over five weeks for medication, psychiatric, and counseling services. Children and adolescents waited 12 weeks for alternative day support arrangements, eight weeks for rehabilitation, and six weeks for therapeutic day treatment.

Examples of the shortage of child and adolescent behavioral health services in the Commonwealth include:

- The critical shortage of acute psychiatric inpatient beds has led many hospitals to turn away children and youth who are suicidal, homicidal and psychotic; for example, over a recent 10 day period during April, 2007, the Virginia Treatment Center for Children turned away 52 children who required acute hospitalization.
- There is only one evidence-based outpatient treatment clinic in the state for children with Autism Spectrum Disorders.
- All CSBs provide emergency services and case management within available resources for children and adolescents, however, intermediate community level services are fragmented and many are not available statewide.

- Children who are not mandated have difficulty accessing CSA funds, even though the CSA system was built to develop a system of care for all needy children.
- Many communities, particularly in rural areas, do not have any specially trained child psychiatrists and child psychologists to treat their children in need.

These examples of service gaps leave families struggling to cope with children who are aggressive, anxious, depressed, disabled, and/or addicted to substances. Even in communities where services exist, they are piecemeal, fragmented and uncoordinated.

Current child and adolescent behavioral health services are disproportionately distributed to the least intensive outpatient services and the most intensive residential services. When children have needs that cannot be met by outpatient therapy, medication and/or case management, often their problems worsen and they are sent to residential services such as acute inpatient hospitals, group homes and residential treatment centers. However, if intermediate level services were made available, most children and youth could be served in their home communities. Such services include:

- Wraparound services
- Day treatment
- Respite care
- Crisis stabilization
- In-home family therapy
- After school intervention
- Intensive outpatient treatment
- Mobile crisis teams
- Intensive case management
- School-based mental health services, and
- Drop-in centers for emotionally and behaviorally troubled teens.

Creating intermediate level services would save money by diverting funds from more costly residential services while simultaneously keeping children and their families together. These intermediate services are less costly and, for the majority of children and adolescents, more clinically appropriate than more intensive inpatient and residential services. The also have the advantage of keeping children and their families together.

Service capacity shortages cannot be solved without expanding workforce capacity and increasing the ability of the current workforce to treat children and adolescents. **Although the Commonwealth has started to address this issue, there continues to be a critical shortage of specially-trained child psychiatrists and psychologists in Virginia, particularly in the rural areas. Over the past ten years, the Commonwealth has invested in a small number of fellowships to expand the number of child psychiatrists and psychologists with specialized knowledge in treating children and adolescents. Additionally, the Department has sponsored a number of conferences on evidence-based systems of care interventions. However, the majority of behavioral health clinicians, pediatricians, and other health care providers who are serving children and adolescents lack the specialized knowledge to effectively treat children and adolescents who have or are at risk of serious emotional disturbances or substance use disorders. Unlike many states such as Massachusetts, New**

Mexico, and Minnesota, Virginia lacks Centers of Excellence in Training that can teach psychiatrists, physicians, therapists and counselors evidence-based treatments that effectively help children. The rapid growth of such problems such as oxycontin and methamphetamine abuse, autism spectrum disorders, and the co-occurrence of mental health, mental retardation and/or substance abuse disorders cannot be addressed when services for other problems are unavailable or stretched to their limits. Without Centers of Excellence in Training to teach clinicians how to deal with the behavioral health problems of our children, we will continue to be ineffective in helping them.

When the behavioral health problems of children and adolescents are not met these problems inevitably spill over into other systems. Some families have had to relinquish custody of their children by placing them in DSS custody so that they could obtain needed mental health services – although recent events such as the Attorney General's opinion, changes in legislation, and changes in DSS regulations may put an end to this practice. Schools have to deal with disruptive children and adolescents who are not receiving necessary mental health and substance abuse treatment services. Primary care physicians are asked to provide medication for children who may be beyond their expertise to treat. Some children simply fall through the cracks. When all else fails, youth become involved in the juvenile justice system, where they may, for the first time, receive some treatment services. Youth who end up involved in the juvenile justice system, including detention and incarceration in state facilities, cost localities and the Commonwealth a great deal of money that could be saved if they were provided with less costly mental health services in the community. **An estimated 50% of all youth involved in the juvenile justice system have mental health and/or substance abuse disorders, which suggests that the treatment system has failed them**. Juvenile detention centers should not be the default child and adolescent behavioral health system.

Ultimately, **the answer is to develop community-based systems of care that have a fully developed continuum of services and supports that include intermediate-level services**. Developing community-based systems of care will allow localities to reduce their current reliance on high-cost, highly restrictive treatments like residential treatment and move toward lower cost, effective services like day treatment and wraparound services. This shift will allow children to be served and in settings that are either at home or in their home community. A fully developed continuum of services and supports will also allow families to stay together, or at least close to each other. It is time we made a significant investment in behavioral health services in our communities for children, adolescents and families.

Current Status of Initiatives

Systems of Care Projects

The Systems of Care Projects are intended to demonstrate evidence-based practices within a system of care framework. The target populations for the four demonstration projects initiated in September 2005 and 2006 are:

- Children with serious emotional disturbances who are involved with the juvenile justice system;
- Children returning from residential care; and

- Children at risk of residential placement.

With $2.0 million in funding from the General Assembly, four CSBs are currently implementing evidence-based practices within systems of care with support from the OCFS. The goal of these projects is to demonstrate the efficacy of evidence-based practices in communities through out the Commonwealth to develop more seamless systems of care. The projects report quarterly progress and data to DMHMRSAS and participate regularly in technical assistance meetings with OCFS staff. National experts have stated that successful systems of care projects require two to four years to demonstrate success.

Current System of Care/Evidence-Based Practice Demonstration Projects:

1. Richmond Behavioral Health Authority (FY 2006, Multisystemic Therapy)
2. Planning District One (FY 2006, Functional Family Therapy)
3. Cumberland Mountain CSB (FY 2007, Functional Family Therapy)
4. Alexandria CSB (FY 2007, Functional Family Therapy) See Appendix D

Mental Health/Juvenile Detention Center Projects

The Department of Juvenile Justice Services estimates that at least 50% of Virginia's juvenile detention population is in need of mental health services, and states that funding from private, federal, state, and local sources has been inadequate to meet the needs of individuals with mental illnesses who are placed in these local facilities. These facilities are not designed for, nor funded to provide, adequate behavioral health care services to local offenders in need. In response to this need, several years ago DMHMRSAS and the Department of Juvenile Justice funded five projects with a combination of federal and state funding to have CSBs provide mental health screening, assessment services, and community based referrals for youths in local juvenile detention facilities. In 2006, the General Assembly provided $1.14 million for nine new projects and picked up the federal share of funding for the others, to bring the total number of projects to 14. In 2007, the General Assembly provided $900,000 in additional funding to bring the total of detention facilities with mental health services to 23. Based on current data, the programs are projected to serve approximately 2,500 youth annually. See Appendix F

Part C

In 2006, the General Assembly funded Virginia's Part C Early Intervention System with the total state allocation of funding for direct services to $7.2 million. In 2006 10,704 infants and toddlers were served. This represented an increase of 6.2% over the 2005 annualized child count. Needs for early intervention have become increasingly well documented during the last year. Substantial reliable data have been provided through the DMHMRSAS Comprehensive State Plan, the Virginia Cost Study, and the reports of several committees comprised of CSB Executive Directors, MR Directors, council coordinators, providers, and families. The increase in the number of potentially eligible children can be attributed to improved medical technology, increased public awareness, and better- informed primary referral sources. The current amount of federal funds is not sufficient to meet the service needs of these children. Only the infusion of state general funds has allowed Virginia's early intervention system to provide appropriate services to all eligible children. See Appendix G- for more details.

The CFBHPP Committee Priority Recommendations for FY 2008-2010

The Child and Family Behavioral Health Policy and Planning Committee recognizes that it is not possible to do all that is necessary to repair the children's behavioral health system in Virginia in one or two or even five years. It will take increasing and sustained efforts over a 10 year period. However, it is critical that a significant investment be made now. This report follows up on the 2006 Child and Family Behavioral Health Policy and Planning Committee report to the Legislature and the recommendations represent continuity within the biennial funding cycle. The following are the policy and operations recommendations for the 2008-2010 biennium:

Policy and Operations Recommendations

While funding recommendations are a major focus of this report, the committee's other recommendations propose policy, legislation, and administrative practice changes to support the transformation process. The following recommendations are comprised of several new recommendations and some from previous reports.

1) Support the efforts of the Department of Medical Assistance Services (DMAS) in collaboration with DMHMRSAS to promulgate new regulations and policies related to Medicaid coverage for substance abuse services for children and adolescents.

2) Conduct a needs assessment to evaluate the service capacity of public and private providers currently providing behavioral health services in public and private schools to identify gaps and determine service needs, coordinating efforts among DMHMRSAS, DOE, the VACSB Child and Family Council, and private providers.

3) Develop and implement a multiple-risk screening instrument across service systems for pregnant and parenting women.

4) Develop professional standards and core competencies for behavioral health clinicians who provide adolescent-specific services, and draft and implement programmatic standards including MH credentials and staff/juvenile ratios by 6/30/09.

5) Amend the State's Medicaid Plan to expand Early Prevention Screening and Treatment (EPSDT) to include Early Intervention Services (EIS) and establish a new Home and Community Based Waiver for Early Intervention Services, under Part C of the Individuals with Disabilities Education Act (IDEA).

6) Develop plans that promote the implementation, as a priority of the DMHMRSAS Office of Child and Family Services, of evidence-based prevention activities. 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.

7) Use the term "care coordination" rather than "case management" with families. Families of children with behavioral health problems do not want to be thought of as

"cases" that need "managing". Families want their care to be coordinated, so that all providers who work with them work together in support of the child and family's goals. Using the term "care coordination" would recognize and value the central role families play in the care of their children.

8) Establish a standard for behavioral health screening, similar to that established for physical health (i.e. scoliosis evaluations, vision/hearing testing), and protocols for statewide implementation of behavioral health screenings of all children and adolescents. These screenings must be performed by licensed mental health professionals and can be done through a variety of ways, e.g., school-based screenings, community services board (CSB) assessments, or through the child's health care provider. With timely screening, referrals for further assessment, interventions, and treatments for symptoms can be provided at the earliest possible point in time, in order to prevent the increase of symptoms that become progressively more disabling.

9) Endorse continued collaboration between the DMHMRSAS and the DOE for training professionals to support individuals with autism and autism spectrum disorders.

10) Endorse the "Skill Competencies for Professionals in Virginia Supporting Individuals with Autism across the Lifespan" developed by the Virginia Autism Council and support the legislative Joint Commission on Health Care's focus on autism spectrum disorders.

11) Broadly disseminate trauma tool kits to all child caring agencies, including but not limited to CSBs, DSS, DOE, and CSA.

12) Encourage DMHMRSAS, in accordance with HJR 774 and in conjunction with the HHR Secretary, to incorporate the funding recommendations from this report in its 2008-2010 biennium budget submission.

Recommendations Requiring Funding

Recommendation 1: Increase Service Capacity

- **Fund Intermediate-Level Community-Based Services @ $20.0 million in FY 2009 and $40.0 million in FY 2010**
  The key to keeping children and adolescents out of high-cost residential services such as residential treatment, group homes, and inpatient psychiatric units is to provide intermediate-level community based services. Intermediate-level services include wraparound services, day treatment, respite care, crisis stabilization, in-home family therapy, after school intervention programs, intensive outpatient treatment, mobile crisis teams, intensive case management, school-based mental health services, and drop-in centers for emotionally and behaviorally troubled teens. These services will not only keep children in their homes and communities, but they will also result in savings from residential services and juvenile justice.

- **Fund 12 System of Care Projects @ $3.6 million**
  Expand the Commonwealth's investment in community-based Systems of Care Projects with a fully developed continuum of services and supports by adding 12 additional projects in FY 2009. These projects will target underserved youth and children by providing evidence-based and promising and best practices services that are not currently available in their localities. These services will keep children in their homes and communities.

- **Fund MR Family Support @ $62,500 for each of 40 CSBs for a total of $2.5 million**
  The goal of Family Support is to provide financial assistance, services, and/or technical supports identified by a family as necessary to maintain their eligible family member in their home. Family Support offers families the opportunity to make informed decisions regarding the care of their loved ones.

- **Fund MR waiver slots @ $6.0 million**
  Waiver services include in-home training, personal assistance, respite, day support, environmental modifications, assistive technology, nursing services, and therapeutic consultation. Once a child receives a slot, the services are available as long as the need exists. Respite and personal assistance may be consumer-directed.

  Approximately one-third of the urgent waiting list is children under the age of 18. Unfortunately, children are not usually able to compete successfully for slots with adults, simply because most children have caretakers who are younger and also tend to have more extended family. Children are not generally at risk of really being homeless. Very few children are judged to be the "most urgent of the urgent" when a slot is available. What often happens is that parents struggle, doing the best they can, as long as they can. When the child becomes an adolescent, the family reaches a crisis point and the child is at risk of needing a more costly out-of-home placement. Rendering services at an earlier time would be of more benefit to the child and family and could prevent more expensive, out-of-home, and possibly out-of-area, placements.

- **Fund Part C Early Intervention Services @ $1.73 million in FY 2009 and $3.746 million in FY 2010**
  Early intervention not only helps children reach their maximum potential, but it saves money in the long run. Early Intervention reduces the cost of school age special education services and other supports as it prevents permanent disabilities in some children and lessens the impact of delays and disabilities in others. Prior to 2005, the growth in the number of children in need of services had remained at a consistent average of 8%. In order to provide services to the increased number of children eligible for Part C Early Intervention Services and prevent higher costs in the educational system later, we need to increase state funding for Part C.

- **Fund 3 Additional Project LINK sites @ $375,000**
  Substance use during pregnancy presents special risks to the mother and her unborn child. In 2002 and 2003, 9.8% of pregnant women nationwide drank alcohol during their pregnancy and 4.3% of pregnant women used an illicit drug (National Survey on Drug Use and Health, June 2, 2005). Of the 104,488 infants born in Virginia in 2005, it is estimated that 10,234 were exposed to alcohol in utero – including 4,284 exposed to heavy alcohol use - and roughly 4,492 infants were exposed in utero to illicit substances.

  Project LINK is a specially funded women's outpatient program that provides intensive case management to substance-using pregnant, parenting and "at-risk" women and their children. When introduced in1992, five sites were funded through the Substance Abuse Prevention and Treatment Block Grant; a sixth site was added in 1999 and two collaborative LINK sites were funded by state general funds in 2000. No new sites have been funded in the past seven years, despite the great need.

- **Fund outpatient Substance Abuse services @ $3.0 million**
  Pregnant and parenting women with substance use disorders have complex, multifaceted treatment needs that few treatment programs are able to accommodate. The majority of pregnant women discontinue their substance use during pregnancy; those who are not able to remain abstinent with the support of outpatient treatment require intensive residential treatment throughout their pregnancies. Current best practices recommend that women be allowed to keep their newborn infants in treatment with them and that intensive, gender-specific, comprehensive services be provided to the mother and appropriate early intervention services be provided to the child.

  The DMHMRSAS utilizes $1 million in state general funds to support residential substance abuse treatment to pregnant and recently postpartum women in three localities: Blue Ridge CSB (cities of Roanoke and Salem, counties of Roanoke, Botetourt and Craig), Richmond Behavioral Health Authority (Central Region) and Hampton/Newport News CSB (Tidewater Region). A private non-profit, residential treatment program for women in Northern Virginia, Demeter House, is able to accommodate pregnant substance-using women and their newborns; however there are no comparable programs in far southwest Virginia. Methamphetamine use and misuse of prescription opiates is a major problem among women in this area and accounts for a significant number of abuse and neglect reports to child protective services.

  Although Medicaid reimbursement is available for residential substance abuse treatment for Medicaid-eligible women during pregnancy and up to two months postpartum, few programs are able to meet Medicaid's rigid standards (since its introduction, only four programs in the state have accessed these funds). Startup funds are not available to support the development of new programs, nor is funding available to support residential services for non-Medicaid eligible women or beyond two months postpartum. This proposal expands perinatal treatment services to far southwest Virginia.

- **Fund school-based mental health clinicians in 20 middle schools in five regions @ $1.8 million**
  Children and schools in Virginia will benefit from initiating school-based mental health services across the state. We propose funding 20 School-Based Mental Health Demonstration Projects, four each in five regions of the state. The Demonstration Projects will provide a full-time therapist employed by the local CSB at each of the selected middle schools, targeting students who experience educational difficulties as a result of psychiatric and/or substance abuse problems. Projects will utilize national best-practice service models that effectively reduce behavioral and emotional disorder-related problems in schools, and improve academic attendance and school performance. Funding for outcome evaluations is included in the request. The results will be disseminated to other CSBs and school systems throughout the state.

- **Fund infrastructure in the Department's Office of Child and Family Services to support these initiatives to increase service capacity statewide @ $990,000**
  The DMHMRSAS Office of Child and Family Services (OCFS) was formed in 2004 and currently has a total of 14 staff to support a comprehensive system of care for children, adolescents and their families. Three of them are grant-funded, and those grants are going run out in FY 2008. That will leave 11 staff to assess state needs and facilitate and coordinate cross-system planning for the behavioral health needs of children and adolescents, 8 of whom work in Part C Early Intervention. The remaining three staff must provide leadership regarding and help integrate mental health, mental retardation, and substance abuse services in 40 CSBs. They must partner with stakeholders and families to improve services for children and develop policies that promote the use of evidence-based, promising and best practices across the Commonwealth.

  These resources are insufficient to meet the current responsibilities of the Office of Child and Family Services. Those responsibilities have grown in the past three years with new programs funded by the legislature. In order to support the comprehensive systems building and reform proposed by these recommendations, the OCFS will require increased infrastructure. Funding the programs without the infrastructure necessary to support them is likely to result in failure of these initiatives. For more detail on the infrastructure needs, see Appendix G.

Total Cost of Recommendation 1: **$39,995,000 in FY 2009**

<u>Recommendation 2: Increase the Size of the Workforce</u>

- **Add funding for four new child psychiatry fellowship slots and two new child psychology internship slots at a cost of $1,036,000 with payback provisions to work in underserved areas in Virginia**

  Virginia has a shortage of specially-trained child and adolescent clinicians, particularly child psychiatrists and psychologists. It has a particular shortage of children's behavioral health service providers in rural areas. In 2007, the Legislature funded four new child psychiatry fellowship slots and four new child psychology internship positions in already

existing fellowship and internship programs at state universities and academic medical centers. Since child psychiatry fellowship slots are two-year positions, the first four slots need to be funded for a second year, and we recommend adding four more, so that four new child psychiatrists will be trained each year. Similarly, we recommend adding two new child psychology internship slots, since each of the three state medical schools can train psychology interns for a total of six to be trained each year. These positions should include payback clauses stating that for each year of funding provided, the fellow or intern agrees to provide one year of behavioral health services in an underserved area of Virginia.

Total Cost of Recommendation 2: **$1,036,000**

Recommendation 3: Enhance Workforce Capacity

- **Establish three Centers of Teaching Excellence to organize coordinate and lead the training of clinicians in evidence-based, promising and best practices for children's behavioral health treatment across the Commonwealth at a cost of $700,000.**

  To provide more behavioral health services to children, youth and their families, we need to increase the skills of providers who specialize in working with children, those who work with children but have received minimal training in how to treat children effectively, and those who could work with them, such as adult therapists, but currently do not. Enhancing the capacity of the children's behavioral health workforce requires building a training infrastructure by establishing university-based teaching Centers of Excellence to develop competency standards and train the current and future workforce in evidence-based treatments. The Centers of Excellence will train both current child-serving clinicians and other clinicians who do not currently serve children in effective, evidence-based treatments for children and youth. Multiple forms of teaching will be used, including regional and web-based trainings, videoconferences, telemedicine, consultation, and technical assistance.

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

Total Cost of Recommendation 3: **$700,000**

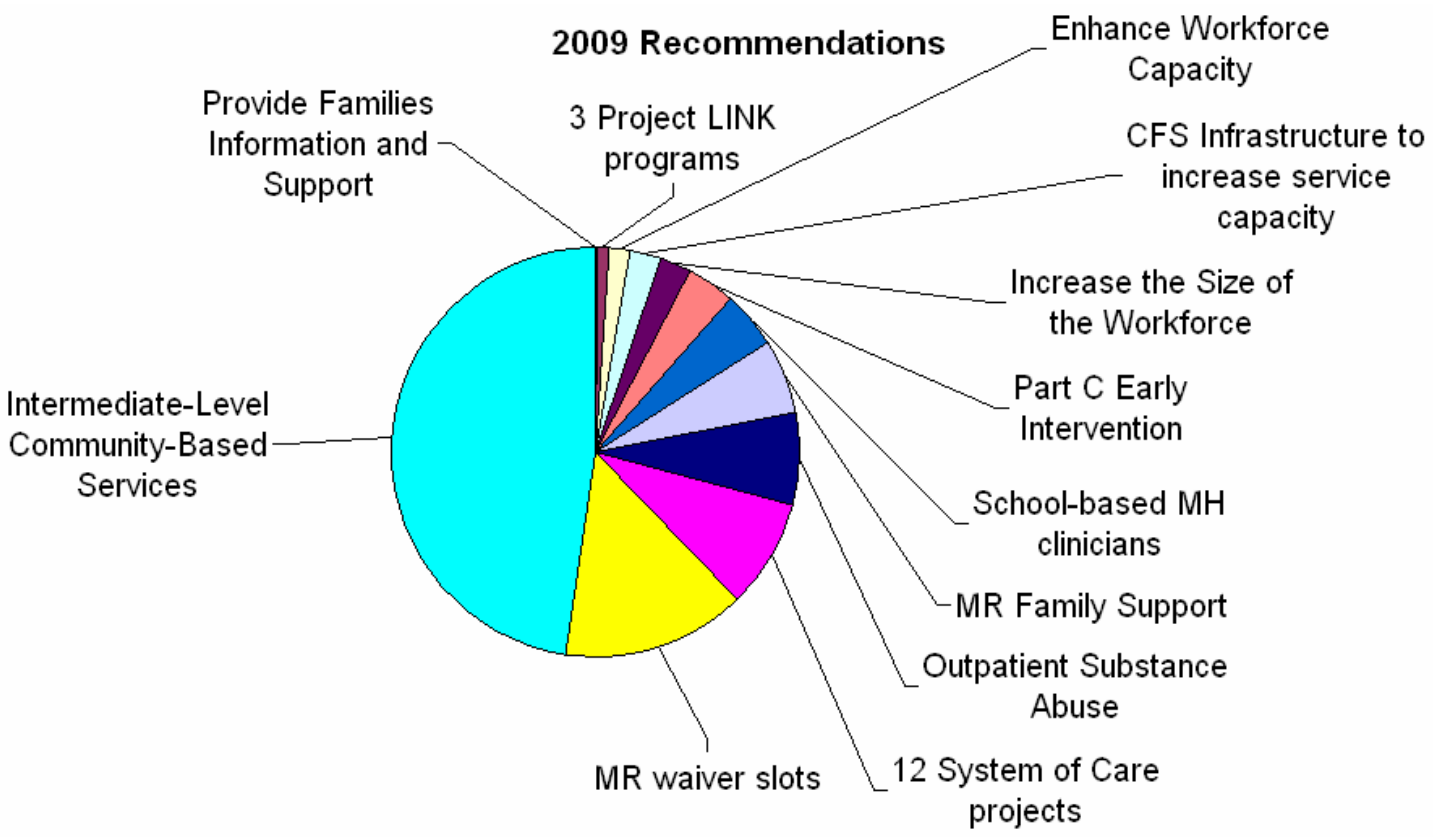
Recommendation 4: Provide Families with Information and Support

- **Fund 1.5 FTE for a Resource/Service Coordinator and administrative support to assist families in accessing needed services for their children and adolescents, educate families about available services, link families with support systems, and educate the public about the needs of children with behavioral health issues @ $100,000**

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

Cost of Recommendation 4: **$100,000**

Total Cost of Recommendations 1-4: $41,831,000 in FY 2009



Conclusion

As reports in previous years have stated, Virginia's behavioral health system for children and adolescents is in crisis. For years we have known that there is insufficient funding for services to address the behavioral health needs of children and adolescents. Landers (2001) noted the following historical data regarding why funding is needed:

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

In this report, the Child and Family Behavioral Health Policy and Planning Committee outline steps to put in place much-needed intermediate-level and missing services for this underserved population. A significant infusion of funds is necessary to provide adequate services and supports across the Commonwealth. We must take action on the recommendations listed in this report; only then will Virginia have a system that meets the needs of its youngest citizens.

Providing a wide range of types and levels of services to children, adolescents, and their families is imperative if we wish to build a strong system of care in Virginia. As was stated in the Richmond Times-Dispatch editorial on May 6, 2007, "The lack of coverage for lesser levels of support also can allow the development of crises that require full-blown intervention and hospitalization. The situation is analogous to the lack of insurance for preventive physical care. Conditions go untreated until someone is rushed to the emergency room. The cost of treatment skyrockets…It is far more sensible to have in place a wide range of social supports and a robust array of mental health services to prevent crises before they occur."

Through the Systems of Care Projects and partnerships with the academic community, Virginia has laid the groundwork for supporting recovery-oriented evidence-based practices for children and adolescents. The DMHMRSAS is committed to continuing to advance evidence-based practices using dissemination and demonstration projects and creating public-private partnerships to guide their implementation. Children are the adults of the future. The Child and Family Behavioral Health Policy and Planning Committee strongly believes that if we do not address the myriad needs for behavioral health services for children and adolescents, we may miss the opportunity to intervene with those who might pose a threat to themselves or others in the future. We must build on the progress that has been made in improving access to behavioral health services for children and adolescents if we are to make services available and accessible in the Commonwealth. This is the year to make significant investment in funding children's behavioral health services a reality.

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Virginia Department of Mental Health Comprehensive Plan, 2006-2012, December 5, 2005.

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Appendix C: 2007 Update to the Ten Year Strategic Plan for Children's Behavioral Health			
Goals	**2006-2012 Interventions/Activities**	**Implementation Status**	**2008-2009 Recommendation**
1. Healthy, strong, resilient, stable families as evidenced by children who: ♦ Live in a safe, nurturing home ♦ Attend school ♦ Make educational progress ♦ Are involved in positive peer activities ♦ Can have their needs for healthy development met in their homes and communities	1. A.1.a. Create a $6 million fund to provide incentive grants to start up new behavioral health services, particularly mid-level services such as: ♦ Wrap-around ♦ Day treatment ♦ After-school behavioral health programs ♦ Intensive outpatient programs ♦ Crisis intervention programs ♦ Respite care ♦ In-home family therapy ♦ Intensive case management ♦ Mobile crisis teams ♦ Drop-in centers for teens ♦ Outpatient co-occurring disorders clinics ♦ Residential treatment for youth with both mental health and substance abuse disorders ♦ Residential treatment for children with both mental retardation and mental health disorders		**Fund Intermediate Community Services @ $20.0 million** **In order for families of children/youth with mental, emotional or behavioral issues to be fully sustained, it is necessary for them to have a full range of in-home supports such as respite, mentoring, and in-home therapy, to name a few. These are all proven measures that wraparound a family, providing them the assistance and support that they need to be successful. Along with family support, trainings are also important. Families can benefit from learning more about their child's disability/issue, advocacy skills, how "the system" works so they can access appropriate services as needed and how to work with their mental healthcare professionals to achieve the optimal outcomes desired by all involved**

Appendix C: 2007 Update to the Ten Year Strategic Plan for Children's Behavioral Health			
Goals	**2006-2012 Interventions/Activities**	**Implementation Status**	**2008-2009 Recommendation**
	1. A.1.b. Increase funding for mid-level services in the Medicaid state plan 1. A.1.c. Add adolescent substance abuse services to the Medicaid state plan and request $5.5 million in funding 1. A.1.d. **Conduct a study of what would be required for DMAS to suspend rather than end Medicaid benefits when a youth is placed in detention**		**Fund 3 additional Project LINK programs @$375,000** **Fund outpatient SA services @ $3.0 million**
	1. A.1.e. **Provide mental health services in all eight remaining juvenile detention centers without them @ $ 1.2 million**	***Funding in the budget for picking up the federal share for the five federal DJJ/MH sites. Development of a process for $900,000 for remaining 9 detention centers.***	
	1. A.1.f. Fully fund early intervention services for at-risk children, including Part C and identification of and services for substance-exposed infants	***Medicaid and Substance Abuse Services for children and adults once Medicaid has amended the state plan.***	**Fund Part C Early Intervention for an average increase in the child count of 6% per child for the per child annual rate @.$1,730,000**
		1. A.1.g. Authorize the Office of Comprehensive Services to use CSA funds flexibly to help start up new services and programs.	
	1. A.2. Build the workforce of the children's behavioral health system 1. A.2.a. Fund four child psychiatry fellowship and two child psychology internship slots @ $438,000 with payback provisions to work in underserved areas in Virginia.	*Funding for four child psychiatry fellowships and four child psychology internships to work in underserved areas in Virginia - $493,000*	**Fund expansion of eligibility requirements and qualifications of behavioral health consultants.** **Fund 4 new child psychiatry fellowship and two child psychology internship slots @ $986,000 with payback provisions to work in underserved areas in Virginia**

Appendix C: 2007 Update to the Ten Year Strategic Plan for Children's Behavioral Health			
Goals	**2006-2012 Interventions/Activities**	**Implementation Status**	**2008-2009 Recommendation**
	1. A.2.b.1. **Establish a university-based teaching center to organize, coordinate and lead the training of clinicians in evidence-based, promising and best practices for children's behavioral health treatment across the Commonwealth @ $300,000** 1. A.2.b.2. **Fund regional trainings in evidence-based children's behavioral health services for behavioral health clinicians @ $200,000**		**Establish teaching centers to organize, coordinate and lead the training of clinicians in telemedicine and other forms of education evidence-based, promising and best practices for children's behavioral health treatment across the Commonwealth @ $700,000**
	1. A.2.b.3. Fund regional trainings in children's behavioral health services for pediatricians and family practitioners @ $200,000		
	1. A.2.b.4. **Establish best practice competency standards** 1. A.2.b.5. Provide local and regional trainings in how to do wraparound services		
	1. A.3. Service agencies communicate and collaborate to meet those needs 1. A.3.a. Provide reimbursement for care coordination and interagency communication between providers **1. A.3.b. Allow public-private partnerships to jointly apply for state funds**		

Appendix C: 2007 Update to the Ten Year Strategic Plan for Children's Behavioral Health			
Goals	**2006-2012 Interventions/Activities**	**Implementation Status**	**2008-2009 Recommendation**
	1. A.3.c. DMHMRSAS will develop criteria to identify local Centers of Excellence in systems of care 1. A.3.d. Fund mentorship/training from local Centers of Excellence to similar communities		**Make prevention activities a central focus: The Department should make prevention activities a centerpiece of its policies and plans regarding children's behavioral health services. Evidence-based prevention services have been shown not only to reduce child and family suffering due to behavioral problems, but also to save money.**
	1. A.3.e. Utilize one lead case manager/care coordinator per family 1. A.3.f. Co-locate providers and agencies and align infrastructure to support collaboration.		**Use language "care coordination": Families of children with behavioral health problems often resent being thought of as "cases" that need "managing", which they experience as dehumanizing. They prefer to have their care coordinated, so that all providers who work with them work in concert with each other towards a set of shared goals. Changing the official term to care coordination would recognize and value the central role families play in the care of their children.**

Appendix C: 2007 Update to the Ten Year Strategic Plan for Children's Behavioral Health			
Goals	**2006-2012 Interventions/Activities**	**Implementation Status**	**2008-2009 Recommendation**
	1. A.4. Services can be accessed through any door 1. A.4.a. Develop and implement a single intake instrument for families with core information for use by DMHMRSAS, DSS, DJJ, VDH, DOE, and OCS 1. A.4.b. Evaluate and make recommendations regarding the possible development and implementation of a uniform management information system for use by DMHMRSAS, DSS, DJJ, VDH, DOE, and OCS 1. A.4.c. **Fund a web-based acute psychiatric bed reporting system @ $75,000**	***$25,000 for real time reporting system for public and private acute psychiatric beds in the Commonwealth.***	
	1. B. Maximize the use of EPSDT screenings 1. B.1. Provide regional trainings and technical assistance on EPSDT to pediatricians, family practitioners, case managers, and other service providers		**Recommend that DMHMRSAS and DMAS work collaboratively to amend the State's Medicaid Plan to support a Home and Community Based Waiver for early intervention services under Part C of the Individuals with Disabilities Education Act (IDEA) to create a new service entitled "Early Intervention Services" (EIS) as a new EPSDT service, available for children who meet the State's eligibility criteria for 0-3 through the Infant & Toddler Connection of Virginia (both those children at risk for and those identified as having a developmental delay or diagnosed medical condition) and who have an Individualized Family Service Plan (IFSP).**

Appendix C: 2007 Update to the Ten Year Strategic Plan for Children's Behavioral Health			
Goals	**2006-2012 Interventions/Activities**	**Implementation Status**	**2008-2009 Recommendation**
	1. C. DMHMRSAS, DOE and VDH will collaborate to develop and implement strategies to keep children with behavioral health problems in school rather than suspend or expel them. 1. C.1. **Provide school-based mental health clinicians in 20 middle schools in five regions @ $1.8 million**		**Conduct a needs assessment coordinating efforts among DOE and DMHMRSAS and include the VACSB Child and Family Council, and private providers to work collaboratively to assess the service capacity of public and private providers currently providing behavioral health services in public and private schools currently and to determine needs and identify gaps** **Fund school-based mental health clinicians in 20 middle schools in five regions @ $1.8 million.**
	1. C.2. Fund bullying prevention programs in schools 1. C.3. Promote alternative education strategies and programs for children with behavioral health problems 1. C.4. Expand care connection centers to include children's behavioral health		**Support behavioral health screenings for all children and youth. This can be performed by licensed MH professionals and can be done a variety of ways; school based screenings or at CSBs or through children's health care provider. Health screenings for other physical aliments are routinely done, i.e. vision and hearing, evaluations, etc with the same expectation for mental health services to minimize issues that severely affect children and youth and provide appropriate interventions and treatment and to alleviate symptoms.**
	1. D.1. DSS will eliminate the practice of placing children in DSS custody solely so that they may access behavioral health services 1. D.2. FAPT teams will be required to serve all children at risk of out of home placement for behavioral health problems.		

Appendix C: 2007 Update to the Ten Year Strategic Plan for Children's Behavioral Health			
Goals	**2006-2012 Interventions/Activities**	**Implementation Status**	**2008-2009 Recommendation**
	1. E.1. Fund pilots for Nurse Home Visitation programs for at-risk pregnant women 1. E.2. Fund pilots for Child-Parent Centers in preschools and elementary schools in high-risk neighborhoods	***Conference budget bill – develop new guidelines for MHI funding. Funding for mental health services for children and adolescents with SED and related disorders which through the Department to CSBs shall be allocated with priority placed on serving those children who are at risk for custody relinquishment.***	**The Office of Comprehensive Services and the State Executive Council are addressing recent changes to Foster Care Policy regarding Custody relinquishment to access services. Monitor and track the Foster Care Policy and Guidelines to be implemented August 15, 2007 that requires the provision of mental health services to families without Relinquishing custody.**
	1.D. DMHMRSAS, DSS, OCS and VDH will collaborate to develop and implement strategies to prevent children from being placed in DSS custody solely to access behavioral health services.		
	1. E. DMHMRSAS, DSS, OCS, VDH and DOE will collaborate on new child abuse prevention efforts		**Broadly disseminate trauma tool kits to all child caring agencies including but not limited to DSS, DJJ, and CSA**.
	1. E.3. Evaluate the outcomes of the existing child abuse and neglect prevention programs in Virginia and compare them with the outcomes of evidence-based programs.		
2. Equitable access to services without regard to racial/ethnic status, socioeconomic status, and geographic location as evidenced by:	2.A. Examine the current health insurance model in Virginia and other states to determine the best approaches to increase the number of children with health insurance 2. A.1. Increase the eligibility level for the FAMIS mother's program to 200% of poverty 2. A.2. Examine the Massachusetts model for providing health insurance to all children to determine if it can be replicated in Virginia		

Appendix C: 2007 Update to the Ten Year Strategic Plan for Children's Behavioral Health			
Goals	**2006-2012 Interventions/Activities**	**Implementation Status**	**2008-2009 Recommendation**
A. All children have health insurance	2. A.3. Promote legislation that provides health insurance for all of Virginia's children		**Support a proposal for increased reimbursement rates for behavioral health consultants and support** **Support a proposal for increasing the hours approved for the work of behavioral consultants**
	2.B. Expand the number of private insurers who offer mental health and substance abuse parity 2.B. Educate private insurers regarding the cost offsets and positive economic impact of insurance coverage for mental health and substance abuse		
2. B. Mental health and substance abuse parity in insurance	2. C.1. Enact the original intent of the Comprehensive Services Act to serve at-risk children with behavioral health problems using a system of care approach 2. C.1.a. Require FAPT teams to serve all children at risk of out of home placement for behavioral health problems 2. C.1.b. The Office of Comprehensive Services will eliminate the distinction between mandated and non-mandated children		
2.C. Children and families have access to behavioral health services and supports when they need them	2. C.2. Provide a public safety net for the mental health, substance abuse and mental retardation needs of children and their families 2. C.2.a. Provide public and private agencies that subscribe to SOC principles @ $6/ million in additional funding as to start up new behavioral health services as described in 1.A.1.a.		**Fund MR Family Support @ $62,500 for 40 CSBs @ @ $2.5 million** **Fund MR waiver slots @ $6.0 million**

Appendix C: 2007 Update to the Ten Year Strategic Plan for Children's Behavioral Health			
Goals	**2006-2012 Interventions/Activities**	**Implementation Status**	**2008-2009 Recommendation**
			The committee supports the efforts of the Department of Medical Assistance Services (DMAS) in collaboration with DMHMRSAS to promulgate new regulations and policies related to Medicaid coverage for substance abuse services for children and adolescents and look forward to their implementation.
	2.C.2.b. Fund system of care pilot projects in 50% of Virginia communities over a 10 year period (**Fund four new pilot projects @ $500,000 each in FY 2008**) 2.C.2.c. Fund a designated child and adolescent service provider for mental health, mental retardation, and substance abuse services in each CSB		**Fund 12 System of Care projects @ $3.6 million**
	2.C.2.d. **Conduct rate studies for Medicaid behavioral health services, particularly for:** ♦ **Outpatient psychiatric care** ♦ **Primary care physicians who provide behavioral health services** ♦ **Acute inpatient hospitalization** ♦ **Day treatment services** ♦ **Intensive in-home family services**		Conduct a comprehensive rate study for Medicaid behavioral health services to assess whether behavioral health service rates need to be increased, particularly in the following areas: outpatient psychiatry; primary care physicians who provide behavioral health services; acute in-patient hospitalization; day treatment; and, intensive in-home family services.

Appendix C: 2007 Update to the Ten Year Strategic Plan for Children's Behavioral Health			
Goals	**2006-2012 Interventions/Activities**	**Implementation Status**	**2008-2009 Recommendation**
	2. C.3. Strengthen family-professional partnerships to improve access to services 2. C.3.a. **Expand funding for a statewide family education, information and support network @ $500,000 to provide families with information about services available to their children, link families with support systems, and educate the public about the needs of children with behavioral health problems**		**Fund one FTE Resource/Service Coordinator to assist families in accessing needed services for their children and adolescents, educating families about available services, linking families with support systems, and educating the public about the needs of children with behavioral health issues and. fund 0.5 FTE administrative support person to assist with general clerical and related administrative duties including assisting in developing data, listserv, website, publishing newsletters, etc. @ $100,000**
	2.C.3.b. Expand and sustain membership of families and youth on local, regional and state boards, councils and committees that make decisions about children's behavioral health services, thereby ensuring authentic involvement of families in policy development that impacts service development in the Commonwealth		
	3. A.1. Develop and distribute standards for uniform screening and comprehensive assessment for children ages 0-21 3. A.1.a. Identify a uniform screening tool to match children in need of behavioral health services to the appropriate levels and types of treatment 3. A.1.b. Identify uniform assessment tools for behavioral health clinicians that support appropriate treatment interventions that are strengths-based, utilize evidence-based and promising practices, and accurately assess children's needs and required levels of care.		**Develop and implement multiple-risk screening instrument across systems for pregnant and parenting women**

Appendix C: 2007 Update to the Ten Year Strategic Plan for Children's Behavioral Health			
Goals	**2006-2012 Interventions/Activities**	**Implementation Status**	**2008-2009 Recommendation**
3. Children are provided with humane, least-restrictive, and effective services that support healthy child development as evidenced by: ♦ Children's needs are accurately assessed			
♦ Children's needs are matched to appropriate treatment interventions and levels of care ♦ Family and child preferences and strengths are driving forces treatment planning ♦ Clinicians and treatment programs utilize evidence-based, promising, and best practices	3. A.2. Provide training in the standards for uniform screening and comprehensive assessment 3. A.2. Fund statewide trainings on uniform assessment tools@ $600,000		
	3. A.3. Implement screening tools that match children's needs and strengths to appropriate treatments and levels of care		

Appendix C: 2007 Update to the Ten Year Strategic Plan for Children's Behavioral Health			
Goals	**2006-2012 Interventions/Activities**	**Implementation Status**	**2008-2009 Recommendation**
	3. A.4. Implement comprehensive assessments that are behavioral, functional and strengths-based and accurately assess all areas of the child's and family's needs including home, school, and community 3. A.4.a. Implement uniform assessment tools statewide @ $500,000		
	3. A.4.b. Place the selected uniform assessment tools in the statewide, shared Management Information System referenced in 1.A.4.b		
	3. A.5. Comprehensive assessments will reflect family and child preferences 3. A.6. Comprehensive assessments will include community-based recommendations for the least restrictive, most normative environment that is clinically appropriate		
	3. B.1. DMHMRSAS, the Commission on Youth (COY), DOE, OCS, DSS and VDH will promote the use of evidence-based and promising practices 3. B.1.a. Update the COY website on evidence-based practices annually with assistance from partner agencies 3.B.1.b. Disseminate information about what is new in evidence-based treatments to CSBs annually 3.B.1.c. Expand the COY website to include promising practices 3. B.1.d. Provide technical assistance in evidence-based practices by doing on-site visits to each CSB annually		**Endorse continued collaboration between DOE and DMHMRSAS for training professionals supporting Individuals with autism.**

Appendix C: 2007 Update to the Ten Year Strategic Plan for Children's Behavioral Health			
Goals	**2006-2012 Interventions/Activities**	**Implementation Status**	**2008-2009 Recommendation**
	3. B.1.e. Establish a fund in the OCFS in DMHMRSAS to offset costs of licensure, training and supervision in evidence-based practices		
	3. B.2. Train clinicians on evidence-based treatment models 3. B.2. Hold alternating annual conferences on systems of care and evidence- based practices in the treatment of children with mental health, mental retardation and substance abuse problems		
	3.C. Develop and implement uniform statewide performance measures and an evaluation/ monitoring process for children's behavioral health services 3. C.1. Fund the development and annual project management costs of a data management system for children's behavioral health outcomes @ $500,000		
	3. C.2. Require all entities receiving funding for children's behavioral health services to collect and report data elements and outcome measures specific to children's behavioral health services in their contracts		
	3. C.3. Outcome data will be reported to DMHMRSAS quarterly 3. C.4. Build in the selected outcome measures into the statewide MIS referenced in 1.A.4.b		

Recommendations for FY 2009 are in bold
Recommendations italicized implemented in 2006

Appendix D: Systems of Care Projects

The systems of care evidence-based practice demonstration projects were funded in 2005 to serve two functions; to further the implementation of a system of care philosophy throughout the Commonwealth resulting in an increase in community based services for youth with SED who are at risk of residential placements and to create a framework reporting valuable outcome data to measure service quality that will inform future funding and program planning decisions.

The implementation challenges and lessons learned from these projects have included the following:

- The staff required to implement the systems of care evidence-based practices projects require special skills and capabilities;
- Retention of staff has been identified as a potential barrier to success of the projects;
- Establishing vendors' capacity and availability necessary for certifying or approving projects for the provision of services needs to occur very early in development;
- Fidelity to the treatment model occasionally conflicts with systems of care principles and sometimes is not compatible with the agency's administrative structure;
- Third party reimbursement is important in sustaining evidence-based practices in Virginia an questions and issues have been identified about the feasibility of recovering costs of the FFT programs through Medicaid and other third party insurance programs;
- The success of the systems of care projects is very dependent on establishing and maintaining collaborative partnerships among community agencies; and,
- There are challenges with collecting data around establishing reliable outcome evaluation procedures.

The Evidence-Based movement is intended to make better use of research findings in typical services settings and to produce greater benefits to consumers. According to the research that is available, consumers of human services are no better off today than they were 25 years ago. According to experts knowledgeable about evidence-based practices, there are six stages of implementation of evidence-based practices; these include exploration, installation, initial implementation, full implementation, innovation, and sustainability. Based on the research conducted by national experts, success evidence-based systems of care projects take two to four years to demonstrate success.

Appendix E: Mental Health/Juvenile Detention Projects

The Department of Juvenile Justice Services estimates that at least 50% of Virginia's detention population is in need of mental health services. DJJ notes that up to 80% would benefit from the provision of services and to 75% of all youth in detention centers have at east one mental health diagnosis. According to a 2006 presentation entitled: *Criminal Justice Policy Issues in Virginia* by representatives from the Virginia Department of Criminal Justice Services describing mental health issues in jails and detention centers in August 2006, juvenile detention centers in the Commonwealth do not have standard treatment services for individuals with behavioral health issues or substance abusing offenders in their custody. These facilities are not designed for, nor funded to provide adequate behavioral health care services to local offenders in need. The report goes on to state that the present funding from private, federal, state, and local sources has been inadequate to meet the needs of individuals with mental illness who are placed in these local facilities. Five of the projects were funded with a combination of federal and state funding and in 2006, the General Assembly provided funding for nine new projects and picked up the federal share of funding to bring the total number of projects to 14 community services boards for the provision of behavioral health screening, assessment services, and community based referrals for children and adolescents in the local juvenile detention facility. Based on the current data, the programs are projected to serve approximately 2,500 youth annually.

Current programs are in operation at:

- Alexandria CSB/Northern VA Detention Home
- Blue Ridge Behavioral Health/Roanoke Detention Center
- Colonial CSB/Merrimac Detention Center
- Danville CSB/W.W. Moore Detention Center
- New River Valley CSB/New River Valley Detention Center
- Region 10 CSB/Blue Ridge Detention Center
- Chesapeake CSB/Chesapeake Juvenile Justice Center
- Chesterfield CSB/Chesterfield Juvenile Detention Home
- Crossroads CSB/Piedmont Juvenile Detention Home
- Norfolk CSB/Norfolk Juvenile Detention Home
- Planning District One Behavioral health/Highlands Juvenile Detention Home
- Richmond Behavioral Health/Richmond Juvenile Detention Home
- Valley CSB/Shenandoah Juvenile Justice Center

It is DMHMRSAS' belief that these programs service to increase local system capacity to identify and intervene in the lives of children involved in the juvenile justice system. Some highlights of the projects' current accomplishments include, but are not limited to:

- 2,531 mental health screening were completed
- 1,091 youth received case management services from mental health case managers
- 1,299 youth received individual counseling with mental health clinicians
- 1,113 youth received group counseling with mental health clinicians
- 238 youth received crisis intervention services with mental health clinicians
- 99 youth were prescribed medications
- 568 service plans were developed and follow-up at the respective CSB

- 20 youth were referred for residential placement/hospitalizations
  82 youth were reported as returning to the facility after discharge and CSB referral

Appendix F: Juvenile Justice-Related Recommendations to the

Child and Adolescent Behavioral Services Policy and Planning Committee

And to the
Behavioral Health Care Subcommittee of the Joint Commission on Health Care

May2007

The Juvenile Justice Subcommittee recommends that CFBHPP provide copies of its recommendations to the Behavioral Health Care Subcommittee of the Joint Commission on Health Care.

The Juvenile Justice Subcommittee of the CFBHPP respectfully submits the following recommendations for inclusion as priorities in the current planning process:

1. Provide ongoing funding for the provision of behavioral health services in each of the twenty-four (24) juvenile detention centers.
2. Conduct bi-annual independent outcome-focused evaluations to determine the most effective methods for meeting the behavioral health care needs of juveniles (a) while they live in juvenile detention centers, and (b) immediately upon their return to communities.
3. Based upon the results of the independent evaluations, by June 30, 2009, establish:
    i. Credentialing standards for professional providers;
    ii. Determine and fund the appropriate numbers of staff positions needed to serve the different numbers of juveniles in each juvenile detention center; and
    iii. Draft and implement programmatic standards for these services.

4. Arrange for DMHMRSAS, DJJ, DOE and representatives of private provider associations to provide joint recommendations for the provision of effective and efficient behavioral health services to juveniles involved in the juvenile justice system to the Behavioral Health Care Subcommittee of the Joint Commission on Health Care.

Appendix G: Mental Retardation Workgroup Recommendations

Child and Family Behavioral Health Policy and Procedure Committee

May 2007

I. Mental Retardation Waiver Slots for Children

Waiver services include in-home training, personal assistance, respite, day support, environmental modifications, assistive technology, nursing services, and therapeutic consultation. Once a child receives a slot, the services are available as long as the need exists. Respite and personal assistance may be consumer-directed.

Approximately one third of the urgent waiting list is children under the age of 18. Unfortunately, children are not usually able to compete successfully for slots with adults, simply because most children have caretakers who are younger and also tend to have more extended family. Children are not generally at risk of really being homeless. Seldom is a child judged to be the "most urgent of the urgent" when a slot is available. What often happens is that parents struggle, doing the best they can, as long as they can. When the child becomes an adolescent, the scenario reaches a crisis point and the child is at risk of needing a more costly out-of-home placement. Rendering services at an earlier time would be of more benefit to the child and family and could prevent more expensive, out-of-home, possibly out of area placements.

Recommendation:

Funding for 580 slots to serve children (ages birth 18) with mental retardation who are currently (3-9-07) on the urgent waiting list for the MR Waiver. Based on the average slot cost ($59,000), the amount of match funding needed would be $17,110,000.

II. Children's Family Support

Family Support is financial assistance for families who provide care for a person with a diagnosis of mental retardation in the home. The goal of Family Support is to provide assistance, services, and/or technical supports identified by a family as necessary to maintain their eligible family member in their home. Family Support offers families the opportunity to make informed decisions regarding supports needed to provide care at home.

In FY 03, the CSB's sustained a 10% cut in state general funds. Many Boards gave up their Children's Family Support funding because there were almost no general funds left. Many families who were on the waiver waiting list or whose child was not eligible for waiver services lost the opportunity for even minimal services.

Recommendation:

Children's Family Support funding to be distributed to CSB's for services needed for children under the age of 18. There is currently only $596,260 available in Children's Family Support funding. The recommendation is for $2,000,000.

III. Part C Early Intervention

In 2006, 10,704 infants, toddlers and their families were served. Trend data indicates that the number of potentially eligible children will continue upward for the number of children served in 2007. A total of 10,212 infants, toddlers and families received Part C early intervention services in the one-year period from December 2, 2004 to December 1, 2005. This number represents a 6.2% increase over the previous year and a 37.8% increase since 2002. The current data reflects the number of children in the system by annualized count (December 2 – December 1 one-year period). For reporting purposes to the Office of Special Education Programs (OSEP), point-in-time (December 1 of each year) is reported however, the annualized count provides a much more accurate picture of the total number of children served. There was a 6.2% increase in the number of children served from 2004 to 2005 and a 37.8% increase from 2002 to 2005.

Total Number of Infants and Toddlers Served in Each Year

Year (12/2 – 12/1)	Total Number Served
2002	7,409
2003	9,076
2004	9,615
2005	10,212
2006	10,704

Recommendation:

The average increase in the child count is currently at 6%. Factoring in a 3% COLA for the per child annual cost the request for the first half of the biennium is $3,118 X 575 children = $1,792,850. Using the same process, the request for the second half of the biennium is $3,212 X 608 children = $1,952,896 + $1,792,850 = $3,745,746.

Recommendation:

Rates paid to providers of early intervention services are inadequate and some localities are losing providers which impact their ability to provide services to children. Establish rates to cover costs of providing services in natural environments.

IV. Autism

Autism is a developmental disability that is diagnosed using specific criteria for impairments to social interaction, communication, interests, imagination and activities. Frequently, autism manifests itself before the age of three. Children with autism are marked by delays in their social interaction and language.

The incidence of diagnosed autism has increased since the 1990s. Reasons offered for this phenomenon include better diagnosis, wider public awareness of the condition, regional variations in diagnostic criteria, or simply an increase in the occurrence of autism spectrum disorders (ASD). In 2005, the National Institute of Mental Health (NIMH) stated the "best conservative estimate" as 1 in 1000. There are numerous theories as to the specific causes of autism, but they have yet to be fully supported by evidence. Proposed factors include genetic influence, anatomical variations (e.g. head circumference), abnormal blood vessel function, and vaccinations. According to the research, their significance as well as implications for treatment remains speculative.

Recommendations:

- **Support continued training collaboration between the Department of Education and the Department of Mental Health, Mental Retardation and Substance Abuse Services.**
- **Support broad dissemination of the *"Skill Competencies for Professionals in Virginia Supporting Individuals with Autism Across the Lifespan"* developed by the Virginia Autism Council.**
- **Support increased rates for behavioral health consultants.**
- **Support expansion of eligibility requirements for qualifications of behavioral health consultants.**

Appendix H: Substance Exposed Newborn Workgroup
CFBHPPC Recommendations

April 2007

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

Children who are substance exposed in utero are at high risk for behavioral, emotional and learning problems as they age. Early identification and intervention is critical for their healthy development and can help the child and their families learn how to effectively cope with the effects of the substance exposure and avert additional complications caused by the postnatal environment. Unfortunately, many youth who were exposed in utero to substances are not identified, may be misdiagnosed and do not receive the services they need. Effective intervention begins at the time of the mother's pregnancy and continues throughout the child's development.

Recommendations Requiring Funding

1) ***Fund participation in the Children's Research Triangle's (CRT) Upstream Solution Program ($30,000 year- ongoing funds***)

The Children's Research Triangle's (CRT)' Upstream Solution program works with states and communities to develop and implement a strategic plan specific to their needs that addresses the twin problems of children affected by pre-natal exposure to alcohol and other drugs and the later difficulties they and other high-risk children experience if their needs go undetected and untreated. CRT's Upstream Solution program works with states and communities to identify and implement strategies - using existing resources - to:

A. Prevent and provide timely interventions for alcohol and other drug use during pregnancy.
B. Provide early identification and early intervention services in the lives of high-risk children.

2) ***Fund 3 new Project LINK sites: $375,000/year ongoing funds (3 @ $125,000 per site)***

Virginia's 8 Project LINK sites provide outreach and intensive case management to pregnant, parenting and "at risk" women and their families in 14 communities in Virginia. Of the 161 babies born to mothers served by Project LINK in SFY 2006, 119 (74%) weighed over 2500 grams i.e. normal birth weight. Fund 3 additional programs in areas of significant need

3) ***Fund Residential Substance Abuse Treatment for Pregnant and Recently Postpartum Women: $1 million 1st year; $ 500,000 year in ongoing funds***

Provide start up and ongoing funds for residential substance abuse treatment in southwest Virginia for pregnant and postpartum women and their newborns. Only 4 residential treatment programs in the Commonwealth provide services for pregnant women and their newborns: Bethany Hall in Roanoke (2 perinatal beds), Rubicon in Richmond (8 perinatal beds), Southeastern Family Project in Newport News (16 perinatal beds) and Demeter House in Alexandria (16 women's beds). Despite the high incidence of methamphetamine and prescription drug abuse amongst women in far southwest Virginia, there are no residential treatment services in that area for pregnant and recently postpartum women and their infants.

1st year funding includes start up expenses. Ongoing funds will support services for children and non-Medicaid eligible women.

4) ***Expand Medicaid coverage to include***
   a) ***Behavioral Health Screenings.*** Provide a separate reimbursement to conduct a *behavioral health screening* that addresses multiple risks i.e. mental health, substance abuse, domestic violence provides additional incentive to medical providers to conduct a standardized screening on all women and refer those in need to the appropriate services.
   b) ***Medically Assisted Treatment for opiate dependent pregnant women.*** Medical *best practices* recommend that pregnant opiate dependent women be maintained on an opiate replacement medication throughout their pregnancy. Medically assisted treatment serves to stabilize the women, reduce risky behaviors, facilitate health-seeking behaviors and control the cycling between intoxication and withdrawal which may result in fetal or birth complications, miscarriage or still birth.
   c) ***Increase Medicaid coverage rates for Substance Abuse Residential Treatment for Pregnant Women and Hospital Day Treatment for Pregnant Women.*** Medicaid rates for residential substance abuse treatment and day hospital have not increased since these services were introduced in 1998.

Recommendations for Un-funded Activities

1) Maintain a sub-workgroup within the CFBHPPC to address the unique needs of substance exposed infants and young children 0 – 5
2) Support use of a uniform multiple risk screen tool for pregnant and parenting women that addresses mental health, substance abuse and domestic violence across systems i.e. child welfare, health care, home visiting programs, mental health etc.

Appendix I: The Office of Child and Family Services Recommendations

In response to various stakeholders workgroups (Special Populations on Children and Adolescents, 329 Legislative Workgroup), DMHMRSAS created the Office of Child and Family Services in April of 2004 and hired a Director. The office merged existing DMHMRSAS child and family resources and staff that were previously in the adult disability office, to operationalize the priority placed on developing an integrated, seamless system of care for children. The Director is responsible for the integrated system of care for children 0-21. Staff resources included the Part C Early Intervention system staff of 8 staff, one staff transferred from the adult disability offices of Mental Health and one from the Substance Abuse office.

In 2005, the Department's Office of Child and Family Services submitted a federal grant to CSAT to develop the necessary infrastructure to support and maintain the ongoing development and provision of adolescent substance abuse services throughout the Commonwealth. This was approved and funded fund for 3 years at $ 1.2M for a full time Adolescent Substance Abuse Treatment Coordinator position, a Training Coordinator and Administrative Assistant within the Office of Child and Family Services. There is total of 14 staff to support a comprehensive system of care for children, this involves a state process to assess, facilitate and coordinate ongoing cross system planning of services for adolescent substance use and co-occurring disorders. This Office provides leadership and direction in developing a seamless system of care that integrates services across disciplines to 40 local community services board. This also involves partnering with stakeholders working to improve services for children, developing policies that promote children and family services, addressing gaps in existing services, developing new services using evidence based practices and expanding existing evidenced based models, increasing family involvement on committees, councils, task forces, addressing children's issues, and increasing family involvement on committees, council, task forces addressing children's issues and increasing funding for children services.

Increased responsibility for building a comprehensive system of care for children across all disabilities is a major goal of the Office but the infrastructure in the Office of Child and Family Services to build the system of care requires a stronger infrastructure to address the needs of the children and their families in the Commonwealth. To go forward with implementing the system of care, the Office of Child and Family Services needs the following, as demonstrated on the following page.

Appendix J: Proposed Budget for Staff for the Office of Child and Family Services

For FY 2008

Personnel	FTE	Fringe	Annual
Training and Technical Assistant Consultant	50,945	23,768	74,713
Training and Technical Assistant Consultant	50,945	23,768	74,713
Training and Technical Assistant Consultant	50,945	23,768	74,713
Family Support Specialist	45,750	22,602	68,352
Program Specialist Autism/MR	50,945	23,768	74,713
Prevention Specialist	50,945	23,768	74,713
1 FTE Office Services Specialist	26,123	18,215	44,338
1 FTE Project Treat	62,400	25,632	88,032
Office Services Specialist	35,352	15,732	51,084
Training Specialist	62,400	25,632	88,032
Supplies/Postage/Copying/Meeting Space			2,000
Equipment			23,000
Telephone			15,364
Staff Travel			26,200
Conferences to support SOC, EBP & Best Practices			207,000
		Total	987,867