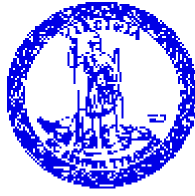


COMMONWEALTH of VIRGINIA

DEPARTMENT OF
MENTAL HEALTH, MENTAL RETARDATION AND SUBSTANCE ABUSE SERVICES
Post Office Box 1797
Richmond, Virginia 23218-1797

JAMES S. REINHARD, M.D.
COMMISSIONER

Telephone (804) 786-3921
Voice/TDD (804) 371-8977
www.dmhmrsas.virginia.gov

June 30, 2008

The Honorable Charles J. Colgan, Sr., Chair
Senate Finance Committee
10th Floor, General Assembly Building
910 Capitol Street
Richmond, VA 23219

Dear Senator Colgan:

Pursuant to Item 311 E of the 2007 *Appropriations Act*, the Department of Mental Health (DMHMRSAS), Mental Retardation and Substance Abuse Services is required to submit by June 30 each year a report on A Policy and Plan to Provide and Improve Access to Mental Health, Mental Retardation and Substance Abuse Services for Children and Adolescents.

This budget item directs this department, in cooperation with the Office of Comprehensive Services, Community Services Boards, Court Service Units, and representatives from community policy and management teams representing various regions of the Commonwealth to develop an integrated policy and plan, including the necessary legislation and budget amendments, to provide and improve access by children, including juvenile offenders to mental health, substance abuse, and mental retardation services.

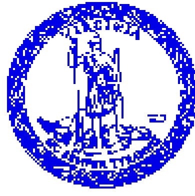
The Child and Family Behavioral Health Policy and Planning Committee (CFBHPPC) requested stakeholder group to study children's services and advise the department regarding necessary changes in services. This report details activities for 2007-2008 and includes the committee's recommendations for fiscal years 2009 and 2010.

Please feel free to contact me or the department's Office of Child and Family Services if you have any questions regarding the attached report at (804) 371-2184.

Sincerely,

James S. Reinhard, M.D.

Enc.
Cc: Hon. Marilyn B. Tavenner, Secretary, Health and Human Resources
Hon. R. Edward Houck
Mr. Joe Flores



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June 30, 2008

The Honorable Lacey E. Putney, Chair
House Appropriations Committee
P.O. Box 406
Richmond, VA 23219

Dear Delegate Putney:

Pursuant to Item 311 E of the 2007 *Appropriations Act*, the Department of Mental Health (DMHMRSAS), Mental Retardation and Substance Abuse Services is required to submit by June 30 each year a report on *A Policy and Plan to Provide and Improve Access to Mental Health, Mental Retardation and Substance Abuse Services for Children and Adolescents*.

This budget item directs this department, in cooperation with the Office of Comprehensive Services, Community Services Boards, Court Service Units, and representatives from community policy and management teams representing various regions of the Commonwealth to develop an integrated policy and plan, including the necessary legislation and budget amendments, to provide and improve access by children, including juvenile offenders to mental health, substance abuse, and mental retardation services.

The Child and Family Behavioral Health Policy and Planning Committee (CFBHPPC) requested stakeholder group to study children's services and advise the department regarding necessary changes in services. This report details activities for 2007-2008 and includes the committee's recommendations for fiscal years 2009 and 2010.

Please feel free to contact me or the department's Office of Child and Family Services if you have any questions regarding the attached report at (804) 371-2184.

Sincerely,

James S. Reinhard, M.D.

Enc.
Cc: Hon. Marilyn B. Tavenner, Secretary, Health and Human Resources
Hon. Phillip A. Hamilton
Ms. Susan Massart

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, 2007 Appropriations Act) July 1, 2007- June 30, 2008

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

Since 2003, the General Assembly has issued budget items 329-G, 330-F, 311-E and 315-E respectively, directing the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) to convene stakeholders to study ways to improve access to services for children and their families across disabilities. Budget language also requires the DMHMRSAS to report the plan to the Chairmen of the Senate Finance and House Appropriations Committees by June 30th of each year. DMHMRSAS convenes the interagency Child and Family Behavioral Health Policy and Planning Committee (CFBHPPC) to study children's services and advise them regarding necessary changes in services. In June 2007, the Department of Mental Health, Mental Retardation and Substance Abuse Services submitted a fifth 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 Governor, and the respective Chairmen of the Senate Finance and House of Appropriations Committees. This June 2007 report satisfied the legislative intent of the budget language contained in 311-E 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.

Below is the current budget language of the 2007 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."*

A variety of studies have been completed over the last six years demonstrating that there is much interest in, and awareness of, the problems in the children's behavioral health services

system in Virginia. When one examines Virginia's behavioral health care system, several themes consistently 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. Since 2004, funding has been approved for a number of initiatives recommended in DMHMRSAS's report on child and adolescent 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 DMHMRSAS's vision for community based care. Nonetheless, 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.

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: developing healthy, strong, and stable families; ensuring equitable access to services without regard to racial/ethnic status, socioeconomic status and geographic location; and providing services that are least-restrictive and support healthy child development. Last year's report included a request to fund ***Intermediate-Level Community-Based Services @ $20.0 million in FY 2009 and $40.0 million in FY 2010.*** Although the 2008 report is not requesting funding for these services in this upcoming budget, the committee wishes to emphasize that, if a goal is to keep children out of residential treatment, group homes and inpatient psychiatric units, intermediate level community based services needs to be provided. These services include crisis stabilization, day treatment, in-home family therapy, intensive outpatient treatment, mobile crisis teams, intensive case management, school-based mental health services, wraparound services, respite care, after school intervention programs, and drop-in centers for emotionally and behaviorally troubled teens. Not only do such services enable

children to remain in their homes and communities, they are also cost effective and can result in savings by diverting youth from residential services and juvenile justice.

The Child and Family Behavioral Health Policy and Planning Committee makes the following recommendations for FY 2009:

Priority Funding Recommendations of the CFBHPPC for FY 2009

New Recommendations

1. **Support the efforts being made by the Council on Reform (CORE):**

    - Recommend that CORE consider the behavioral health needs of children in foster care as well as those not in foster care that require services, and encourage CORE to involve behavioral health professionals in this process as it unfolds.
    - Encourage CORE to support the role of CSBs as public providers of services to children involved in the CSA process and in providing intensive care coordination to children in, or at-risk, of residential placement.

2. **Oversight of the 40 new child-specific positions at CSBs:**

    - Develop a process through the DMHMRSAS' Office of Child and Family Services using the CSB Performance Agreements to ensure that each CSB allocates funding for a fulltime child and adolescent position serving the behavioral health needs of children in the locality as directed by the 2008 General Assembly.
    - Fund infrastructure in the Department's Office of Child and Family Services (OCFS) to support and monitor this initiative to increase the provision of intermediate care services to children and families statewide @ $75,000.

3. **Increase Medicaid Community Mental Health Service Rates @ 13 million:**

    - Increase Medicaid Community Mental Health Service rates as recommended by the DMAS Medicaid Behavioral Health Services Workgroup @ $26.4 million ($13.0 million General Fund). Low Medicaid rates have led many clinicians to decline or limit the number the number of Medicaid eligible children and/or adolescents they serve. It is anticipated that increasing Medicaid reimbursement rates will increase the availability of services for youth who are Medicaid eligible and improve their ability to access services.

Funding Recommendations Carried Over from the 2007 Report

1. **Increase Service Capacity:**

    a. **Fund 12 additional 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 2010. These projects will target children, adolescents and their families who are underserved.

b. **Fund school-based mental health services in 20 middle schools in five regions @ $2.0 million**
The Demonstration Projects will provide a full-time therapist employed by the local CSB at each of the 20 selected middle schools, targeting students who experience educational difficulties as a result of psychiatric and/or substance abuse problems. The demonstration projects will be placed in schools that provide Student Assistance Programming or plan to establish student assistance services and will be integrated with the student assistance services. Funding is included to train CSB and school staff regarding integration of services within school settings.

2. **Enhance Workforce Capacity:**

- **Establish 3 Teaching Centers of Excellence @ $700,000**
  The Centers of Excellence will organize, coordinate, and lead the training of clinicians and other service providers in evidence-based, promising, and best practices for children's behavioral health treatment across the Commonwealth.

3. **Provide Families with Information and Support:**

- **Fund 2.0 FTE for a Resource/Service Coordinator and administrative support @ $125,000**
  These staff will educate the public about the needs of children with behavioral health issues; inform families regarding available services, assist families in accessing needed services for their children and adolescents and link families with appropriate support systems. This request includes funds to support operating expenses, office supplies and printing.

New 2008 request	**13,075,000**
Carried over from 2007	**6,425,000**
Total funding request	**$19,500,000**

2008 Report of the Child and Family Behavioral Health Policy and Planning Committee

Introduction and Background

Since 2002 the General Assembly, through its budget process (budget items 329-G, 330-F, 311-E and 315-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.

The past six years have seen an increase in interest in children's mental health, mental retardation, and substance 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. The General Assembly, JLARC, and the Office of the Attorney General 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 General Assembly 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 General Assembly 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.*"

The 2008 General Assembly Session proved to be a very active session for behavioral health initiatives and for children's services initiatives. Some of the significant outcomes of the 2008 General Assembly Session include legislation to:

- Facilitate the disclosure of necessary information between parties providing services to youth who may be dangerous to themselves or others.
- Require public universities to implement threat assessment teams and early warning systems and to require sharing of complete student records between high schools and universities.
- Increase payments to foster and adoptive families.
- Enhance and increase training for foster care workers.
- Allow Temporary Assistance to Needy Families payments to family members of a child who is in custody.
- Establish uniform guidelines for intensive care coordination for children in, or at-risk of, residential placement through the Comprehensive Services Act (CSA).

DMHMRSAS', the Commission on Youth (COY), and the Office of Comprehensive Services (OCS) have worked together to develop a vision for a strengthened system of care for children and their families in need of behavioral health services across Virginia. Several initiatives across agencies have supported this vision. Recent efforts in the Commonwealth include:

a) In collaboration with the Commission on Youth, DMHMRSAS held its second system of care conference in 2007. The first system of care conference was held in 2005;

b) the General Assembly funded systems of care, evidence-based demonstration projects in four localities (two urban and two rural) across the state (2006, 2007);

c) the General Assembly funded behavioral health positions to work in 23 detention centers across the state (2006-2008);

d) the General Assembly funded four child psychiatry fellowship and four child psychology internship positions with payback provisions to work in underserved areas of Virginia (2007);

e) the Department of Social Services (DSS) eliminated the need for families to relinquish custody of their children in order to receive mental health care (2007);

f) the Department of Medical Assistance Services (DMAS) received a 5 year demonstration grant to provide community alternatives to psychiatric residential treatment facilities for children. The demonstration grant 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 (2007).

g) DMAS amended the State Medical Facilities Plan to provide Medicaid funds for substance abuse treatment for adolescents (2007);

h) DMHMRSAS received a 3 year grant from the federal Substance Abuse and Mental Health Services Administration (SAMHSA), called Project TREAT to develop state level infrastructure and provide workforce development to support adolescent substance abuse services across systems (2005);

i) OCS adopted a new treatment planning instrument tool, the Child and Adolescent Needs and Strengths (CANS) which will be introduced July 2008;

j) CORE was established to complement and support the First Lady Anne Holton's "For Keeps" initiative and reform children's services across multiple agencies. CORE is being piloted in 13 communities and will eventually be taken statewide (2008);

k) the General Assembly required OCS to provide education and annual training for CSA staff on best practices and evidence-based practices; develop and implement mandatory uniform guidelines for intensive care coordination services for children in or at risk for placement in residential care through the CSA program and develop and implement uniform data collection standards for CSA (2008).

The Child and Family Behavioral Health Policy and Planning Committee (CFBHPPC) feels that each of these are important steps; however, 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 continue its efforts to develop a range of services and supports for children and adolescents across the Commonwealth to address unmet needs. The Commonwealth must also enhance the capacity and skills of its public and

private workforce in order to provide the level of services needed for an adequate array of services for Virginia children and their families.

The Council on Reform

More recently the Secretary of Health and Human Resources has initiated an important children's services reform effort. Convened by the Secretary, the Council on Reform (CORE) began meeting in December, 2007 and has mapped out a series of steps to reform the children's services system. The CORE committee includes the Secretary, the Special Assistant for Children's Services Reform and numerous state and local agency representatives. Several "change drivers" are the impetus for the CORE, including:

- First Lady Anne Holton's "For Keeps" initiative to promote permanent homes for foster children.
- Sharply increasing Comprehensive Services Act costs; and
- Findings of a study conducted by the Annie E. Casey Foundation of services in Virginia.

These system reform efforts will focus on policy, legislative and budget initiatives to achieve improved outcomes for children.

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) and other community services providers. 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 number of children and adolescents under 18 who received mental health services in 2005 was 26,125. In 2006, the number increased to 27,114 and in FY 2007, the number increased to 30,082. (Source: Community Consumer Submission FY 2007, DMHMRSAS) According to data from the DMHMRSAS Comprehensive Plan for 2008-2014, during the period January through April 2007, 1,680 children and adolescents were on waiting lists for specific CSB mental health services. An additional 234 adolescents were on waiting lists to receive substance abuse treatment. These youth were fortunate to at least be waiting in places where services and waiting lists were available. There are 1,646 residential beds, 290

acute inpatient care beds and 64 state inpatient care beds that specifically target children and adolescents with mental and behavioral health needs. There are no state beds and only one private residential treatment program in Virginia for adolescents who have a substance use disorder.

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 2008-2014 Comprehensive State Plan dated December 6, 2007, children and adolescents waited over a month for initial assessments for mental health and mental retardation services and almost three weeks for an initial assessment for substance abuse services. Young children waited over two weeks for infant and toddler Early Intervention services. Adolescents waited just under three weeks for outpatient substance abuse treatment services, two weeks for intensive residential treatment and four weeks for supportive residential treatment. Children and adolescents in need of mental health services waited over 5 weeks for in-home services, therapeutic day treatment, as well as rehabilitation/habilitation services and over 9 weeks for alternative day support services. Children and adolescents with intellectual disabilities waited 53 weeks for highly intensive residential, 57 weeks for intensive residential treatment and 43 weeks for supportive residential services. Across disability areas the average wait for psychiatric services was about 5 weeks.

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.
- There are no state funded adolescent substance abuse treatment beds and only one private residential substance abuse program for adolescents
- 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.
- Most CSBs do not offer inpatient day treatment, intensive residential treatment, opioid detoxification or maintenance for adolescents who have a substance use disorder. Only a little over half provide substance use motivation treatment, substance use case management and in-home treatment for substance use or co-occurring disorders.

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 often provided in a fragmented and uncoordinated manner.

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. They 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. The Department has sponsored a number of conferences on evidence-based systems of care interventions and, over the past three years, has been able to use federal funds to provide additional training related to the treatment of adolescent substance abuse.

DMHMRSAS' state adolescent treatment coordination grant, Project TREAT (Training and Resources for Effective Adolescent Treatment), is targeted at developing state level infrastructure to support services for adolescents who have a substance use or co-occurring substance use and mental health disorders. Workforce development activities funded through the grant have supported training for both CSB staff as well as staff from other child-serving

agencies. DMHMRSAS provided technical assistance and skills-based training in selected evidence-based practices to staff at 18 CSBs as well as offered supervisor training to all CSBs. DMHMRSAS funded training in the evidenced-based practice MET/CBT 5 for staff from the Department of Juvenile Justice and partnered with the Department of Education to support student assistance programming training. In addition, DMHMRSAS provided 8 regional knowledge exposure trainings on evidence-based practices and a wide variety of other education and training opportunities at no cost for providers across systems who work with substance using youth. These trainings have also offered valuable collaboration and networking opportunities for providers across systems. The grant which has supported these trainings ends July 2008.

Despite these different efforts, the majority of behavioral health clinicians, pediatricians, and other health care providers across service delivery systems 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. Providers also need ongoing educational opportunities to keep them updated regarding the newest developments in treatment. 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 as prescription drug 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. Centers of Excellence in Training will enable Virginia to better prepare clinicians to deal with the behavioral health problems of our children and provide interventions that are both clinically and cost effective.

When the behavioral health problems of children and adolescents are not met these problems inevitably spill over into other systems. Some families have relinquished custody of their children and placed them in DSS custody in order to obtain needed mental health services – although recent events such as the Attorney General's opinion, changes in legislation, and changes in DSS regulations should 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. Children with untreated mental health and/or substance use problems are not able to focus on learning and may fall behind academically or drop out, eventually becoming unemployed or underemployed adults. 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 may often 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 served earlier and provided with less costly mental health services in the community. According to the Department of Juvenile Justice, Research & Evaluation Section, Data Resource Guide, (Fiscal Years 2004 through 2007) the 2007 cost to incarcerate a juvenile for one year is $102, 204 (DJJ per capita cost: $82,790 + correction education per capita cost $19,414). 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.

The most effective approach to serving youth 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 seems time Virginia made a significant investment in behavioral health services in our communities for children, adolescents and families.

Current Initiatives to Improve Access to Community Services

The following are selected initiatives to expand community services for children. These are areas where the CFBHPPC has focused attention and recommended funding in prior years.

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 FYs 06 and 07 are:

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

With $2 million in funding from the General Assembly, four CSBs are currently implementing evidence-based practices within systems of care with support from the DMHMRSAS. The goal of these projects is to demonstrate the efficacy of evidence-based practices in communities throughout the Commonwealth and to develop more seamless systems of care. The projects report quarterly progress and data to DMHMRSAS and participate 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, Dialectical Behavioral Therapy)

In addition to the evidence-based practices, Virginia's system of care projects provide an array of other community services, including:

1. Intensive in-home services

2. Therapeutic day treatment in schools
3. Case management/Intensive case management
4. Head Start case management/Alternative day support
5. Outpatient services
6. Family partner/Family support programs
7. Foster care prevention services

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

- The staff involved in implementation of 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 and 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 strives to make better use of research findings in typical services settings and to produce greater benefits to consumers. According to some research, consumers of human services are no better off today than they were 25 years ago. According to evidence-based practices experts, 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 of evidence-based systems of care projects take two to four years to achieve demonstrable success.

Through its federal grant, Project TREAT, DMHMRSAS has recently funded training in other evidence-based practices targeted at adolescent substance use or co-occurring disorders. Through the grant, DMHMRSAS is providing technical assistance to 18 CSBs to help them select an evidenced based practice of their choice and receive training in it. The 18 CSBs are each in different stages of their training and implementation; however, as their efforts unfold they will provide DMHMRSAS with additional information about adopting and implementing evidence-based practices (EBPs) and how they can be best integrated into systems of care.

CSB Services in Juvenile Detention Centers

The Department of Juvenile Justice Services (DJJ) estimates that at least 50% of Virginia's juvenile detention population is in need of behavioral health services, and states that funding from private, federal, state, and local sources has been inadequate to meet the needs of youth with behavioral healthcare needs 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 through a Juvenile Accountability Block Grant 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 fourteen. In 2007, the General Assembly provided $900,000 in additional funding to bring the total of detention facilities with mental health services to twenty-three. Based on current data, the programs are projected to serve approximately more than 2,500 youth annually. DHMRSAS provides technical assistance and support to the 23 programs to assist them in addressing the challenges of serving youth in this setting using a short-term intervention and case management approach.

Currently programs are in operation at:

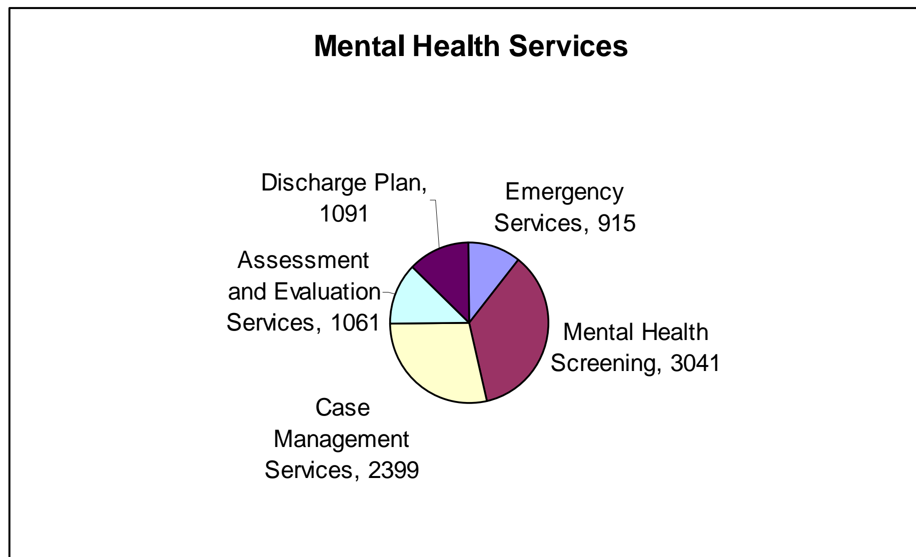
- Alexandria CSB/Northern VA Detention Home
- Blue Ridge Behavioral Health/Roanoke Detention Center
- Central Virginia CSB/ Lynchburg Detention Center
- Region 10 CSB/Blue Ridge Detention Center
- Chesapeake CSB/Chesapeake Juvenile Justice Center
- Chesterfield CSB/Chesterfield Juvenile Detention Home
- Colonial CSB/Merrimac Detention Center
- Crossroads CSB/Piedmont Juvenile Detention Home
- Danville CSB/W.W. Moore Detention Center
- District 19 CSB/Crater Juvenile Detention Home
- Fairfax-Falls Church CSB/Fairfax Juvenile Detention Home
- Hampton-Newport News CSB/Newport News Juvenile Detention Home
- Henrico CSB/Henrico Juvenile Detention Home
- Loudoun CSB/Loudoun Juvenile Detention Home
- New River Valley CSB/New River Valley Detention Center
- Norfolk CSB/Norfolk Juvenile Detention Home
- Northwestern CSB/Northwestern Juvenile Detention Home
- Planning District One Behavioral health/Highlands Juvenile Detention Home
- Prince William CSB/Prince William Juvenile Detention Home
- Rappahannock CSB/Rappahannock Juvenile Detention Home
- Richmond Behavioral Health/Richmond Juvenile Detention Home
- Valley CSB/Shenandoah Juvenile Detention Center

- Virginia Beach CSB/Virginia Beach Juvenile Detention Home

These programs serve to increase local system capacity to identify and intervene in the lives of children involved in the juvenile justice system. Some highlights of the services that have been provided to children in juvenile detention centers include, but are not limited to:

Of the 9189 children admitted to detention centers in FY 08:

- 3,041 mental health screenings were completed
- 2,399 youth received case management services from mental health case managers
- 915 youth received emergency services with mental health clinicians
- 1061 youth received assessment and evaluation services
- 1091 discharge plans were developed



Part C Early Intervention Services

In 2007, Virginia's Part C Early Intervention System, in partnership with a team of consultants and several stakeholder groups, initiated planning for systems improvements related to financing for early childhood and family supports and services. It has always been the intent of the Individuals with Disabilities Education Act (IDEA) that states' early intervention systems be funded through existing resources, including third party payors, with federal and state funds used primarily as the "glue" money to pull the system together and as the payor of last resort for services not covered through other sources. Over the period of 2007, stakeholder groups met around four priority areas: the Part C allocation formula and rates for early intervention services, the Part C data system (ITOTs), family cost participation, and Early Intervention/Medicaid. The consultants were asked to synthesize the input of the stakeholder groups and other department feedback and provide a series of recommendations, including expected impact, implementation

plans, and cost projections, for the DMHMRSAS (as lead agency for Part C/IDEA) to consider. Implementation of the recommended changes will result in additional funding for the early intervention system, allowing state and federal resources to be allocated in way that honors the true intent of IDEA.

For reporting purposes to the Office of Special Education Programs (OSEP), point-in-time data (as of December 1 of each year) is reported. However, the annualized count provides a much more accurate picture of the total number of children served. In 2007, 11,095 infants, toddlers and their families received services in Virginia's early intervention system. A total of 10,704 infants, toddlers and families received Part C early intervention services in the one-year period from December 2, 2005 to December 1, 2006. This number represents a 4% increase over the previous year and a 50% increase since 2002. The table below provides the annualized child count for each year from 2002 to 2007. Trend data on the number of potentially eligible children indicates that the number of children served will continue upward in 2008.

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
2007	11,095

The CFBHPP Committee Priority Recommendations for FY 2009-2010

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. This report follows up on the 2007 Child and Family Behavioral Health Policy and Planning Committee Report to the Legislature and the recommendations represent continuity within the biennial funding cycle.

Policy and Operations Recommendations

The Child and Family Behavioral Health Policy and Planning Committee (CFBHPPC) has continued to study the needs of children and their families who require behavioral health services in Virginia and has identified several areas where improvements are needed. Each of these areas have been noted and addressed in past DMHMRSAS reports to the General Assembly. Although some gains have been made in each area related to services for children and adolescents, significant improvements are still needed to correct the:

- Lack of adequate service capacity;
- Limited access to care;
- Absence of a full continuum of community-based care;

- Shortage of child and adolescent psychiatrists and psychologists;
- Fragmentation and lack of continuity of services;
- Lack of information and support for families regarding services for children and
- how to access them;
- Lack of family and youth involvement when developing services; and
- Lack of use, statewide, of evidence-based treatments for children and adolescents.

As noted in the 2007 report as well as in 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."*

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: 1) developing healthy, strong, and stable families; 2) ensuring equitable access to services without regard to racial/ethnic status, socioeconomic status and geographic location; and 3) providing services to youth and their families that are least-restrictive and support healthy child development.

The 2008 General Assembly took an important step in the provision of children's behavioral health services by funding one child and adolescent position for each of the forty Community Services Boards (CSBs). This will be a wonderful addition, especially for smaller CSBs which have few, if any, positions dedicated to serving children and/or adolescents. It is anticipated that, over time, many CSBs will require additional positions, especially those which cover large metropolitan areas.

The CFBHPPC thanks all of those involved in approving this important contribution to children's services. The committee appreciates the opportunity to continue the dialogue regarding additional service capacity as there exists the need to build strong intermediate level services across many CSBs. The following recommendation related to intermediate services was included in last year's 2007 report:

> *"**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*."

Although the 2008 report is not requesting funding for these services in this upcoming budget due to last years identified budget constraints, we wish to preface this year's recommendations

by noting that intermediate services continue to be minimal or completely lacking in many CSBs across Virginia and will need to be addressed in the near future.

The CFBHPPC submitted the following priority recommendations for FY 2010 to improve the system of care for children and their families:

Priority Recommendations for FY 2010

New Recommendations:

1. **Support the efforts being made by the CORE group:**

    - Commend the governor and others for their commitment to this project.
    - Encourage the group to involve behavioral health professionals in the processes as it unfolds.
    - Recommend that the group consider the behavioral health needs of children in foster care who require services.
    - Recommend that the group considers the behavioral health needs of other children not involved in foster care who require intermediate level services in communities.
    - Support the role of CSBs in providing intensive care coordination to children in or at-risk of residential placement.
    - Support the role of CSBs as public providers of services to children involved in the CSA process.

2. **Oversight of new child-specific positions at CSBs:**

    - Develop a process through the DMHMRSAS' Office of Child and Family Services using the CSB Performance Agreements to ensure that each CSB allocates funding for fulltime child and adolescent position serving the behavioral health needs of children in the locality
    - Fund infrastructure in the Department's Office of Child and Family Services (OCFS) to support this initiative to increase the provision of intermediate care services to children and families statewide @ $75,000.

Increase Medicaid Community Mental Health Service Rates

3. **Increase Medicaid Community Mental Health Service rates as recommended by the DMAS Medicaid Behavioral Health Services Workgroup @ $26.4 million ($13.0 million General Fund)**

    - In the 2007 report and in the 10 year plan, the CFBHPPC recommended that the Department of Medical Assistance Services (DMAS) conduct a study of behavioral health service rates, some of which have not been raised since 1990 and others of which have not been raised since 1997. DMAS convened a workgroup and

conducted a rate study. The report noted that, for Community Mental Health Rehabilitation services, "no other Medicaid service has gone for such a long time period without a rate increase." The workgroup recommended a 10% rate increase for community mental health services whose rates were established in 1990-91 and a 5% rate increase for community mental health services whose rates were established in 1997 at a cost of $26.4 million ($13.0 million General Fund). Since low Medicaid rates have led many clinicians to decline to accept Medicaid or severely limit the number of Medicaid patients they treat, increasing these Medicaid rates could increase access to mental health care for many children who receive Medicaid. (The full rate study can be accessed at http://www.dmas.virginia.gov/downloads/pdfs/pr-MH_Rate_Study.pdf.)

Funding Recommendations Carried Over from 2007

1. **Increase Service Capacity** (From Recommendation 1 in the 2007 Report)

a. Fund 12 additional System of Care projects @ $3.6 million

The General Assembly has previously funded four System of Care projects: two projects were funded in FY 06; two additional projects were funded FY 07. The goal of these projects was to develop more seamless systems of care and demonstrate the efficacy of evidence-based practices in communities. DMHMRSAS is strongly committed to providing family-focused services within the community. The CFBHPPC is requesting to expand the Commonwealth's investment in community-based Systems of Care Projects with a fully developed continuum of services and supports by adding twelve additional projects in FY 2010. These projects will target children and their families who are underserved, involve families in developing and identifying needed services and address both mental health, mental retardation and substance abuse service needs. By providing evidence-based, promising and best practices services that are not currently available in these localities, these projects will enable children to remain with their families and be served within their community.

b. Fund school-based mental health services in 20 middle schools in five regions @ $2.0 million

Children and schools in Virginia will benefit from initiating school-based mental and behavioral health services across the state. All children attend school and this is often the setting where they and their families can most easily access services. Currently, some schools are able to offer mental health services to youth who are Medicaid eligible. The proposed services would ensure that services are available to all children in need of assistance regardless of their funding. The committee proposes funding twenty School-Based Mental and Behavioral 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 such as the national student assistance programs, that effectively reduce behavioral and emotional disorder-related problems in schools, and improve academic attendance and school performance. Projects will be expected to partner with schools that already have a student assistance program or plan to develop such services. This request includes funds to train CSB and school staff regarding effective collaboration and integration of mental and behavioral health services within the school setting as well as support outcome evaluations. The results will be disseminated to other CSBs and school systems throughout the state so that others may replicate the services.

2. **Enhance Workforce Capacity (From Recommendation 3 in the 2007 Report):**

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

     To provide more behavioral health services to children, youth and their families, Virginia needs 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 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.

3. **Provide Families with Information and Support:** (From Recommendation 4 in the 2007 Report)

   - **Fund 2.0 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 @ $150,000**

     Even in communities where behavioral health services for children are available, families are often not aware of what kinds of services are available nor where to find them. A statewide family information network will enable Virginia to link families in need of services with services available in their communities. Linking them with other families who have gone through or are going through similar problems will enable them to receive and provide peer support to one another. 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.

New 2008 request	**$13,075,000**
Carried over from 2007	**6,425,000**
Total funding request	**$19,425,000**

Conclusion

Virginia's behavioral health system for children and adolescents is undergoing reform. For years, it has been known that there is insufficient funding for services to address the behavioral health needs of children and adolescents

In this report, the Child and Family Behavioral Health Policy and Planning Committee outlines steps to put in place much-needed intermediate-level and frequently unavailable services for this underserved population. A significant infusion of funds seems necessary to provide adequate services and supports for children and adolescents across the Commonwealth. If action is taken on the recommendations listed in this report, Virginia will move faster toward a system that meets the needs of its youngest citizens. Studies indicate that 95% of adults with a substance use disorder began their use in adolescence. Similarly, many mental health disorders begin in childhood and adolescence. Children do not grow out of their mental and behavioral health problems. Left untreated, their problems become worse as they age, result in more harmful consequences to themselves and society and become more costly to treat.

Providing a wide range of types and levels of services to children, adolescents, and their families is imperative if Virginia wishes to build a strong and effective system of care. The state has laid the groundwork for supporting evidence-based and promising practices for children and adolescents. Over the past 6 years, significant collaboration has occurred between the various state agencies as well as public and private providers that serve children and youth. Systems in Virginia are poised to move forward but need additional funding to increase service capacity and enhance the quality of services provided. 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 the myriad needs for behavioral health services for children and adolescents are not addressed, the opportunity to intervene with those who might pose a threat to themselves or others in the future may be missed. Virginia must build on the progress that has been made in improving access to behavioral health services for children and adolescents in order to make services available and accessible statewide. This is an important year to make a significant and timely investment in funding children's behavioral health services.

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Appendix C: 2008 Update to the Ten Year Strategic Plan for Children's Behavioral Health Services			
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	Though not funded by the 2008 General Assembly; included for future consideration as part of 2009 recommendations	**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**

Recommendations for FY 2009 are in bold
Recommendations italicized implemented

Appendix C: 2008 Update to the Ten Year Strategic Plan for Children's Behavioral Health Services			
Goals	**2006-2012 Interventions/Activities**	**Implementation Status**	**2008-2009 Recommendation**
Continued:	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**	Submitted but not successful in 2008 General Assembly Submitted but not successful in 2008 General Assembly	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 2007 budget for picking up the federal share for the five federally funded sites. Development of a process for allocating $900,000 for remaining nine 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.	

Recommendations for FY 2009 are in bold
Recommendations italicized implemented

Appendix C: 2008 Update to the Ten Year Strategic Plan for Children's Behavioral Health Services			
Goals	**2006-2012 Interventions/Activities**	**Implementation Status**	**2008-2009 Recommendation**
	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.	*2007 General Assembly: 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
	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**	Though not funded by the 2008 General Assembly; included for future consideration as part of 2009 recommendations	**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		

Recommendations for FY 2009 are in bold
Recommendations italicized implemented

Appendix C: 2008 Update to the Ten Year Strategic Plan for Children's Behavioral Health Services			
Goals	**2006-2012 Interventions/Activities**	**Implementation Status**	**2008-2009 Recommendation**
	1. A.3. Service agencies communicate and collaborate to meet those needs 1. A.3.a. Provide reimbursement for care coordination and interagency communication between providers **1. A.3.b. Allow public-private partnerships to jointly apply for state funds**		
	1. A.3.c. DMHMRSAS will develop criteria to identify local Centers of Excellence in systems of care 1. A.3.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 the term "care coordination" instead of "case management:" 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.

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Appendix C: 2008 Update to the Ten Year Strategic Plan for Children's Behavioral Health Services			
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.***	

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Appendix C: 2008 Update to the Ten Year Strategic Plan for Children's Behavioral Health Services			
Goals	**2006-2012 Interventions/Activities**	**Implementation Status**	**2008-2009 Recommendation**
	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).
	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 twenty middle schools in five regions @ $1.8 million**	 Submitted but not successful in 2008 General Assembly	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 twenty middle schools in five regions @ $2.0 million.**

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Appendix C: 2008 Update to the Ten Year Strategic Plan for Children's Behavioral Health Services			
Goals	**2006-2012 Interventions/Activities**	**Implementation Status**	**2008-2009 Recommendation**
	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.	***DSS established new guidelines fall 2007 to prevent this from happening.***	
	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	***From the 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 December 15, 2007 that requires the provision of mental health services to families without Relinquishing custody.

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Appendix C: 2008 Update to the Ten Year Strategic Plan for Children's Behavioral Health Services			
Goals	**2006-2012 Interventions/Activities**	**Implementation Status**	**2008-2009 Recommendation**
	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		
A. All children have health insurance	2. A.3. Promote legislation that provides health insurance for all of Virginia's children	2009 recommendations include a request to increase in Medicaid rates	**Support a proposal for increased reimbursement rates for behavioral health consultants** Support a proposal for increasing the hours approved for the work of behavioral health consultants

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Goals	**2006-2012 Interventions/Activities**	**Implementation Status**	**2008-2009 Recommendation**
	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.	Submitted but not successful in 2008 General Assembly	Fund MR Family Support @ $62,500 for 40 CSBs @ @ $2.5 million Fund MR waiver slots @ $6.0 million

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		Medicaid policies & procedures introduced July 1, 2007	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 ten year 2.C.2.c. Fund a designated child and adolescent service provider for mental health, mental retardation, and substance abuse services in each CSB	Though not funded by the 2008 General Assembly; included for future consideration as part of 2009 recommendations ***The FY 2009 budget funds a child clinician for 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**	***DMAS conducted a rate study for behavioral health services, which concluded that many rates had not been increased since 1990 or 1997. The report recommended a 10% rate increase for community health services whose rates were established in 1990-91 and a 5% rate increase for community mental health services whose rates were established in 1997 at a total cost of $26.4 million ($13.0 million General Fund).*** (Included in funding request for 2009)	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.

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Appendix C: 2008 Update to the Ten Year Strategic Plan for Children's Behavioral Health Services			
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**	Though not funded by the 2008 General Assembly; included for future consideration as part of 2009 recommendations @ $125,000	**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. @ $125,000**
	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		

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Goals	**2006-2012 Interventions/Activities**	**Implementation Status**	**2008-2009 Recommendation**
	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
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			

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

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Goals	**2006-2012 Interventions/Activities**	**Implementation Status**	**2008-2009 Recommendation**
	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.
	3. B.1.e. Establish a fund in the OCFS in DMHMRSAS to offset costs of licensure, training and supervision in evidence-based practices		

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Goals	**2006-2012 Interventions/Activities**	**Implementation Status**	**2008-2009 Recommendation**
	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	***DMHMRSAS's Project TREAT funded EBP training for adolescent SA providers at 18 CSBs*** ***COY and DMHMRSAS held a conference on evidenced-based treatments and system of care Sept 2007 in Roanoke.***	
	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		

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Recommendations italicized implemented