Report Regarding Acute Psychiatric Services for Children and Adolescents
(Item 315.BB.2.)

To the Chairmen of the House Appropriations and Senate Finance Committees

December15, 2009

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COMMONWEALTH of VIRGINIA

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To: Chairmen, House Appropriations and Senate Finance Committees

Pursuant to Item 315.BB.2., the Department of Behavioral Health and Developmental Services submits this Report Regarding Acute Psychiatric Services for Children and Adolescents.

The report was informed by the deliberations and findings of the Team as well as previous studies and research and recommends two options for the future of the facilities. DBHDS appreciates and thanks the Team for its work and support during this process.

If you have any questions regarding the report, please feel free to contact me at (804) 786-3921.

Sincerely,

James S. Reinhard, M.D.

Enc.
Cc: Hon. Marilyn B. Tavenner
Hon. R. Edward Houck
Mr. Joe Flores
Ms. Susan Massart
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Ruth Anne Walker

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Executive Summary

The Commissioner of the Department of Behavioral Health and Developmental Services (DBHDS), formerly the Department of Mental Health, Mental Retardation, and Substance Abuse Services[1], was directed by the 2009 General Assembly to develop options for the future of the Commonwealth Center for Children and Adolescents (CCCA) and the adolescent unit at Southwestern Virginia Mental Health Institute (SWVMHI). These options were to be informed by the work of a State and Community Consensus Team that would examine the need for public acute psychiatric services for children in Virginia.

Background. Governor Kaine's budget for FY 2010 proposed the closure of CCCA and the SWVMHI adolescent unit by June 30, 2009. These two state-operated facilities provide public acute inpatient mental health services to children from all regions of the Commonwealth. In response to public opposition, the 2009 General Assembly's final budget did not close these two facilities. The General Assembly also required the Commissioner of DBHDS to establish a State and Community Consensus Team and report on the findings of this team and make recommendations for alternative approaches to provide care in these two facilities.

Options. Based on the deliberations of the State and Community Consensus Team, coupled with previous reports referenced and appended, this report outlines two options two options for the current and future role of CCCA and SWVMHI's adolescent unit:

Option 1: ***Close CCCA and SWVMHI's adolescent unit. Utilize state general funds currently used for operation of these facilities for the purchase of private mental health treatment for uninsured children in each region of the Commonwealth.*** The Commonwealth could provide state general funds for the purchase of private mental health treatment services in each region of the Commonwealth. Previous research indicates that there are mental health services available in the community for children. There are 15 acute inpatient psychiatric providers in the Commonwealth that provide acute inpatient mental health services to children, thirteen of these are private providers with 245 licensed psychiatric beds.[2] In addition, there are over 1800 beds in 25 residential treatment facilities that provide intensive services for youth.[3] The number of licensed residential beds continues to expand over time. For example, for the quarter ending June 30, 2009, there were 1696 licensed residential beds available to treat youth and there were 1860 such beds for the quarter ending September 30, 2009.[4] It is anticipated that the number of acute private psychiatric beds for children will also expand

[1] The Department's name was changed on July 1, 2009.
[2] 37.2-308 Child and Adolescent Data, July 1 –September 30, 2009
[3] 37.2-308 Child and Adolescent Data, July 1 –September 30, 2009
[4] 37.2-308 Child and Adolescent Data, April 1 –June 30, 2009 compared to 37.2-308 Child and Adolescent Data, July 1 –September 30, 2009.

with recent changes to the Code of Virginia which eases state approval for inpatient psychiatric beds.[5]

Bed capacity to serve children in Virginia is sufficient, but a significant number of children and their families do not have adequate insurance coverage to pay for services in their community. Data indicates one quarter to one half of admissions at these facilities are related to inadequate health insurance coverage. Funds to pay for local purchase of services could prevent admissions to CCCA and SWVMHI's adolescent simply because of the lack of insurance coverage.

Second, the Commonwealth could provide a small amount of start up funding to establish additional crisis stabilization and intensive support services for youth in each region of Virginia. Medicaid provides funding for child crisis stabilization and other intensive services and start up funds could help get these services up and running for Medicaid and privately insured children. This would prevent admissions to CCCA and SWVMHI adolescent unit for many children. A sample indicates that at least 10% admissions fall into this category. Finally, the DBHDS and the Department of Juvenile Justice could partner to establish a mental health unit to provider services to children who are incarcerated. These children represent between 5-8% of admissions to CCCA and SWVMHI adolescent unit.

Option 2: ***Continue to support publicly-funded acute inpatient psychiatric care through the operation of CCCA and SWVMHI's adolescent unit.*** The Commonwealth should maintain a publicly-funded safety net that includes acute inpatient services. Funding should be aligned so services are delivered in children's communities closer to home. Currently, every CSB utilizes services at CCCA and a significant number of CSBs in the western part of Virginia use SWVMHI's adolescent unit. Children and their families must travel vast distances from Northern Virginia, Tidewater, and the Southside to receive intensive services provided at CCCA. Ideally, all children should receive services as close to their home community as possible. Funding to operate these two facilities could be used instead provide services in every region of Virginia. It is preferable to have services available in each locality.

Team Findings. The Team found that both CCCA and SWVMHI adolescent unit are an important part of the safety net the Commonwealth provides for youth who need psychiatric services. They found that public funds should continue to support this safety net at first through the two facilities and then as services become available in each community, through those communities and regions. The State and Community Consensus Team also recommended additional funding for community services, improved coordination and collaboration to enhance existing services and improving data collection between public and private providers.

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[5] VDH issued a Request for Applications on November 13, 2009 for acute inpatient psychiatric beds. Previously Certificate of Public Need applications were required to increase the number of inpatient psychiatric beds.

Conclusion. The State and Community Consensus Team supports continued expansion of community-based intensive psychiatric services for youth in the Commonwealth as does DBHDS. Based on the findings of the Team, previous reports and date, DBHDS believes Option 1, if paired with state general funds, will spur the development of services in each locality of the Commonwealth and ensure that each child in each community receives appropriate intensive mental health services. Resources should be invested in a state and community consensus team to work with private providers, community service boards, the Office of Comprehensive Services, the Department of Medical Assistance Services and others to develop a comprehensive plan for cultivating services in each region of the Commonwealth that are of consistent availability and quality.

Introduction

The Commissioner of the Department of Behavioral Health and Developmental Services (DBHDS), formerly the Department of Mental Health, Mental Retardation, and Substance Abuse Services[6], was directed by the 2009 General Assembly to develop options for the future of the Commonwealth Center for Children and Adolescents (CCCA) and the adolescent unit at Southwestern Virginia Mental Health Institute (SWVMHI). These options were to be informed by the work of a State and Community Consensus Team that would examine the need for public acute psychiatric services for children in Virginia.

Governor Kaine's budget for FY 2010 proposed the closure of CCCA and the SWVMHI adolescent unit by June 30, 2009. These two state-operated facilities provide public acute inpatient mental health services to children from all regions of the Commonwealth. In response to public opposition, the 2009 General Assembly's final budget did not close these two facilities. The General Assembly also required the Commissioner of DBHDS to establish a State and Community Consensus Team and report on the findings of this team and make recommendations for alternative approaches to provide care in these two facilities. Item #315 BB.2. of the 2009 *Appropriation Act* states:

2. The Commissioner of the Department of Mental Health, Mental Retardation and Substance Abuse Services shall establish a state and community consensus and planning team for the purpose of developing a plan to examine the current and future role of the Commonwealth and private sector in providing acute psychiatric services for children and adolescents. The team shall consist of department staff and representatives of affected consumers, local government officials, advocates, state hospital employees, community services boards, behavioral health authorities, and public and private child and adolescent mental health service providers, and other interested persons, as determined by the Commissioner. In addition, members of the House of Delegates and the Senate representing the localities served by the hospital may serve on the state and community planning team.

The state and community planning team, under the direction of the Commissioner, shall

> *(i) identify the characteristics of the child and adolescent population currently served at the CCCA and SWVMHI,*
> *(ii) describe the service needs of the children served at each facility,*
> *(iii) determine what services are currently available, or would need to be available in the community, to adequately provide treatment for these children,*
> *(iv) consider alternate approaches to delivering services appropriate for some or all of the patient population,*
> *(v) define the state's continuing role and responsibility in providing inpatient services for children and adolescents,*
> *(vi) identify funding trends and policies for providing public and private services,*
> *(vii) report on the cost of providing public and private psychiatric services, and*
> *(viii) detail other strategies to promote high quality, community-based care while maintaining a safety net for children and adolescent in need of acute psychiatric services.*

The Commissioner shall report to the Chairmen of the House Appropriations and Senate Finance Committee on the findings of the state and community planning team no later than November 1, 2009.

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[6] The Department's name was changed on July 1, 2009.

This report provides information about the current populations served at the facilities and describes additional services required to address the needs of these populations across the Commonwealth. DBHDS provides two options for consideration based on the Team's findings.

(i) Identify the Characteristics of the Child and Adolescent Population Currently Served at the CCCA and SWVMHI

The Commonwealth Center for Children and Adolescents has 48 licensed beds, serves children from ages 4 to 18 years old, and receives referrals from all 40 community service boards. Southwestern Virginia Mental Health Institute's adolescent unit has 16 licensed beds, serves children from 13 to 18 years old, and receives the majority of its referrals from community service boards in southwest Virginia. SWVMHI adolescent unit does not admit children under the age of 13, so children requiring public care younger than 13 are admitted to CCCA. Nearly all CSBs refer children to CCCA from ages 9-12 years. Table 1 describes the children who are admitted to these two facilities. Table 2 describes the primary diagnoses of the populations served at these two facilities.

Table 1: Populations served by CCCA and SWVMHI Adolescent Unit

<table>
<tr><th>Description of Population Served</th></tr>
<tr><td>1. Individuals who have severe behaviors which are unable to be managed by private hospitals. Referrals are made to state facilities for either direct admission or transfer from the private hospitals of individuals with the following presentations/types of behavior:

Severe self injurious behavior, such as cutting
Episodes of severe aggression, particularly from those who are above average in height and/or weight
Inappropriate/deviant sexual behavior, including history
Developmental disabilities (including intellectual disabilities, autism, deaf/hearing impaired, deaf/visually impaired etc). in conjunction with significant aggression/violent behavior problems
Repeat admissions who are on private hospital "do not admit" lists despite having valid insurance
Property destruction
Attempted runaway
Fire setting
</td></tr>
<tr><td></td></tr>
<tr><td>2. Individuals with complicated (risky and/or expensive) co-morbid medical histories and physical conditions, including morbid obesity, congestive heart failure, cancer, brain cyst, tube-feeding, cerebral palsy, unmanaged diabetes, etc.</td></tr>
<tr><td></td></tr>
<tr><td>3. Individuals admitted to private sector who need a longer length of stay than coverage allows and there is no payer source:

Admitted to private sector on TDO (temporary detaining order which is paid for through the Supreme Court of Virginia), but no further payer source is available so transfer to state-run facilities is pursued at expiration of TDO
Judged by private insurance companies or Medicaid to no longer meet "acute psychiatric inpatient treatment" criteria, but determined by clinicians in private sector as not stable enough to leave hospital level of care and/or not safe to be discharged to the available next level or community placement
</td></tr>
<tr><td></td></tr>
</table>

4. Individuals who have no payer source and are denied admission by the private sector:
    - Individuals who have had insurance but whose benefits are completely exhausted and then are transferred to state facilities
    - Individuals whose families have never applied for Medicaid and so do not if they are eligible based on family income
    - Individuals who are eligible for FAMIS, but which won't pay for psychiatric hospitalization if the psych unit is not connected to or part of a med/surg hospital

5. Individuals who have juvenile justice/court involvement:
    - Children and adolescents with mental health problems who are highly aggressive and assaultive and have serious legal charges are typically not admitted to or maintained in private hospitals but are sent to state facilities such as CCCA and SWVMHI
    - Individuals from Detention Centers – private facilities may accept if the charges are misdemeanor and not violent offenses or history and if there is a payer source
    - Individuals on Ten Day Court Ordered Evaluations – private hospitals are generally unable to perform intensive inpatient evaluations regularly ordered by the juvenile courts to guide dispositional and risk management decisions. Private facilities may accept if the charges are misdemeanor and not violent offenses or history and if there is a payer source
    - Private facilities rarely if ever accept individuals from Department of Juvenile Justice facilities. These adolescents requiring inpatient psychiatric treatment are sent to CCCA and returned to the DJJ facility upon discharge

6. Populations who need short-term acute stabilization, particularly where the distance to a private facility is greater than to a public facility:
    - Far Southwestern Virginia where the closest adolescent facility is SWVMHI Adolescent Unit and admission to a private facility is distance prohibitive for the family and community of origin
    - The Interstate 81 corridor far west section of the HPR I catchment area from Winchester in the north to Staunton or Lexington where private facilities are too far for family involvement

7. Individuals without a clear place to be discharged to, most likely because of #1 and/or #2 above.

Table 2: Admission Profiles -FY 2008

Primary Diagnosis	CCCA	SWVMHI Adolescent Unit
Mood Disorders	38%	40%
Co-occurring Mental Health & Substance Use Disorders	24%	26%
Primary Substance Use Disorder	1%	7%
Other	37%	27%

Source: OIG Presentation to State and Community Consensus Team, May 14, 2009

(ii) Describe the Service Needs of the Children Served at Each Facility

The two facilities provide comprehensive psychiatric assessments, crisis stabilization and short-term intensive treatment services using interdisciplinary treatment teams. They provide psychopharmacology, supportive counseling, therapeutic recreation, individual therapy, group and family therapy, and full-day onsite educational services. Tables 3 and 4 outline utilization data for CCCA and SWVMHI's adolescent unit, respectively.

Table 3: Office of the Inspector General Report— Commonwealth Center for Children and Adolescents Inspection, OIG Report #167-08, December 10, 2008

CCCA UTILIZATION DATA FOR FY04 THROUGH FY08					
	FY04	**FY05**	**FY06**	**FY07**	**FY08**
Number of Admissions	479	537	521	558	605
Number of Discharges	491	538	510	561	601
Number of Readmissions Within 30 days	42	40	45	42	48
Average Daily Census	33.4	29	31.5	34.3	33
Average LOS (days)	27.6	19.6	22.2	22.7	20.2
Median LOS (days)	15	13	15	14	13
Total Persons Served*	511	557	540	588	632
% Bed Occupancy	70%	60%	66%	71%	69%
Cost Per Bed Day	$776.06	$943.46	$920.16	$914.92	$987.00
Total Inpatient Days	12219	10577	11514	12510	12114
# 100 Days and Over LOS	20	2	7	9	11
% of Total Discharges	4.07%	0.37%	1.37%	1.60%	1.83%
# 7 Days and Under LOS	93	133	119	135	169
% of Total Discharges	18.94%	24.72%	23.33%	24.06%	28.12%

Source: CCCA Utilization Management Database
*Total = End of Month Census + Discharges

Table 4: SWVMHI Adolescent Unit Data, 2008

SWVMHI UTILIZATION DATA FOR FY04 THROUGH FY08					
	FY04	**FY05**	**FY06**	**FY07**	**FY08**
Number of Admissions	225	191	231	223	228
Number of Discharges	232	189	232	224	233
Number of Readmissions Within 30 days (% of total admissions)	8 3.6%	5 2.6%	16 6.9%	11 4.9%	15 6.6%
Average Daily Census	5.9	4.7	7.6	7.6	9.4
Average LOS (days)	9.54	9.31	12.43	13.5	16.47
Median LOS (days)	6	6	9	8	10
Total Persons Served*	236	194	237	229	233
% Bed Occupancy	36.7%	29.5%	47.4%	47.4%	58.5%
Cost Per Bed Day	$1160.52	$1422.52	$1,036.09	$1070.80	$996.17
Total Inpatient Days	2148	1721	2768	2767	3428
# 100 Days and Over LOS	0	0	1	1	3
% of Total Discharges	0%	0%	0.4%	0.4%	1.3%
# 7 Days and Under LOS	112	111	95	90	87
% of Total Discharges	48.28%	58.73%	40.95%	40.18%	37.34%

Source: SWVMHI Utilization Management Database
*Total = End of Month Census + Discharges

The children admitted to CCCA and SWVMHI adolescent unit have a variety of insurance resources, are uninsured, or have exhausted their existing insurance benefits. Table 5 shows the payor mix for this population. Approximately 8% of children admitted to CCCA come from local juvenile detention centers or DJJ facilities. In addition, approximately 9% are admitted at the time of having some court involvement (e.g. evaluations).[7] For SWVMHI, the numbers are between 5-6% for both categories.[8]

Table 5: Payor Mix

	Medicaid	**Commercial**	**Uninsured**	**Other**
SWVMHI (FY2008)	70%	13%	17%	0%
CCCA (FY07-2nd qrtr FY09)	35%	12%	44%	10%

Source: SWVMHI Utilization Data and CCCA AVATAR Data.

CCCA and SWVMHI Adolescent Unit have a partnership with the Commonwealth of Virginia's Department of Education and the local school divisions where the hospitals are located. These divisions provide full-day, on-site education programs to children at the facilities. These partnerships are required by Virginia Code §22.1-7 and school services must be provided to children in both facilities. In coordination with the facility treatment team and the home school division, education is tailored to meet each individual student's needs. A minimum of 5 ½ hours a day of instruction is provided and instructors ensure that the educational services provided will allow the student to at least maintain his or her current level of academic functioning and provides a smooth transition back to previous educational settings. The instructors also ensure that all students identified as disabled have an updated Individualized Education Plan (IEP) and ensures compliance with the following federal and state regulations:

1. *Code of Virginia* 22.1-7 and 22.1-214.2
2. *Regulation Governing Special Education Programs for Children with Disabilities in Virginia*, July 7, 2009
3. *Individuals with Disabilities Education Improvement Act 2004*, PL 108-446
4. Section 504 of the *Rehabilitation Act of 1973*
5. 12VAC35-46 *Regulations for Children's Residential Facilities*

These educational services are critical to assisting with treatment and ensuring smooth transition back to the child's home community. During the 2008-2009 school year, CCCA and SWVMHI Adolescent Unit had 245 special education students with active IEPs with the following disabilities (Table 6):

[7] CCCA Admissions Data, 2009. 49 admissions out of 605 in FY09 were from DJJ or Detention and 53 admissions were from children with court-ordered involvement.
[8] SWVMHI Admissions Data, 2009. 12 admissions out of 189 in FY09 were from Detention and 11 admissions were from children with court-ordered involvement.

Table 6: Special Education Students by Disability Category CCCA and SWVMHI (08-09 School Year)

Disability Category	Frequency 08-09
Autism	17
Deaf/Blindness	0
Developmental Delay	5
Emotional Disturbance	106
Hearing Impairment/Deaf	2
Intellectually Disabled	21
Multi- Disabilities	20-
Ortho- Impairment	0
Other Health Impairment	37
Severe Disabilities	5
Specific Learning Disability	27
Speech/Language	3
Traumatic Brain Injury	2
Visual Impairment	0

(iii) Determine What Services are Currently Available, or Would Need to Be Available in the Community, to Adequately Provide Treatment for these Children

Existing Private Provider Acute Inpatient Psychiatric Services
Previous research indicate that there are mental health services available in the community for children. However, the data indicates that the level and scope of services varies across the Commonwealth

There are 15 acute inpatient psychiatric providers in the Commonwealth that provide acute inpatient mental health services to children, thirteen of these are private providers with 245 licensed psychiatric beds.[9] Appendix A shows detailed data from twelve of these acute inpatient psychiatric private providers and compares it CCCA and SWVMHI's adolescent unit. In addition, there are over 1800 beds in 25 residential treatment facilities that provide intensive services for youth.[10] The private providers typically have shorter lengths of stay and provide fewer or no educational services. In addition, those children with commercial insurance are more likely to be admitted to a private facility.

The number of licensed residential beds continues to expand over time. For example, for the quarter ending June 30, 2009, there were 1696 licensed residential beds available to treat youth and there were 1860 such beds for the quarter ending September 30, 2009.[11] It anticipated that the number of acute private psychiatric beds for children will also expand

[9] 37.2-308 Child and Adolescent Data, July 1 –September 30, 2009
[10] 37.2-308 Child and Adolescent Data, July 1 –September 30, 2009
[11] 37.2-308 Child and Adolescent Data, April 1 –June 30, 2009 compared to 37.2-308 Child and Adolescent Data, July 1 –September 30, 2009.

with recent changes to the Code of Virginia which eases state approval for inpatient psychiatric beds.[12]

Existing Community-Based Services

The OIG completed an extensive review of community-based mental health services for children in April 2008.[13] The report found that families seeking services for children with mental health and substance abuse needs faced differences in service availability depending on where they lived. In addition to this variability, the OIG found stakeholders (CSBs and families) were satisfied with services when they could receive them, but were dissatisfied with the availability, array, and types of services for children. Data collected from the CSBs in January 2008 shows that mental health services are available for youth, but intensive services such as emergency services, crisis stabilization, home-based therapy, school-based day treatment, and residential services are present in far few numbers than all mental health services.[14]

State general funds and local funds make up a relatively small portion of funds dedicated to children's services. The OIG's study found that Medicaid is the largest funding source in CSB budgets for children's services, even in those communities that offer a wide array of services. CSBs indicated when surveyed for the study that the leading factor in the development of an array of children's services is the fiscal support and cooperation of the local CSA Community Policy and Management Team. In addition, collaboration with other community agencies at the local level to identify and develop needed services lead to additional services for youth.

The OIG's report identified several services that, if available, could help prevent placement in residential or short-term psychiatric facilities out of the child's community. These included:

- home-based intensive wrap-around services,
- substance abuse outpatient services,
- residential options in the community,
- outpatient mental health services,
- additional types of assessment and evaluation services,
- educational support and treatment for families, and
- community-based services for children with problematic sexual behaviors.

These needs are similar to those identified by the SOCAT. The SOCAT recommended increased support for the development of emergency services/crisis stabilization, case management/care coordination, intensive in-home/home-based services and intensive care coordination.

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[12] VDH issued a Request for Applications on November 13, 2009 for acute inpatient psychiatric beds. Previously Certificate of Public Need applications were required to increase the number of inpatient psychiatric beds.
[13] Appendix D
[14] Appendix D, page 43 of OIG report #149-08.

Services Needed in the Community to Adequately Provide Treatment
The Team recommended a series of specific community-based services to address immediate needs for children who are in psychiatric crisis and could potentially prevent admission or readmission to private psychiatric facilities, CCCA, or SWVMHI's adolescent unit. They include crisis stabilization services, incentives for communities to have a basic set of community services beyond emergency services and case management, creative and flexible funding needs related to the development of a full continuum of community-based services, and additional psychiatric professionals or access to psychiatric professionals through telemedicine approaches.

The Team also identified deficits in community services for children who are involved with the courts system, DJJ, or local juvenile detention centers. These children have specialized needs that are not currently addressed in the community or by psychiatric providers. These children may require long-term mental health treatment in secure settings similar to adult forensic populations. They may also require additional supports upon discharge from correctional treatment. There have been significant reductions in funding to court services units and the Virginia Juvenile Community Crime Control Act in the past several years and this has significantly reduced services to help prevent admission to care.

The critical services needed to address immediate needs of children in their home communities were:

- ***Inpatient Care.*** *The Commonwealth has the responsibility to maintain a publicly-funded safety net that includes acute inpatient services. Funding should be aligned so services are delivered in children's communities closer to home.* Acute inpatient mental health services for youth in crisis—regardless of their health history, behavioral history, or insurance status—should exist in each region as an alternative to the current model.

- ***Funding for Services.*** *Support continued expansion of home and community-based services so children can be served in their home communities with additional services and supports that currently do not exist in Virginia's localities.* The Commonwealth must develop a full continuum of community services for youth, including crisis intervention services, crisis stabilization services, case management, intensive in-home services, intensive care coordination, day treatment in schools, respite care, and parent support programs.

(iv) Consider Alternate Approaches to Delivering Services Appropriate for Some or All of the Patient Population

The State and Community Consensus Team found that CCCA and SWVMHI's adolescent unit provide a valuable service for children, families, and localities that lack sufficient community-based resources and services to provide acute inpatient mental health care. DBHDS proposes the following plans to address the lack of resources and services and reduce or eliminate the need for the two facilities:

- **Provide state general funds for the purchase of private mental health treatment services in each region of the Commonwealth.** The State and Community Consensus Team agreed that ultimately all children should be able to receive services in their own communities, close to their families.

  The Commonwealth should begin to address this concern by providing general funds for bed purchase in each Health Planning Region. If state general funds currently used for operation of CCCA and SWVMHI's adolescent unit were used in lieu of operating the centers, sufficient funding would exist to provide coverage to uninsured children who currently receive care at the two centers.

  CSBs would receive a general fund allocation of funds to purchase care for children in their Region. The funds would be used to treat children who are uninsured, have exhausted insurance benefits, or have significant behavioral challenges and require additional lengths of stay. A sample of admissions and discharges at CCCA and SWVMHI's adolescent unit between July 2009 and November 2009 indicates that 18% of admissions at CCCA were because of inadequate health care coverage and half at SWVMHI of those discharged had no health insurance coverage or benefits had been exhausted. This comports with FY08 and FY09 data from the two centers as well (Table 6).

  The Commonwealth could provide funding to purchase beds in localities from private providers. Data indicates there are more than 2000 beds statewide among private psychiatric and residential providers and recent changes to COPN laws may stimulate further private expansion of mental health beds for children and adolescents. Based on this data, lack of bed capacity is not the issue. Providing funds to ensure care for uninsured or underinsured children is critical to providing more regionalized services across the Commonwealth.

- **Provide start up funds for crisis stabilization and other intensive support services.** Medicaid provides funding for child crisis stabilization and other intensive support services, including residential care and in-home services. The Commonwealth should provide start up general funds to CSBs to develop regional crisis stabilization and intensive services for children and adolescents. Once units or services are operational, Medicaid and private insurance can provide services to many children in these units. Current expansion of crisis stabilization services for adults in Virginia has successfully reduced admissions to state adult mental health treatment facilities. There are significant number of children who receive care at CCCA and to a greater extent SWVMHI because they fall into Table 2: category 6 and require short-term stabilization. These services could be developed across the Commonwealth to eliminate the need for these services at CCCA and SWVMHI.[15]

[15] A FY10 sample of 221 admissions at CCCA showed 29 children admitted because they lack crisis stabilization services in their area. 59 discharges out of a sample of 100 discharges at SWVMHI were related to a lack of short-term crisis services.

- **Establish a forensic mental health unit at a local juvenile detention center or state juvenile correctional center to provide services to children who are incarcerated.** Children who are incarcerated and have mental illness require specialized care that ensures they are receiving appropriate mental health treatment. While it is most desirable to offer these services through a private provider or other health facility setting, a specialized unit could be established at a state or juvenile detention center to treat children. This unit could provide mental health treatment and provide sufficient security appropriate to this small population of challenging children. Data indicates that between 5-8% of admissions at CCCA and SWVMHI adolescent unit are from juvenile detention centers or DJJ.[16] A unit that provides sufficient space to treat these children could be established and funded with state general funds.

(v) Define the State's Continuing Role and Responsibility in Providing Inpatient Services for Children and Adolescents

DBHDS supports a continuing public role in providing inpatient services for a critical number of children with complex behavioral and health care needs, who may interface with the court or juvenile correctional system, and or have no or have exhausted insurance resources. DBHDS outlines a path forward in providing services statewide to children in their home communities in Section (iv) above. Critical services that can be established to provide support for regionalized intensive psychiatric care for children include: (1) state general funds for uninsured or underinsured children who currently receive care at CCCA or SWVMHI because of lack of resources. Funds currently used to operate CCCA and SWVMHI's adolescent unit could be redirected for this purpose; (2) crisis stabilization and other intensive support services for children to prevent admission to acute inpatient psychiatric or residential providers for extended periods, and (3) a specialized unit to provide treatment to children who are in local or state juvenile detention centers. Current operating funds from CCCA and SWVMHI's adolescent unit could also be redirected to funds items (2) and (3).

The DBHDS plan would help to provide state resources to establish services across the Commonwealth. It would ensure that children are provided the most appropriate care in their own communities, whenever possible and provide specific resources through the juvenile justice system for children in need.

(vi) Identify Funding Trends and Policies for Providing Public and Private Services and (vii) Report on the Cost of Providing Public and Private Psychiatric Services

Currently, the number of private residential care beds are increasing despite recent changes in CSA reimbursement for residential services. In addition, the number of private psychiatric beds for youth are expected to increase with changes in the state's Certificate of Needs laws. The number of intensive in-home treatment providers is also expanding to address children's needs. This expansion in private capacity is supported by Medicaid

[16] This represented 49 admissions at CCCA in FY09 and 12 admissions at SWVMHI in FY09.

policies that provide payment for these services for children. CSA also provides funding for intensive in-home and other services for youth in that program.

Many of the children who receive services at CCCA and SWVMHI's adolescent unit are not initially CSA-eligible because they are not in the foster care system or at-risk for foster care. CCCA and SWVMHI adolescent unit patients typically fall under the non-mandated category of eligibility for CSA and so services may be limited or it may take several months to put services in place. The State and Community Consensus Team supports additional work in this area to address these gaps for children who are at substantial risk of further problems and fall into this non-mandated category. The Team supports greater alignment between Medicaid and CSA payments and services offered so that communities and private providers are encouraged to develop services in their area for youth in lieu of sending children outside their home communities for care.

(viii) Detail Other Strategies to Promote High Quality, Community-Based Care while Maintaining a Safety Net for Children and Adolescents in Need of Acute Psychiatric Services

The State and Community Consensus Team met on May 14, June 22, and September 17 in Staunton, Richmond, and Marion, respectively, to develop the recommendations and respond to the General Assembly directive. Team members included representatives from the DBHDS Central Office, the two state facilities, community service boards, advocates, former patients served at CCCA, parents of children treated at CCCA and SWVMHI, local and state government, private psychiatric care providers, and legislators (Appendix B). After the June 22 meeting, the Team broke into three workgroups to allow for additional discussion and research in three categories:

1. Role of CCCA and SWVMHI Adolescent Unit. This workgroup examined current data about the centers and sought to identify ways to improve services, target high-need populations not currently served by other providers, and determine how to advance training and center of excellence models through the centers;

2. ***Crisis and Alternative Services.*** This workgroup used the recommendations of previous related studies and data to identify which services are needed in the community to prevent or defer admission to CCCA or SWVMHI adolescent unit; and

3. ***Juvenile Justice Services.*** This workgroup examined how children who are involved with the courts, in juvenile detention centers, or are in Department of Juvenile Justice (DJJ) custody utilize acute mental health services, including at CCCA and the SWVMHI unit.

These workgroups met separately between July and September to develop recommendations to the State and Community Consensus Team. Those recommendations were discussed at the Team's September 17th meeting and are reflected in this report.

The State and Community Consensus Team built on the significant work already underway in the Commonwealth to transform our children's services system. The work of this Team is preceded by reports from the System of Care Advisory Team (SOCAT), The Office of the Inspector General (OIG), Commission on Youth, and many others (Table 7). In total, at least 18 reports or studies have been issued in the past two years directly addressing or pertaining to Virginia's behavioral health care system for children. Each of these reports has sought to address services for youth who have a mental, behavioral and/or developmental disability.[17]

Table 7: Recent Studies Regarding Behavioral Needs of Youth

Reporting Entity	Date of Report
Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS)	
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	June 30, 2008
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)	June 30, 2007
A Report on Virginia's Part C Early Intervention System (Budget Item 312 K.2, 2006 Appropriations Act)July 1, 2006 – June 30, 2007	June 30, 2007
State Facility Bed Use for Children and Adolescents: Report to the Department of Mental Health, Mental Retardation, and Substance Abuse Services and the Child and Family Behavioral Health Policy and Planning Committee	2006
Office of the Inspector General (OIG)	
Inspection of the Commonwealth Center for Children and Adolescents Report – November 2008 #167-08	December 10, 2008
Review of Community Services Board Child and Adolescent Services Report March – April # 149-08	September 19, 2008
Survey of Community Services Board Child and Adolescent Services Report-October 2007 # 148-07	March 31, 2008
Commission on Youth (COY)	
Guide to Local Alternative Education Options for Suspended and Expelled Students in the Commonwealth (RD 144)	April 2008
Collection of Evidence-Based Practices, 3rd Edition (HD 21)	January 2008
Alternative Education Options (RD 194, Interim Report)	April 2008
Establishment of an Office of Children's Services Ombudsman (RD 117 Final report)	March 2008
Establishment of an Office of Children's Services Ombudsman (Interim Report)	January 2007
At-Risk Youth Served in Out-of-State Residential Facilities (RD 353)	July 2006
Joint Legislative Audit Review Committee (JLARC)	
Mitigating the Costs of Substance Abuse Services	June 2008
Evaluation of House Bill 83: Mandated Coverage of Autism Spectrum Disorders	September 2008
Follow Up Report: Custody Relinquishment and the Comprehensive Services Act	March 2007

[17] Table 1 is generated from the 2009 SOCAT report: "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." Report to the General Assembly, July 1, 2008- June 30, 2009 (Appendix B).

Legislative Committees	
Executive Summary of the Study by the Joint Legislative Audit and Review Commission of Autism Services in the Commonwealth	2009
Senate Document 8 Executive Summary of the Joint Subcommittee to Study Strategies and Models of Substance Abuse Treatment and Prevention (SJR 77)	2008
Comprehensive Services Act	
Residential Services for Children in the Comprehensive Services Act; Utilization, Length of Stay and Expenditures Statewide and by Locality; Program Year 2008	December 2008
FY08 Critical Service Needs Gaps	January 8 , 2009
Commonwealth of Virginia Commission on Mental Health Law Reform Progress Report on Mental Health Law Reform December 2008	December, 2008

The State and Community Consensus Team drew heavily from the findings and recommendations in the SOCAT report entitled, "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" (Appendix C) and two reports from the OIG.

The OIG reports were "The Inspection of Commonwealth Center for Children and Adolescents (OIG #167-08) and "Review of Community Service Board Child and Adolescent Services (OIG# 149-08) (Appendices E and F, respectively). Each of these reports documents the need for community-based services to serve youth with mental illness, substance use and/or other behavioral disorders as well as the need to create better integration between CCCA and SWVMHI's adolescent unit and the communities they serve.

Many of the findings and recommendations in the reports described above and those in this report are being addressed through the Children's Services System transformation. In 2007, the Annie E. Casey Foundation assessed Virginia's foster care services and offered technical assistance to the Commonwealth to develop a child-centered, family-focused, collaborative system of community-based services for young people and create opportunities for permanent family connections for older children in foster care or at risk of entry into the foster care system.

The focus of this report was on acute mental health services for youth. The Team agreed that is was essential to highlight critical services that are at the core of expanding access to these acute services and complement the additional community-based services being developed through the broader child transformation efforts. The Team recommends several services and options that could accelerate the development of acute mental health community-based services. Each requires additional funding or resources to ensure adequate, statewide implementation. These are outlined in Appendix D.

Conclusion

Based on the State and Community Consensus Team recommendations to develop additional services across the state for children, DBHDS recommends two options:

Option 1: ***Close CCCA and SWVMHI's adolescent unit. Utilize state general funds currently used for operation of these facilities for the purchase of private mental health treatment for uninsured children in each region of the Commonwealth.*** The Commonwealth could provide state general funds for the purchase of private mental health treatment services in each region of the Commonwealth. Previous research indicates that there are mental health services available in the community for children. There are 15 acute inpatient psychiatric providers in the Commonwealth that provide acute inpatient mental health services to children, thirteen of these are private providers with 245 licensed psychiatric beds.[18] In addition, there are over 1800 beds in 25 residential treatment facilities that provide intensive services for youth.[19] The number of licensed residential beds continues to expand over time. For example, for the quarter ending June 30, 2009, there were 1696 licensed residential beds available to treat youth and there were 1860 such beds for the quarter ending September 30, 2009.[20] It is anticipated that the number of acute private psychiatric beds for children will also expand with recent changes to the Code of Virginia which eases state approval for inpatient psychiatric beds.[21]

Bed capacity to serve children in Virginia is sufficient, but a significant number of children and their families do not have adequate insurance coverage to pay for services in their community. Data indicates one quarter to one half of admissions at these facilities are related to inadequate health insurance coverage (Table 6). Funds to pay for local purchase of services could prevent admissions to CCCA and SWVMHI's adolescent simply because of the lack of insurance coverage.

Second, the Commonwealth could provide a small amount of start up funding to establish additional crisis stabilization and intensive support services for youth in each region of Virginia. Medicaid provides funding for child crisis stabilization and other intensive services and start up funds could help get these services up and running for Medicaid and privately insured children. This would prevent admissions to CCCA and SWVMHI adolescent unit for many children. A sample indicates that at least 10% admissions fall into this category. Finally, the DBHDS and the Department of Juvenile Justice could partner to establish a mental health unit to provider services to children who are incarcerated. These children represent between 5-8% of admissions to CCCA and SWVMHI adolescent unit.

Option 2: ***Continue to support publicly-funded acute inpatient psychiatric care through the operation of CCCA and SWVMHI's adolescent unit.*** The Commonwealth should maintain a publicly-funded safety net that includes acute inpatient services. Funding should be aligned so services are delivered in children's communities closer to home. Currently, every CSB utilizes services at CCCA and a significant number of CSBs

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[18] 37.2-308 Child and Adolescent Data, July 1 –September 30, 2009
[19] 37.2-308 Child and Adolescent Data, July 1 –September 30, 2009
[20] 37.2-308 Child and Adolescent Data, April 1 –June 30, 2009 compared to 37.2-308 Child and Adolescent Data, July 1 –September 30, 2009.
[21] VDH issued a Request for Applications on November 13, 2009 for acute inpatient psychiatric beds. Previously Certificate of Public Need applications were required to increase the number of inpatient psychiatric beds.

in the western part of Virginia use SWVMHI's adolescent unit. Children and their families must travel vast distances from Northern Virginia, Tidewater, and the Southside to receive intensive services provided at CCCA. Ideally, all children should receive services as close to their home community as possible. Funding to operate these two facilities could be used instead provide services in every region of Virginia. It is preferable to have services available in each locality.

The State and Community Consensus Team supports continued expansion of community-based intensive psychiatric services for youth in the Commonwealth as does DBHDS. Based on the findings of the Team, previous reports and date, DBHDS believes Option 1, if paired with state general funds, will spur the development of services in each locality of the Commonwealth and ensure that each child in each community receives appropriate intensive mental health services. Resources should be invested in a state and community consensus team to work with private providers, community service boards, the Office of Comprehensive Services, the Department of Medical Assistance Services and others to develop a comprehensive plan for cultivating services in each region of the Commonwealth that are of consistent availability and quality.

Appendix A: Comparison of Private and Public Inpatient Psychiatric Facilities for Children (Team - Workgroup #1)

HPR	LOCATION	Facility Name	Number of Beds		Total # Acute Care Admissions	Total # TDO Admissions	Total # Acute Care Bed Days	School	Type
			Licensed	Staffed					
V	Portsmouth	Bon Secours Maryview	12	12	473	12	2,853	Yes	Full day school program
III	Roanoke	Carilion Clinic	12	12	260	52	1,977	?	No information was able to be retrieved
I	Lynchburg	Centra Virginia Baptist Hospital	14	14	729	272	4,109	?	No information was able to be retrieved
IV	Richmond	HCA- Chippenham Tucker Pavillion	18	18	788	56	3,732	No	No services
II	Fairfax	HCA- Dominion [2]	52	52	977	41	8,811	Yes	1 hour only, for SPED students
III	Roanoke	HCA-Lewis Gale	24	14-20	497	99	2,836	Yes	One facilitator for school assignments, the local school division can come in and provide and services that have begun for students with Special Education Needs.
II	Fairfax	Inova Fairfax Hospital [3]	6	N/A	125	3	648	No	No services
IV	Petersburg	PSI - Poplar Springs	23	23	615	273	3,770	Yes	Remedial work is offered
V	Hampton	Riverside Behavioral Health Center	10	10	350	1	2,111	Yes	Acute--stay enrolled in their own schools; parents can bring in assignments for them to work on Residential--Attends school on site in a full program
I	Fredericksburg	Snowden @ Fredericksburg [4]	16	16	584	40	3,053	Yes	Tutorial, one hour/day
V	Virginia Beach	PSI - Virginia Beach Psychiatric Center	23	23	Received data but requires verification			Yes	3 hours/day
IV	Richmond	VCU - Virginia Treatment Center for Children	40	24	542	155	4,766	Yes	5 1/2 hours per day, full school programs; **is a state operated program**
		Facility Name	Number of Beds		Total # Acute Care Admissions	Total # TDO Admission	Total # Acute Care Bed Days	School	Type
			Licensed	Staffed					
III	Marion	SWVMHI FY 2008	16	16	228	151	3428	Yes	5 1/2 hours per day, Full school state operated
III	Marion	SWVMHI FY 2009	16	16 10 (3/1-6/30)	189	119	1989		
I	Staunton	CCCA FY 2008	48	48	605	257	12114	Yes	5 1/2 hours per day, Full school state operated
I	Staunton	CCCA FY 2009	48	48	605	255	11518		

1 Data in this table was compiled in July/August 2009 and reflects the most recent 12-month period available for that facility. [2] The majority of Dominion's transfers are due to third party denials.
3 N/A: Inova Fairfax Hospital is licensed to take up to 6 adolescents at a time. This is an adult unit that accomodates the adolescent admissions.
4 Payor mix information reflects both adult and child/adolescent.
[5] Actual percentages of "covered or approved" Bed Days: Medicaid 33%, Commercial 10%, leaving 57% of bed days not reimbursed by 3rd party payors; FY 2009 actual percentages of "covered or approved" Bed Days: Medicaid 32%, Commercial 7%, leaving 61% of bed days not reimbursed by 3rd pary payors

Appendix A: Comparison of Private and Public Inpatient Psychiatric Facilities for Children (Team - Workgroup #1)

Facility Name	**Payor Mix (as % of Bed Days)**							**Avg. Length of Stay**	**Occupancy Rate**	**Discharge Status (as % of all discharges)**				**Estimated Patients Inside/Outside Service Area**		**# Patients referred to State Facility**
	VA Medicaid	**Other Medicaid**	**Medicare**	**Tricare**	**Commercial**	**Self Pay**	**Other**			**Home**	**Residential**	**State Facility**	**Other**	**% Inside**	**% Outside**	
Bon Secours Maryview	38	0	<1	15	46	1	0	6.2	62%	90%	10%	0	0	99	1	0
Carilion Clinic	65	0	0	1	33	1	0	6.6	39%	93%	4%	3%	0%	92	8	7
Centra Virginia Baptist Hospital	55	0	0	0	40	1	4	5.6	80%	N/A	N/A	N/A	N/A	54	46	31
HCA-Chippenham Tucker Pavillion	42	0	0	0	49	3	5	4.7	57%	96%	0	0	4%	94	6	8
HCA- Dominion [2]	8	0	0	0	81	2	10	9	45%	87%	0	0	13%	94	6	27
HCA-Lewis Gale	55	0	0	0	39	2	4	5.7	49%	88%	0	0	12%	81	19	39
Inova Fairfax Hospital [3]	31	0	0	4	55	8	2	5.18	N/A	N/A	N/A	N/A	N/A	71	29	N/A
PSI - Poplar Springs																
Riverside Behavioral Health Center	16	0	0	22	55	6	1	6.03	57%	92%	5%	2%	1%	90	10	6
Snowden @ Fredericksburg [4]	14	<1	15	5	43	22	0	5.23	52%	98%	1%	1%	0	90	10	6
PSI - Virginia Beach Psychiatric Center																
VCU - Virginia Treatment Center for Children	60	0	0	1	33	4	2	8.78	65%	86%	4%	3%	7%	62	38	15
Facility Name	Payor Mix (as % of Bed Days)							Avg. Length of Stay	Occupancy Rate	Home/ Foster Home	Residential	Group Home	Detention DJJ	% Inside Catchment Area	% Outside Catchment Area	# Patients referred to State Facility
	VA Medicaid	Other Medicaid	Medicare	Tricare	Commercial	Self Pay	Other			Home	Residential	State Facility	Other	% Inside	% Outside	
SWVMHI FY 08	705	0	0	0	13	0	17	14.7	59%	71%	16%	5%		95%	5%	N/A
SWVMHI FY 09	78				14		8	10.5	34%	67%	14%	7%		87%	13%	N/A
CCCA FY 2008[5]								20.2	69%	64%	14%	4%				N/A
CCCA FY 2009[5]								19.4	66%	64%	13%	7%				N/A

1 Data in this table was compiled in July/August 2009 and reflects the most recent 12-month period available for that facility. [2] The majority of Dominion's transfers are due to third party denials.
3 N/A: Inova Fairfax Hospital is licensed to take up to 6 adolescents at a time. This is an adult unit that accomodates the adolescent admissions.
4 Payor mix information reflects both adult and child/adolescent.
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Appendix A: Comparison of Private and Public Inpatient Psychiatric Facilities for Children (Team - Workgroup #1)

Reason for Referral to State Facility								
Aggression/ Threatening/ Acting Out	**Suicidal/ Depressed**	**10 Day Evaluation**	**Self Cutting/Self Abuse**	**Psychoses**	**Depression**	**Sexually Inappropriate**	**Benefits Exhausted**	**Other**
N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
5	2	0	0	0	0	0	0	0
0	0	0	0	0	0	0	18	13
4	0	0	0	4		0	0	0
0	0	0	0	0	0	0	27	0
8	3	0	3	4	0	2	10	9
N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
6	0	0	0	0	0	0	0	0
3	1	0	2	0	0	0	0	0
5	2	0	0	3	3	0	0	2

1 Data in this table was compiled in July/August 2009 and reflects the most recent 12-month period available for that facility. [2] The majority of Dominion's transfers are due to third party denials.
3 N/A: Inova Fairfax Hospital is licensed to take up to 6 adolescents at a time. This is an adult unit that accomodates the adolescent admissions.
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Appendix B: State and Community Consensus Team Members

Name	Organization
Margaret Nimmo Crowe	Voices for Virginia's Children
Mira Signer	National Alliance for the Mentally Ill (NAMI) Virginia
Vicky Hardy-Murrell	Virginia Federation for Families/ Mental Health America
Robert Gunther, MD	Virginia—American Academy of Pediatrics (AAP)
Betsy Strawderman	Prince William CSB
Diana Barnes	District 19 CSB/ Virginia Association of Community Service Boards (VACSB) Council
Lisa Moore	Mt. Rogers CSB
Robert Tucker	Valley CSB
Sandy Bryant	Central Valley CSB
Barbara Shue	CCCA
Cynthia McClaskey	SWVMHI
Joe Tuell	CCCA
Renee Musser Hummell	Former patient
Dean Lynch	Virginia Association of Counties (VACO)
Macy Fox	Parent
Naomi Verdugo	Parent
Allison Marcus	United Methodist Family Services (UMFS-Leland House)
Bill Semones	Centra Health
Debbie Tanner	Riverside
Jim Krag	Psychiatric Society of Virginia
Rick Bridges	United Health Services (UHS—Marion)
Betty Dixon	National Counseling Group
Catherine Hancock	Department of Medical Assistance Services (DMAS)
Merilee Fox	Virginia Department of Education (DOE)
Heidi Dix	DBHDS
James Reinhard, MD	DBHDS
James Stewart	Office of the Inspector General (OIG)
Pam Fisher	DBHDS
Janet Lung	DBHDS
Steve Peed, MD Mark Derbyshire	Department of Juvenile Justice (DJJ) Carillion Clinic

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 July 1, 2008- June 30, 2009

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

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 2002, the General Assembly has approved *Appropriation Act* language (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. The language also requires DMHMRSAS to report the plan to the Chairmen of the Senate Finance and House Appropriations Committees as follows:

> *"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."*

DMHMRSAS convenes the interagency Systems of Care Advisory Team (SOCAT) – previously known as the Child and Family Behavioral Health Policy and Planning Committee (CFBHPPC) - to study children's services and advise it and the General Assembly regarding necessary changes in services. In June 2008, DMHMRSAS submitted its sixth consecutive report, *A Policy and Plan to Provide and Improve Access to Mental Health and Substance Abuse Services to Children, Adolescents and Their Families*. This report delineated recommendations to improve access to services for children and their families. The report included recommendations to address unmet service needs, funding, infrastructure, and system issues.

Over the past seven years there has been considerable interest in the children's behavioral health services system and numerous reports and studies have been generated. Besides DMHMRSAS, several state executive and legislative agencies have generated reports and

recommendations related to mental and behavioral health services needed by youth. These include the Office of the Inspector General (OIG), the Virginia Commission on Youth (COY), the Joint Legislative Audit and Review Committee (JLARC), and the Virginia Commission on Mental Health Law Reform (CMHLR). Independent legislative committees, such as the Joint Subcommittee to Study Strategies and Models of Substance Abuse Treatment and Prevention (SJR 77), have also been asked to study special areas of concern. In total, at least 18 reports or studies have been issued in the past 2 years directly addressing or pertaining to Virginia's behavioral health care system for children. These reports have identified similar findings, including:

- Lack of service capacity;
- Limited access to care;
- Lack of a full continuum of community-based care;
- Shortage of child and adolescent psychiatrists and psychologists;
- Fragmentation of services;
- Families unaware of available services;
- Lack of family and youth involvement;
- Lack of statewide evidence-based treatments; and
- Reliance on other systems to provide care.

The numerous reports, initiatives and activities described in this and previous reports have laid a helpful foundation for ongoing change. As Virginia continues its efforts to develop a broader range of services and supports for children and adolescents across the Commonwealth, stakeholders are working to address unmet needs and ensure that providers have the required skills and knowledge to provide better-coordinated services for children and their families.

In recent years multiple efforts to transform behavioral health care services for children, adolescents and adult services have been implemented. DMHMRSAS continues its Transformation Initiative to reform the community behavioral health system by implementing a vision that includes consumer- and family- driven services promoting resilience in children and the highest possible level of participation in community life including school, work, family and other meaningful relationships. Through an ongoing collaboration and coordination process across child-serving agencies, focus has expanded into a comprehensive, cross-agency effort that includes Medicaid, juvenile justice, social services, education and comprehensive services.

DMHMRSAS participated in two federal grants to effect system transformation – one to address services for adolescents with a substance use or co-occurring mental health disorder; the other to transform services for adolescents and adults who have co-occurring mental health and substance use disorders. Two other state-directed initiatives, the *Children's Services System Transformation* and *Smart Beginnings*, have emerged in Virginia. Both are large, complex, interagency efforts aimed at

changing how services are delivered to children and their families across the Commonwealth; however, those initiatives focus on different populations.

The SOCAT offers recommendations in the following areas for FY 2010:

- **Improving the Availability of Child and Adolescent Behavioral Health Services Available across Virginia's Communities**

- **Future Funding (as state budget conditions improve)**

The recommendations are detailed on pages 22 through 25.

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

Introduction and Background

Since 2002, the General Assembly approved *Appropriation Act* language (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. The language also requires DMHMRSAS to report the plan to the Chairmen of the Senate Finance and House Appropriations Committees as follows:

> *"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."*

The Role of the Systems of Care Advisory Team (SOCAT)

Since its inception, the System of Care Advisory Team (SOCAT, formerly named CFBHPPC) has focused on identifying strategies to develop a more comprehensive system of care for youth within the Commonwealth. In order to provide the General Assembly with a comprehensive overview and recommendations for improving this system, DMHMRSAS has sought input from public and private agencies and partnerships annually.

In 2006 at the request of the Secretary of Health and Human Resources, the workgroup and the department developed a 10-year strategic plan to enhance Virginia's service system for children and their families. SOCAT has assessed system strengths and challenges; explored the range of services needed by children and adolescents; and identified strategies to enhance coordination and collaboration among key agencies. The workgroup is currently revising and updating this plan. This report includes an overview of the status of Virginia's system of care for youth and recommendations for improving this system[22].

Many recommendations have been implemented and a number of initiatives requiring funding have been supported by the General Assembly. These include:

- Part C Early Intervention Funds (2003: $7,200,000)
- System of Care/Evidence Based Practice Demonstration Projects (2006: $1,000,000; 2007: $1,000,000)
- Juvenile Detention Centers Projects Mental Health Screening and Assessment Services (2006: $1,140,000; 2007: $900,000)
- Child Psychiatry / Child Psychology Fellowships (2007: $483,000)
- Web Based Reporting of Hospital Beds (2008: $25,000)
- CSB Child and Adolescent positions (2008: $2,800,000)

Progress updates on these initiatives are provided in Appendix A.

Along with the work of the System of Care Advisory Team, many reports in recent years have sought to address services for youth who have a mental, behavioral and/or developmental disability.

Reporting Entity	Date of Report
Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS)	
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	June 30, 2008
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)	June 30, 2007
A Report on Virginia's Part C Early Intervention System (Budget Item 312 K.2, 2006 Appropriations Act)July 1, 2006 – June 30, 2007	June 30, 2007

[22] Copies of previous reports may be accessed on the Virginia General Assembly's Legislative Information System website (http://legis.state.va.us) under Reports to the General Assembly

State Facility Bed Use for Children and Adolescents: Report to the Department of Mental Health, Mental Retardation, and Substance Abuse Services and the Child and Family Behavioral Health Policy and Planning Committee	2006
Office of the Inspector General (OIG)	
Inspection of the Commonwealth Center for Children and Adolescents Report – November 2008 #167-08	December 10, 2008
Review of Community Services Board Child and Adolescent Services Report March – April # 149-08	September 19, 2008
Survey of Community Services Board Child and Adolescent Services Report- October 2007 # 148-07	March 31, 2008
Commission on Youth (COY)	
Guide to Local Alternative Education Options for Suspended and Expelled Students in the Commonwealth (RD 144)	April 2008
Collection of Evidence-Based Practices, 3rd Edition (HD 21)	January 2008
Alternative Education Options (RD 194, Interim Report)	April 2008
Establishment of an Office of Children's Services Ombudsman (RD 117 Final report)	March 2008
Establishment of an Office of Children's Services Ombudsman (Interim Report)	January 2007
At-Risk Youth Served in Out-of-State Residential Facilities (RD 353)	July 2006
Joint Legislative Audit Review (JLARC)	
Mitigating the Costs of Substance Abuse Services	June 2008
Evaluation of House Bill 83: Mandated Coverage of Autism Spectrum Disorders	September 2008
Follow Up Report: Custody Relinquishment and the Comprehensive Services Act	March 2007
Legislative Committees	
Executive Summary of the Study by the Joint Legislative Audit and Review Commission of Autism Services in the Commonwealth	2009
Senate Document 8 Executive Summary of the Joint Subcommittee to Study Strategies and Models of Substance Abuse Treatment and Prevention (SJR 77)	2008
Comprehensive Services Act	
Residential Services for Children in the Comprehensive Services Act; Utilization, Length of Stay and Expenditures Statewide and by Locality; Program Year 2008	December 2008
FY08 Critical Service Needs Gaps	January 8 , 2009
Commonwealth of Virginia Commission on Mental Health Law Reform Progress Report on Mental Health Law Reform December 2008	December, 2008

Unmet Behavioral Needs of Virginia's Children

According to the most recently available prevalence data, the estimated number of Virginia youth ages 9 to 17 who had a serious emotional disturbance (level of functioning score of 60) in 2005 was between 84,923 and 103,794.[23] . The National Survey of Drug Use and Health (NSDUH)[24] further estimated that during 2005-2006, 47,000 youth ages 12-17 (7.53%) and 162,000 Virginia youth age 18-25 (19.88%) abused or were dependent on illicit drugs and/or alcohol in Virginia. In addition, the NSDUH estimated that 56,000 youth were estimated to have had experienced a major depressive episode in the past year during the survey period.

In 2008, Virginia's CSBs provided services to a portion of these youth. Less than 45% of those believed to have a serious emotional disturbance and less than 10% estimated to have a substance use disorder obtained services at a CSB. The same year, 737 youth received acute care services in a DMHMRSAS inpatient psychiatric facility – a significant increase over the preceding year. It is not known why outpatient services for youth 12 – 25 declined from FY 2007 to FY 2008, why hospitalizations increased and if the two might even be related.

Disability Area	**CSB Services**				**DMHMRSAS Acute Care**
	# Served 0 – 11 yrs	**# Served 12 -17 yrs**	**# Served 18 - 25**	**Waiting List 1/1 - 4/1/07**	**# Served**
Mental Health					
2007	12,617	17,430	16,185	1680	513
2008	12,608	14,961	9,659	NA	737
Substance Use					
2007	572	6,697	11,755	234	
2008	320	4,069	9,659	NA	

Despite recent gains, Virginia's child and adolescent behavioral health system still requires improvement in order to meet the needs of many children and adolescents. Improvements are needed in regard to a comprehensive continuum of care and increased service capacity, particularly in rural areas. According to the OIG's 2007 survey of CSB child and adolescent services, of those children and adolescents who do receive services, most receive basic services - emergency services, case management, office based treatment and sometimes medication management. Even when communities are able to offer more comprehensive services, access may be limited by funding restrictions.

Five recent surveys have attempted to assess available services and/or identify gaps:

- CSA's *2008 Survey of Critical Service Gaps;*

[23] Estimate obtained utilizing methodology published by the U.S. Center for Mental Health Services (CMHS) of the Substance Abuse and Mental Health Services Administration (SAMHSA) in the Federal Register, Volume 63, No. 137, Friday, July 17, 1998. and applied to prevalence rates of the 2005 Estimated Population data.

[24] Trends in Substance Use, Dependence or Abuse, and Treatment among Adolescents: 2002 to 2007,NSDUH December 4, 2008

- OIG's *Survey of Community Services Board Child and Adolescent Services - October 2007*;
- DMHMRSAS' *CSB Survey of Services for Adolescent Substance Use and Co-Occurring Disorders (2007)* and *Private Provider Survey of Services for Adolescent Substance Use and Co Occurring Disorders (2008);* and, the
- Virginia Federation of Families' *Family Services Survey (2009).*

Each year CSA surveys stakeholders to identify perceptions of service gaps at the community level. Data is analyzed both regionally and statewide. The top 10 statewide service gaps identified through CSA's FY 2008 survey were, in order of priority:

1. Crisis intervention
2. Intensive substance abuse services
3. Intensive care coordination
4. Wraparound services
5. Parent/family skills training
6. Alternative education day services
7. Transportation
8. Psychiatric assessment
9. Substance abuse prevention
10. Respite care services

The OIG's report, *Review of Community Service Board Child and Adolescent Services,* drew on both survey and interview findings and provides considerable detail regarding funding and services for youth across the disability areas as well as information regarding the interface between CSB and CSA services. The OIG report provided these observations regarding child and adolescent services available through the CSBs:

- "Whether measured by expenditures, staffing, or percentage of child population served, the availability of mental health services for children and adolescents offered by CSBs varies widely among communities "[25]
- "Few CSBs offer a large array of child and adolescent services sufficient to meet the needs of their community. Many CSBs have very limited services available to children. A few have virtually no service system designed especially for children[26]

The OIG found that 32 CSBs provide mental health services to children and adolescents within a dedicated specialized unit and 8 CSBs serve children along with adults. Many of the OIG's findings focused on the lack of child and adolescent services across Virginia's public behavioral health services system[27]:

- Only 2 CSBs offer all of the 5 highly specialized, high impact services (children's emergency services, crisis stabilization, home-based therapy, school-based day treatment, and local residential services) that are considered by stakeholders, CSB staff, and the OIG to offer the most promise to serve children with severe needs and

[25] OIG *Review of Community Service Board Child and Adolescent Services March-April 2008*
[26] Ibid.
[27] Ibid.

help prevent residential placement. The average number of intensive services offered by all CSBs is 1.7.

- Access to services for uninsured families and those that are not eligible for a dedicated source of funding for children and adolescents is extremely limited.
- Child and adolescent services at many CSBs are full to capacity - resulting in long waiting periods. The average wait for all youth services at a CSB was 26 days
- Stakeholder agencies are concerned that CSBs do not offer an adequate array of services, CSB services for youth with substance abuse needs or autism spectrum disorders are inadequate and that wait times in general are too long.

DMHMRSAS' Project TREAT grant surveyed CSBs and licensed residential providers regarding the nature and availability of services for youth with substance use or co-occurring substance use and mental health disorders. Survey responses revealed that CSBs work primarily with youth who abuse alcohol and marijuana and have co-occurring substance use and mental health disorders and identified that:

- CSBs lack supervisory staffs that have expertise in treating adolescents with substance use or co-occurring disorders.
- Almost 40% of the CSBs do not use standardized instruments to screen adolescents and 42% do not use standardized instruments to assess adolescents for substance use or co-occurring disorders.
- Few CSBs implement evidence based practices (EBPs).
- Almost three-fourths do not offer or plan to offer: Multi-systemic Family Therapy, Multidimensional Family Therapy, Functional Family Therapy, Contingency Management, Seeking Safety, ACRA, or Seven Challenges.
- Just over half implement motivational treatment services or Cognitive Behavioral Treatment (CBT).

Of those CSBs that do offer EBPs:

- Almost a quarter do not have supervisors trained in that modality who oversee staff.
- The majority do not monitor fidelity to the model.
- Due to the lack of funds, few CSB are able to access residential substance abuse treatment services for youth.

The OIG's survey went one step further than either the TREAT or CSA survey and asked respondents to also identify those factors that "hinder" the development of children's services. Depending upon the disability referenced the responses they received varied. The impediments most frequently cited related to children's mental health services were:

- Lack of flexible funding for non-CSA mandated children,
- Lack of flexibility in Medicaid for ineligible services and ineligible family members,
- Lack of children's health insurance coverage,
- Lack of prevention funding, and
- Difficulty recruiting and retaining qualified child mental health staff.

The explanations provided for not developing adolescent substance abuse services were:

- Lack of state funding for children's substance abuse services; and
- Lack of support for outpatient services.

SOCAT's findings and recommendations have been remarkably consistent with the numerous reports referenced on page 7-8 of this report. There appears to be general consensus that Virginia's current child and adolescent services system needs:

- A full continuum of services;
- Increased service capacity;
- Improved access to care;
- Greater access to child and adolescent psychiatrists and psychologists;
- Ongoing education and training opportunities to ensure that providers achieve and maintain the necessary skills and expertise to provide services;
- Mechanisms to address transitions between services and ensure continuity of services;
- Adequate service information and support for families including how to access services;
- Greater involvement of family and youth in service development; and,
- Increased use of evidence-based treatments (EBTs) for children and adolescents across the Commonwealth.

Initiatives for Serving Children and Adolescents in Virginia

Adoption of National Initiatives that Address the "Whole Child"

It is broadly recognized that serving the needs of youth involves multiple systems, and, individuals are best served when there is a high degree of service coordination focusing on the "whole child" and the family. Virginia has adopted three national initiatives that address the needs of Virginia's children in crisis:

- *Communities in Schools* is a national school dropout prevention program primarily active in the Richmond metropolitan area.
- *Coordinated School Health* is a multi-systemic approach to attending to the bio-psycho-social-spiritual needs of children promoted by the Center for Disease Control. This approach has been embraced by Student Services staff at the Virginia Department of Education.
- *Systems of Care* can trace its origins to the Institute of Mental Health's Child and Adolescent Service System Program (CASSP). Initially developed for children with serious disorders, the "system of care" concept has since been extended to include all children. The "systems of care" concept has been embraced by DMHMRSAS, the Comprehensive Services Act (CSA) and Virginia's Children's Services Transformation Initiative.

Each of these national initiatives recognizes the need to serve the "whole child" and the importance of addressing children's need for nurturance, education, and healthcare. All three maintain focus on the psychological well-being of the child, while simultaneously addressing other areas of need, and also invite public and private agencies to collaborate in problem-solving for the children they serve.

State Initiatives that Address the Needs of the Whole Child

In recent years, two state initiatives aimed at transforming children's services, the *Children's Services System Transformation* (formerly CORE) and *Smart Beginnings*, have emerged in Virginia. Both are large, complex efforts designed to change how services are delivered, but focus on different populations.

Children's Services System Transformation

In 2007, the Annie E. Casey Foundation assessed Virginia's foster care services and offered technical assistance to the Commonwealth to develop a child-centered, family-focused, collaborative system of community-based services for young people and design permanent family connections for older children in foster care or at risk of entry into the foster care system. The Casey Foundation's efforts have been targeted at helping to reduce the number of youth leaving foster care without a permanent home to go to, as well as contain CSA's escalating costs. Originally known as the Council on Reform (CORE), the *Children's Transformation* efforts initially involved the Department of Social Services (DSS), CSA and DMHMRSAS at both the state and local level. Thirteen communities were selected as pilot sites with four common goals:

- Increase the number and rate at which youth in foster care moved into permanent family arrangements (permanency);
- Reduce placement in congregate care settings while increasing the number of at-risk children and youth placed with kin and foster parents;
- Devote more resources to community-based care; and,
- Embrace data and outcome-based performance management.

In January 2009, the newly named *Children's Services System Transformation*, expanded its transformation efforts statewide, and invited the Department of Juvenile Justice (DJJ), the Department of Education (DOE) and other stakeholders to participate in its efforts to effect change within local systems of care for all youth.

In mid-fall 2008, the *Children's Services System Transformation* invited SOCAT to participate more directly in its efforts. In December, DMHMRSAS and SOCAT facilitated an interactive "round robin" presentation on systems of care efforts in 8 localities to the participating *Transformation* sites. Each of the 8 localities described their respective initiatives and responded to audience questions about interagency collaboration and other elements of community-based systems of care. The featured localities included the four recipients of DMHMRSAS' ongoing systems of care demonstration project grants which had been recommended by SOCAT and funded by the General Assembly in previous years. SOCAT continues to collaborate with the *Children's Transformation* initiative through CSA, and SOCAT members now serve on several of the *Transformation* subcommittees.

Smart Beginnings: Home Visiting Consortium and the Infant Mental Health Work Group

The *Smart Beginnings* initiative is designed to improve services for children 0 to 5 and ensure that they enter school ready to learn. Smart Beginnings is coordinated by two organizations - the Virginia Early Childhood Foundation (a public-private partnership founded in 2005 to implement long-term strategies for improving school-readiness for all young children age's birth to 5), and the Governor's Working Group on Early Childhood Initiatives.

The *Smart Beginnings Initiative* consists of 5 workgroups that address the following overarching goals: governance and financing; parent support and education; early care and education; public engagement and health.

The *Initiative's* Health Workgroup is tasked with building and sustaining a system that ensures all families of children prenatal to 5 years of age have access to a full range of medical, dental and behavioral health care. The workgroup includes two subgroups - the Home Visiting Consortium and the Infant Mental Health Workgroup - which address the continuum of prevention, early intervention, treatment and support services for Virginia's youngest citizens.

- The Home Visiting Consortium (HVC) brings together 10 different state supported home visiting programs which serve children 0 to 5 and their families and includes representatives from VDH, DOE, DSS, DMAS and DMHMRSAS. The Consortium's efforts to enhance and coordinate services, develop uniform standards and address workforce development for this population received national attention this year.

- The Infant Mental Health Workgroup focuses on services for children 0 to 5 at risk for or in need of mental health services and their families. Like the HVC, it brings together a cross-section of agencies and organizations to take a comprehensive approach to increasing access to behavioral and developmental services for youth 0 to 5 years and developing training for the staffs that serve them.

Each of these *Smart Beginnings* workgroups addresses professional development/parent education, service delivery/practice, system collaboration and policy. SOCAT has invited the chairs of the Home Visiting Consortium and the Infant Mental Health Workgroup to update SOCAT on their respective efforts and explore how the groups might interface with one another.

The *Children's Services System Transformation* and the *Smart Beginnings Initiative* both work independently across systems to develop and implement recommendations regarding service development, provider training, data collection, funding polices and procedures for the respective populations they serve.

DMHMRSAS's Grant Funded System Transformation Efforts: Mental Health and Substance Abuse Services

Since 2004, DMHMRSAS has participated in two federal grant-funded initiatives aimed at implementing major system transformation. In 2004, DMHMRSAS received a Co-occurring Systems Integration Grant (COSIG) from the Substance Abuse and Mental Health Services Administration (SAMHSA) to provide integrated mental health and substance abuse services for both adults and adolescents. The Virginia System Integration Project (VASIP) has focused its efforts on transforming CSB and DMHMRSAS facility services to ensure they are "co-occurring capable" and able to deliver effective services to youth and adults who have co-occurring disorders.

DMHMRSAS was awarded a three-year State Adolescent Treatment Coordination (SAC) grant from SAMHSA in 2005 to enhance infrastructure to support substance abuse services for adolescents. Project TREAT (Training and Resources for Effective Adolescent Treatment) was required by SAMSHA to hire an Adolescent Substance Abuse Coordinator, convene an interagency workgroup to identify and address barriers at the state and local level which impede the delivery of adolescent substance abuse treatment services, and complete a financial map that identified public expenditures for substance abuse and mental health services across all youth serving systems. TREAT's interagency workgroup functions as a subgroup of SOCAT and provides input to SOCAT for this report. Grant efforts focused on collaboration, funding, family involvement, workforce development, and implementation of evidence based practices (EBP). TREAT has also worked closely with VASIP/COSIG to develop services and infrastructure for youth who have co-occurring mental health and substance use disorders. TREAT funds supported a wide variety of cross-system workforce development activities.

Grant-funded activities also included providing technical assistance, guidance, and support to 16 CSBs to support implementation of an evidenced based practice (EBP) intended for youth who have a substance use, or substance use and another, co-occurring disorder. Each board was aided in the selection of an EBP suited to its needs and resources, and funding was provided to train their staff. Three CSBs were trained in Dialectical Behavior Treatment (DBT), 3 in the Seven Challenges EBP; 5 chose Motivational Enhancement Therapy/ Cognitive Behavioral Therapy (MET/CBT) and 5 selected Motivational Interviewing (MI); 1 CSB received additional training in Contingency Management. In order to sustain the activities of the Project TREAT grant and continue efforts to enhance services for youth with substance use and co-occurring disorders, DMHMRSAS will retain the Adolescent Coordinator position after grant funding ends July 30, 2009.

In summary, a number of initiatives have focused on enhancing interagency or multi-system collaboration and have sought to coordinate activities with other efforts. Other efforts have proceeded more independently or have only recently begun to explore how they might work with existing groups. This increased focus on children's services is positive but brings with it the potential for duplication of effort. In order to maximize the Commonwealth's resources and expenditures, SOCAT would like to see greater coordination between the different efforts to transform our system of care for youth.

Recent Legislative Efforts to Improve Service for Youth

The 2008 General Assembly was an active session for behavioral health initiatives and children's initiatives. In response to the Virginia Tech tragedy, the 2008 General Assembly addressed the disclosure of necessary information between parties providing services to youth who may be dangerous to themselves or others. As precautionary measures, public universities were required to implement threat assessment teams and early warning systems and to require sharing of information between high schools and universities. In response to concerns regarding the under-funding of the Commonwealth's public mental health system, funds were identified to support additional staff statewide – including funds to support one additional youth position at each of the 40 community service boards.

In the same year, the legislature approved the following measures to support efforts to transform CSA services:

- Increasing payments to foster and adoptive families.
- Allowing Temporary Assistance to Needy Families (TANF) payments to be made to family members of a child in custody.
- Requiring enhanced and increased training for foster care workers.
- Requiring the State Executive Council to develop and establish uniform guidelines for intensive care coordination for children in, or at-risk, of residential placement through the Comprehensive Services Act (CSA)

An update regarding Virginia's progress with implementing intensive care coordination services is provided in Appendix B.

Lastly, in 2008 the legislature approved the renaming of DMHMRSAS. This measure was an effort to support the department's mission, and to move away from the stigma associated with the term "mental retardation." The 2009 General Assembly unanimously approved the new name, Department of Behavioral Health and Developmental Services (DBHDS), and it is scheduled to go into effect July 1, 2009.

The 2009 Session addressed issues related to services for autism spectrum disorders (ASD). Following extensive study and consideration begun in 2005, responsibility and oversight of ASD services was assigned to DMHMRSAS where a lead office will be developed to address developmental disabilities. The legislature also resumed consideration of House Bill 83, introduced in 2008, which proposed mandating insurance coverage for the diagnosis and treatment of ASD in individuals under 21. The revised version, House Bill 1588, received much attention from both opponents and supporters. No action was taken on the bill by the House Commerce and Labor Committee during the 2009 General Assembly Session.

Impact of Recent State Budget Cuts

Understandably, a good portion of the 2009 General Assembly Session focused on Virginia's budget deficit and efforts to meet a three billion dollar revenue shortfall. As a result of this fiscal reality, few behavioral health initiatives and, more specifically, few

children's services initiatives were funded. Funds were not available to implement the Office of Children's Services Ombudsman approved during the 2008 session.

However, although budget concerns dominated the most recent session, the legislature did address several important issues related to mental and behavioral health services for children and adolescents. Legislation was approved in 2008 regarding mandatory outpatient treatment for adults but not adolescents, but in 2009, the legislature took up this issue and sought to close the loop for adolescents. Other legislation was approved that allows a family member to transport an individual under emergency custody.

Due to the dire fiscal situation, the 2009 legislature was unable to fund any new services for youth and, in another cost saving measure, cut funding for the child psychiatry and psychology fellowships previously funded in 2007. In addition, the Governor's budget recommended closing the Commonwealth Center for Children and Adolescents (CCCA) and the Adolescent Unit at Southwest Virginia Mental Health Institute (SVMHI). However, this budget item was modified by the General Assembly and DMHMRSAS was directed to convene a state and community planning team to develop a plan regarding the future role of the Commonwealth and the private sector in providing acute care services to children, adolescents, and their families. As part of the new group's discussion, DMHMRSAS' role as the "safety net" for children and their families and ensuring that all youth have access to appropriate services must be addressed and resolved.

Necessary CSBs budget reductions also resulted in hiring freezes and community concerns that delayed some of the boards from filling the community-based child and adolescent behavioral health positions funded in 2008.

Family Involvement

Families who have children with behavioral health needs require support services within their communities. The availability of family services and interventions rely solely on local community resources; as a result, family support services vary considerably by locality. Although CSA funding is available to all communities for children who are mandated to receive services, many youth and their families are not eligible to receive CSA supported services. Therefore, there are gaps in the funding stream structure for these children and adolescents.

Support, guidance and assistance for families are currently provided by the Virginia Federation of Families (VA-FOF). VA-FOF is a statewide, family-run program affiliated with Mental Health America (MHA) and funded by DMHMRSAS through the federal Community Mental Health Services Block Grant. These federal funds support one staff person and limited operating expenses; additional assistance is provided through the use of volunteers. VA-FOF serves families of children and adolescents who have special health care needs - particularly those with mental, emotional and behavioral challenges. They provide one-on-one resource/service coordination and trainings for parents and family members to help them develop the necessary skills and knowledge to navigate

Virginia's system of care, advocate for their child's personal needs and obtain services. The Federation routinely serves 20 to 30 families and/or professionals each month.

VA-FOF participates on many state-level committees, councils, commissions, taskforces and workgroups to help represent the needs and viewpoints of children, youth and their families. It assists and supports the formation of local Federation of Family chapters and support groups across the Commonwealth and through those chapters provides pertinent information to families, professionals and service providers in localities through brown bag luncheons, seminars, conferences and trainings. The Federation has reached out to groups of various sizes - anywhere from 10 to 400 individuals – to:

- Discuss the importance of the work underway for families;
- Explain how to engage and assist other families; and
- Share how interested participants can become involved.

In conjunction with DMHMRSAS, VA-FOF surveyed family members and caregivers in May 2009 regarding their needs and experiences obtaining services for children with special needs. As part of the survey, responders were also invited to indicate if they wished to participate in VA-FOF activities. DMHMRSAS received 169 responses to the survey and plans to disseminate the results after analysis is completed.

In partnership with Medical Home Plus, DMHMRSAS and other child-serving agencies, VA-FOF coordinates a conference each year for families and professionals that focuses on issues confronting families of children and adolescents who have special health care needs. The 4th Annual *"Strong Roots for a Healthy Future"* Conference will be held in Roanoke this summer.

DMHMRSAS has sought to transform Virginia's community behavioral health system and implement 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. Families benefit from support and guidance during stressful times and need to know who to contact when questions arise. DMHMRSAS supports the idea of an information and support resource to help families navigate through the behavioral health system in Virginia

Current Status of Children's Services

As previously stated, the numerous reports, initiatives and activities described in this and previous reports have laid a helpful foundation for ongoing change. Virginia must continue its efforts to develop a range of services and supports for children and adolescents across the Commonwealth that address the unmet needs identified in these reports. The *Children's Services System Transformation* and *Smart Beginnings* have created momentum to address some of these issues and it is imperative that we continue their efforts. It is also critical that the Commonwealth support ongoing education and training opportunities for youth service providers as a means of ensuring that they have

the necessary skills and knowledge to appropriately serve Virginia's children and their families.

Also referenced earlier, Virginia is experiencing significant economic problems which hinder the availability of either additional enhancements to current services or support of new initiatives in the next biennium. However, this year's report offers recommendations that require little or no new funding and are in line with recommendations from past reports. Budget limitations notwithstanding, the recommendations below are designed to help develop strategies to create a long-term plan for the effective use of funds as they become available.

Policy Perspective

DMHMRSAS is mandated by the *Code of Virginia* to perform three very essential roles relative to children in need of mental health services. First, in §37.2-315, the *Code* stipulates that DMHMRSAS *"in collaboration with CSBs, behavioral health authorities, state hospitals and training centers, consumers, consumers' families, advocacy organizations, and other interested parties"* is responsible for providing the state with a Comprehensive State Plan that is updated on a biennial basis. The plan must identify *"the needs and resource requirements for providing services and supports to persons with mental illness, mental retardation, or substance abuse across the Commonwealth."* This aggregate needs assessment data is used by the state for system-wide planning processes and resource development.

Second, the department is expected to exercise a system leadership role that involves coordinating the development of *"strategies"* to address the identified mental health, intellectual disability, and substance abuse needs of children in Virginia (also in § 37.2-315). As such, DMHMRSAS is responsible for promoting and facilitating the development of appropriate and effective behavioral health care services for children. The department establishes performance contracts and allocates state funding to the local community services boards/behavioral health authorities (§37.2-508. 37.2-509), and works collaboratively with other state agencies, private providers, and consumers/families to facilitate the development and provision of needed services.

Lastly, the department fills an essential "safety net" role and, according to the *Code of Virginia*, is the governmental entity responsible for ensuring that all children in Virginia have access to acute psychiatric care when this level of service is clinically indicated. The vast majority of children in Virginia are appropriately and effectively served through locally operated community-based mental health systems of care and do not require hospitalization. However, inpatient psychiatric hospitalization is required for those children who, in acute situations, cannot be safely served in less restrictive community settings. Many of these children are appropriately treated in privately operated community psychiatric hospitals; others have been unable to access services from a private facility due to their co-occurring forensic, behavioral, medical and/or developmental conditions. In recognition of this situation, the *Code* (§16.1-345) requires that DMHMRSAS assume responsibility for securing the clinically required inpatient

care needed for these children. Specifically, it is mandated that children in need *"be placed in a mental health facility designated by the Commissioner of the Department of Mental Health, Mental Retardation and Substance Abuse Services."* when no other local willing facility can be located. The state's responsibility to secure hospitalization when needed is reiterated in several other sections of the Code.

The system of care model policy recognizes that children with serious behavioral health problems are served by multiple systems and may enter through any door. The model is based on the belief that services must be individualized and tailored to the needs of each child and their family and provided in a planned, thoughtful and coordinated manner. In order to provide services that are truly integrated and coordinated however, these services - as well as the policies, procedures, and regulations which accompany them - must themselves be developed and implemented in a coordinated manner at both the local and state level. This requires a shift in how Virginia's youth serving systems work.

Critical Issues

Community Service Board Child and Adolescent Behavioral Health Services

SOCAT recommends that additional services for children and adolescents, e.g. emergency services/crisis stabilization, case management/care coordination, intensive in-home/home based services, and intensive care coordination be added to the required core. Presently, the *Code of Virginia* requires in §37.2-500 and §37.2-601 that CSBs provide emergency services and, subject to the availability of funds, case management services. As previously stated, services vary amongst localities, with some CSBs providing a more extensive array of services and others currently providing only those which are mandated.

Best Practices recommend that children are best served when a continuum of services is available to meet their respective clinical needs. The *FY08 Comprehensive Services Act Critical Service Gaps Survey*, which was completed by 70% of the Community Policy and Management Teams (CPMTs) across the state, identified the following statewide gaps in child and adolescent services:

- Crisis intervention,
- Intensive substance abuse services,
- Intensive care coordination,
- Wraparound services, and
- Parenting skills training.

Virginia's *Children's Services System Transformation* initiative is currently seeking ways to reduce out-of-home placements which are both costly and not always in the best interest of the child. CSB's have identified the following services as amongst those which could prevent out-of-home placement:

- Case management or intensive care coordination;
- Crisis stabilization;
- School based therapeutic day treatment, and
- Increased access to psychiatric services.

Acute Psychiatric Services for Children and Adolescents

Background and Concerns

Since the early 1970s, both CCCA and the Adolescent Unit at SWVMHI have been part of the statewide array of public mental health services for children and adolescents (including child and adolescent services at Eastern State Hospital and the Virginia Treatment Center for Children, and adolescent services at Central State Hospital). As such, these facilities provided the public behavioral health safety net for children and their families who were not served elsewhere. Now, only two public facilities for this population remain.

The need for inpatient care for high risk children and adolescents in the Commonwealth seems to be increasing. In fiscal year 2008, 605 children and adolescents were admitted to CCCA. This year CCCA is on track to serve approximately 650 youth. In the last ten years, admissions to CCCA have increased by 50%. During the same period, Virginia's community based behavioral health care services for youth have increased only moderately.

Many of the children and adolescents served at CCCA and SWVMHI are transferred there from private facilities because their insurance is exhausted; they are too violent or dangerous, or because, though seen as needing to leave the private facility, they are not seen as safe for discharge to the community or another less restrictive setting.

Over the past several decades, Virginia's public and private facilities which serve children and their families have developed positive relationships, maintained an open dialogue, and have come to recognize one another's strengths.

Considerations for the Study Group

A comprehensive system of care encompasses a wide array of intervention services ranging from least restrictive to most restrictive. It is preferable that children remain in their home and receive community-based services; however, there are times when some children and their families require more intensive, specialized services that can only be provided in an acute care setting.

Outpatient, community-based treatment is necessary and ideal; however, it is not always possible. When it is not clinically appropriate to provide outpatient services there must be a reasonable alternative. Even if community-based preventative care were adequately funded, there will always be some individuals that need a more intensive level of service. Therefore, we support the work of the State and Community Consensus Planning Team reviewing these issues and the future of inpatient care as one part of the system of care for children.

Should privatization occur, the Commonwealth will need to establish mechanisms to assure that these children receive the acute psychiatric services they require. Where services are to be provided by community hospitals through the provision of state funds, it is essential that mechanisms be in place to assure that:

- Pprivate facilities assume the safety net responsibilities currently performed by DMHMRSAS at CCCA and SWVMHI;

- Contractual arrangements clearly articulate eligibility requirements and assure that providers maintain a "no reject" policy for all children and adolescents that meet eligibility requirements; and,

- Community hospitals are not impeded by “scope of services” and zoning restrictions and are willing and able to increase their bed capacity.

Other questions that will need to be considered and addressed should CCCA and SWMHI close, include:

- Who will provide the intensive inpatient evaluations regularly ordered by the courts to guide dispositional and risk management decisions?
- What is the likelihood that the use of juvenile detention settings to house adolescents with behavioral health problems will increase and what can we do to avoid such an outcome?
- How will the safety net responsibilities for children and adolescents with behavioral health problems be assured for individuals who cannot be managed in community, juvenile detention, or juvenile correctional settings?
- Will children and adolescents with behavioral health problems who cannot be treated or managed in juvenile detention or correctional settings remain there longer or will they be released without adequate treatment into the communities?
- Who will monitor the implementation of statewide intensive inpatient services?
- What is a realistic estimate of the number of youth who may require financial support so they may receive inpatient psychiatric care services? What is a reasonable amount for the Commonwealth to set aside to treat them in a private facility?

Recommendations

In these tight financial times, SOCAT and DMHMRSAS remain focused on the behavioral health needs of Virginia’s children and families. The recommendations included in this report contain items that require little or no funding. This year’s report also confirms support of previous recommendations from past reports that have a fiscal impact, but with the understanding that funding is not available.

Recommendations to Improve the Uniformity of Child and Adolescent Behavioral Health Services Available across Virginia’s Communities

- Improve clarity around the intent of the clause from §37.2-500 and §37.2-601 that states that CSBs *“ shall include emergency services and, subject to the availability of funds appropriated for them, case management services”* According to the OIG’s survey of CSB services for children and adolescents, not all boards provide case management services for youth across all disabilities. Clarifying the intent of the language will ensure that CSBs, at a minimum, offer both emergency and case management services to children and adolescents.

- Recommend CSBs develop and offer the following four services as the CSB core child and adolescent services:
    1. emergency/crisis stabilization;
    2. care coordination (case management);
    3. intensive in-home/home-based services; and
    4. intensive care coordination.

- As part of their Critical Service Gaps Survey, request that CSA assess the reason identified service gaps are not available and/or not utilized and what actions are needed to correct the situation
- In support of the statewide Children's Services System Transformation, provide resources to develop and sustain a statewide training system which will assist community services boards and local CSA teams to assess family needs and develop community based continuums of care to meet those needs.
- Require that adequate provisions are in place to assure that our "most difficult to treat youth" have access to acute care services.
- Continue the Special Advisor on Children's Services position that coordinates child and adolescent services system transformation activities across all child-serving agencies and consider having the position report to the Governor.
- Continue to develop the six interconnected foundation building blocks identified by the Children's Services System Transformation to change Virginia's approach to delivering services. These are:
    1. Practice model - This set of shared principles provides a clear structure that guides policy, practice, and behavior and drives accountability;
    2. Training - This involves retooling the state's training system by adopting a model of competency-based ongoing in-service training;
    3. Resource Family Development - This is the process of recruiting, developing, and supporting resource families, which include foster, adoptive, and kinship parents;
    4. Managing by Data - This involves developing a consistent process for capturing and using data to support decision-making, improve practice quality, track child and family progress over time, and promote accountability;
    5. Family Engagement Model - This leverages family resources and gives a stronger voice to children and families through active engagement with staff and other important stakeholders in decisions that affect a child's life; and
    6. Community Based Continuum - The family-based practice model renews commitment to expanding community-based approaches, providing incentives and building local service capacity to meet growing demand, restructuring existing services, assuring intensive care coordination, and supporting community-based alternatives to detention.

- Review progress in other states that have been successful in transforming their children's services system.

Recommendations for Future Funding (when state budget conditions improve)

Over the years in numerous reports, several key areas have consistently been identified as problematic. It is unlikely we will see improvements in any of these key areas unless the Commonwealth actively seeks to address them. SOCAT realizes that it is unlikely that funding will be available to support the following services in the coming year. Nevertheless, it wishes to acknowledge these needs and encourage the General Assembly to develop a plan for identifying funds that can be dedicated to improving the system of care for Virginia's children. To paraphrase the children's writer Antoine de St Exupery, a goal without a plan is only a wish.

1. **Problem:** Virginia lacks adequate capacity for mental and behavioral health care services for children and adolescents
   Request: Increase support for intermediate level community based services e.g. e.g. emergency services/crisis stabilization, case management/care coordination, intensive in-home/home based services, and intensive care coordination in order to avert more costly intensive residential care.
   Rationale: CSBs and other community programs lack sufficient staff and/or available resources to develop or enhance existing services. They will require start up funds in order to introduce new services that can become self-sustaining through 3rd party payment such as insurance, Medicaid, CSA etc.

2. **Problem:** Virginia lacks sufficient staff to provide the level of guidance and oversight necessary to transform its children's services system as desired.
   Request: Fund additional positions in child serving agencies to provide monitoring, oversight and technical assistance.
   Rationale: Without additional staff, youth serving agencies will not be able to provide the necessary level of technical assistance, monitoring and oversight to implement best practice models and new services uniformly across the Commonwealth. Adding staff will enable the Commonwealth to regain capacity lost as a result of previous budget shortfalls

3. **Problem**: Providers who serve children and adolescents lack skills and knowledge necessary to implement evidence based programs and practices and effectively coordinate services between youth serving systems.
   Request: Enhance Workforce Capacity—Establish 3 Teaching Centers of Excellence @ $700,000
   Rationale: As long as new staff enter the workforce; research identifies new information and innovations are made in service delivery, providers will need to be able to readily access ongoing education and training opportunities in order to update their skills and remain proficient in their areas.

4. **Problem:** Families lack information regarding how and where to access services.

Request: Provide families with information and support—Fund 2.0 FTE for a Resource/Service Coordinator and administrative support @ $125,000
Rationale: The requested family support services will help parents and caregivers locate and access support services in a timely manner for children who have a mental health, substance use disorder or intellectual disability - thus averting more expensive, crisis-oriented services. Currently, Virginia relies solely on federal funds to support such services. These funds are very limited and sufficient to support only one position; additional services must be provided through volunteers. State funds would support 2 additional staff who would be available to 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 the appropriate support systems. This request includes funds to support operating expenses, office supplies and printing.

5. **Problem:** Due to a shortage of providers, psychiatric assessment, psychological testing and medication follow-up services are not available to children and adolescents in a timely manner
   Request: Reinstate psychiatry and psychology fellowships: $483,000
   Rationale: The Commonwealth is experiencing a significant shortage of psychiatrists and psychologists with expertise in treating children and adolescents who have a mental health or co-occurring mental health and substance use disorder and/or intellectual disability. Fellowships that stipulate service payback can serve as a valuable incentive – especially in underserved areas – to attract practitioners in training and enable the Commonwealth to increase the availability of these services.

6. **Problem:** Children and their families have difficulty accessing and coordinating behavioral health services
   Request: Provide services where they are most accessible to youth: in school and in their community
   a. Fund 12 additional System of Care projects @ $3.6 million
   b. Fund school-based mental health services in 20 middle schools in five regions @ $2.0 million

   Rationale: Children are most easily reached and served while in the school setting where they are in regular attendance. Community based services for children tend to be less disruptive and less costly than out of home care and are most effective when coordinated with other needed services. Supporting additional sites that provide mental and behavioral health services in the school will enable us to identify and serve youth more easily - before they develop more severe problems and repercussions. The system of care model supports communities efforts to develop necessary services, ensures that children and their families are able to access services and that these services are provided in a coordinated manner.

APPENDIX A

UPDATES ON PREVIOUSLY FUNDED INITIATIVES TO IMPROVE ACCESS TO CARE

Each year this report has included funding recommendations to enhance or provide new services. Funding for the following initiatives to expand community services for children was awarded as a result of recommendations made in past reports.

SYSTEM OF CARE PROJECTS

With $2 million in funding from the General Assembly, DMHMRSAS continues to support four systems of care grant projects. Ongoing funds for the demonstration projects were allocated in 2006 (1 million) and 2007 (1 million). The systems of care projects emphasize a collaborative cross-agency approach to serving children and adolescents with challenging emotional issues. The initial grant guidance required the implementation of a specific evidence-based practice (EBP), either Multi-systemic Therapy (MST) or Functional Family Therapy (FFT) in each of the four projects. However, over time it became apparent to some of the grant communities that the EBP they chose was not feasible for them. These projects asked and received permission from DMHMRSAS to alter their original plans regarding the requirement of the specific EBP. In spite of the challenges associated with implementing an EBP, cumulative data from each project indicates they are benefiting through improved outcomes for youth and their families. In addition, all have benefited by increasing their ability to provide community-based services and building systems of care capacity. 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.

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)
2. Planning District One (FY 2006)
3. Cumberland Mountain CSB (FY 2007)
4. Alexandria CSB (FY 2007)

The evidence-based practices currently offered by these CSBs are Multi-systemic Therapy (MST), Functional Family Therapy (FFT), and Dialectical Behavioral Therapy (DBT). In addition to the evidence-based practices, Virginia's systems 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
4. Wraparound Services
5. Alternative Day Support
6. Outpatient Services
7. Intake
8. Crisis services
9. Psychiatric services
10. Family partner/Family support programs
11. Specialized family therapy
12. 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,

CSB SERVICES IN JUVENILE DETENTION CENTERS

Through this initiative, CSBs provide short-term behavioral health services to youth while in juvenile detention and coordinate follow-up care after they leave the detention center. 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 2003 DMHMRSAS applied for and received Juvenile Accountability Block Grant funding that enabled CSBs to provide mental health screening, assessment services, and community based referrals for youths in 5 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 - bringing the total number of projects to fourteen. In 2007, the General Assembly provided $900,000 in additional funding which enabled DMHMRSAS to provide mental health screening and assessment services to a total of twenty-three. Based on current data, the programs are projected to serve 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.

Programs are in operation at all 23 Juvenile Detention Centers:

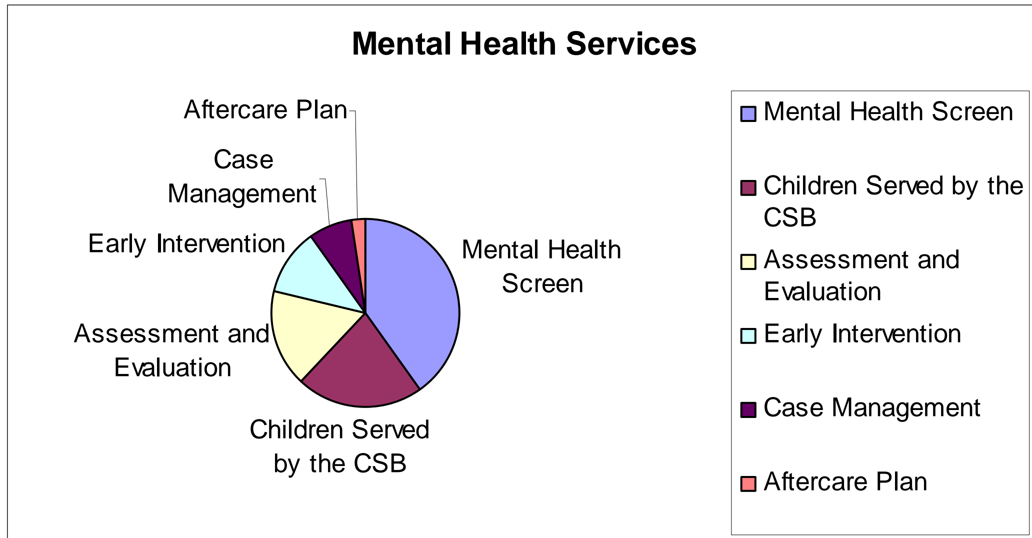
- Alexandria CSB/Northern VA Detention Home
- Blue Ridge Behavioral Health/Roanoke Detention Center
- Central Virginia CSB/ Lynchburg Detention Center
- Region 10 CSB/Blue Ridge Detention Center
- Chesapeake CSB/Chesapeake Juvenile Justice Center
- Chesterfield CSB/Chesterfield Juvenile Detention Home
- 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 (also serves James River Detention Center)
- 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

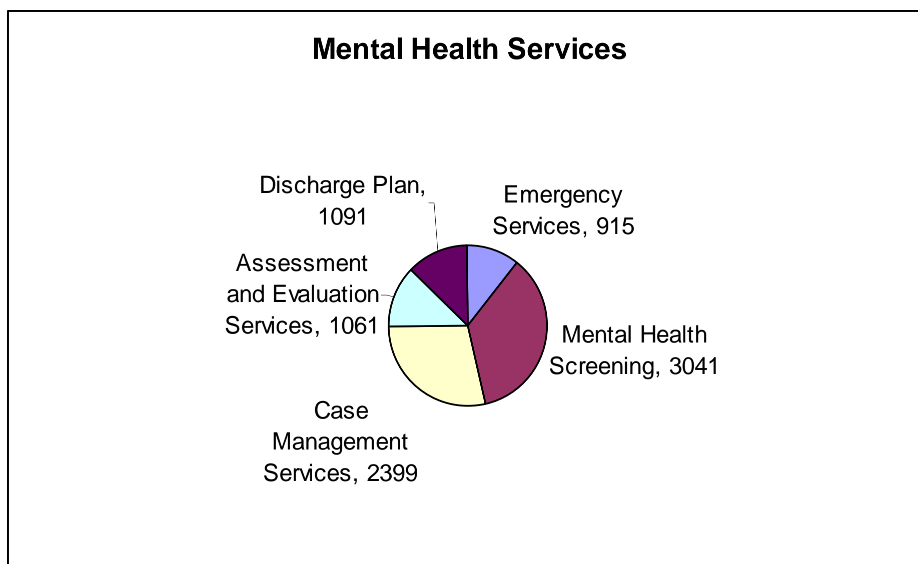
These programs serve to increase local system capacity to identify and intervene in the lives of children involved in the juvenile justice system. Some highlights of the

services that have been provided to children in juvenile detention centers include, but are not limited to:

Of the 6371 children admitted to detention centers in the first two quarters of FY09:

- 5,522 mental health screenings were completed
- 2,987 children were served by the CSB
- 1,026 youth received case management services from mental health case managers
- 1,547 youth received early intervention services with mental health clinicians
- 2,315 youth received assessment and evaluation services
- 329 discharge plans were developed





PART C/ EARLY INTERVENTION SERVICES

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
2008	11,352

DMHMRSAS is the lead agency in Virginia for Part C Early Intervention Services. DMHMRSAS works with a variety of stakeholders representing providers, advocates and families to examine Virginia's Part C system, identify the system's unique strengths and challenges, and make recommendations about infrastructure changes to improve Virginia's Part C system. Plans to transition Part C Early Intervention Services to the Virginia Department of Health effective July 1, 2009 were revised and it was determined that Part C services would continue to be located within DMHMRSAS. Community Services Boards serve a large number of infants and toddlers in programs funded through the Part C program. In 2008, 11,351 infants, toddlers, and their families were served, indicating that the trend will continue upward for the number of children served in 2009. This is due, in part, to better outreach and child find.

The Infant & Toddler Connection of Virginia has been working toward a transformation of Virginia's Part C System. Included in the transformation are a Medicaid Initiative in collaboration with the Department of Medical Assistance Services (DMAS);

enhancement of the Part C data system; revision of the Family Cost Participation process; and initiation of a Service Pathway approach to the provision of Part C services.

The Medicaid Initiative will result in Part C services being billed to Medicaid under Early Periodic Screening, Diagnosis and Treatment (EPSDT). This will enable providers to access payment for the additional Part C service of Special Instruction as well as a revision in the rate structure. A process is also being put in place for the training and certification of all Part C providers. This will align with both Medicaid requirements and the Office of Special Education Program's (OSEP) requirement that all Part C Systems have a Comprehensive System for Personnel Development (CSPD) in place. The Medicaid Initiative is expected to be implemented by October 01, 2009.

Updates continue to be made to the Infant and Toddler On-Line Tracking System (ITOTS) in order to better meet the reporting requirements of the Federal Government and to assist local systems in reporting data. Additional changes and improvements to the data system will occur. Collaboration is also underway related to data coordination between Part C and Medicaid related to the Medicaid Initiative.

In order to ensure a consistency to all families related to Family Cost Participation, a revision is being made to the existing Ability to Pay process. An Implementation Task Force is currently providing input on these changes.

Finally, following additional information related to federal requirements, the Part C office will be implementing a Service Pathway for the provision of Part C services. The Pathway will provide a consistent framework for local Part C systems to follow while allowing some autonomy within the process and improving the eligibility determination process.

PSYCHIATRY / PSYCHOLOGY FELLOWSHIPS

Funds ($483,000) were allocated as part of the 2008 budget to support the Child psychiatry / child psychology workforce development initiative which was implemented in SFY 2007-2008. These funds supported student fellowships for child psychiatrists and child psychologists to work in underserved areas of the Commonwealth. Two institutions of higher education, the Medical College of Virginia (MCV) and Eastern Virginia Medical School responded to a Request for Applications (RFA) and were awarded funds on the basis of their applications. In the first year (2007 – 2008), Eastern Virginia Medical School received $138,452 and the Medical College of Virginia received $248,439. During the first year (2007-2008), Eastern Virginia Medical School enrolled two pre-doctoral child psychology interns and the Medical College of Virginia (MCV) enrolled one child psychiatry fellow and two child psychology interns for the training year. In the initiative's second year (2008-2009) Eastern Virginia Medical School enrolled two pre-doctoral child psychology interns and one child psychology postdoctoral fellow for a total of three psychology interns. During the same training year, MCV signed a second child psychiatry fellow and two child psychology interns, for a full cohort of two child psychiatry fellows and two child psychology interns starting in July, 2008. As

part of the reductions necessary to balance Virginia's budget, funding for the fellowships were cut from the 2010 budget. As a result of these cuts, funding for Eastern Virginia Medical School will be discontinued after June 30, 2009 and MCV will receive continued funding to support the psychiatry fellow who will graduate in June of 2010.

As noted earlier in this report, the loss of these funds poses a serious concern for children's services. There continues to be a significant shortage of child psychiatrists in both the private and public sector. Many communities, particularly those in rural areas, do not have ready access to child psychiatrists and child psychologists to treat children in need of service. Without support or incentives to encourage child psychiatrist and child psychologists to work in underserved areas it will be difficult to improve children's access to psychiatric services.

WEB BASED TRACKING OF ACUTE CARE BEDS FOR YOUTH

As cited in the Commission on Youth's report on *Serious Emotional Disturbed Children Requiring Out-of-Home Placement* (HD 23, 2002), clinicians' noted difficulty in locating acute psychiatric inpatient beds for children and adolescents. As a result, there may be significant delays in hospitalizing youth with serious mental illness. As of January 2009, there were 256 child and adolescent private sector acute psychiatric inpatient beds. In addition, there are 64 beds in state-operated facilities. However, the number of private beds can be misleading because not all hospitals reserve beds for adolescent use. Some hospitals use these beds flexibly for short-term acute and long-term residential care. Other facilities serve both adolescents and young children in their beds on a "first come, first served" basis". Private hospitals may not admit youth with certain diagnoses because they may be unable to serve these youth within their scope of practice. Technology can offer a solution to this problem by allowing clinicians to obtain information on bed availability at the touch of a button thus making it faster and easier to locate beds for this population.

In response to this finding, budget language was included in the 2002 Appropriation Act which directed the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS), in conjunction with Virginia Hospital and Healthcare Association and private providers, to determine "the feasibility and cost of developing a web-based system for providing daily updated information on licensed and available acute psychiatric beds for children and adolescents." This study revealed that establishing a web-based bed tracking system was both feasible and cost-effective. Benefits of establishing a web-based system are:

- a significant decrease of time spent by clinicians and case-mangers on finding an available bed for children and youth who are a danger to themselves or others, thereby increasing the safety of the children and youth of the Commonwealth;
- a significant decrease of time spent by hospital administrative staff receiving and managing repetitive requests on bed availability;
- simplification of admissions to private facilities because CSB staff, psychologists, psychiatrists, licensed clinical social workers and other

providers could quickly locate available beds appropriate for their clients needs;

- an accurate count/census of all licensed, staffed and available beds;
- Greater awareness of screen-out criteria for these beds; and
- Minimal cost with implementing the tracking system with the benefits greatly outweighing the cost.

As estimated by DMHMRSAS, the cost to develop this system is $23,500. Annual maintenance would cost $8,700.00. Additionally, DMHMRSAS did not find that there would be a significant burden placed on private providers in updating/maintaining the data for this system. While a recommendation was proposed for the Virginia Health Information (VHI) to develop a web-based reporting system, funding was not appropriated for this system.

In July 2003, the Joint Commission on Health Care (JCHC) revisited the issue of establishing a web-based bed reporting system. Workgroup meetings were held during the fall of 2004. In January 2005, the JCHC submitted a budget amendment for $75,000 requiring DMHMRSAS to issue an RFP and select a vendor to develop a reporting system. The requested funding was not included in the adopted budget. In 2006, JCHC staff re-convened meetings of a stakeholder workgroup and it was again recommended that DMHMRSAS contract with VHI to develop and operate the system. Additional parameters were added to the bed-reporting system including the ability to classify available beds by type, listing the availability of adult beds, listing whether the facility had secure or non-secure units and including other restrictions such as the ability to serve aggressive patients or sex offenders. A budget amendment for $50,000 was introduced to fund the development and operation of the proposed bed-reporting system. Funding of $25,000 was included in the approved budget for fiscal year 2008.

At this time, the web-based reporting system for acute psychiatric beds is still in development. The Psychiatric Bed Registry Task Force has been meeting regularly to review the progress of the website development and offer suggestions for its improvement. A demo of the web-based tracking system has been created and is now being tested.

CHILD AND ADOLESCENT POSITIONS

The 2008 General Assembly allocated funds to support one new child and adolescent position at each CSB. These funds became available July 1, 2008 and, as of March 2009, at least 22 CSBs indicated that they had filled their respective position. Several boards, especially those affiliated with their local government entity, noted difficulties or delays filling their positions due to budget concerns and hiring freezes imposed at the local level. Each board was allowed to design the new position to meet their respective needs. Although CSBs elected to use these funds to improve services for children in a variety of ways, several patterns emerged. A number of boards elected to focus on services for youth involved in the legal system. At least 9 boards indicated that they will be utilizing their new position to provide services to youth who are involved in the legal system i.e.

either involved with the courts or a court service unit, receiving services at a Detention Center or transitioning from detention to community care. Another 4 boards chose to hire a staff person to provide intensive care coordination (ICC) while two other boards will use their position to improve access to services. Several boards hired staff to provide specific services: 1 hired a supervisor for child and adolescent services; 2 hired clinicians to provide Multi-systemic Therapy (MST) , an evidence based program for youth with complex needs; 1 board hired a school psychologist, 1 a family therapist and 1 school based mental health and substance abuse services. The remaining boards indicated that they hired a child and adolescent clinician but did not indicate whether this individual would serve a specific population of youth or provide specialized services.

APPENDIX B

INTENSIVE CARE COORDINATION

The 2008 General Assembly directed the State Executive Council (SEC) to oversee the development and implementation of mandatory uniform guidelines for intensive care coordination (ICC) services for children who are at risk of entering, or are placed in, residential care through the Comprehensive Services Act (CSA) program. The purpose of ICC services are to effectively maintain, transition, or return a child home or to a relative's home, family-like setting, or community at the earliest appropriate time that addresses the child's needs. The development phase of the Guidelines occurred May 2008-August 2008 and included drafting the guidelines, broad stakeholder review and a public comment period.

On August 28, 2008, the SEC voted to endorse the Guidelines for Intensive Care Coordination (ICC) and to establish a workgroup to discuss and clarify operational aspects of the new guidelines. The SEC also approved and endorsed the following three general rules to guide the implementation:

- ICC is a reimbursable CSA service
- The local community service board (CSB) is the entity responsible and accountable for the provision and oversight of ICC. Requires the CSB to collaborate with the local community policy and management team (CPMT) in determining how best to provide the service; the CSB and local CPMT may agree to contract the service out to another provider but the CSB remains accountable for oversight of the service.
- All children in or at risk of congregate/group care are to receive ICC, but services may be phased in based on local priorities.

The multidisciplinary implementation workgroup met from September 2008 through January 2009. The group considered in depth the three general rules and also discussed how various community roles should interface to assure best practice. They also reviewed the ICC Guidelines but did not recommend any changes to them. Several products were developed as a result of the group's work. They include:

- Development of a Toolkit for Intensive Care Coordinators that was posted on DMHMRSAS and Office of Comprehensive Services (OCS) websites. The Toolkit is based on the Wraparound process and includes tools that have been endorsed by the National Wraparound Initiative, Research and Training Center on Family Support and Children's Mental Health, Portland State University, Oregon.
- Development of a Frequently Asked Questions document that is also posted on the DMHRMSAS and OCS websites.
- Table of rate information from sample localities that is included in the Toolkit.
- Role Clarification Chart

- Establishment of a statewide ICC Network for the purposes of support and ongoing technical assistance.
- Collaboration with the CSA Training workgroup associated with the Children's Services System Transformation.

Currently fifteen CSBs offer ICC services and six of these have more than one ICC position. Ten other CSBs are in discussion with their local CPMTs to work on implementation of the service. At the first ICC network meeting held in February 2009, twenty four CSBs and thirteen CSA teams were represented. Plans for the ICC Network are to meet approximately every other month rotating around the state to allow equal participation from all localities. There will also be continued technical assistance from the Office of Child and Family Services at DMHMRSAS and continued collaboration with the Children's Services System Transformation regarding training, technical assistance, and participation in regional collaboratives.

APPENDIX C

Systems of Care Advisory Team (SOCAT)

(Formerly Child and Family Behavioral Health Policy and Planning Committee)

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Appendix D: Writing Committee- 2009 Report

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Appendix D: Additional Services Recommended by State and Community Consensus Team

- **Mobile Crisis Outreach Teams** - 24/7 response to the child's home during crises, to provide crisis intervention, evaluation, family support, behavioral assistance, medical evaluation, etc.

- **Crisis Stabilization Support Services** - 24/7 availability of family support services provided on an ongoing basis in times of crises. Ongoing behavioral support, family counseling, case management, etc, in the home (or foster home), extending through a period of crisis.

- **Expanded Basic CSB Emergency Services -** more staffing, back up, children's specialty services for existing CSBs to provide 24/7 emergency response capacity - the telephone/evaluation/disposition emergency service that all CSBs now offer for youth.

- **Next day Availability of Evaluations and Medication** by psychiatric personnel (psychiatrists or nurse practitioners experienced with children) after initial crisis response.

- **Support for the Virginia Child Psychiatry Access Project (VCPAP)** would support and enhance the role of the primary care provider (PCP) in the assessment and treatment of children and adolescents with behavioral health problems (Appendix G).

- **Support for Telemedicine** would support the development of additional telemedicine services to provide psychiatric care via teleconference or support regional psychiatry consortiums that provide coverage across a region.

- **Study of Children's Forensic Mental Health -**A study to determine the most appropriate methodology to establish a children's forensic mental health unit in Virginia. As noted previously, a significant percentage of incarcerated youth have mental health problems. Currently, many private psychiatric facilities and private residential programs will not treat these youth because of these children's security requirements.

- **Support for Follow-Up Services to Reduce Recidivism or Relapse** - In 2006, the General Assembly made clear its intention to provide services to previously incarcerated youth through mandating Mental Health Services Transition Plans for youth released from juvenile correctional centers as well as post-dispositional detention programs. These youth, as well as the much greater number of youth on probation in the community, have needs for mental health and substance abuse services. While local detention centers and state juvenile justice centers provide mental health and substance abuse services to youth in their facilities, often there

are limited resources to provide follow-up services in the community after they are released. State budget reductions have caused further deterioration of services. These services are critical in efforts to reduce recidivism. The Team recommends the following options to support community services upon discharge that could prevent readmission and/or reincarceration:

- Continued provision of state general funds to CSBs to provide crisis intervention and discharge planning in the Commonwealth's 24 juvenile detention facilities;
- Additional funding for the Commonwealth's 24 juvenile detention facilities for the provision of psychiatric support and treatment;
- Elimination of the "non-mandated" Comprehensive Services Act category with the establishment of all children involved with the juvenile justice system as a "mandated" category, if sufficient local and/or funding exists;
- Elimination of any waiting period between discharge from a juvenile justice or mental health treatment facility and access to Medicaid benefits or other supportive services;
- Funding for CSB early intervention and diversion programs that provide mental health and supportive services to divert young offenders and first-time offenders from the juvenile justice system;
- Establish specialized programs to provide services to children with intellectual disabilities who should be, where appropriate, diverted from the juvenile justice system; and
- Improve the availability of community-based mental health and substance abuse services for youth involved in the juvenile justice system.

- **Coordination and Collaboration to Enhance Existing Services.** The Team supports reduction of regulatory or other barriers so that money follows each child. During its work, the Team identified many opportunities to improve how state facilities, private facilities, CSBs, schools, local DSS, and CSA programs work together to minimize admissions to inpatient care. In many cases, the Team felt that state or local policies created barriers to coordination and prevented the flow of dollars moving with a child throughout the services system. The Team believes more work needs to be done to minimize regulatory or other barriers and ensure that money follows each child as they move from setting to setting. This will ensure children receive the most appropriate services to meet their individual needs.

- **Enhance or improve existing services in state facilities -** For instance, additional expertise may need to be developed in specialties such as autism. There are also job sharing and training opportunities that can be explored between state facilities, CSBs and other community programs, public and private.

- **Encourage and support the development of a full continuum of mental health services in each community.** Provide funding and technical assistance to help communities develop and sustain a basic set of services beyond emergency services and case management.

- **Continue to dialog with Office of Comprehensive Services** to encourage communication, use of creative and flexible funding strategies, collaboration among child serving agencies and exploration of other linkages that will enhance services.

- **Develop centers of training and excellence-** Key providers can offer specific training related to assessing community service needs, building relationships with community partners and families, and creative service planning including how to creatively use funding streams (Appendix H).

- **Seek greater flexibility in the use of the Psychiatric Residential Treatment** through the Medicaid program and explore strategies that other states have implemented that could be beneficial to Virginia.

Office of the Inspector General for Mental Health,
Mental Retardation and Substance Abuse Services

Commonwealth Center for Children and Adolescents
Staunton, Virginia
Inspection

James W. Stewart, III / Inspector General

OIG Report #167-08
Issued: December 10, 2008

The Office of the Inspector General for Mental Health, Mental Retardation & Substance Abuse Services (OIG) conducted an inspection at the Commonwealth Center for Children and Adolescents (CCCA) in Staunton, Virginia. An unannounced visit occurred on November 1, 2008 with an additional site-visit on November 3, 2008. Over the course of the two day inspection, interviews were conducted with 27 members of the staff including administrative, clinical, and direct care staff. In addition to staff interviews, surveys were completed with 29 additional members of the direct care staff across all shifts. Observations regarding unit activities occurred on all three shifts, including weekend shifts. Staffing patterns were noted, including the use of overtime.

Documentation reviews included:

- Ten clinical records or 36% of the records of the children that had experienced seclusion or restraint incidents during the previous quarter (July – September)
- Facility data relevant to the use of seclusion and restraint, staff injuries, utilization reviews, and staff turnover

Additional source of information included:

- DMHMRSAS AVATAR Census Information
- Presentation to the State Human Rights Committee by Carolyn Lankford on October 24, 2008 regarding the State Incentive Grant to Build Capacity for Alternatives to Seclusion and Restraint
- DMHMRSAS Bed Days Utilization Data by Age/Group, HPR and Case Management Community Services Board (CSB)
- *Six Core Strategies for Reducing Seclusion and Restraint Use© Draft Example: Policy and Procedure on Debriefing for Seclusion and Restraint Reduction Projects,* Kevin Huckshorn, Director, NTAC, National Association of State Mental Health Program Directors
- *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*, Report to the Governor and General Assembly by James Reinhard, MD, DMHMRSAS

Section I – Facility Utilization

Utilization of state-operated psychiatric beds for children and adolescents has been an area of focus for the OIG since 2002. Currently, according to the DMHMRSAS *Integrated Policy and Plan to Provide and Improve Access to Mental Health, Mental Retardation and Substance Abuse Services for Children, Adolescents and Their Families (FY2008),* "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 for adolescents with a substance use disorder".

CCCA is the only inpatient facility operated by DMHMRSAS that is dedicated solely to the care and treatment of children and adolescents. This 48-bed freestanding facility is located in Staunton and has been in operation at its current site (adjacent to Western State Hospital) since 1996. CCCA serves children and adolescents age 4 up to the age of 18. The facility's service area includes all 40 community services boards across the Commonwealth. The only other state-operated inpatient beds are located at Southwestern Virginia Mental Health Institute (SWVMHI) in Marion, Virginia where a 16 bed unit is operated for adolescents (age 13 up to the age of 18).

CCCA works with the referring community services boards to determine whether an alternative plan to avoid hospitalization can be developed. Administrators report that multiple factors are considered at the time of admission including:

- The person's history in treatment, including current clinical presentation,
- The lethality and risks associated with the person's symptoms,
- The family's capacity for coping with the situation, and
- The community's capacity to safely serve the individual in an alternate setting

Individuals admitted to CCCA have a primary diagnosis of mental illness. According to information provided by the facility, approximately 65% of the adolescents served have co-occurring mental health and substance use disorder (MH/SA) diagnoses. A majority of the children and adolescents admitted also have significant behavior problems.

During FY2008, 632 persons were served at the facility. Of this number:

- 269 (43%) were females and 363 (57%) males
- 153 or 23% ranged from the age of 0-12; 479 (76%) were in the age range of 13-18 years old.
- 113 (18%) were classified as forensic admissions; of these 62% (70) were identified for court-ordered evaluations
- 519 (82%) were civil admissions.

On the last day of the inspection (November 3, 2008), the facility had a census of 27 or a bed occupancy of 56%. The regional distribution of home CSBs for the children hospitalized on November 3, 2008 was:

- HPR I (northwest) 8 (30%)
- HPR II (north) 5 (19%)
- HPR III (southwest) 2 (7%)
- HPR IV (central) 7 (26%)
- HPR V (east) 5 (18%)

The table below provides information regarding the utilization of the facility over the last five fiscal years:

CCCA UTILIZATION DATA FOR FY04 THROUGH FY08					
	FY04	**FY05**	**FY06**	**FY07**	**FY08**
Number of Admissions	479	537	521	558	605
Number of Discharges	491	538	510	561	601
Number of Readmissions Within 30 days	42	40	45	42	48
Average Daily Census	33.4	29	31.5	34.3	33
Average LOS (days)	27.6	19.6	22.2	22.7	20.2
Median LOS (days)	15	13	15	14	13
Total Persons Served*	511	557	540	588	632
% Bed Occupancy	70%	60%	66%	71%	69%
Cost Per Bed Day	$776.06	$943.46	$920.16	$914.92	$987.00
Total Inpatient Days	12219	10577	11514	12510	12114
# 100 Days and Over LOS	20	2	7	9	11
% of Total Discharges	4.07%	0.37%	1.37%	1.60%	1.83%
# 7 Days and Under LOS	93	133	119	135	169
% of Total Discharges	18.94%	24.72%	23.33%	24.06%	28.12%

Source: CCCA Utilization Management Database
* Total = End of Month Census + Discharges

- There were 605 admissions at CCCA during FY08. This represents an 8% increase in admissions over FY07. 78% of all bed use days for children and adolescents for the 64 state-operated beds occurred at CCCA. Facility administrators report that the increase in admissions has been attributed to limited community resources for dealing with children and adolescents during the acute phase of their illnesses, more forensic admissions, and increasingly diagnostically complicated cases.
- The number of persons served annually has increased steadily from 511 in FY04 to 632 in FY08, a 19% increase over five years. The number of individuals

readmitted to the facility within 30 days of discharge during FY08 represented 8% of the admissions.

- Unit 4 (adolescent unit) had the highest number of admissions for FY08 with 172 or 29%.
- The average daily census of 33 in FY08 is essentially the same as FY04 at 33.4.
- More than a quarter (28.12%) of the discharges that occurred in FY08 took place in a period of less than 7 days.
- Only 1.83% or 11 discharges that occurred in FY08 took place in a period of 100 days or over.
- The average length of stay at CCCA has dropped 27% over the past five years from 27.6 days to 20.2 days.
- The median LOS for FY08 is 13 days. This is compared to the median LOS for FY07 which was 14 days.
- The majority of children discharged (62%) returned to their family residence.

The table below outlines the type of discharge placements for all persons discharged from CCCA during FY2008.

FY08 Type of Discharge Placement	Actual Discharge Placements	% of Discharges
Family Residence	370	61.56%
Own Home	1	0.17%
Virginia State Facility (DMHMRSAS)	2	0.33%
Other	11	1.83%
Home of Non-Relative	4	0.67%
MH Residential Treatment Center	87	14.48%
MH Group Home/Halfway House	23	3.83%
MH Supervised Apartment	2	0.33%
MH Residential Respite/Emerg Shelter	3	0.50%
MH Specialized Foster Care	11	1.83%
Jail/Detention	84	13.98%
Corrections	3	0.50%
Grand Total	601	100.00%

Source: CCCA Data Management (Avatar)

All civil admissions to the facility are prescreened by CSB emergency services. This screening includes an assessment to determine if less restrictive alternatives are available in the community.

The following table shows the number of admissions in FY08 by community services boards. The table on the left is sorted alphabetically; the table on the right is sorted from highest number of admissions to lowest.

CSB	Number of Admissions	CSB	CSB Region	Highest to Lowest
Alexandria	11	Prince William County	2	59
Alleghany Highlands	7	Fairfax-Falls Church	2	38
Arlington	11	Richmond BHA	4	38
Blue Ridge	8	Henrico Area	4	37
Central Virginia	36	Central Virginia	1	36
Chesapeake	4	Valley	1	36
Chesterfield	14	New River Valley	3	35
Colonial	2	Rappahannock Area	1	31
Crossroads	19	Region Ten	1	31
Cumberland Mountain	7	Northwestern	1	24
Danville-Pittsylvania	1	Rappahannock Rapidan	1	23
Dickenson County	1	Crossroads	4	19
District 19	17	Harrisonburg-Rockingham	1	18
Eastern Shore	6	District 19	4	17
Fairfax-Falls Church	38	Hampton-Newport News	5	17
Goochland-Powhatan	3	Chesterfield	4	14
Hampton-Newport News	17	Loudoun	2	14
Hanover	2	Alexandria	2	11
Harrisonburg-Rockingham	18	Arlington	2	11
Henrico Area	37	Rockbridge Area	1	10
Highlands	1	Blue Ridge	3	8
Loudoun	14	Norfolk	5	8
Middle Peninsula Northern	6	Alleghany Highlands	3	7
Mount Rogers	5	Cumberland Mountain	3	7
New River Valley	35	Eastern Shore	5	6
Norfolk	8	Middle Peninsula Northern	5	6
Northwestern	24	Virginia Beach	5	6
Piedmont	5	Mount Rogers	3	5
Planning District 1	3	Piedmont	3	5
Portsmouth	2	Southside	4	5
Prince William County	59	Chesapeake	5	4
Rappahannock Area	31	Goochland-Powhatan	4	3
Rappahannock Rapidan	23	Planning District 1	3	3
Region Ten	31	Colonial	5	2
Richmond BHA	38	Hanover	4	2
Rockbridge Area	10	Portsmouth	5	2
Southside	5	Danville-Pittsylvania	3	1
Valley	36	Dickenson County	3	1
Virginia Beach	6	Highlands	3	1
Western Tidewater	0	Western Tidewater	5	0
TOTAL	601	TOTAL		601

Source: DMHMRSAS Avatar

The total population of Virginia in FY08 was approximately 7,567,700 persons. Of this number 1,863,274 were children 0 through 17 years of age. The following two tables provide the bed day utilization per 50,000 population (0 through 17) for the 40 community services boards:

CCCA Bed Days Utilized Per CSB For FY 2008 Sorted Alphabetically						
CSB	**0-17 Population**	**CSB Region**	**Urban/Rural**	**0-17 Population per 50K**	**Bed Days Used at CCCA**	**Bed Days Utilized at CCCA per 50K**
Alexandria	24,912	2	Urban	0.50	277	556.0
Alleghany Highlands	4,995	3	Rural	0.10	86	860.9
Arlington	33,551	2	Urban	0.67	119	177.3
Blue Ridge	55,636	3	Urban	1.11	127	114.1
Central Virginia	52,916	1	Rural	1.06	866	818.3
Chesapeake	61,522	5	Urban	1.23	119	96.7
Chesterfield	78,781	4	Urban	1.58	528	335.1
Colonial	34,663	5	Urban	0.69	107	154.3
Crossroads	21,570	4	Rural	0.43	291	674.5
Cumberland Mountain	20,145	3	Rural	0.40	165	409.5
Danville-Pittsylvania	24,894	3	Rural	0.50	16	32.1
Dickenson County	3,351	3	Rural	0.07	10	149.2
District 19	40,263	4	Rural	0.81	548	680.5
Eastern Shore	12,060	5	Rural	0.24	247	1,024.1
Fairfax-Falls Church	267,650	2	Urban	5.35	1,106	206.6
Goochland-Powhatan	10,007	4	Rural	0.20	64	319.8
Hampton-Newport News	86,052	5	Urban	1.72	293	170.2
Hanover	25,212	4	Urban	0.50	31	61.5
Harrisonburg-Rockingham	25,017	1	Rural	0.50	348	695.5
Henrico Area	78,646	4	Urban	1.57	772	490.8
Highlands	14,048	3	Rural	0.28	9	32.0
Loudoun	74,857	2	Urban	1.50	378	252.5
Middle Peninsula NN	29,808	5	Rural	0.60	81	135.9
Mount Rogers	25,313	3	Rural	0.51	72	142.2
New River Valley	31,216	3	Rural	0.62	443	709.6
Norfolk	57,279	5	Urban	1.15	250	218.2
Northwestern	50,149	1	Rural	1.00	454	452.7
Piedmont	30,051	3	Rural	0.60	141	234.6
Planning District 1	19,876	3	Rural	0.40	28	70.4
Portsmouth	26,039	5	Urban	0.52	53	101.8
Prince William County	122,122	2	Urban	2.44	1,241	508.1
Rappahannock Area	86,350	1	Urban	1.73	321	185.9
Rappahannock Rapidan	38,829	1	Rural	0.78	498	641.3
Region Ten	47,982	1	Rural	0.96	415	432.5
Richmond BHA	44,499	4	Urban	0.89	660	741.6
Rockbridge Area	7,673	1	Rural	0.15	81	527.9
Southside	18,869	4	Rural	0.38	145	384.2
Valley	25,480	1	Rural	0.51	565	1,108.7
Virginia Beach	115,725	5	Urban	2.31	126	54.4
Western Tidewater	35,267	5	Rural	0.71	0	0.0
Total	**1,863,274**			**37.27**	**12,081**	**324.2**

Source: DMHMRSAS Bed Utilization Data

CCCA Bed Days Utilized per CSB For FY 2008 Sorted by Bed Days Utilized						
CSB	**0-17 Population**	**CSB Region**	**Urban/Rural**	**0-17 Population per 50K**	**Bed Days Used at CCCA**	**Bed Days Utilized at CCCA per 50K**
Valley	25,480	1	Rural	0.51	565	1,108.7
Eastern Shore	12,060	5	Rural	0.24	247	1,024.1
Alleghany Highlands	4,995	3	Rural	0.10	86	860.9
Central Virginia	52,916	1	Rural	1.06	866	818.3
Richmond BHA	44,499	4	Urban	0.89	660	741.6
New River Valley	31,216	3	Rural	0.62	443	709.6
Harrisonburg-Rockingham	25,017	1	Rural	0.50	348	695.5
District 19	40,263	4	Rural	0.81	548	680.5
Crossroads	21,570	4	Rural	0.43	291	674.5
Rappahannock Rapidan	38,829	1	Rural	0.78	498	641.3
Alexandria	24,912	2	Urban	0.50	277	556.0
Rockbridge Area	7,673	1	Rural	0.15	81	527.9
Prince William County	122,122	2	Urban	2.44	1,241	508.1
Henrico Area	78,646	4	Urban	1.57	772	490.8
Northwestern	50,149	1	Rural	1.00	454	452.7
Region Ten	47,982	1	Rural	0.96	415	432.5
Cumberland Mountain	20,145	3	Rural	0.40	165	409.5
Southside	18,869	4	Rural	0.38	145	384.2
Chesterfield	78,781	4	Urban	1.58	528	335.1
Goochland-Powhatan	10,007	4	Rural	0.20	64	319.8
Loudoun	74,857	2	Urban	1.50	378	252.5
Piedmont	30,051	3	Rural	0.60	141	234.6
Norfolk	57,279	5	Urban	1.15	250	218.2
Fairfax-Falls Church	267,650	2	Urban	5.35	1,106	206.6
Rappahannock Area	86,350	1	Urban	1.73	321	185.9
Arlington	33,551	2	Urban	0.67	119	177.3
Hampton-Newport News	86,052	5	Urban	1.72	293	170.2
Colonial	34,663	5	Urban	0.69	107	154.3
Dickenson County	3,351	3	Rural	0.07	10	149.2
Mount Rogers	25,313	3	Rural	0.51	72	142.2
Middle Peninsula Northern	29,808	5	Rural	0.60	81	135.9
Blue Ridge	55,636	3	Urban	1.11	127	114.1
Portsmouth	26,039	5	Urban	0.52	53	101.8
Chesapeake	61,522	5	Urban	1.23	119	96.7
Planning District 1	19,876	3	Rural	0.40	28	70.4
Hanover	25,212	4	Urban	0.50	31	61.5
Virginia Beach	115,725	5	Urban	2.31	126	54.4
Danville-Pittsylvania	24,894	3	Rural	0.50	16	32.1
Highlands	14,048	3	Rural	0.28	9	32.0
Western Tidewater	35,267	5	Rural	0.71		0.0
Total	**1,863,274**			**37.27**	**12,081**	**324.2**

Source: DMHMRSAS Bed Utilization Data

- Valley Community Services Board had the highest bed usage (1,108.7 days) per population of 50,000. This is the CSB in closest proximity to the Commonwealth Center.
- Prince William CSB had the greatest number of admissions to the Center (59), about 10% of all admissions this past year. The total bed use days for the CSB was 1,241, ranking it as 13th in highest actual bed usage per a population of 50,000.
- Western Tidewater Community Services Board is the only CSB that did not have any admissions to CCCA in FY08.
- Of the ten CSBs with the highest bed day usage per population of 50,000, nine are classified as rural boards. The regional distribution of these 10 CSBs is:
  - Region I – 4 CSBs
  - Region III – 2 CSBs
  - Region IV – 3 CSBs
  - Region V – 1 CSBs
- Of the CSBs classified as urban, Richmond Behavioral Health Authority had the highest bed day utilization per population of 50,000 (741.6) and Virginia Beach CSB had the lowest bed day utilization (54.4).
- Of the ten CSBs with the lowest bed day usage per population of 50,000, 50% are classified as rural boards and 50% as urban boards. The regional distribution of these 10 CSBs is:
  - Region III- 4 CSBs
  - Region IV – 1 CSB
  - Region V - 5 CSBs
- The bed day usage per population of 50,000 by region from highest to lowest was as follows:
  - HPR I (northwest) 530.5
  - HPR IV (central) 478.1
  - HPR II (north) 298.3
  - HPT III (southwest) 239.0
  - HPT V (east) 139.9
- 65% of the total number of bed days used in FY2008 was by rural boards and 35% by urban boards.
- While this inspection focused solely on CCCA, it may be of interest to the reader to see bed utilization statewide for both CCCA (48 beds) and SWVMHI (16 beds). A chart summarizing total utilization of state operated child and adolescent beds can be found in Attachment A. SWVMHI is located in Region III.

Findings and Recommendations

Finding 1.1: DMHMRSAS resources for addressing the mental health and behavioral needs of the children and adolescents in the Commonwealth are underutilized at CCCA.

- With licensed capacity of 48 beds, the average daily census at CCCA was 33 in FY08. Over the past five years this has ranged from a high of 34.3 to a low of 29.

- The bed occupancy rate was 69% in FY08. Over the past five years this has ranged from a high of 71% to a low of 61%.
- CCCA is well-staffed with small units and maintains high staff to children ratios. For example there are five full-time PhD psychologists and five board certified child and adolescent psychiatrists for this 48-bed facility.
- A full complement of professional staffing is maintained even though the census runs well below capacity. This results in CCCA having the highest cost per bed ($987) day of all the DMHMRSAS mental health facilities.
- 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".
- As documented in *OIG Report #149-08 / Review of Community Services Boards Child and Adolescent Services*, "Few community services boards offer a large array of child and adolescent services with sufficient capacity to meet the needs of their community. Many community services boards have very limited services available to children. A few have virtually no service system designed especially for children".

Finding 1.2: A significant percentage of admissions to CCCA were stabilized within seven days or less.

- Of the persons served in FY08, 169 or 28.12% were discharged within seven days of admission.
- There have been a number of outcome studies that have demonstrated it is in the best interest of a child, his family and ultimately the community that the child be treated in his community and family setting as opposed to an institutional setting whenever possible. Serving children in their home community can diminish the additional trauma that can result from separation from friends and family and disruption of daily activities, as well as the trauma often associated with institutional care.
- Many of these individuals could be successfully stabilized in the community if more appropriate community based crisis stabilization services, including psychiatric services, were available.

Finding 1.3: A significant percentage of admissions to CCCA were referred as ten-day court ordered evaluations.

- Of the persons served in FY08, 113 (18%) were classified as forensic admissions; 62% (70) of this total were identified for court-ordered evaluations.
- The court-ordered evaluations represent 11% of all the persons served at the facility according to information provided by DMHMRSAS.
- The approximate costs of completing the ten-day evaluations at the FY08 average cost per bed day of $987 is just under $10,000.

- Many of these individuals could be evaluated in the detention center or other setting in the community from which they came if sufficient clinical expertise and funding for these services were available in the child's home community.

Recommendation 1: It is recommended that DMHMRSAS review the current utilization of child and adolescent resources in facility settings and redirect funding in order to provide secure specialized community based crisis stabilization services for children and adolescents and provide appropriate clinical capacity to conduct juvenile forensic evaluations through the CSBs or regional teams.

***DMHMRSAS Response**: Governor Tim Kaine announced this week a proposal that would include the closing of the Commonwealth Center for Children and Adolescents in mid-2009. In early January 2009 a team of relevant stakeholders will be convened to assess the relevant variables and develop a comprehensive plan for addressing the treatment and recovery needs for the individuals and families served by the facility. The allocation of available funding, community programming, and a mechanism for performing juvenile forensic evaluations will be amongst the issues addressed in this plan.*

Section II - State Incentive Grant for Alternatives to Seclusion and Restraint

One of the findings identified by the OIG during the FY2007 inspection at CCCA (OIG Report #145-07) was that the facility continues to have a very high number of behavioral management incidents that result in the use of seclusion and restraint. Despite previous efforts, it was noted that the facility had been unable to sustain any significant reduction in the use of seclusion and restraint in the preceding five years.

In 2007, DMHMRSAS was awarded approximately $214, 000 by SAMSHA to develop alternatives to the use of seclusion and restraint (SR). CCCA was one of the state-operated facilities selected for participation in this initiative. The first year of this three year grant ended in October 2008. The strategies and activities that the facilities are undertaking to reduce the use of seclusion and restraint are based on the Public Health Prevention Model and NASMHPD's, *Six Core Strategies to Reduce the Use of Seclusion and Restraint.*

In brief, the public health prevention model has three levels of prevention activities:

- The first level or primary prevention strategies call for structuring the environment of care and clinical support in a manner that anticipates and plans interventions for handling each individual's risk factors prior to an event occurring. An example is the development of safety plans at the time of admission.
- The second level of prevention strategies calls for a foundation of tools for staff to use at the time that a situation is escalating into a potential crisis such as removing the child from the conflicting situation and/other deescalating techniques.

- The final level of prevention is to develop methods of review such as staff and consumer debriefings in order to assess the situation and develop new strategies for handling similar circumstances if they arise.

The *Six Core Strategies to Reduce the Use of Seclusion and Restraint* outlines strategies for assessing an organization's culture and its readiness for reducing the use of restrictive procedures. The strategies are to be applied broadly to the organization. This starts with the role and commitment of the organization's leadership team in actualizing the changes to reduce seclusion and restraint. The core strategies include activities/interventions that are consistent with the public health prevention model, such as active supervision, increased clinical contact for direct care staff, and debriefings.

The primary goals for the first year of the grant were to begin the process of organizational assessment, develop a strategic plan for addressing the key elements of the core strategies and initiate early stage interventions.

Findings and Recommendations

Finding 2.1: CCCA engaged in a number of promising activities designed to reduce the use of seclusion and restraint as a result of the facility's participation in the SAMSHA Grant.

- The Center convened a Seclusion and Restraint Steering Committee to oversee implementation of the core strategies. Serving on the committee was a person receiving services.
- The Center developed a strategic plan for implementing the goals identified by the Steering Committee.
- Multiple training events have been completed.
- The Management of Violence and Aggression Survey (MAVAS) was administered to staff and the results reported.
- Two NASMHPD consultants visited the Center to assess the facility's readiness for change. The consultants provided feedback to the organization regarding leadership's commitment to the reduction of seclusion and restraint; the impact of reducing seclusion and restraint on the treatment environment; clinical treatment activities; and how effectively clinical policies, procedures and practices support the mission, vision, and values of both DMHMRSAS and a trauma-informed environment of care.
- Members of the facility leadership team reported that CCCA has revised its organizational structure. This includes having direct care staff report to the unit psychologists to assure that there is clinical link between the child's individualized treatment goals and the activities of direct care activities.
- The creation of safety plans at the time of admission has occurred for some of the children admitted to the facility
- The Center has proposed a number of environmental changes, including adding comfort areas, painting and murals, and softer lighting.

Finding 2.2: Staff, at all levels, voiced a commitment to the reduction of seclusion and restraint initiative and were able to discuss strategies for creating a trauma-informed environment and sustaining the facility's current seclusion and restraint reduction efforts.

- Members of the facility leadership team expressed optimism regarding the current effort to reduce seclusion and restraint. Among the reasons they believe the initiative will be successful are the following:
    - A positive partnership with DMHMRSAS central office that is based on a common goal and vision.
    - A structure and support for identifying realistic goals and strategies through the grant
    - Ongoing assistance and feedback from NASMHPD consultants
    - The recent organizational change that enhances the role of psychologists in providing clinical supervision and support.
- Members of the Psychology Department conveyed that the recent organization change provides them with a structure for providing increased clinical supervision of direct care staff in order:
    - To enhance their skill sets,
    - To assure greater practice consistency across shifts in crisis management and in the provision of treatment objectives, and
    - To increase direct care staff awareness of trauma-informed practices.
- The organizational change also allows members of the psychology staff to provide direct supervision to shift coordinators so that there can be greater links to clinical services and supports around the clock.
- The majority (78%) of the direct care staff interviewed expressed being excited at the proposed organizational changes and being committed to the success of the seclusion and restraint reduction initiative.

Finding 2.3: CCCA eliminated the use of prone restraint effective July 1, 2008.

- Members of the facility's leadership team reported that the effort to eliminate prone restraint began with a philosophical agreement by the leadership team. Related activities included:
    - Assuring that all staff were trained in behavioral management techniques
    - Modifying TOVA training to highlight the elimination of this practice.
    - Holding meetings for direct care staff with the senior leadership team and supervisory staff to listen to and address any concerns they have about the proposed change before the target elimination date
    - Setting a target date and assuring compliance through increased supervision and support.
- 70.4% of the direct care staff surveyed responded positively to the following statement - *The facility's decision to eliminate the use of prone restraints has had positive results.*
- Prior to the total elimination of prone restraints, the facility's use of this restrictive intervention had decreased. The following shows the number of prone restraints documented by the facility in FY08. (Statistics for July through December 2007 were reported in OIG Report #145-07).

Frequency of Prone Restraint Use At CCCA For FY2008													
	July 07	Aug 07	Sept 07	Oct 07	Nov 07	Dec 07	Jan 08	Feb 08	Mar 08	Apr 08	May 08	June 08	Total
All Units	18	19	17	9	3	20	3	5	3	4	4	1	106

Source: CCCA Office of Risk Management Database

Finding 2.4: The use of seclusion and restraint at CCCA decreased 8.9% between FY07 and FY08.

The following two charts show a comparison of the use of seclusion and mechanical restraints between FY07 and FY08.

CCCA Incidents of Seclusion & Mechanical Restraint by Shift FY2007							
	Day	% Day	Evening	% Evening	Night	% Night	Total
Seclusion	263	36%	447	61%	25	3%	735
Mechanical Restraint	48	27%	119	66%	12	7%	179
Total	311	34%	566	62%	37	4%	914

CCCA Incidents of Seclusion & Mechanical Restraint by Shift FY2008							
	Day	% Day	Evening	% Evening	Night	% Night	Total
Seclusion	254	37%	393	58%	34	5%	681
Mechanical Restraint	26	17%	115	76%	11	7%	152
Total	280	34%	508	61%	45	5%	833

Source: CCCA Office of Risk Management Database

- There were 914 incidents of seclusion and restraint in FY07 as compared the 833 combined incidents of seclusion and restraint for FY08. This represents an 8.9% decrease.
- In FY07, there were 735 incidents of seclusion as compared to the 681 incidents in FY08.
- There were 179 incidents of mechanical restraint usage in FY07 and 152 incidents reported for FY08.
- The percentage of incidents per shift were about the same in FY07 and FY08, with the majority of incidents occurring during the evening shift.
- Direct care staff attribute the high incidents of seclusion and restraint during the evening shift to:
    - Limited resources and staff for designing and conducting structured activities
    - Fewer experienced staff scheduled for work during the 2nd shift
    - No active links between the clinical staff and direct care providers, particularly on the weekends.

Recommendation 2: It is recommended that CCCA review and redirect clinical staff and resources in an effort to decrease the incidence of seclusion and restraint during the evening shift.

DMHMRSAS Response: *CCCA has received a copy of this OIG Report for review and comment. In light of the announcements referenced above regarding the potential closure of the facility, a conference call is planned for early January 2009 to discuss plans for a focused reduction of seclusion and restraints on the evening shift including resource allocation and programming.*

Finding 2.5: Overall, the clinical records do not consistently reflect an orientation to trauma-informed care practices.

- Even though all of the records reviewed were consumer specific and clearly outlined the reasons for hospitalization and provided for a comprehensive psychosocial history, not all of records reviewed provided a clear assessment of the abuse or trauma experienced. Slightly more than half of the records documented assessment of abuse or trauma that was witnessed by the consumer. None of the records reviewed identified clear trauma-informed strategies in the consumer's treatment plan.
- 83% of the records reviewed did not identify the consumer's and/or the authorized representative's preferred treatment interventions for behavioral management.
- Only 12.5% of the records reviewed contained a safety plan so that staff are not constantly reacting to specific consumer's aggression or challenging behaviors.
- Almost all of the records reviewed did not contain evidence in the progress notes that issues associated with identified trauma experiences were being actively addressed
- Discharge summaries in a majority of the records reviewed did not reflect the ongoing necessity for treatment to address issues associated with trauma.

Finding 2.6: There was no evidence in the clinical records that clinical debriefings are used to identify alternative treatment strategies that can be used in the future to minimize the use of restrictive procedures.

- The use of restrictive procedures was clearly documented in the clinical record.
- All the incidents documented included the clinical justification for the use of the restrictive intervention.
- There was evidence in each of the records reviewed that debriefings routinely occurred after the use of restrictive intervention.
- None of the incidents in any of the records reviewed showed evidence that the debriefings are used to identify alternative strategies that become part of the consumer's treatment.

Section III – Workforce Development

NASMHPD's Six Core Strategies to Reduce the Use of Seclusion and Restraint states that the goal for workforce development is "to create a treatment environment whose policy,

procedures, and practices are grounded in and directed by a thorough understanding of the neurological, biological, psychological and social effects of trauma and violence on humans and the prevalence of these experiences in persons who receive mental health services and the experiences of our staff. This includes an understanding of the characteristics and principles of trauma informed care systems. It also includes the principles of recovery-oriented systems of care such as person-centered care, choice, respect, dignity, partnerships, self-management, and full inclusion. Intervention is designed to create an environment that is less likely to be coercive or conflictual and is implemented primarily through staff training and education and Human Resources and Development activities."

CCCA, with assistance from the NASMHPD consultants, is exploring a number of objectives for addressing the core strategy for workforce development. Among the objectives being considered are the following:

- Introduce recovery/resiliency, prevention, and performance improvement theory and rational to all staff
- Revise the organizational mission, philosophy, and policies and procedures to address the theory and principles of trauma-informed systems of care.
- Address staff empowerment issues
- Explore unit "rules" with an eye to analyzing them for logic and necessity.

Findings and Recommendations

Finding 3.1: Direct care staff indicate that communication within the facility and the support they receive from more senior staff have improved.

- 82.7% of the staff responded positively to the survey statement - *The senior leadership team has created an open and comfortable work environment for expressing my ideas.*
- When asked on the survey to respond to whether *Communication within the facility between the senior leadership team and direct care staff is effective and provides me with an understanding of the facility's strategic objectives,* a slight majority (55.15%) of direct care staff responded positively.
- 72.4% of the staff had a positive response when asked whether they have received the training they need to effectively reduce the use of seclusion and restraint.
- 92.8% of the staff reported that the skills they have been taught have enabled them to be effective in handling the behavioral challenges of the persons served.
- Staff reported feeling increasingly supported by their supervisors while indicating a desire for more clinical support and supervision.
  - 89.6% of the staff surveyed indicated a positive response to the statement, M*y supervisor is readily available to help me problem-solve options for intervening with individuals with challenging behaviors in lieu of seclusion and restraint.*
  - 93% of the staff reported positively to the comment *My supervisor is readily available to assist me in the physical management of a consumer.*

- Only 53.6% provided a positive response to the following statement, *When it is necessary for me to engage in the physical management of an individual, the clinical staff are readily available to assist.*
- 72.4% of the staff surveyed responded positively when asked if they would recommend to others working at CCCA

Finding 3.2: The majority (20 of 29) of staff surveyed reported feeling safe while performing their duties at the facility.

- The staff that reported feeling safe in the environment indicated that this is due primarily to increased training and closer supervision. Six of the 22 staff interviewed reported a correlation between the elimination of prone restraint and staff safety.
- There were 224 reported incidents of staff injury at the facility in FY08. Of these, 68% or 153 incidents resulted during the use of restrictive interventions. This compares to 98% of total incidents in FY07.
- Sixty or 39% of the injuries occurred during incidents of seclusion
- 38% or 58 of the injuries occurred during incidents involving the use of mechanical restraints
- Thirty-five or 23% of the injuries occurred during incidences of physical restraint.

Finding 3.3: The rate of turnover among the direct care staff at the facility remains high.

- The turnover rate for DSA II positions at CCCA was 46.7% for FY08. This is compared to a turnover rate for the same positions of 57.5% in FY07.
- The following table compares the turnover rate for DSA Is and IIs at CCCA during FY07 and FY08.

Turnover of Direct Care Staff at CCCA			
DSAs I & II			
Fiscal Year	Average Filled	Separations	Turnover %
FY07	43.5	25	57.5%
FY08	43	20	46.5%

Source: DMHMRSAS Avatar

- Of the direct care staff that participated in the OIG survey, the average years of service was 16 months. The median length of service was 14 months.
- 87% of the staff answered negatively when asked to respond to the following statement - *During the past 12 months, there have been fewer turnovers in direct care positions.*
- The following table shows the years of service for DSA positions at CCCA as of December 2008.

DSA Positions at CCCA by Length of Service			
	Less the 1 year	**1-2 years**	**3 or more years**
DSA II	23	18	6
DSA III	1	7	10

Source: CCCA HR Database

- 49% of the DSA IIs have been employed at the facility for less than 1 year.
- The majority of DSA IIIs (55%) have 3 or more years of service.
- Of the total of DSA IIs and DSA IIIs, 75% have less than 3 years of service.

Attachment A

Statewide Bed Days Utilized for FY 2008 Sorted Alphabetically								
CSB	0-17 Population	CSB Region	Urban/Rural	0-17 Population per 50K	Bed Days Used at CCCA	Bed Days Used at SWVMHI	Total Bed Days Used	Bed Days Utilized per 50K
Alexandria	24,912	2	Urban	0.50	277		277	556.0
Alleghany Highlands	4,995	3	Rural	0.10	86		86	860.9
Arlington	33,551	2	Urban	0.67	119		119	177.3
Blue Ridge	55,636	3	Urban	1.11	127	957	1,084	974.2
Central Virginia	52,916	1	Rural	1.06	866	5	871	823.0
Chesapeake	61,522	5	Urban	1.23	119		119	96.7
Chesterfield	78,781	4	Urban	1.58	528		528	335.1
Colonial	34,663	5	Urban	0.69	107		107	154.3
Crossroads	21,570	4	Rural	0.43	291		291	674.5
Cumberland Mountain	20,145	3	Rural	0.40	165	140	305	757.0
Danville-Pittsylvania	24,894	3	Rural	0.50	16	180	196	393.7
Dickenson County	3,351	3	Rural	0.07	10	108	118	1,760.6
District 19	40,263	4	Rural	0.81	548	13	561	696.7
Eastern Shore	12,060	5	Rural	0.24	247		247	1,024.1
Fairfax-Falls Church	267,650	2	Urban	5.35	1,106		1,106	206.6
Goochland-Powhatan	10,007	4	Rural	0.20	64		64	319.8
Hampton-Newport News	86,052	5	Urban	1.72	293		293	170.2
Hanover	25,212	4	Urban	0.50	31		31	61.5
Harrisonburg-Rockingham	25,017	1	Rural	0.50	348		348	695.5
Henrico Area	78,646	4	Urban	1.57	772		772	490.8
Highlands	14,048	3	Rural	0.28	9	115	124	441.4
Loudoun	74,857	2	Urban	1.50	378		378	252.5
Middle Peninsula Northern	29,808	5	Rural	0.60	81		81	135.9
Mount Rogers	25,313	3	Rural	0.51	72	490	562	1,110.1
New River Valley	31,216	3	Rural	0.62	443	787	1,230	1,970.1
Norfolk	57,279	5	Urban	1.15	250		250	218.2
Northwestern	50,149	1	Rural	1.00	454		454	452.7
Piedmont	30,051	3	Rural	0.60	141	126	267	444.3
Planning District 1	19,876	3	Rural	0.40	28	474	502	1,262.8
Portsmouth	26,039	5	Urban	0.52	53		53	101.8
Prince William County	122,122	2	Urban	2.44	1,241		1,241	508.1
Rappahannock Area	86,350	1	Urban	1.73	321	1	322	186.5
Rappahannock Rapidan	38,829	1	Rural	0.78	498		498	641.3
Region Ten	47,982	1	Rural	0.96	415		415	432.5
Richmond BHA	44,499	4	Urban	0.89	660	20	680	764.1
Rockbridge Area	7,673	1	Rural	0.15	81		81	527.9
Southside	18,869	4	Rural	0.38	145	9	154	408.1
Valley	25,480	1	Rural	0.51	565	8	573	1,124.4
Virginia Beach	115,725	5	Urban	2.31	126		126	54.4
Western Tidewater	35,267	5	Rural	0.71			0	0.0
Total	**1,863,274**			**37.27**	**12,081**	**3,433**	**15,514**	**416.3**

Source: DMHMRSAS Bed Utilization Data

Statewide Bed Days Utilized for FY 2008 Sorted by Bed Utilization								
CSB	0-17 Population	CSB Region	Urban/Rural	0-17 Population per 50K	Bed Days Used at CCCA	Bed Days Used at SWVMHI	Total Bed Days Used	Bed Days Utilized per 50K
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Prince William County	122,122	2	Urban	2.44	1,241		1,241	508.1
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Piedmont	30,051	3	Rural	0.60	141	126	267	444.3
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Loudoun	74,857	2	Urban	1.50	378		378	252.5
Norfolk	57,279	5	Urban	1.15	250		250	218.2
Fairfax-Falls Church	267,650	2	Urban	5.35	1,106		1,106	206.6
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Virginia Beach	115,725	5	Urban	2.31	126		126	54.4
Western Tidewater	35,267	5	Rural	0.71			0	0.0
Total	**1,863,274**			**37.27**	**12,081**	**3,433**	**15,514**	**416.3**

Source: DMHMRSAS Bed Utilization Data

Attachment B

Direct Care Staff Survey

	Strongly Agree	Agree	Disagree	Strongly Disagree
I was asked to provide input to the development of the facility's current seclusion and restraint initiative.	7.1%	46.4%	32.1%	14.3%
I am generally involved in decision making that affects my job.	17.2%	41.4%	37.9%	3.4%
The senior leadership team has created an open and comfortable work environment for expressing my ideas.	31.0%	51.7%	17.2%	0.0%
Communication within the facility between the senior leadership team and direct care staff is effective and provides me with an understanding of the facility's strategic objectives.	3.4%	51.7%	27.6%	17.2%
The facility's decision to eliminate the use of prone restraints has had positive results.	11.1%	59.3%	25.9%	3.7%
I have received the training I need to effectively reduce the use of seclusion and restraint.	3.4%	69.0%	20.7%	6.9%
The skills I have been taught have enabled me to be effective in handling the behavioral challenges of the persons I serve.	10.7%	82.1%	7.1%	0.0%
I am able to interact with members of the senior leadership team because they are frequently (several times per week) on my unit.	10.3%	44.8%	31.0%	13.8%
When it is necessary for me to engage in the physical management of an individual, the clinical staff are readily available to assist.	14.3%	39.3%	32.1%	14.3%
My supervisor is readily available to assist me in the physical management of a consumer.	62.1%	31.0%	6.9%	0.0%
My supervisor is readily available to help me problem-solve options for intervening with individuals with challenging behaviors in lieu of seclusion and restraint.	58.6%	31.0%	10.3%	0.0%
I am treated with respect by the people I work with.	32.1%	46.4%	21.4%	0.0%
Employees work well together to solve problems and get the job done.	20.7%	69.0%	10.3%	0.0%
During the past 12 months, there have been fewer turnovers in direct care positions.	0.0%	13.6%	40.9%	45.5%
I would recommend others to work for this facility.	0.0%	72.4%	27.6%	0.0%

Review of Community Services Board Child and Adolescent Services

Office of the Inspector General For Mental Health, Mental Retardation & Substance Abuse Services

James W. Stewart, III
Inspector General

Report # 149-08
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Office of the Inspector General

Review of Community Services Board Child and Adolescent Services

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Section I

Office of the Inspector General

Review of Community Services Board
Child and Adolescent Services

Executive Summary

The Office of the Inspector General for Mental Health, Mental Retardation & Substance Abuse Services (OIG) has conducted a two-stage review of the mental health, intellectual disabilities, and substance abuse services for children, adolescents, and their families offered by Virginia's Community Services Boards. The goal of the review was to assess the range, nature, and other characteristics of Virginia's public community mental health, intellectual disabilities, and substance abuse services for children and adolescents.

This report is the second in a series of two on this subject. The first report, **OIG Report # 148-07 "Survey of Community Services Board Child and Adolescent Services,"** compiled and compared data on the development and current array of children's services from surveys that were completed by all 40 CSBs. It was published on the OIG website (www.oig.virginia.gov) on March 31, 2008.

The second stage of the review reported here consisted of site visits at 34 of the 40 CSBs and interviews with 520 persons who are affiliated with the CSA process in every county and city in Virginia. Site visits included interviews with staff and supervisors, review of records, and telephone interviews with parents or caregivers of children served by the CSBs.

Findings and Recommendations

A. Findings related to service availability

1. Families seeking services for children and adolescents with mental health service needs face enormous differences in service availability depending on where they live. Whether measured by expenditures, staffing, or percentage of child population served, the availability of mental health services for children and adolescents offered by CSBs varies widely among communities.

2. Few CSBs offer a large array of child and adolescent services with sufficient capacity to meet the needs of their community. Many CSBs have very limited services available to children. A few have virtually no service system designed especially for children.

3. Child and adolescent services at CSBs are mostly full to capacity, resulting in long waiting periods for new persons to access services. The average wait for all services, from all CSBs that reported was 26 days.

4. Representatives from stakeholder agencies express dissatisfaction with the levels of CSB service availability in their communities. Specific areas of concern include the following:
   - Wait time for access to services is too long.
   - The wide array of services that are needed to serve children is not available.
   - Services to children with substance abuse needs and autism spectrum disorders are inadequate.

5. Access to services for uninsured families and those that are not eligible for a dedicated source of funding for children and adolescents is extremely limited.

B. Findings related to service funding

1. Medicaid is the largest source of funding in CSB budgets for child and adolescent services. Statewide it composes 47.9% of funding for all three disabilities combined. For mental health services Medicaid makes up 54.1% across the state.

2. The majority of the CSBs that have developed more extensive systems of services for children have done so through the use of Medicaid, and not through special grants or CSA funding. The six highest per capita funded CSBs average 72% of their funding for mental health services from Medicaid. It is important to note however that 30% of the CSBs receive 10% or less of their funding for mental health services from Medicaid.

3. State general funds and local funding make up a comparatively small portion of total funds for child and adolescent services statewide. Total funding statewide includes 11.9% state funds and 17% local dollars for all three disabilities. For CSB mental health budgets, state funding is 10.7% and local funding is 12%.

4. CSA funds paid to CSBs for purchase of services make up a very small portion of CSB budgets for mental health services at only 8.6%. The budgets of 72% of the CSBs include less than 10% of their funding from CSA.

C. Findings related to service quality

1. Parents/caregivers of children receiving services at CSBs report very high levels of satisfaction with the CSB services their children are receiving.

2. Family level of involvement with CSB staff in the planning and provision of services is quite high. Families and stakeholders confirmed this involvement.

3. In the majority of cases reviewed, CSB involvement with and collaboration with other agencies was limited or did not occur.

4. Progress toward treatment goals is generally good for services provided by CSBs.

5. CSB assessments for co-occurring substance abuse needs in children receiving mental health services were not found to be comprehensive. When substance abuse was identified, treatment goals related to substance abuse were present in approximately half of the cases.

6. Few CSBs offer comprehensive, formal programs that have broad national recognition as "evidence-based practices" (EBP). Many CSBs, however, utilize elements and principles that are found in EBP literature.

7. Stakeholder ratings of multiple measures of overall CSB service quality were modestly positive (54.4% positive), but with dissatisfaction shown by a large minority of respondents (38.2% negative).

8. Access to services for parents and caregivers of children and coordination of children's services with services to parents is not adequate.

D. Findings related to CSA and interagency coordination

1. CSBs are not the provider of choice for community-based CSA-funded mental health services in many communities. Only just over half of stakeholder respondents say their CSBs fulfill this role.

2. CSA funds are only a minor source of support for children's services at CSBs. Average CSA funding for CSBs is only 6.8%. 42% of CSBs report receiving no CSA funding. The highest level of CSA funding for any CSB is 33%.

3. Many agency stakeholders say their CSBs do not adequately make clear what services they offer or who is eligible for services, and they express dissatisfaction with the limitations on service availability.

4. The leading factor CSBs cite that has helped them develop children's services is the support and cooperation of the local CSA CPMT and other community agencies to work together on meeting community needs.

5. Over half the CSBs (55%) say they have developed one or more specific services to help improve the provision of services offered to children in the CSA process. These services include intensive care coordination and utilization management.

E. Findings related to CSB workforce issues

1. CSBs have great difficulty recruiting and retaining qualified staff to provide children's services. They list it as the second highest factor that has hindered development of services.

2. CSBs have inadequate psychiatric time to meet the needs of the children in their communities. Only 12.5% of the CSBs report that they have adequate psychiatric resources. CSBs estimate that an additional 25 FTE psychiatrists are needed statewide. The average wait time to see a psychiatrist for children who are currently being served by CSBs is 37 days.

3. The leading suggestion from CSBs for what can be done at the state level to improve the development of children's services is the provision of training, especially on evidence-based, effective services to children and families. (Note: Respondents were asked to list factors other than simply "increase funding.")

4. CSB staff describes morale on their teams as very high.

F. Findings related to preventing out-of-community residential placements

1. Only partial agreement exists among CSBs and the agency stakeholder community about the services that are most needed to prevent out-of-community residential placements.

G. Overarching findings related to the development of CSB services

Three primary and interdependent factors were identified by the OIG as the leading determinates of whether or not CSBs have developed more comprehensive systems of services that meet the needs of families and stakeholder agencies:

1. The extent to which leadership has been exercised to place a priority on the development of children's services, to develop community and interagency relationships, to use creativity and skill in making use of funding from Medicaid, grants, and CSA. This leadership comes from CSB board members, executive director, leader of children's services, or some combination of these persons.
2. Limited availability of funding to provide services for uninsured families and children that do not qualify for CSA and other categorical programs for children.
3. Relatively limited use of CSBs by local communities to provide services that are reimbursed by CSA.

Recommendations

1. It is recommended that DMHMRSAS lead an interagency process to develop a comprehensive plan for the provision of publicly supported, community based mental health, intellectual disability and substance abuse services for children, adolescents and

their families. The objective of this plan will be to determine the base level of services that should be available in every community, clarifying the array of services and per capita capacity that will be needed. The plan should leverage all available sources of funds such as Medicaid, CSA, special grants to support services and then estimate the level of additional state funds needed to achieve a balanced, flexible funding base to address the needs of those families that are uninsured or not eligible for other dedicated sources of reimbursement. The planning process should include input from relevant state and local agencies and the private provider community. The target date for the completion of the plan would be no later than July 1, 2009. To assure that adequate staffing and planning expertise can be dedicated to the development of this plan, it is recommended that DMHMRSAS seek the assistance of experts with experience in planning for systems of MH/ID/SA services for children, adolescents and families to supplement departmental staffing.

It is further recommended that DMHMRSAS present the plan to the General Assembly clarifying the level of support that can be anticipated from non-state sources and identifying specific needs from state sources to enable responsible expansion of services in the first two years of implementing the plan.

It is further recommended that in subsequent legislative cycles DMHMRSAS provide a report to the General Assembly that claries progress achieved in expanding services for children, adolescents and children according to the plan, documents success in leveraging funds from non-state sources, and requests annual increases in state funds that will assure solid, responsible growth of a new system of services based on the comprehensive plan.

2. It is recommended that every CSB appoint a single person to lead services for children and adolescents.

3. It is recommended that DMHMRSAS provide leadership in determining the areas of training and staff development that are needed to increase consistency in the quality of services delivered by CSBs statewide to children and adolescents. It is further recommended that DMHMRSAS develop a plan for assuring that this training is made available to CSB staff.

4. It is recommended that the CSBs that have developed the more comprehensive systems of services for children and adolescents share information with other CSBs regarding the organizational, interagency collaboration, staffing, and funding factors that have enabled their success. DMHMRSAS and/or the Virginia Association for Community Services Boards could facilitate this educational effort.

5. It is recommended that CSBs evaluate their methods for assessing substance abuse to assure comprehensive evaluation of the need for substance abuse treatment, particularly when the identified problem is mental health or intellectual disability related.

Section II - Introduction

The Office of the Inspector General for Mental Health, Mental Retardation and Substance Abuse Services (OIG) conducted a review of services for children and adolescents provided by the 40 Community Services Boards (CSBs) during November 2007 through May 2008. The goal of the review was to assess the range, nature, and other characteristics of Virginia's public community mental health, intellectual disabilities[1], and substance abuse services for children and adolescents[2]. The review also assessed the views held toward these services by families that use these services and those of the stakeholder community – the partner agencies that join with the CSBs in the collaborative planning and service delivery process known as the Comprehensive Services Act for Children and At-Risk Youth (CSA).

The first phase of the OIG review was a 63-question survey that all 40 CSBs completed. These surveys described the children's services provided by each CSB in considerable detail, including staffing, budget, service levels, and other information. **OIG Report # 148-07 "Survey of Community Services Board Child and Adolescent Services"** compiled the data from the surveys and compared CSB services across many variables. It was published on the OIG website (www.oig.virginia.gov) on March 31, 2008.

The second phase of the review consisted of site visits at 34 of the 40 CSBs. The CSBs that were visited serve jurisdictions that contain 99% of the population of Virginia, and 94% of the age 0-17 population. Site visits included interviews with staff and supervisors, review of records, and telephone interviews with parents or caregivers of children served by the CSBs (the same children whose records were reviewed).

The third phase of the review was a survey of the approximately 1500 persons who are affiliated with the CSA process in every county and city in Virginia. These "stakeholders" include all representatives and alternates to CSA Community Policy and Management Teams (CPMT) and CSA Family Assessment and Planning Teams (FAPT) from departments of social services, health, juvenile justice, CSBs, public schools, private agencies, local government, and family members.

Input to the Review

The OIG sought input to the design of the review of CSB children's services from a wide variety of sources:

- Secretary of Health and Human Resources and staff
- Senate and House staff
- Virginia Commission on Youth staff
- Joint Legislative Audit and Review Committee (JLARC) staff

[1] The OIG uses the term intellectual disabilities wherever possible, except in cases where the term mental retardation is used in formal titles or previously published items.
[2] Hereafter, only the term children will be used to refer to both children and adolescents.

- Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) leadership and children's services staff
- Office of Comprehensive Services for Youth and At-Risk Youth and Families (CSA) staff
- Supreme Court Commission on Mental Health Law Reform – Child and Adolescent Task Force
- Child and Family Behavioral Health Policy and Planning Committee
- Virginia Association of Community Services Boards (VACSB)
- Community services boards (CSB) children's services directors
- Families, interagency staff, and other attendees at Systems of Care Conference (September 16-17, 2007)
- Local CSA and Departments of Social Services (DSS) directors and staff.

Statements of Quality

A process of extensive review of literature on children's mental health, substance abuse, and intellectual disability services, along with the input process described above, led to the creation of 9 statements of quality by which the OIG assessed services in the review. The widely accepted "Systems of Care" model[3] offered a framework for many of the statements of quality, but the criteria selected were individually verified by the input received by the OIG and described in terms relevant to the service and funding structures of Virginia. The overall design of the review and the creation of all the questions included in the interviews, checklists, and questionnaires were based on these statements of quality:

1. The families and caregivers of children receiving services are the leading participants and determinants of service needs and plans, assisted by professionals.
2. Services are community-based and designed to help children stay in their own families, in their own communities to the greatest extent possible.
3. The services provided are individually matched and appropriate to the individual needs and desires of the child and family and are described in a comprehensive services plan that is updated and changed as a result of changes in circumstances and desires of the family.
4. Services are the least restrictive possible and are delivered in the most normative environment possible.
5. Services are holistic (encompassing a wide range of life needs in different environments) and long term in their scope, rather than problem or symptom focused and specific only to one environment, e.g., school.
6. Services address the needs of the family as a system, with family and adult services available in a convenient and responsive manner.

[3] From Stroul, B & Friedman, R (1986). *A system of care for children and youth with severe emotional disturbances* (rev, ed., p. 17). Washington, D.C: Georgetown University Child Development Center, National Technical Assistance Center for Children's Mental Health.

7. Services are well coordinated and collaborative with other main service and support systems for children and families in the community.
8. Staff are well trained (including cultural competence) for state-of-the-art services for children and families, receive good clinical supervision and support, and evaluated according to best practices and measurable outcomes for the persons they serve.
9. The CSB gives children's services a high priority, is a good partner in the CSA process, and offers a comprehensive range of services that are accessible in a timely and smooth manner.

Section III – CSB Child and Adolescent Program Site Visit Inspections

Process of the Site Visits

The OIG visited 34 CSBs, omitting only the 6 CSBs that either did not identify specific children's services staff or reported extremely small children's services staffing levels in the OIG survey sent to all CSBs. The six CSBs that were omitted from the site visit phase of the review included Chesapeake, Dickenson County, Eastern Shore, Goochland-Powhatan, Portsmouth, and Southside. All 40 CSBs were included in phase 1 - the survey of all CSBs' services – and phase 3 – the stakeholder interviews.

The site visits were announced to the CSBs approximately 5 working days before the visits in order for the CSBs to arrange for the OIG inspectors to meet with all children's services supervisors and staff. Upon arrival at the CSB, the inspectors made a random selection of records from cases of children currently receiving services or recently closed. The number of cases selected ranged from 10 to 35, depending on the size of the CSB's services for children (measured by number of assigned staff). CSB staff had no involvement in the selection of cases to be reviewed. The record sample from all the CSBs totaled 469. Records were reviewed according to a specific checklist. All questionnaires and checklists used in the review are available in the appendix of the online version of this report at the OIG website. Names and phone numbers of parents or caretakers were collected, when available, from the records that were reviewed. Meetings were held with all supervisors and all staff who could be made available without severe disruption to ongoing service commitments. A total of 234 supervisors and 859 staff were interviewed. All interviews were conducted in groups, with participants completing confidential, self-administered, written questionnaires, followed by brief open discussions. Site visits took place between March 4, 2008 and April 3, 2008.

Family Interviews

OIG inspectors made phone calls to all of the parents or caregivers whose names and phone numbers were available in the records of the sample of 469 children's records reviewed in the site visits. Of the 469, some had no caregiver information in the record, many had wrong or discontinued numbers, many were unreachable although at least three attempts were made to reach them, and a few refused or were unable to complete the

interviews. Interviews were completed with 175 persons, or 37% of the record review sample.

Inspectors used a questionnaire that asked respondents to indicate their agreement or disagreement with 13 statements about the services their child is receiving, the child's progress, and their satisfaction with the services. A table showing all the statements and responses is shown below.

Family or Caregiver Survey	**Strongly Agree % (n)**	**Agree % (n)**	**Disagree % (n)**	**Strongly Disagree % (n)**	**Not Applicable % (n)**
CSB staff members treat my child with dignity and respect.	61.1% (107)	38.3% (67)	0% (0)	.6% (1)	0% (0)
CSB staff members speak to my child and me in a way we understand.	53.1% (93)	43.4% (76)	3.4% (6)	0% (0)	0% (0)
My child and I actively worked with the staff members to develop a treatment plan that accurately addresses my child's current problems, issues and/or behaviors.	39.7% (69)	48.9% (85)	5.7% (10)	2.9% (5)	2.9% (5)
The CSB staff members we work with understand our problems and ask my opinion about what kind of help we want and need.	40.0% (70)	53.1% (93)	4.6% (8)	1.7% (3)	.6% (1)
The CSB staff members we work with have the skills, knowledge and abilities to help my child.	42.9% (75)	53.1% (93)	3.4% (6)	.6% (1)	0% (0)
The CSB staff member answers or returns my calls in a reasonable time.	44.0% (77)	49.1% (86)	5.7% (10)	.6% (1)	.6% (1)
I am satisfied with the amount of time the staff member spends with my child.	40.0% (70)	51.4% (90)	6.3% (11)	1.1% (2)	1.1% (2)
My opinion (whether good or bad) regarding my child's treatment is important to the staff member and is heard.	43.4% (76)	49.1% (86)	4.6% (8)	2.3% (4)	.6% (1)
We are getting as much help as we need at this time for my child.	30.9% (54)	54.3% (95)	11.4% (20)	3.4% (6)	0% (0)
Our staff member is open and honest with us.	43.7% (76)	55.2% (96)	.6% (1)	.6% (1)	0% (0)
Overall, my child and/or family benefits from the services being provided.	40.6% (71)	52.6% (92)	5.7% (10)	1.1% (2)	0% (0)
Overall, I have noticed improvement in the issues and/or behaviors that brought my child into services.	28.6% (50)	56.0% (98)	9.1% (16)	5.1% (9)	1.1% (2)
Overall, I am satisfied with the services that my child is receiving.	40.0% (70)	56.0% (98)	1.7% (3)	1.7% (3)	.6% (1)

- The parents and caregivers who were interviewed expressed very high levels of satisfaction with the services their children are receiving. All statements received positive ratings (strong agreement or agreement) concerning families' satisfaction with the services their child is receiving.
- The statements with the highest levels of agreement ("strongly agree" or "agree") were:
  - 99.4% - "CSB staff members treat my child with dignity and respect."
  - 98.9% - "Our staff member is open and honest with us."
  - 96.5% - "CSB staff members speak to my child and me in a way we understand."
- The statements with the lowest level of agreement ("strongly disagree" or "disagree" were:
  - 84.6% - "Overall, I have noticed improvement in the issues and/or behaviors that brought my child into services."
  - 85.2% - "We are getting as much help as we need at this time for my child."
  - 88.6% - "My child and I actively worked with the staff members to develop a treatment plan that accurately addresses my child's current problems, issues and/or behaviors.

Record Reviews

A total of 469 clinical records of children currently receiving mental health services, or cases recently closed, were drawn at random by the OIG staff from rosters of clients. To enhance comparability across CSBs, cases were only drawn from the services that are most widely found in all CSBs, here listed in descending order of commonality (a full description of what services are provided by all CSBs is found in **OIG Report #148-07 Survey of Community Services Board Child and Adolescent Services** found at www.oig.virginia.gov):

- Case Management
- Outpatient Therapy
- Home Based Therapy
- School Based Day Treatment

OIG inspectors reviewed records using an 11-item checklist that assessed such things as family involvement in service planning, holistic approach to meeting child and family needs, interagency cooperation, levels and nature of case management activity, improvement of the child, screening and treatment for co-occurring substance abuse conditions, and the range of other services received by the child.

The distribution of the **types of services** reviewed is shown in the table below.

Service Type Reviewed	**% of the sample (n)**
Case Management	48.2% (223)
Outpatient Therapy	21.6% (100)
In-Home Therapy	17.9% (83)
Day Treatment	12.3% (57)

The **family situations** of the children were assessed and tabulated. The vast majority of children being served reside with one or more of their parents or other relatives (92.2%), with only 5.8% residing in foster families and 2.0% in other living arrangements such as group homes.

The degree to which treatment is planned with the **involvement or leadership of the family** is a key indicator of quality for child and family services. OIG inspectors reviewed treatment plans, progress notes, and treatment team documents to assess the degree of involvement of families in the need assessment and service planning process.

- Families are routinely involved in helping to plan their children's mental health services – 82.8% of records showed some degree of family involvement in developing the service plan.

Family Directed Treatment Planning	**% (n)**
There is little or no record of the family's involvement with the IFSP.	13.4% (63)
There is evidence that the CSB staff member elicited and received input from the family about the plan.	70.4% (330)
The plan expresses the family's goals, a family-focused plan, with the staff member in a support and resource role.	12.4% (58)
It is apparent to the OIG inspector that caregiver involvement is impractical, not possible, or clinically irrelevant or inadvisable.	3.2% (15)

A **holistic approach** to services was also assessed. Whether the child is treated as a whole person, in a family system, with school and community involvement and with a future to prepare for, rather than focusing on a set of symptoms or problem behaviors, were the markers for finding a holistic approach to treatment.

- In about a quarter of the records (24.1%) it was difficult to see the "whole child." The treatment was not judged to be holistic.
- Inspectors judged 13.4% of records to reflect comprehensive, holistic, multi-faceted assessments and approaches to service.
- The majority (62.3%) were somewhere between these two positions.

Interagency coordination and collaboration are essential to good service outcomes, as most of the children served are involved with multiple services agencies such as schools, social services, court services, and many others, and it is clearly in the interest of the child and the families for all these agencies to work together. In Virginia the CSA system mandates coordination and collaboration for many children.

Records were reviewed to assess these qualities. *Cooperation* was defined as communication and sharing of information and plans, as distinct from *collaboration*, which was seen as joint and complementary planning and activity, such as might occur in a carefully developed FAPT plan. The following table displays the results of the interagency coordination assessment:

Interagency-Intersystem Coordination	**% (n)**
The CSB service operates substantially alone. Minimal consultation or communication.	28.4% (133)
The CSB service operates cooperatively with a few relevant agencies (other CSB services, referral source, dialogue with schools), with appropriate communication and sharing of information, but the service is CSB driven and cooperation is secondary.	58.8% (276)
The CSB services are collaborative with other key agencies – planned and executed as a team, with harmonious and complementary parts and roles.	9.8% (46)
Interagency collaboration is not applicable to this service.	2.6% (12)

- In over a quarter of the cases (28.4%) there was very little or no evidence of interagency coordination in the record. In 58.8% of the cases the CSB service operated cooperatively with a few relevant agencies, but the service is CSB driven and cooperation is secondary. While this may be appropriate in some limited focus outpatient therapy services, which were deemed "not applicable" by OIG inspectors, it is difficult to imagine children with mental health problems not being involved with several service providers, with the attendant need for coordination.

- Only 9.8% of the records were judged to show true collaboration (as defined above) between the CSB and other agencies.

Case management is a central service for children and families in a comprehensive service system. All but two CSBs reported that they offer some degree of children's mental health case management.[4] The OIG has studied adult intellectual disabilities and mental health case management in two other statewide, systemic service reviews.[5] This review of children's services used substantially the same approach as in those reviews to assess the nature and levels of activity of case managers serving children. Of the 469 records that the OIG reviewed, 223 were reviewed with a focus on case management services.

Progress notes and service tickets or logs documenting services from the immediately preceding quarter were reviewed to assess the level of case management activity measured by face-to-face contacts and their location.

- Face-to-face contacts with the child averaged 4.1 for the quarter for all cases reviewed (223).
- All contacts with the family (face-to-face, telephone, email, etc.) averaged 6.8 over the quarter.
- The location of visits varied fairly evenly among sites:

Case Management –Location of Face to Face Contacts in Various Settings in the Last 3 months	Mean (average)
Out in the community	2.75
At the child's school	2.72
In a CSB office	2.52
In the child's residence	2.03

The type of activity that the case managers engaged in with or on behalf of their clients has been assessed in all OIG reviews of case management. The following table shows the number of times each of the listed types of activities was noted in all of the children's records over the preceding three months.

Evidence that the CSB Staff Member Engaged in the Following Activities in the Last Quarter	% Indicating Yes (n)
Supportive counseling/behavioral consult to family	41.2% (193)
Contact with other CSB services	36.7% (172)
Contact with schools	33.7% (158)
Advocacy for child	16.8% (79)

[4] OIG Report #148-07
[5] OIG Report # 128-06 (MH) and OIG Report #142-07 (MR)

Contact with other social services agencies	15.8% (74)
Arrangement of medical services	14.3% (67)
Contact with DSS	8.7% (41)
Contact with court services unit	5.8% (27)
Participation with FAPT process for child	5.8% (27)
Contact with CSB emergency services	2.3% (11)

The **degree of improvement** in the child's condition was also the subject of record reviews. Inspectors made an overall judgment of whether the condition or problems for which the child was referred were improved over the past year of service.

- Minimal or no progress or set backs were noted in 36.2% of the cases.
- Moderate, mixed, or partial achievement of goals was seen in 58.8% of the cases.
- Highly positive, consistent achievement or progress toward goals was seen in 3.4% of the cases.

Co-occurring conditions of substance abuse and mental health problems are known to be common, especially in older adolescents. As has been done in most OIG community and facility reviews, some effort was made to determine whether the possible substance abuse needs of children are assessed and treated in children's mental health services.

- In 76.1% of cases there was some evidence that substance abuse was assessed. However, many of these assessments were judged by OIG inspectors to be superficial - cursory completion of checklists.
- Of the total of 469 records, 44, or 9.4% had some indication of substance abuse in the record. Some of these were explicit and addressed in problem assessment, and some were evident to inspectors from referral or other information, but were not formally noted as problems in the record. The incidence of substance abuse reported in the records seemed lower than expected by the inspection teams. However, it is not possible to compare this observed presence of substance abuse to research-based estimated rates due to the fact that age of the child was not a measured variable in this review and incidence rates are known to vary by age.
- Of the 44 records in which OIG staff noted substance abuse issues, treatment goals for substance abuse were evident in 56.8% of cases, but in 43.4% of the cases where substance abuse was evidently a problem, no substance abuse treatment was noted in the record.

Records were also reviewed to assess what **other CSB services the child and family were receiving** or had received in the last year. The table below shows the frequency with which other CSB services were noted in the records.

All Services That the Record Shows the Child is Receiving From the CSB in the Last Year	% (n)
Case Management	70.6% (331)
Medication Management (psychiatry service)	63.8% (299)
Outpatient Therapy	46.7% (219)
In-Home Therapy (includes MST, FFT)	22.6% (106)
Day Treatment (school based)	22.0% (103)
Other (mentoring, mental health support services, professional family care, respite)	4.7% (22)

Staff interviews

CSBs were asked to invite all staff who work in children's services to meet with OIG inspectors, except for those staff who had extended travel or clinical or contractual obligations. 859 staff were interviewed at the 34 CSBs. Staff were interviewed in groups, during which they privately completed a confidential written interview, and then engaged in a brief group discussion with OIG staff.

The following chart shows a breakdown of how many staff, who were interviewed, work in the various services areas offered by the CSBs.

Types of Services Represented by Staff[6]	% (n)
Case Management	40.4% (347)
Outpatient Therapy	24.1% (207)
In-Home Therapy	15.1% (130)
Day Treatment	32.7% (281)
Other	12.8% (110)

[6] Respondents were able to choose more than one response.

- **Staff tenure** in their current jobs averaged 3.4 years and 7.4 years overall in other clinical services work with children, including their current jobs.

- **Case management caseloads.** Persons who are case managers or who had case management as part of their job responsibilities are the largest group of CSB staff working with children. Case managers were asked to estimate their current caseloads, adjusted for full time equivalence.

    - The average caseload (adjusted for part time staff to full time equivalence) is 21.4.

    - As was the case in other OIG reviews of case management, children's services case managers said they must spend a lot of time each week – average of 40% -on administrative duties characterized as "paperwork."

The degree to which need assessment and **service planning are driven by the client** is an important statement of quality in many types of services. It is no less so for children's mental health services, although parents, rather than children, make the major decisions about treatment. Many recent OIG reviews of different types of services have focused on this issue and contrasted what staff reported were their practices in this area and what OIG review of records showed. As shown in the section of this report on family interviews, parents or caregivers were relatively pleased with their level of input on this issue (see page 14). Similarly, in the section on record reviews, OIG review showed good family involvement (see page 16). The table below contrasts staff ratings of their own practices and OIG findings in the records.

Family Directed Treatment Planning: Comparison of Staff Interview and Record Review Data	**Staff Description of Practices % (n= persons)**	**OIG Evaluation of Sample of Records % (n=records)**
Staff develops the service plan and explains it to the family	11.9% (102)	13.4% (63)
CSB staff member elicited and received input from the family about the plan.	55.1% (473)	70.4% (330)
The plan expresses the family's goals, a family-focused plan, with the staff member in a support and resource role.	25.8% (222)	12.4% (58)
It is apparent to the OIG inspector that caregiver involvement is impractical, not possible, or clinically irrelevant or inadvisable.	NA	3.2% (15)

Staff were asked to state their agreement or disagreement with a variety of statements concerning their impressions of CSB children's services, using a 4-point Likert scale of Strongly Agree, Agree, Disagree, or Strongly Disagree. No options for "not applicable" or "do not know" were given; respondents were told to leave questions blank if they did not apply. An extract of staff questions and answers is shown in the

tables below. The full survey with all question and answers is found in the appendix of the online version of this report.

Questions Related to Service Quality and Priority Of Children's Services at CSBs	**SA % (n)**	**A % (n)**	**D %(n)**	**SD %(n)**
Most of the children I serve show improvement as a result of the services we provide.	23.4% (196)	70.6% (591)	5.4% (45)	.6% (5)
Our agency allows families (or surrogate families, if child is in placement) enough choice and self-determination in developing services for their children.	22.6% (192)	68.5% (581)	7.9% (67)	.9% (8)
Child services are a high priority of the leadership of my CSB.	39.0% (330)	48.4% (410)	10.6% (90)	2.0% (17)
My agency stresses and supports extensive interagency coordination and collaboration in my work with children.	44.9% (383)	49.2% (420)	5.2% (44)	.7% (6)
The children I work with have access to a psychiatrist when they need to, without undue waiting.	11.8% (98)	44.9% (374)	31.1% (259)	12.2% (102)
The families I serve can call me – or another member of my team or a supervisor covering for me – during evenings or weekends (not just call CSB's ES program).	22.3% (178)	26.7% (213)	33.5% (268)	17.5% (140)
Mental health and substance abuse services at my agency are well integrated – the children I serve receive substance abuse services without barriers or challenges.	12.6% (88)	50.9% (355)	30.4% (212)	6.0% (42)
Mental health and intellectual disabilities services at my agency are well integrated – the children I serve receive mental retardation services without barriers or challenges.	9.6% (63)	51.4% (338)	31.2% (205)	7.9% (52)
When children and families I serve experience psychiatric or behavioral crises, our agency provides timely, effective crisis intervention to keep the people we serve safe in our community.	34.7% (288)	53.9% (448)	9.3% (77)	2.2% (18)

- Areas of high agreement
    - CSBs' support for interagency coordination.
    - Improvement of children served (most responses were "agree" vs. "strongly agree", suggesting improvement may be limited, consistent with the severity of needs seen).
    - Involvement of parents (similar low levels of "strongly agree" – many staff comments expressed frustration that families were not as involved as staff hoped or thought they should be).

- Areas of lower agreement
    - Timely access to psychiatry services
    - Evening and weekend staff availability
    - Integration of substance abuse and intellectual disabilities services with mental health services.

Questions Related to Staff Training and Support	SA % (n)	A % (n)	D %(n)	SD %(n)
My agency has provided me with specific training regarding family-centered services within the past two years.	13.4% (112)	43.9% (366)	36.3% (302)	6.4% (53)
My agency has provided me with specific training regarding evidence based practices for children within the past two years.	12.1% (98)	45.1% (367)	35.2% (286)	7.6% (62)
I am well prepared by training or experience to deal with co-occurring mental health and substance abuse disorders among the children and families I serve.	15.6% (131)	45.8% (385)	33.7% (283)	4.9% (41)
I am well prepared by training or experience to deal with co-occurring mental health and mental retardation disorders among the children and families I serve.	10.1% (85)	38.1% (320)	40.1% (337)	11.7% (98)
I am well prepared by training and agency supports to relate to the cultural diversity of my clients (e.g., race, language, etc.).	24.7% (210)	57.1% (485)	15.8% (134)	2.5% (21)
I am well prepared by training and support from my agency to understand and work with the processes of the Comprehensive Services Act for At Risk Youth and Families (CSA).	17.2% (143)	47.7% (396)	30.0% (249)	5.1% (42)

- Generally, ratings for training and support are lower than for service quality measures.

- Lowest ratings are for mental retardation (51.8% disagree), evidence-based practice (42.8% disagree), substance abuse (38.6% disagree), and family-centered services (42.7% disagree).

- Just less that half of the staff indicate that they are not well prepared to work with those who have co-occurring mental health and substance problems and co-occurring mental health issues and mental retardation.

Questions Related to Staff Morale and Work Conditions	SA % (n)	A % (n)	D %(n)	SD %(n)
My children's services team has good morale.	34.6% (293)	47.5% (403)	14.0% (119)	3.9% (33)
I receive effective, quality clinical supervision.	36.2% (308)	43.8% (373)	15.5% (132)	4.6% (39)
My job is professionally stimulating and satisfying.	30.7% (262)	53.8% (459)	13.4% (114)	2.1% (18)
I feel safe working out in the community or in the homes of the people I serve.	21.3% (171)	63.2% (506)	13.1% (105)	2.4% (19)
The expectations placed on me by my agency are clear and consistent.	16.7% (143)	57.8% (494)	22.0% (188)	3.4% (29)

My caseload is too large for me to do all that I would like to do for the children I serve.	22.0% (186)	28.4% (240)	41.0% (346)	8.5% (72)
The paperwork I must maintain is a burden and it interferes with service provision.	28.8% (246)	38.6% (329)	30.9% (264)	1.6% (14)

- Morale is very positive (82.1% gave positive responses).

- Highest ratings went to staff feelings of safety working out in the community and in the homes of clients (84.5%) and their feelings that their jobs are professionally stimulating and satisfying (84.5%). The quality of clinical supervision also drew high marks (80%).

- Lower ratings went to caseload size (50.4% said that caseloads are too large) and paperwork concerns (67.6% said that paperwork interferes with service provision).

Questions Related to Interagency Coordination	**SA % (n)**	**A % (n)**	**D %(n)**	**SD %(n)**
My agency stresses and supports extensive interagency coordination and collaboration in my work with children.	44.9% (383)	49.2% (420)	5.2% (44)	.7% (6)
I am well prepared by training and support from my agency to understand and work with the processes of the Comprehensive Services Act for At Risk Youth and Families (CSA).	17.2% (143)	47.7% (396)	30.0% (249)	5.1% (42)
I provide regular reports about the services I provide to the referring, collaborating, and/or funding agency (e.g., DSS, CSA).	24.9% (202)	52.3% (424)	20.3% (165)	2.5% (20)
Other CSA partner agencies (DSS, schools, court services, etc.) are generally open to collaboration and coordination of services to the families I serve.	30.3% (256)	60.4% (510)	8.2% (69)	1.1% (9)
Staff at the other community agencies I work with have an accurate understanding about what the CSB can and cannot do.	6.3% (50)	50.4% (403)	38.0% (304)	5.4% (43)

- Three issues received the highest "disagree" ratings from staff:
    - Staff training and support for CSA roles (35.1% disagree)
    - Provision of regular reports to CSA referral sources (22.8%)
    - Other agencies have accurate understandings of what the CSB can and cannot do (43.4%)

Supervisors Interview

A total of 234 supervisors of children's services at CSBs were interviewed by OIG staff. Interviews were conducted in small groups, with the supervisors independently completing a confidential 15-question survey, followed by a short group discussion of issues.

Experience. CSB children's services supervisors average 6.4 years tenure in these roles, and 14.7 years overall of work with children.

Access in emergencies. When asked if families are able to reach CSB children's services providers when crises occur in the evenings, nights, or weekends, almost 70% said families must call the agency-wide CSB emergency services number. Smaller percentages noted that families can call their providers of home-based or therapeutic foster care services or that other staff, such as case managers, sometimes give families their home numbers.

Measurement of staff competency. Supervisors were asked, "What do you do to assess or measure competence in all the skills that direct services staff who work with children and families must have?" Answers detailed the conventional techniques of clinical and administrative supervision, quality analysis of records, staff training, assurance of degrees and experience before hiring, etc. Only 6.5% mentioned use of family feedback or interviews and just over 5% said they measured competency with objective methods.

Case management caseloads. Case management is the most widely available CSB service to children among CSBs. Supervisors were asked to estimate the current average caseload of their case managers, adjusted for full time equivalence. The statewide average of their responses was 30.3. When asked what they considered the ideal or target size for children's case management, the supervisor's average answer was 23.9. Overall, they estimated that an additional 109 case managers are needed statewide. In the staff interview, (p.21) the average of staff responses given to a question about caseload size was 21.4.

As was done with the overall Survey of CSB Child and Adolescent Services (OIG Report #148-07) and with the Stakeholders Interview phase of this review (see page 28), supervisors were asked, "What 2 or 3 services that are not now available in your community would do the most to prevent having to place children in residential programs outside your community?"

What 2 or 3 services that are not now available in your community would do the most to prevent having to place children in residential programs outside your community?	**% of total comments**
Increased use of in-home therapy, expanded models of services, eligible recipients	13.5%
24 hour crisis stabilization programs, local, family-based	11.2%
Increased availability of a range of local, community-based residential options such as foster care, professional parents.	9.9%
Respite care. Temporary respite from having the child in the home, to build parenting strengths, handle crises, etc.	9.5%

Expanded and more flexible funding for day treatment, especially school-based.	9.3%
Training and supports for families, especially on behavioral management techniques.	7.4%
Expanded outpatient mental health therapy services, evaluations, earlier interventions, more flexible funding	6.5%
Expanded substance abuse treatment services (intensive outpatient, detox, residential treatment)	4.2%
Increased availability of psychiatric and medication services	4.2%
Treatment of caregivers' mental health and substance abuse problems, family treatment	3.8%
After school and summer day treatment, and alternative day treatment for children suspended or expelled from school	3.6%
Other services under 3%: Mentoring, special child crisis intervention capabilities, expanded prevention and early intervention services, transition to adult services (MHSS), transportation, vocational preparation, cultural and linguistic capability, increased parental accountability.	<3%

Supervisors were also asked what had helped and what had hindered the development of child and adolescent services at their specific CSB.

What factors have been most helpful in developing services for children and families in your community?	**% of total comments**
Cooperation and partnership with stakeholders, CSA support, interagency support, creativity among community partners.	35.3%
Leadership shown by the CSB – some cite the director of child services, the executive director, and board.	17.9%
Community needs for services, expressed need from stakeholders, pressure from community to develop services, poverty.	7.8%
Talented, qualified, creative staff at CSB	7.1%
Grants from state, other sources	6%
Availability of Medicaid funding for children's services	4.3%

CSA funding to purchase services from the CSB	3.2%
Other factors noted less than 3% of total items: Non mandated money from GA, leadership from local government, input from families, partnering with universities, trainings provided to staff.	<3%

What factors have most hindered the development of services for children and families in your community?	**% of total comments**
Lack of flexible funding for children without Medicaid, CSA funding, or other insurance, Medicaid and/or CSA funding too restrictive, MDCD does not cover all needed services.	35.8%
Difficulty recruiting and retaining qualified staff (non-medical)	17.9%
Lack of cohesion and cooperation among agencies, CSA, and CSB, lack of local support, CSA preference for private providers, "turf issues"	13%
Transportation, large rural areas, families can't come in for services, home based services too expensive in rural areas.	11.1%
Lack of support from families, families do not seek/make use of services, need help themselves, do not cooperate	6.2%
Difficulty recruiting and retaining child psychiatrists	3.4%
Other factors noted less than 3% of total items: lack of priority for child services at CSB, lack of priority for child services at DMHMRSAS, state, agency structure limits child services, over-reliance on grants, fees, risky or unstable funding, loss of staff time due to administrative requirements, rigidity, lack of creativity.	<3%

Supervisors were asked, "What one or two changes do you think are most needed to improve child and family services in Virginia?" (Instructions asked them to extend their answers beyond "more money.")

"What one or two changes do you think are most needed to improve child and family services in Virginia?"	**% of total comments**
Expand types of eligible services and make funding more flexible, especially Medicaid, to meet needs of family members, non SED children, at risk children, prevention, non-mandated	30.1%

Increase community education, awareness, recognition of the need for children's services.	11.4%
DMHMRSAS, state increase priority for children's services, achieve parity with support for adult services	9.8%
DMHMRSAS provide training for staff at CSBs, especially on EBP	5.8%
Find and retain more staff and more qualified staff to work in children's mental health services,	5.8%
Provide accountability and supports for parent involvement in services for their children and themselves	5.8%
Assist communities with providing psychiatric services, work with universities	4.3%
Improve coordination among CSA partner agencies at state level as well as at local level	4%
Decrease paperwork requirements on CSB service providers	4%
Improve transportation or provide resources to counter effects of large geographic areas and/or traffic and families' lack of transportation, CSB expense of providing outreach services in these situations.	3.7%
Improve transition of children from schools to CSB-operated community services	3.1%
Other factors noted less than 3% of total items: create shared vision for system of care, create mandates for children's services at CSBs, mandate that the CSB be the provider of CSA services, improve monitoring of private providers, improve SA and MH cooperation at state and local level, more bilingual and culturally competent staff, vocational services.	<3%

Section IV – Stakeholders Survey

Process of Stakeholders Survey

The OIG developed a questionnaire that assessed impressions of CSB services held by staff from CSA partner agencies from each city and county in Virginia. The 26 question survey focused on:

- Views of CSB as a provider of MH, SA, and MR services to children
- Views of CSB as CSA partner

– Community service needs and gaps
– Priority services to reduce/prevent residential placements

Contact information was obtained for all members (and alternates) of the CPMTs and FAPTs in all of Virginia's cities and counties. Over 1500 persons received emailed invitations from the Inspector General to participate in a survey about CSB mental health, intellectual disabilities, and substance abuse services and the needs of each community. The invitation contained a link to the OIG website to access the survey online. The survey was anonymous and confidential. 520 persons responded to the invitation and completed the 26-question survey. A complete report of the results of the survey is found in the appendix of the online version of this report at the OIG website.

Respondents represented a wide range of community partners and CSA representatives.

Organization Represented	Response %	Response N
Department of Social Services	28.4	145
Public schools	15.1	77
Juvenile and Domestic Relations Court services unit	11.4	58
Health Department	6.7	34
Private provider	9.2	47
Family member	2.4	12
Local governmental official	6.7	34
Child advocacy organization	2.0	10
State agency	5.7	29
Other	12.5	64
Answered question		510
Skipped question		10

Stakeholders Interview

Respondents were asked to state their agreement or disagreement with a variety of statements concerning their impressions of CSB children's services, using a 5-point Likert scale of Strongly Agree, Agree, Disagree, Strongly Disagree, and Not Applicable/Don't Know. For the presentations below, responses are collapsed into Agree or Disagree. If the sum does not add to 100%, the balance is N/A.

A rating average is also computed for the responses for each question. Strongly Agree is rated 1, Agree is 2, Disagree is 3, and Strongly Disagree is 4. Thus the lower the mean or average of ratings, the more favorable is the judgment of stakeholders on that issue.

Responses have been grouped into three categories:

1. Impressions of the CSB as a mental health services provider for persons referred by stakeholders,
2. Impressions of the CSB as a provider of specialized services,

3. Impressions of the CSB as a services planning and collaboration partner in the CSA process.

1. Impressions of Stakeholders of the CSB's Provision of Mental Health Services to Children they have Referred	**Agree %**	**Disagree %**	**Rating Average** (Range – high of 1 to low of 5)
CSB services for children involve families in the assessment of needs and the development of treatment plans for their children when possible.	78.3	10.7	2.02
The CSB provides services to children and families that reflect Evidence Based Practices.	68.8	16.6	2.16
My local CSB has state-of- the-art knowledge and expertise about child and family mental health issues.	62.9	34.9	2.35
Overall, CSB mental health services for children have good treatment outcomes.	57.3	35.3	2.40
I am usually satisfied with the results when seeking services from the CSB for children with mental health needs.	60.7	37.4	2.42
The CSB keeps me informed about the progress of treatment for children that are referred to them by our agency.	48.0	37.0	2.47
My CSB is able to provide services not only those children and families who have Medicaid, FAMIS, or CSA funding, but also to those who do not have these resources.	54.5	30.2	2.48
I find that most of the children I see with mental health needs can be served by the CSB.	44.0	51.0	2.62
Access to CSB child mental health services is timely and efficient.	33.1	65.1	2.92
Average rating			**2.40**

- The highest level of stakeholder satisfaction with the CSB as a provider deals with the CSBs' efforts to involve families in the development of services for their children – a 2.02 average rating.

- The two statements with the lowest level of stakeholder satisfaction with the CSB as a provider concerns the CSBs' (1) "Access to CSB child mental health services is timely and efficient." – a 2.92 average rating and (2) "I find that most of the children I see with mental health needs can be served by the CSB." – a 2.62 average rating.

- These are the lowest ratings given to CSBs and are the only two ratings on the survey for which the percentage of negative rating is over 50%. These ratings reflect many written comments in the Stakeholders Survey that CSB waiting lists, due to limited service capacity, are a major problem in meeting the mental health needs of children and families. Comments relate to the reality or perception that many CSBs limit services to children with severe emotional disturbance and/or with Medicaid.

2. Impressions of Stakeholders of the CSB as a Provider of Specialized Services	**Agree %**	**Disagree %**	**Rating Average**
The CSB does a good job of meeting the needs of children with mental retardation.	54.9	27.9	2.33
When a child experiences a psychiatric or behavioral crisis, the CSB Emergency Services program is a responsive and effective means to keep the child and the community safe.	52.2	43.0	2.48
The CSB does a good job of meeting the needs of children with substance abuse problems.	38.6	46.3	2.59
The CSB does a good job of meeting the needs of children with autism and other developmental disorders.	39.6	42.6	2.62
Average rating			**2.51**

- The highest level of stakeholder satisfaction with the CSB as a provider of specialized services concerns the CSBs' efforts to serve children with intellectual disabilities – a 2.33 average rating.

- The lowest level of stakeholder satisfaction with the CSB as a provider of specialized services concerns the CSBs' efforts to serve children with autism and other developmental disorders – a 2.62 average rating. This is tied with "Most of the children I see with mental health needs can be served by the CSB" as the second lowest rating of all categories.

- N/A or Do Not Know ratings were higher for these items than for most, probably because fewer people have experience with these services for special populations.

- The relatively low rating for provision of substance abuse services is significant, as the CSB is the only provider of out patient substance abuse services for children without health insurance in many communities.

3. Impressions of Stakeholders of the CSB as a services planning and collaboration partner in the CSA process	Agree %	Disagree %	Rating Average
The CSB collaborates with my agency in jointly planning and providing services to individual children with mental health needs.	64.8	31.1	2.23
There is a common vision among local agencies about a systems of care model and serving kids in families, rather than in congregate care settings.	65.5	30.7	2.27
The CSB is open to criticism and input about its services from other agencies.	55.0	37.3	2.40
Staff at our agency understand the regulations and parameters that guide the CSBs role and services.	57.9	38.9	2.40
The CSB does a good job of explaining its strengths and limitations to our staff and the community of agencies with which I work.	52.9	43.1	2.43
Staff at the CSB understand the regulations and parameters that guide our agency's role and services.	55.2	39.4	2.44
The CSB is an effective partner with my agency and the CSA in increasing the availability of mental health services for children and families through grants, contracts, and other means.	53.4	41.2	2.45
The CSB is a vigorous and effective partner in our local CSA system.	62.6	35.0	2.47
My local CSB is usually the provider of choice for children who are served by our community's FAPT/CPMT processes.	54.2	49.4	2.57
Average rating			**2.41**

- The highest level of stakeholder satisfaction with the CSB as an interagency partner concerns shared understandings among local agencies about systems of care model – a 2.27 average rating.

- The lowest level of stakeholder satisfaction with the CSB as an interagency partner concerns whether the CSB is the provider of choice for FAPTs and CPMTs – a 2.57 average rating.

- Generally, the ratings are positive, all over 52% favorable.

Stakeholders Opinions of CSB Strengths

The 520 respondents to the Stakeholder Survey were asked the question, "What does the CSB do well?" about the CSB that serves their locality. While not everyone responded to this question, there were a total of 454 comments made by stakeholder respondents. OIG staff analyzed the text comments and categorized them into separate statements of

quality. The following table displays the frequency with which each statement was noted by respondents.

What does the CSB do very well?	Number of times the comment was noted	% of total comments
The CSB communicates, cooperates, and collaborates well with partner agencies in the community. Helps improve system of care.	67	14.8%
The CSB provides effective services for children. Many excellent services to meet community needs.	50	11.0%
The CSB is a leader and expert on mental health services for the community. Highly skilled clinical staff – knowledgeable, competent, qualified.	35	7.7%
The CSB does a good job of providing specialized services to children with developmental and intellectual disabilities, and with early intervention programs.	33	7.3%
The CSB provides services regardless of the family's ability to pay. Services targeted to indigent population. Good at finding funding, stretching funds, etc.	31	6.8%
The CSB is an active partner in the CSA process, good representation or facilitation of FAPT/CPMT activities.	31	6.8%
Substance abuse evaluations and treatment and prevention services are good, considered effective.	31	6.8%
Positive statements about working with CSB staff - work well with families, listen, have good rapport, accessible, easy to work with, informed, client-oriented, friendly.	22	4.8%
Case management services are valued.	19	4.2%
Other positive observations at 4% or less: emergency services, assessments/diagnoses, adult services, share resources/provide training, long term services, psychiatric/medication services, day treatment.		<4%
Negative observations. "Nothing," no progress in years, focus on adults, not timely in response, understaffed, not open to working with CSA, highly restrictive entry criteria,	23	5.1%

inconsistent.		
Not applicable, don't know, don't work with CSB.	13	2.9%

Stakeholders Opinions of CSB Weaknesses

The 520 respondents to the Stakeholder Survey were asked the question, "What is your biggest criticism of the CSB?" While not everyone responded to this question, there were a total of 454 comments made by stakeholder respondents (this is exactly the same number as positive comments, shown above).

What is your biggest criticism of the CSB?	Number of times the comment was noted	% of total comments
There is a waiting list for CSB services. Access/intake are slow, not client-friendly, services take a long time to start after first contact.	107	23.6%
The CSB does not offer the comprehensive range of services needed by children and families in our community (most responses noted that the CSB lacks funding to do so).	42	9.3%
The CSB is not collaborative with other agencies, poor communication, does not understand other agencies' roles.	36	7.9%
The CSB does not provide adequate substance abuse evaluation and treatment services for children and adolescents, SA services are of poor quality.	26	5.7%
The CSB is overly reliant on Medicaid. Eligibility for persons without insurance, Medicaid, or CSA funding is very limited; co-pays are excessive. Service eligibility is limited, excludes many referrals.	23	5.1%
CSBs are understaffed, staff stretched too thin to do well, too much paperwork.	21	4.6%
Criticism of staff qualifications, knowledge, supervision, reputation, energy, commitment.	20	4.4%
Emergency services are slow to respond, not helpful for children and families in crisis except for hospital screening.	20	4.4%

Other negative observations at less than 4% each: Over reliance on case management. High staff turnover, frequent change of worker assigned to families/agencies. Lack of outpatient counseling services and evaluations services for children. Limited access to psychiatry/medication services. Limited CSB services in certain communities or jurisdictions served by the CSB, e.g., smaller, rural counties in the CSB service area. Lack of Evidence Based Services, services not innovative. Inadequate services for children with intellectual disabilities. CSB services, eligibility, structure are not understood, frequently change. CSB is quick to close cases for non-compliance. Treatment for parents is separate from children, difficult to obtain. Poor executive leadership. Inconsistent participation in FAPT/CPMT. Inadequate services for children with autism/Asberger's. Limited services for adolescents with serious mental illnesses, poor transition to adult services.		<4%
No criticism, "none"	13	3.1%

Services Needed to Reduce Residential Placements

Stakeholders were asked, "What service that is not now available in our community, would do the most, if it were available, to help prevent out of community residential placements". There were a total of 489 responses to this question.

"What service that is not now available in our community, would do the most, if it were available, to help prevent out of community residential placements"	Number of times the comment was noted	% of total comments
More home-based intensive services to children and families, "wrap-around" services.	74	15.1%
Increased availability of substance abuse services for children – outpatient and intensive outpatient.	53	10.8%
More residential options in the local area, including group homes, therapeutic foster care, improved and expanded foster care, foster care for families, professional parents, sponsored placements.	41	8.4%
Increased availability of mental health outpatient and	37	7.6%

intensive outpatient services for children.		
Broader range and increased availability of assessment and evaluation services	35	7.2%
Educational, support, and treatment services for families. parents.	29	5.9%
Community-based treatment for sexually acting-out, behavior problem children	23	4.7%
Mentoring services – services that match a behavioral aide, coach, "buddy" with children receiving services.	21	4.3%
Respite services for children in crisis, parents needed break from care of children with difficulties	21	4.3%
Crisis intervention, crisis stabilization services, crisis supports in the home.	20	4.1%
Shorten the wait for services, improve access to services.	18	3.7%
Support and therapy groups for children, e.g., anger management.	16	3.3%
Increased access to psychiatric care.	16	3.3%
More day support/day treatment programs	15	3.1%
Other services listed less than 3% of the total listed: More case management, more service access for children without Medicaid or other funds, more services delivered in the schools, more team approach across agencies, additional services for children with autism, anti-gang services, improve overall service quality, sheltered employment and vocational opportunities, residential SA treatment, Spanish language services.		<3%

Section V – Findings and Recommendations

A. Findings related to service availability

1. Families seeking services for children and adolescents with mental health service needs face enormous differences in service availability depending on where they live. Whether measured by expenditures, staffing, or percentage of child population served, the availability of mental health services for children and

adolescents offered by CSBs varies widely among communities. Across the 40 CSBs:

- Per capita funds budgeted for services ranges from a high of $258.36 to a low of $0.96 per child. Highest is 300 times the lowest.
- Staff to community population ratios range from the richest staffing at 1 staff member to 237 child population to the leanest staffing at 1 staff member to 15,380 population. Richest is 40 times the leanest.
- Service penetration rate in the community ranges from a high of 1.21% of the population of children and adolescents in the community to a low of 0.38% of the population. Highest penetration rate is 15 times the lowest.

2. Few CSBs offer a large array of child and adolescent services with sufficient capacity to meet the needs of their community. Many CSBs have very limited services available to children. A few have virtually no service system designed especially for children.
   - Analysis of service availability data provided by CSBs[7] showed no CSB offers all 48 of the services listed in the survey and only one CSBs offer a complete array of 12 *key* services, and many offer only a few.[8]
     - The average number of services offered by all CSBs is 7.6 (of 12 key services). The range is from 4 services to 12.
     - 12 CSBs (30%) of CSBs offer only 6 or fewer services.
     - 6 CSBs (15%) of CSBs offer 10 or more services.
     - Only one (Hampton-Newport News CSB) offers all 12.

   - A further analysis was conducted to assess the availability of 5 highly specialized, high impact services that are considered (by stakeholders, CSB staff, OIG) to offer the most promise to serve children with severe needs and help prevent residential placement. These services are specialized children's emergency services, crisis stabilization, home-based therapy, school-based day treatment, local residential services.
     - Only 2 CSBs (5%) offer all 5 intensive services.
     - The average number of intensive services offered by all CSBs is 1.7, with a range from 0 to 5.
     - 7 (17.5%) CSBs offer none. 11 (27.5%) offer only one of the intensive services.

3. Child and adolescent services at CSBs are mostly full to capacity, resulting in long waiting periods for new persons to access services. The average wait for all services, from all CSBs that reported was 26 days.

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[7] Data on service availability was provided to the OIG for publication in **OIG Report # 148-07 "Survey of Community Services Board Child and Adolescent Services,"** published on the OIG website (www.oig.virginia.gov) on March 31, 2008. This data was combined and selected from 48 separate services to a core group of 12 services for this analysis. The 12 key services are the following: specialized children's emergency services, crisis stabilization, evaluations for CSA services, psychiatric/medication, office-based MH therapy, office-based SA therapy, MH, MR, and SA case management, home-based therapy, school-based day treatment, local residential services.

[8] A table showing the availability of the key services by CSB is found on page 44 of this report.

- The average wait for outpatient services is 30.0 days.
- The average wait for psychiatry services is 31.2 days.
- The average wait for intensive home based services is 21.3 days.
- The average wait for case management services is 20.7 days.

4. Representatives from stakeholder agencies express dissatisfaction with the levels of CSB service availability in their communities. Specific areas of concern include the following:
   - Wait time for access to services is too long.
   - The wide array of services that are needed to serve children is not available.
   - Services to children with substance abuse needs and autism spectrum disorders are inadequate.

5. Access to services for uninsured families and those that are not eligible for a dedicated source of funding for children and adolescents is extremely limited.

B. Findings related to service funding

1. Medicaid is the largest source of funding in CSB budgets for child and adolescent services. Statewide it composes 47.9% of funding for all three disabilities combined. For mental health services Medicaid makes up 54.1% across the state.

2. The majority of the CSBs that have developed more extensive systems of services for children have done so through the use of Medicaid, and not through special grants or CSA funding. The six highest per capita funded CSBs average 72% of their funding for mental health services from Medicaid. It is important to note however that 30% of the CSBs receive 10% or less of their funding for mental health services from Medicaid.

3. State general funds and local funding make up a comparatively small portion of total funds for child and adolescent services statewide. Total funding statewide includes 11.9% state funds and 17% local dollars for all three disabilities. For CSB mental health budgets, state funding is 10.7% and local funding is 12%.

4. CSA funds paid to CSBs for purchase of services make up a very small portion of CSB budgets for mental health services at only 8.6%. The budgets of 72% of the CSBs include less than 10% of their funding from CSA.

C. Findings related to service quality

1. Parents/caregivers of children receiving services at CSBs report very high levels of satisfaction with the CSB services their children are receiving.
   - All interview questions received a majority positive response from families.
   - Ratings ranged from 84.6% positive responses to 99.4%.

2. Family level of involvement with CSB staff in the planning and provision of services is quite high. Families and stakeholders confirmed this involvement.

- 88.6% of family members said they were involved with the development of their child's treatment plan.
- 78.3% of agency stakeholders agreed that CSBs involve families in the planning and provision of services.
- OIG review of records showed good to excellent parental involvement in 82.8% of cases.

3. In the majority of cases reviewed, CSB involvement with and collaboration with other agencies was limited or did not occur.
    - 28.4% of records reviewed show very little or no interagency cooperation or communication.
    - 58.8% of records showed some cooperation, but not active collaboration.
    - Only 9.8% showed true "system of care" collaborative approaches with community partners.

4. Progress toward treatment goals is generally good for services provided by CSBs.
    - OIG review of records showed improvement and progress toward goals in 62.2% of cases reviewed.
    - 84.6% of family members said improvement occurred in the issues that brought the child into services.
    - 57.3% of agency stakeholders said there have been good treatment outcomes in children served by the CSB.

5. CSB assessments for co-occurring substance abuse needs in children receiving mental health services were not found to be comprehensive. When substance abuse was identified, treatment goals related to substance abuse were present in approximately half of the cases.

6. Few CSBs offer comprehensive, formal programs that have broad national recognition as "evidence-based practices" (EBP). Many CSBs, however, utilize elements and principles that are found in EBP literature.

7. Stakeholder ratings of multiple measures of overall CSB service quality were modestly positive (54.4% positive), but with dissatisfaction shown by a large minority of respondents (38.2% negative).

8. Access to services for parents and caregivers of children and coordination of children's services with services to parents is not adequate.

D. Findings related to CSA and interagency coordination

1. CSBs are not the provider of choice for community-based CSA-funded mental health services in many communities. Only just over half of stakeholder respondents say their CSBs fulfill this role.

2. CSA funds are only a minor source of support for children's services at CSBs. Average CSA funding for CSBs is only 6.8%. 42% of CSBs report receiving no CSA funding. The highest level of CSA funding for any CSB is 33%.

3. Many agency stakeholders say their CSBs do not adequately make clear what services they offer or who is eligible for services, and they express dissatisfaction with the limitations on service availability.

4. The leading factor CSBs cite that has helped them develop children's services is the support and cooperation of the local CSA CPMT and other community agencies to work together on meeting community needs.

5. Over half the CSBs (55%) say they have developed one or more specific services to help improve the provision of services offered to children in the CSA process. These services include intensive care coordination and utilization management.

E. Findings related to CSB workforce issues

1. CSBs have great difficulty recruiting and retaining qualified staff to provide children's services. They list it as the second highest factor that has hindered development of services.

2. CSBs have inadequate psychiatric time to meet the needs of the children in their communities. Only 12.5% of the CSBs report that they have adequate psychiatric resources. CSBs estimate that an additional 25 FTE psychiatrists are needed statewide. The average wait time to see a psychiatrist for children who are currently being served by CSBs is 37 days.

3. The leading suggestion from CSBs for what can be done at the state level to improve the development of children's services is the provision of training, especially on evidence-based, effective services to children and families. (Note: Respondents were asked to list factors other than simply "increase funding.")

4. CSB staff describes morale on their teams as very high.

F. Findings related to preventing out-of-community residential placements

1. Only partial agreement exists among CSBs and the agency stakeholder community about the services that are most needed to prevent out-of-community residential placements.
   - CSBs rated crisis stabilization programs, community-based residential alternatives such as improved foster care, and school-based therapeutic day treatment as the top three needed services.
   - Agency stakeholders rated community-based residential alternatives, increased and improved home-based services, and increased and improved substance abuse treatment as their top three.

G. Overarching findings related to the development of CSB services

Three primary and interdependent factors were identified by the OIG as the leading determinates of whether or not CSBs have developed more comprehensive systems of services that meet the needs of families and stakeholder agencies:

1. The extent to which leadership has been exercised to place a priority on the development of children's services, to develop community and interagency relationships, to use creativity and skill in making use of funding from Medicaid, grants, and CSA. This leadership comes from CSB board members, executive director, leader of children's services, or some combination of these persons.
2. Limited availability of funding to provide services for uninsured families and children that do not qualify for CSA and other categorical programs for children.
3. Relatively limited use of CSBs by local communities to provide services that are reimbursed by CSA.

Recommendations

1. It is recommended that DMHMRSAS lead an interagency process to develop a comprehensive plan for the provision of publicly supported, community based mental health, intellectual disability and substance abuse services for children, adolescents and their families. The objective of this plan will be to determine the base level of services that should be available in every community, clarifying the array of services and per capita capacity that will be needed. The plan should leverage all available sources of funds such as Medicaid, CSA, special grants to support services and then estimate the level of additional state funds needed to achieve a balanced, flexible funding base to address the needs of those families that are uninsured or not eligible for other dedicated sources of reimbursement. The planning process should include input from relevant state and local agencies and the private provider community. The target date for the completion of the plan would be no later than July 1, 2009. To assure that adequate staffing and planning expertise can be dedicated to the development of this plan, it is recommended that DMHMRSAS seek the assistance of experts with experience in planning for systems of MH/ID/SA services for children, adolescents and families to supplement departmental staffing.

It is further recommended that DMHMRSAS present the plan to the General Assembly clarifying the level of support that can be anticipated from non-state sources and identifying specific needs from state sources to enable responsible expansion of services in the first two years of implementing the plan.

It is further recommended that in subsequent legislative cycles DMHMRSAS provide a report to the General Assembly that claries progress achieved in expanding services for children, adolescents and children according to the plan, documents success in leveraging funds from non-state sources, and requests annual increases in state funds that will assure solid, responsible growth of a new system of services based on the comprehensive plan.

2. It is recommended that every CSB appoint a single person to lead services for children and adolescents.

3. It is recommended that DMHMRSAS provide leadership in determining the areas of training and staff development that are needed to increase consistency in the quality of services delivered by CSBs statewide to children and adolescents. It is further recommended that DMHMRSAS develop a plan for assuring that this training is made available to CSB staff.

4. It is recommended that the CSBs that have developed the more comprehensive systems of services for children and adolescents share information with other CSBs regarding the organizational, interagency collaboration, staffing, and funding factors that have enabled their success. DMHMRSAS and/or the Virginia Association for Community Services Boards could facilitate this educational effort.

5. It is recommended that CSBs evaluate their methods for assessing substance abuse to assure comprehensive evaluation of the need for substance abuse treatment, particularly when the identified problem is mental health or intellectual disability related.

DMHMRSAS Response:

I am writing to thank you for sending me the final Office of the Inspector General Report "Review of Community Services Board Child and Adolescent Services." I appreciate the broad scope of the report and the work you and the staff of the Office of the Inspector General have done over the past year. I will be discussing the findings and recommendations of the report with other DMHMRSAS leadership in the coming weeks.

Of particular interest is how our agency can work in partnership with the community services boards and their interagency teams to utilize the findings related to service availability, funding, and interagency coordination to improve and build the service array for children with behavioral health problems. Your inventory of service availability documents the wide diversity in the level of community services, noting some communities with strong systems, and others with very limited services.

The report is timely in that it coincides with, and its findings are consistent with, many efforts at the state and local level to make improvements to the child serving system, including the First Lady's For Keeps Initiative, the Virginia Council on Reform, and legislation passed in the 2008 General Assembly session affecting the Virginia Comprehensive Services Act and the Community Services Boards. The development of a wide array of community-based services is critical to the success of these efforts. The information in your report will be a most useful tool in planning for these system changes. Once again, I thank you and your staff for this very important work.

James S. Reinhard, M.D.
Commissioner, DMHMRSAS

Children's Service Availability by CSB (January 2008)														
CSB	ES Child (Spec)*	Crisis Stab*	CSA Evals	MH Psych.	Office Based MH Therapy	Office Based SA TX	MH Case Mgmt	MR Case Mgmt	SA Case Mgmt	Home-Based Therapy*	School Based Day Tx*	Residential Services*	Number of MH Services Available	Number of Intensive Services*
Alexandria		1	1	1	1	1	1	1	1	1			9	2
Alleghany Highlands				1	1	1	1	1	1	1			7	1
Arlington	1	1	1	1	1	1	1	1	1				9	2
Blue Ridge	1		1	1	1	1	1	1	1	1	1		10	3
Central VA	1	1		1	1	1	1	1	1	1	1	1	11	5
Chesapeake				1	1	1	1	1	1				6	0
Chesterfield				1	1	1	1	1	1	1	1		8	2
Colonial				1	1	1	1	1	1	1			7	1
Crossroads				1	1	1	1	1	1				6	0
Cumberland Mt.				1	1	1	1	1		1			6	1
Danville-Pitts		1		1	1	1	1	1	1	1			8	2
Dickenson			1	1	1	1	1		1				6	0
District 19				1	1	1	1	1			1		6	1
Eastern Shore	1	1		1	1	1	1						6	2
Fairfax-Fall Church		1		1	1	1	1	1				1	7	2
Goochland Pow				1	1	1		1					4	0
Hampton NN	1	1	1	1	1	1	1	1	1	1	1	1	12	5
Hanover	1		1	1	1	1	1	1	1	1	1		10	3
Harrisonburg-Rock				1	1	1	1	1					5	0
Henrico				1	1	1	1	1	1	1			7	1
Highlands				1	1	1	1	1		1			6	1
Loudoun			1	1	1	1	1	1	1	1			8	1
Middle-Penn NN	1	1	1	1	1	1	1	1		1			9	3
Mt. Rogers			1	1	1	1	1	1		1	1		8	2
New River Valley	1	1	1	1	1	1	1	1	1		1		10	3
Norfolk					1	1	1	1					4	0
Northwestern				1	1	1	1	1	1	1	1		8	2
Piedmont			1	1	1	1	1	1	1	1	1		9	2
Planning District 1	1	1	1	1	1	1	1	1	1	1		1	11	4
Portsmouth				1	1	1	1	1	1	1			7	1
Prince William			1	1	1	1	1	1	1	1	1		9	2
Rapp-Area			1	1	1	1	1	1	1	1	1		9	2
Rapp-Rapidan			1	1	1	1	1	1	1				7	0
Region Ten				1	1	1	1	1		1	1		7	2
Richmond		1	1	1			1	1	1	1	1	1	9	4
Rockbridge Area			1	1	1	1	1	1		1	1		8	2
Southside				1	1	1	1	1		1			6	1
Valley				1	1	1	1	1		1	1		7	2
Virginia Beach			1	1	1	1	1	1	1		1		8	1
Western Tidewater				1			1	1	1		1		5	1
Total	9	11	18	39	38	38	39	38	26	26	18	5		

* Intensive services include (B) Emerg. Services (Designated Children's Service), (C) Crisis Stab., (K) Home-Based Therapy, (L) School-Based Day Treatment, (M) Residential Services

Section VI.

Appendix

Record Review Instrument:

Office of the Inspector General
CSB Child and Adolescent Services Record Review

CSB ☐☐☐ Name of Child ________ OIG Reviewer ________ Date ☐☐-☐☐-☐☐

Service Type Reviewed: ○ Case Management ○ Outpatient Therapy ○ In-Home Therapy ○ Day Treatment

1. Child is: ○ living with natural parents, one parent, relative(s), or adoptive parents
○ living in placement with foster or other surrogate parents
○ other ________________

2. Family-Directed Treatment Planning (review last year)

Review the assessment, annual and quarterly treatment plans, and progress notes for evidence of family involvement in assessing the problems and developing and adjusting the treatment plan. For older adolescents when appropriate, the child's involvement may be stressed more. Treat foster family as family if there is no contact allowed with natural parents.	*Pick one only*
There is little or no record of the family's involvement with the ISP. The assessment and the plan are based on the clinician's or referring agency's view of needs. Family preferences, goals, strengths, and solutions do not strongly influence the plan and if present at all, are an add-on. Focus on family deficits not strengths.	○
There is evidence that the CSB staff member elicited and received input from the family about the plan. The plan shows effort to obtain or include input by the family. There is some statement of family's preferences, goals, strengths, and solutions. Family present at meeting, signs treatment plan. Plan is a shared effort between staff and family.	○
The plan expresses the family's goals, a family-focused plan, with the staff member in a support and resource role. Caregivers are actively involved in the child's treatment. The plans express the family's wishes and preferences and aims at family-strengthening solutions.	○
It is apparent to the OIG inspector that caregiver involvement is impractical, not possible, or clinically irrelevant or inadvisable. Equivalent to "not applicable." Parent behavior makes involvement impossible. CPS referral.	○

3. Holistic Approach - focus on the whole child, in his or her environment (review last year)

Is there evidence of a holistic approach to treatment? Is the child seen as a whole person, in family, school, and community environments, with an overall goal of achieving stability and success in the community, avoiding residential placement, and building life strengths in all areas (behavioral, school, social, family strengthening, health, social network, etc.)	*Pick one only*
Clinical focus is primarily on symptoms and behaviors with little attention to a comprehensive view of the child as a whole person (with health, school, social, family needs and issues). Assessment is piecemeal and symptom-focused, rather than child and family-focused. The goals are for specific behavior change, rather than strength-building for success in the community. A "band aid" approach. A comprehensive assessment tool may be incomplete or partially complete.	○
Clinical focus, assessments, treatment planning, and interventions are more comprehensive than above, but less comprehensive than below. A partially filled-in picture of a whole child and relevant family, school, and community systems is evident, but assessments and interventions are not comprehensive, multi-faceted, and systemic. Some team input.	○
Clinical focus includes a comprehensive, holistic, multi-faceted assessment of the child, with symptoms or behaviors seen in a context of a whole person, who is in family, school, and community systems. Assessments, clinical interventions and goals address health, family, social, and school needs and capabilities. Team input to assessment/plan. A "whole child" approach.	○

4. Interagency - Intersystem Coordination (review last year)

Is there evidence of a coordinated approach to treatment, with consultation, input, involvement, and coordination with family, extended family, referring agency, relevant agencies and systems in the child's life? Include schools, Departments of Social Services, court services units, healthcare, social or recreational organizations, etc.	*Pick one only*
The CSB service operates substantially alone. Minimal consultation or communication. Little to no evidence of collaboration or connection to other services. Focus is on the CSB worker and the child, parents.	○
The CSB service operates *cooperatively* with a few relevant agencies (other CSB services, referral source, dialogue with schools), with appropriate communication and sharing of information, but the service is CSB driven and cooperation is secondary. FAPT process, with some cooperative planning, but still segmented responsibility among agencies.	○
The CSB services are *collaborative* with other key agencies - planned and executed as a team, with harmonious and complementary parts and roles. Frequent, open communication, joint planning, joint or closely collaborated action.	○
Interagency collaboration is not applicable to this service.	○

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Family Agency Contact Interview:

Office of the Inspector General
CSB Adult Child and Adolescent Services Review

Family and Agency Contact Interview

Date ☐☐-☐☐-☐☐ CSB ☐☐☐ Child ____________________

1. Family Contact? ☐ Name ____________________ Phone Number ______________

2. Agency Contact? ☐ Name ____________________ Phone Number ______________

3. Agency Represented:

○ DSS ○ Schools ○ J & D Court ○ Health ○ Other ________

4. **Family or Caregiver Survey**. Indicate respondent's choice by using this scale:
SA= Strongly Agree; A= Agree; D= Disagree; SD= Strongly Disagree; NA= Not Applicable, Not Experienced.
Fill in the bubble of the choice that most closely represents your view.

	SA	A	D	SD	NA
4a. CSB staff members treat my child with dignity and respect.	○	○	○	○	○
4b. CSB staff members speak to my child and me in a way we understand.	○	○	○	○	○
4c. My child and I actively worked with the staff members to develop a treatment plan that accurately addresses my child's current problems, issues and/or behaviors.	○	○	○	○	○
4d. The CSB staff members we work with understand our problems and ask my opinion about what kind of help we want and need.	○	○	○	○	○
4e. The CSB staff member we work with has the skills, knowledge and abilities to help my child.	○	○	○	○	○
4f. The CSB staff member answers or returns my calls in a reasonable time.	○	○	○	○	○
4g. I am satisfied with the amount of time the staff member spends with my child.	○	○	○	○	○
4h. My opinion (whether good or bad) regarding my child's treatment is important to the staff member and is heard.	○	○	○	○	○
4i. We are getting as much help as we need at this time for my child.	○	○	○	○	○
4j. Our staff member is open and honest with us.	○	○	○	○	○
4k. Overall, my child and/or family benefits from the services being provided.	○	○	○	○	○
4l. Overall, I have noticed improvement in the issues and/or behaviors that brought my child into services.	○	○	○	○	○
4m. Overall, I am satisfied with the services that my child is receiving.	○	○	○	○	○

5. **Agency Contact Survey**. Indicate respondent's choice by using this scale:
SA= Strongly Agree; A= Agree; D= Disagree; SD= Strongly Disagree; NA= Not Applicable, Not Experienced.
Fill in the bubble of the choice that most closely represents your view.

	SA	A	D	SD	NA
5a. CSB staff members treat the children they work with with dignity and respect.	○	○	○	○	○
5b. CSB staff members speak to children and family members in a way they understand.	○	○	○	○	○
5c. The CSB staff member involves caregivers in the development of a treatment plan that accurately addresses the child's current problems, issues and/or behaviors.	○	○	○	○	○
5d. The CSB staff member involves me as a collaborating agency in the development of a treatment plan that accurately addresses the child's current problems, issues and/or behaviors.	○	○	○	○	○
5e. The CSB staff member keeps me informed about treatment progress with the child.	○	○	○	○	○

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Staff Interview:

36972

Office of the Inspector General
CSB Adult Child and Adolescent Services Review
Staff Interview

Date [ ][ ]-[ ][ ][ ]-[ ][ ]   CSB [ ][ ][ ]

1. The service in which you work:
○ Case Management ○ Outpatient Therapy ○ In-Home Therapy ○ Day Treatment ○ Other ______________

2. How long have you been employed in your current job, serving essentially same caseload? [ ][ ] years [ ][ ] months

3. How much experience have you had, including this job, in a clinical position with children? [ ][ ] years [ ][ ] months

For case management only:

4. How many children are in your current caseload? [ ][ ][ ] What percentage of a FT position do you spend in CM activities? [ ][ ] %

5. Estimate the percentage of your time each week that is taken up by documentation requirements (paperwork)? [ ][ ] %

Indicate your agreement with the following statements. If a statement is not applicable, leave it blank: SA= Strongly agree; A= Agree; D= Disagree; SD= Strongly disagree.	SA	A	D	SD
My agency stresses and supports extensive interagency coordination and collaboration in my work with children.	○	○	○	○
My agency provides the training I need to be as effective in my job as possible.	○	○	○	○
The expectations placed on me by my agency are clear and consistent.	○	○	○	○
Child services are a high priority of the leadership of my CSB.	○	○	○	○
My caseload is too large for me to do all that I would like to do for the children I serve.	○	○	○	○
The paperwork I must maintain is a burden and it interferes with service provision.	○	○	○	○
Our agency allows families (or surrogate families, if child is in placement) enough choice and self-determination in developing services for their children.	○	○	○	○
My agency has provided me with specific training regarding family-centered services within the past two years.	○	○	○	○
My agency has provided me with specific training regarding Evidence Based Practices for children within the past two years.	○	○	○	○
I am well prepared by training or experience to deal with co-occurring *mental health* and *substance abuse disorders* among the children and families I serve.	○	○	○	○
I am well prepared by training or experience to deal with co-occurring *mental health* and *mental retardation disorders* among the children and families I serve.	○	○	○	○
I am well prepared by training and agency supports to relate to the cultural diversity of my clients (e.g., race, language, etc.)	○	○	○	○
I am well prepared by training and support from my agency to understand and work with the processes of the Comprehensive Services Act for At Risk Youth and Families (CSA).	○	○	○	○
I provide regular reports about the services I provide to the referring, collaborating, and/or funding agency (e.g., DSS, CSA).	○	○	○	○
Other CSA partner agencies (DSS, schools, court services, etc.) are generally open to collaboration and coordination of services to the families I serve.	○	○	○	○
My children's services team has good morale.	○	○	○	○
I receive effective, quality clinical supervision.	○	○	○	○
My job is professionally stimulating and satisfying.	○	○	○	○
I feel safe working out in the community or in the homes of the people I serve.	○	○	○	○

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Stakeholder Interview:

45123

Office of the Inspector General
CSB Adult Child and Adolescent Services Review
Stakeholders Interview

Date [ ][ ]-[ ][ ]-[ ][ ]   CSB [ ][ ][ ]

1. Type of Stakeholder:

O FAPT member O CPMT member O CSA Coordinator O Family Member O Other ________________

2. Agency Represented:

O DSS O Schools O J&D Court O Health O Other________________

3. **Stakeholders survey**. Please use this scale to record your agreement with the following statements:
SA= Strongly Agree; A= Agree; D= Disagree; SD= Strongly Disagree; NA= Not Applicable, not experienced.
Fill in the circle of the choice that most clearly represents your view.

Please respond to the following statements with your degree of agreement.	SA	A	D	SD	NA
a. I am usually satisfied with the results when seeking services from the CSB for children with mental health needs.	O	O	O	O	O
b. My local CSB has state-of-the-art knowledge and expertise about child and family mental health issues.	O	O	O	O	O
c. My local CSB is usually the provider of choice for children who are served by our community's FAPT/CPMT processes.	O	O	O	O	O
d. The CSB collaborates with my agency in jointly planning and providing services to individual children with mental health needs.	O	O	O	O	O
e. The CSB is open to criticism and input about its services from other agencies.	O	O	O	O	O
f. The CSB is a vigorous and effective partner in our local CSA system.	O	O	O	O	O
g. The CSB keeps me informed about the progress of treatment for children that are referred to them by our agency.	O	O	O	O	O
h. Staff at our agency understand the regulations and parameters that guide the CSBs role and services.	O	O	O	O	O
i. Staff at the CSB understand the regulations and parameters that guide our agency's role and services.	O	O	O	O	O
j. The CSB is an effective partner with my agency and the CSA in increasing the availability of mental health services for children and families through grants, contracts, and other means.	O	O	O	O	O
k. CSB services for children involve families in the assessment of needs and the development of treatment plans for their chidren when possible.	O	O	O	O	O
l. The CSB provides services to children and families that reflect Evidence Based Practices.	O	O	O	O	O
m. Overall, CSB mental health services for children have good treatment outcomes.	O	O	O	O	O
n. Access to CSB child mental health services is timely and efficient.	O	O	O	O	O
o. There is a common vision among local agencies about a systems of care model and serving kids in families, rather than in congregate care settings.	O	O	O	O	O
p. The CSB does a good job of explaining its strengths and limitations to our staff and the community of agencies with which I work.	O	O	O	O	O

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Supervisor Interview:

Office of the Inspector General
CSB Child and Adolescent Services Review
Supervisor Interview

CSB: ______________________________*Date:*________________________

1. How long have you been in a position that supervises child and adolescent services at this CSB? _______years
2. How many years of service have you had overall in your career, as a provider or supervisor of clinical service for children and adolescents, including your current job? ______ years
3. What do you do to assure or increase family involvement and family-centered services in your programs?
4. What do you do to assure interagency coordination and collaboration in the provision of your services to children and families?
5. What provision is made for families to reach their case manager, clinician, or other staff that they know and work with when crises occur on evenings or weekends, or staff vacations – or do calls only go to the CSB's emergency services team?
6. What do you do to assess or measure competence in all the skills that direct services staff who work with children and families must have?
7. What do you do to assist children and their families about transitioning from special education or CSA services into mental health, mental retardation, or substance abuse services at your agency?
8. What do you do to measure the quality and customer satisfaction of the child and family services you provide?
9. For your child case management staff, what is the average caseload now? ____What should be the target caseload size for a full time child case manager in Virginia? _____ How many more child case managers do you estimate your CSB needs to adequately meet needs? ____
10. What do you do to prepare child case managers for the roles of program evaluator, service monitor, and advocate – skills they are not likely to have learned in academic training or other jobs.
11. What 2 or 3 services that are not now available in your community would do the most to prevent having to place children in residential programs outside your community?
12. What factors have been most helpful in developing services for children and families in your community?
13. What factors have most hindered the development of services for children and families in your community?
14. For children's SA or MR services supervisors (circle which one you are):
    Assess the CSB's support and priority for developing these services and any special reasons why they have or have not developed.
15. What one or two changes do you think are most needed to improve child and family services in Virginia (try to extend your answers beyond "more money")?

Virginia Child Psychiatry Access Project

The Virginia Child Psychiatry Access Project (VCPAP) is a program that supports and enhances the role of the primary care provider (PCP) in the assessment and treatment of children and adolescents with behavioral health problems. This program is modeled after the highly successful Massachusetts Child Psychiatry Access Project (MCPAP).

Primary care practices in Virginia may participate in the program after receiving an orientation and agreeing to maintain an integral role in the treatment of psychiatric problems of their patients. Participating primary care providers have real-time access to mental health professionals who can provide telephone consultations, and/or arrange to see patients for initial consultations and brief transitional therapy as needed.

Five Regional VCPAP teams will be located in Academic Medical Centers in Northern Virginia, Central Region, Tidewater, Blue Ridge, and Southwest Virginia.

The VCPAP team is comprised of a Medical Director, Team Administrator, Child/Adolescent Psychiatrist, Care Coordinator and Licensed Independent Clinical Social Worker.

PCPs will initially make contact with the VCPAP team by means of a centralized telephone access line.

<u>Additional Information</u>

- The VCPAP team providers are accessible for consultation Monday through Friday, 9am - 5pm
- PCPs will a centralized phone number to access their regional VCPAP team members. The call will be immediately received by either the Case Coordinator or by an Intake Worker. The Care Coordinator will help to determine and facilitate the appropriate consultative services. As needed, the VCPAP child psychiatrist or therapist will be paged immediately. Pages will be answered as soon as possible: either immediately or upon completion of a patient encounter.
- As an outcome of the telephone consultation, the VCPAP provider may offer to see the patient and family directly. The direct services may include
- Diagnostic consultation (child psychiatrist or therapist)

- Assisting the family to access resources in the community (care coordinator or therapist)
- Brief interim therapy to address urgent issues until definitive services are in place (therapist)
- Training events for Primary Care Providers will be organized through faculty at each of the five medical centers (Virginia Treatment Center for Children, Inova Fairfax Hospital for Children, University of Virginia Hospital, Children's Hospital of the Kings Daughters, Virginia Tech/ Carilion Hospital)
- Services are provided regardless of insurance benefits; however, insurance carriers will be billed for face-to-face services as applicable.
- Although VCPAP does not provide direct crisis services, the VCPAP team will consult with PCPs by telephone to provide advice regarding management of behavioral health crises in the primary care setting.
- VCPAP will provide bilingual services for patients and families as needed

Total funding for five VCPAP Team Centers for two years:

$200,000/yr per center = $1,000,000/yr=$2,000,000 total

Funding for the project would include salaries toward each VCPAP Team, to offset costs of consulting (instead of seeing and directly billing patients), and for development and implementation of program infrastructure as well as training for primary care providers.

- Child and Adolescent Psychiatrist at $70,000/yr
- Care Coordinator at $30,000/yr
- Clinical Social Worker at $40,000/yr
- Child Behavioral Therapist at $40,000/yr
- Infrastructure and training curriculum and sessions for PCPs at $20,000/yr

Appendix H

Centers of Excellence: Suggestions for Better Children's Mental Health Delivery in Virginia

The CAMHSCCPT supports the recommendation of the Systems of Care Advisory Team (SOCAT) in their report to the legislature, "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, July1, 2008-June 30, 2009" regarding the creation of three Teaching Centers of Excellence in Virginia (P. 24-25). Such centers would increase education and training opportunities for providers and community service personnel to get to and remain at the leading edge of innovative, evidence-based care that effectively intervenes with children in need of services as early and as thoroughly as possible. The centers would also provide expert assistance through multiple collaborative efforts to the many providers of children's mental health throughout the state of Virginia. Child and adolescent psychiatrists and psychologists are a scarce resource that could be more effectively utilized by these centers. SOCAT suggests Centers of Excellence be partnerships between the three public children's residential acute facilities and their nearby public universities (CCCA and UVA; SWVMHI's adolescent unit and UVA; and VTCC with VCU) together with the Department of Behavioral Health and Developmental Services. Areas of special interest include:

- Developing collaboration models for primary and mental health care providers,
- Educating primary care providers about mental health, developmental, special needs, substance abuse and co-occurring issues by child and adolescent psychiatrists and psychologists,
- Creating overviews and training on specific behavioral health symptoms, diagnoses and treatments as they relate to children and adolescents,
- Developing learning modules about psychopharmacology for providers and community services,
- Delivering trauma-informed care training,
- Promoting the reduction and elimination of seclusion and restraints training throughout children's systems (public, private, residential, day treatment, schools, the justice system), as envisioned by the three year federal study grant ongoing at Commonwealth Center for Children and Adolescents and monitored by the Department of Behavioral Health and Developmental Services,
- Creating protocols for diagnoses and mental health system pathways in Virginia for providers, for community services, and for families so that children are treated earlier as well as more effectively and efficiently,
- Increasing youth peer inclusion and youth peer-driven care,
- Increasing family involvement and family-driven care,
- Developing training regarding privacy laws and issues: HIPPA, HIPPA and substance abuse, state privacy laws, and minor informed consent laws, especially

for multiple providers, as collaborative efforts will multiply the number and complexity of transmissions of protected health information.

Some of the above ideas are further developed in various "Strategies" in the "Chapter Action Kits" located at the American Association of Pediatrics website (especially "Collaborate with Mental Health Providers," (see p. 1235 for Center of Excellence suggestions) "Partner with Child-Serving Agencies," (see pp. 6-29, 6-32, 6-33, 6-39, and 6-46) and "Partner with Families"), http://www.aap.org/mentalhealth/mh2ch.html.

Also useful to consider are: "Improving Mental Health Services in Primary Care: Reducing Administrative and Financial Barriers to Access and Collaboration" (*Pediatrics* 2009; 123; 1248-1251, see the recommendations and conclusions on pp. 1250-1251) and its accompanying background paper, accessible at http://www.aap.org/mentalhealth/. These two papers deal with access, barriers, collaboration, a model protocol, federal and state privacy issues, coding, and insurance, all of which point to a demonstrated need for a better children's system and some of which could be addressed effectively by Centers of Excellence.

The American Academy of Child and Adolescent Psychiatrists (www.aacap.org) discusses rural telepsychiatry for children on its website: http://www.aacap.org/cs/root/developmentor/telepsychiatry. Telepsychiatry, especially for rural children, is already being practiced. Grants could be explored for start-up funding here in Virginia (for example CATCH, Community Access to Child Health).

Community-based services for children and adolescents with behavioral health and developmental disabilities will be greatly enhanced through the development of centers of excellence across Virginia. These centers will work actively with stakeholders across the state to build the workforce capacity to competently serve the needs of children and families.