COMMONWEALTH of VIRGINIA

DEPARTMENT OF
BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES

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July 1, 2010

The Honorable Charles J. Colgan, Chair
Senate Finance Committee
General Assembly Building, Room 317
Richmond, Virginia 23219

Dear Senator Colgan:

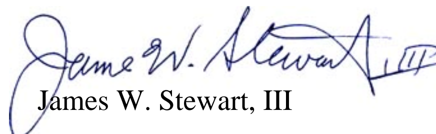
Pursuant to the 2009 *Appropriation Act* Item 315-E, the Department of Behavioral Health and Developmental Services is required to submit a report on *A Policy and Plan to Provide and Improve Access to Mental Health, Mental Retardation and Substance Abuse Services for Children and Adolescents by* June 30 of each year.

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

This report details activities for 2009-2010 to provide and improve access by children and their families to mental health, intellectual disability and substance use disorder services, and includes recommendations for the 2010-2011 fiscal years.

Please contact Janet Lung, Director of the Office of Child and Family Services at janet.lung@dbhds.virginia.gov or (804) 371-2137 if you have any questions regarding the attached report.

Sincerely,



James W. Stewart, III

Cc: The Honorable William A. Hazel Jr., MD
The Honorable R. Edward Houck
Joe Flores
Frank Tetrick
Ruth Anne Walker

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July 1, 2010

The Honorable Lacey E. Putney, Chair
House Appropriations Committee
PO Box 406
Richmond, Virginia 23219

Dear Delegate Putney:

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Please contact Janet Lung, Director of the Office of Child and Family Services at janet.lung@dbhds.virginia.gov or (804) 371-2137 if you have any questions regarding the attached report.

Sincerely,

James W. Stewart, III

Cc: The Honorable William A. Hazel Jr., MD
The Honorable Harvey B. Morgan
Ms. Susan Massart
Frank Tetrick
Ruth Anne Walker

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, 2009- June 30, 2010

to the Chairs of the House Appropriations and Senate Finance Committees

July 1, 2010

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***Appropriation Act* Item 304 D**

I. EXECUTIVE SUMMARY

General Assembly Guidance

Since 2002, the General Assembly approved *Appropriation Act* language (Items 329-G, 330-F, 311-E, and 315-E respectively) directing the Department of Behavioral Health and Developmental Services (DBHDS) to convene stakeholders to study ways to improve access to services for children and their families across disabilities. The language also required DBHDS 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."

To assist in this process, DBHDS convened an interagency workgroup to study children's services and advise it regarding needed changes as well as strategies to implement these changes. The workgroup changed its name several times over the years and in December 2008, adopted the name, the Systems of Care Advisory Team (SOCAT).

Language for the DBHDS report was edited and updated during the 2010 General Assembly Session; consequently, this report to the 2011 General Assembly will be the last one submitted in response to the original budget language.

In June 2009, the Department submitted its seventh consecutive report, *A Policy and Plan to Provide and Improve Access to Mental Health and Substance Abuse Services to Children, Adolescents and Their Families*. That report delineated recommendations to improve access to services for children and their families as well as ways to address unmet service needs, funding, infrastructure, and system issues. This report to the 2011 General

Assembly identifies many of the ongoing concerns and recommendations noted by the workgroup in previous reports.

There has been considerable interest in the children's behavioral health services system over the past 20 years and numerous reports and studies have been generated. In addition to DBHDS, various state executive and legislative agencies generated reports 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), were also asked to study special areas of concern. These reports identified and reported similar findings and concerns regarding Virginia's behavioral health care services for youth, 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 have laid a helpful foundation for ongoing change. Unfortunately, in this era of unprecedented budget concerns, it has been difficult to identify new funds to support service needs. Consequently, Virginia's child-serving systems have become increasingly resourceful and creative in their efforts to address concerns. As Virginia continues its efforts to develop a broader range of services and supports for children and adolescents across the Commonwealth, stakeholders work collaboratively to address unmet needs and ensure that providers have the required skills and knowledge to provide better-coordinated services for children and their families.

DBHDS continues its Transformation Initiative to reform the community behavioral health system by implementing a vision that includes individual- 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.

Two state-directed initiatives, the *Children's Services System Transformation* and *Smart Beginnings*, have emerged in recent years. Both are large, complex, interagency efforts

aimed at changing how services are delivered to children and their families across the Commonwealth. Whereas the *Children's Services System Transformation* has focused primarily on school age youth, *Smart Beginnings* has addressed the needs of early childhood.

This report includes a brief update on the current status of children's behavioral health care in the Commonwealth, recommendations funded by the General Assembly in past years and examples of the creative ways in which Virginia's child serving systems have sought to improve behavioral health care services for children.

Aware of the current budget dilemma, the workgroup identified those efforts most critical to transforming Virginia's behavioral health care services for children with the hope that, once funds do become available, these recommendations will be funded. When funds are available, the workgroup recommends that the following areas be addressed:

1) **Fund community systems of care and increased community service capacity.** Virginia needs to provide a basic array of behavioral health care services for children and adolescents that are available uniformly across the Commonwealth from the least intensive to the most intensive

2) **Fund behavioral heath services in school settings**. Children spend most of their day in school and can be most easily reached in the school setting. Behavioral health professionals need to be on site in schools so that children can continue to learn and are able to remain in their community.

3) **Fund workforce development for child behavioral health professionals.** A comprehensive workforce development program is recommended that would target training to professionals at all levels. This could be accomplished through a partnership between DBHDS and a state university.

4) **Reinstate funding for fellowships to ensure Virginia is able to retain an adequate supply of children's behavioral health care providers**. To the extent possible, fellowships for professions such as psychiatry, psychology, social work and other behavioral disciplines should be made available. There should be an emphasis on fellowships for professionals who will make a commitment to work in rural and underserved areas.

This series of reports has been the first to focus on services for all youth – regardless of their disability, funding source or the system within which they received services – and has involved stakeholders from all of Virginia's youth serving systems as well as, public and private providers and family members. Involving such an extensive cross section of participants enabled members to better understand these different systems and how they interact with another to shape Virginia's services for children and their families. The workgroup strongly believes that interagency coordination has been strengthened through the collaboration of its membership and supports an interagency approach in every aspect of services to children.

II. HISTORY OF GENERAL ASSEMBLY REQUIREMENTS AND REPORTS

The Virginia General Assembly introduced budget language in 2001 which required that the Department of Behavioral Health and Developmental Services (DBHDS) submit an annual report to the legislature regarding a plan for improving access for children and adolescents to behavioral health and developmental services. The following language was in appropriations language from 2001 through 2009.

> *"The Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS), the Department of Medical Assistance Services (DMAS), and the Department of Juvenile Justice Services (DJJ), in cooperation with the Office of Comprehensive Services (OCS), Community Services Boards (CSBs), Courts Service Units (CSUs) 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 costs and sources of the funding for the services, the strengths and weaknesses of the current services delivery system and administrative structure, and recommendations for the improvement. The plan shall examine funding restrictions of the Comprehensive Services Act which impede rural localities from developing local programs for children who are often referred to private and residential treatment facilities for services and make recommendations regarding how rural localities can improve prevention, intervention, and treatment for high-risk children and families, with the goal of broadening treatment options and improving quality and costs effectiveness. The Department of Mental Health, Mental Retardation, and Substance Abuse Services shall report the plan to the Chairmen of the Senate Finance and House Appropriations Committees by June 30th of each year".*

Each year, with the support of an interagency workgroup, DBHDS has submitted a report and recommendations to the General Assembly regarding ways to improve behavioral health services for children[1]. DBHDS convened an extensive workgroup in 2002 to provide input for their first report. The initial workgroup evolved into the Child and Family Behavioral Health Care Planning and Policy Committee (CFBHPPC) and included those organizations specified in the amendment language, additional representatives from public and private stakeholders including the VAFOF, and members from DBHDS pre-existing Child and Adolescent Special Populations Workgroup. In late 2008, the CFBHPPC adopted the name Systems of Care Advisory Team (SOCAT) in order to better reflect their mission of promoting optimal systems of care for children throughout the Commonwealth. Throughout this document the group will be referred to as the workgroup. Since its inception, the workgroup has met monthly to address concerns regarding children's behavioral health. Having been in budget language for almost a decade, this item was edited and updated in the 2011 budget bill. The 2010 *Integrated Policy and Plan to Provide and Improve Access to Mental Health, Mental*

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[1] *For the purpose of this document, the term "children" applies to individual's birth through 17.*

Retardation and Substance Abuse Services for Children, Adolescents and Their Families will be the last report submitted in response to the earlier budget language.

Issues affecting children have been studied and researched extensively in Virginia from a variety of perspectives and numerous recommendations have been made to the General Assembly related to improving services for children. When developing the first Integrated Policy and Plan Report, DBHDS drew on previous reports submitted to the General Assembly including House Document 23, *Final Report of the Commission On Children: Children with Emotional Requiring Out-of-Home Treatment;* the Final Report: Senate Document 25, 2002 *Studying Treatment Options for Offenders Who Have Mental Illness or Substance Abuse Disorders* (2002) and the Secretary of Health and Human Resources*' A Plan for Improving Services and Containing Costs in the Treatment and Care of Children Under the Comprehensive Services Act for At-Risk Children and Families* (2002), as well as the multiple studies and reports referenced in these documents.

These studies and reports provided the Workgroup with a wealth of information on historical developments, geographic and population needs, the cost of implementing services and systemic considerations relevant to the legislations Policy and Plan. In their first report, the Workgroup identified a number of key themes and recommendations that were presented in these earlier documents on child and adolescent behavioral health care:

- Develop a **system of care** for children and adolescents with behavioral health care needs that involve all state and local agencies serving children;
- Establish **service systems that are child-centered, family-driven, community–based, and culturally competent**;
- Build **family support networks**;
- Establish a **child and adolescent office within the DMHMRSAS**;
- Request **funding to build capacity** for consistent services filling identified gaps to include a comprehensive continuum of prevention, early, intervention, and intensive therapeutic services;
- Develop mental health **services for incarcerated children**;
- **Eliminate funding and service silos** by blending and braiding resources;
- Recommend **Code regulatory changes** to support revision and expansion of state and local systems of care;
- **Promote evidence-based and best practices** in services for children with behavioral health disorders; and
- **Conduct statewide training** to build capacity and strengthen system of care values

These same concerns have been reiterated in subsequent reports and documents over the years. Many – but not all – of the numerous documents issued since 1988 regarding Virginia's behavioral health care system for children are identified in Appendix C of this report.

III. Summary of Findings and Concerns Identified in Prior Years

A. Behavioral Health Care Needs of Children

The workgroup sought consensus on how an "ideal" system of mental health, mental retardation and substance abuse services for children and their families should function, what services should be available and identified the following "essential foundation principles:"

- All children in need receive appropriate and timely services;
- There must be significant family and children involvement at all levels of planning, decision-making, and service delivery;
- There must be agency collaboration at state and local levels;
- There must be sufficient and flexible funding for services;
- There must be an adequate amount of services/treatments that are: evidence-based/promising and/or best practices; child-centered; family-driven; culturally competent; strengths-based; and community-based;
- Services must be coordinated and integrated with each other, including behavioral health and health care;
- Services must be individualized and driven by an individualized service plan;
- Preventive and early intervention services must be a central area of emphasis;
- There must be sufficient funding for research on innovative interventions;
- There must be an adequate supply of qualified professionals; and
- There must be seamless access, equity, and efficacy of services.

B. Community Systems of Care

The workgroup has been strongly influenced by the System of Care model and principles; their "essential foundation principles" are very similar to the values and principles of the national System of Care model espoused by the federal Substance Abuse and Mental Health Services Administration (SAMHSA). SAMHSA describes a System of Care as "… a coordinated network of community-based services and supports that are organized to meet the challenges of children and youth with serious mental health needs and their families. Families and youth work in partnership with public and private organizations to design mental health services and supports that are effective, that build on the strengths of individuals, and that address each person's cultural and linguistic needs. A system of care helps children, youth and families function better at home, in school, in the community and throughout life."[2]

Systems of Care is not a program — rather it is a philosophy of how care should be delivered. Because a serious emotional disturbance touches every part of a child's life, children and adolescents with serious emotional disturbances and their families require many kinds of services from a variety of sources, such as schools, community mental health centers, and social service organizations. The Systems of Care approach recognizes

[2] SAMHSA website, June 2010

the importance of family, school and community, and seeks to promote the full potential of every child by addressing their physical, emotional, intellectual, cultural and social needs.

The core values and principles of the Systems of Care model specify that services be:

- Community based;
- Child-centered and family-focused;
- Culturally competent (i.e., provided in the appropriate cultural context and without discrimination related to race, national origin, income level, religion, gender, sexual orientation, age, or physical disability);
- Be based on the needs of the child and their family;
- Promote partnerships between families and professionals;
- Involve collaboration between multiple agencies and service sectors;
- Involve provision of individualized supports and services based on strengths and needs in multiple domains;
- Promote culturally responsive supports and services; and
- Include a system of ongoing evaluation.

Virginia's Office of Comprehensive Services (OCS) subscribes to the System of Care model and seeks to provide treatment and coordinate services for the children and families served through the Comprehensive Services Act (CSA) in accordance with the System of Care values and principles. Unfortunately many Virginia communities lack necessary treatment and service components – thus making it difficult to provide needed services. Those children in need of services but who are not eligible to receive services through CSA or another form of third party reimbursement often have even greater difficulty accessing services in their communities.

C. Status of Virginia's Behavioral Health Care Services for Children

When developing DBHDS' report to the 2006 General Assembly, the workgroup looked at three recent studies (i.e., The Child and Adolescent Special Population Workgroup Report, the Custody Relinquishment Committee Report, and the 2004 329-G Report). Based on these and other studies they observed that, although there had been much interest in and awareness of the significant problems in Virginia's children's behavioral health services system, many of the challenges noted in these studies had continued and needed to be addressed in order to transform services for children and their families. The workgroup identified and addressed the following problems in Virginia's behavioral health service system for children:

1) Lack of service capacity.
2) Lack of access to care.
3) Lack of a full continuum of community based care.
4) Lack of service integration.
5) Lack of knowledge and information.
6) Lack of family involvement.
7) Lack of comprehensive quality standards and minimum competencies.

8) Lack of evidence-based treatments.

Although many communities have improved their services since the 2006 report; these problems remain unresolved statewide. In recent years, the state budget crisis has made it difficult to fund new or enhance existing services. Unable to allocate new funds, the legislature has, nevertheless, sought to minimize reductions and maintain existing children's services.

1. **<u>Lack of service capacity</u>.** The greatest deficit identified in Virginia's children's behavioral health service system has been the lack of service capacity. Not only are services unavailable in many areas but almost every community in the Commonwealth still lacks a full continuum of services (from the most intensive to the least intensive) for children. Without a continuum of care, there is no continuity of care for children in which children can step down to a lower level of care when they are ready – and, if needed, step up to higher levels of care – that are the least restrictive for them. Due to the lack of sufficient capacity of intermediate-level community-based services in their home communities, children and adolescents continue to be placed in services that are either less intensive or more restrictive than they require. Although improvements have occurred in individual communities through the Children's Transformation efforts, there remains considerable variation in services across communities. This variation means that children are not able to access the same continuum of services in all communities and, when families move, they may not be able to continue to access the same type of services their child previously received.

The most recent efforts to identify Virginia's service gaps have been CSA's 2009 Critical Service Gap Survey and the Office of the Inspector General (OIG's) 2007 Survey of Community Service Boards (CSBs) Child and Adolescent Services. Each year since 2007, CSA has surveyed communities to identify critical service gaps for children. The CSA survey identifies regional differences and statewide gaps as well as barriers that have prevented communities from developing needed services. The 4 most significant gaps identified in CSA's 2009 survey[3] were the lack of:

1) crisis intervention and stabilization services
2) intensive substance abuse services
3) emergency shelter care
4) acute psychiatric hospitalization services

[3] *FYO 9 Critical Service Gaps, Office of Comprehensive Service, January 29, 2010* (PowerPoint presentation, CSA website)

CSA Critical Needs Service Gaps[4]	2007	2008	20009
Crisis services	#1	#1	#1
Intensive substance abuse services	#6	#2	#2
Emergency shelter care	#14	#20	#3
Acute Psychiatric Hospitalization	#19	#21	#4

CSA has suggested that the increasing gaps reported for crisis, family and outpatient behavioral heath services appear to be a function of seeking to serve children with more severe needs within community settings[5]. The CSA survey also asks communities to identify any new services they may have introduced. Of the communities surveyed in 2009, 80% reported that they had introduced new services. As a result of local needs and changes in the match rates, the most commonly reported new services from the FY09 survey included:

- Therapeutic Foster Care services
- School based Mental Health Day Treatment
- Intensive In-home Services
- Regular Foster Care/Family Care services
- Intensive Care Coordinator services

Introducing shelter care, acute psychiatric hospitalization services, crisis stabilization or residential substance use programs for youth within communities are complicated and expensive undertakings. While intensive outpatient substance abuse services for adolescents may appear to be easier to introduce, these services also require new funds for staff and to cover start up expenses.

2. Lack of access to care. Families in both rural and urban areas continue to have difficulty obtaining needed behavioral health services for their children. Although all CSBs are required to provide crisis services and case management services to children, according to the Office of the Inspector General's (OIG) report, less than half of the CSBs reported that they were able to provide adequate capacity for case management services for children and 11 boards (27.5%) failed to offer case management services for youth who had a substance use problem.[6]

[4] ibid
[5] Ibid.
[6] *Survey of Community Services Board Child and Adolescent Services, October 2007 Report # 14807*, (3/31/08)

Survey of Community Children's Services[7]				
	CSB Services			**Private Services**
Children's Case Management Services	Not offered by CSB	Offered by CSB; Capacity adequate	Offered; capacity not adequate	
Mental Health	2	21	16	
Mental Retardation	2	18	15	2
Substance Abuse	11	12	13	1

Many communities – both urban and rural - are still not able to guarantee minimum services (i.e., individual therapy, family therapy and medication management) for children and their families. Families in crisis continue to experience significant waiting periods before they are able to access outpatient services and may only receive the help they need if their child is acutely hospitalized because he is in imminent danger to themselves or others. Even when children are discharged from a hospital, families face long waits before they can access services in their communities or may discover that recommended services are not available in their community. Each year since CSA initiated their Critical Service Gaps Survey in 2007, the lack of crisis and stabilization services has been identified as the #1 service gap for children across the Commonwealth. Last year, acute psychiatric hospitalization ranked as the 4th most significant service gap – up from the #21 in 2008 and #19 in 2007.

3. <u>Lack of a full continuum of services</u>. Children and adolescents in Virginia with serious emotional disturbances are at increased risk of out-of-home placements due to the lack of consistent, integrated community-based services in the areas where they live. These children often require intensive therapeutic interventions, parental support, medications, the involvement of multiple agencies, short-term inpatient hospitalizations, and long-term residential treatment to address their pervasive problems. Untreated, these children require the most intensive and costly services over their lifespan.

The workgroup identified an ideal continuum of care for children which they included in their report to the 2006 General Assembly. This array was divided into those services and treatments that can be provided while a child is in the home (or a home-like environment), those provided in out-of-home services as well as the service supports and essential supportive services necessary to meet the specialized needs of children. Although a child or adolescent will only utilize those services within the array that best fit his or her particular needs, communities must provide access to the full service array in order to adequately meet the mental health, mental retardation and substance abuse service needs of the children and families they serve.

[7] ibid

Community Services	Out-of-Home/Residential
Prevention	Therapeutic Foster care
Early Intervention/Intervention	Therapeutic Group Care
Crisis /Emergency	Therapeutic Camp
Assessment	Independent Living
Outpatient Treatment	Crisis Residential
Intermediate Care	Inpatient Hospitalization
Home-Based Services	
Day Treatment	
Family Support	
Service Supports	
Case management/care coordination	Health Care and Medical Services
Family training, counseling , home visits	Nutritional Services
Respite Care	Occupational and Physical Therapy
	Speech language pathology
Supportive Services	
Transportation	Self help groups
Legal services	Advocacy

Effective care coordination is an essential service in the continuum of care and is necessary to ensure the child and family's easy and efficient navigation of behavioral health and developmental services. For this reason, case management is a required service at each community services board. As previously noted, however, not all boards are able to provide this service for all children who have a mental health, substance use or intellectual disability. Intermediate care includes services such as afterschool intervention; school based mental health services; drop-in centers for emotionally and behaviorally troubled teens and other wrap around services.

Based on the needs of their community, funding and other variables, the community service boards offer different levels and intensities of services. While some boards are able to offer or provide access to an array of the services on this list, the majority do not.

4. Lack of service integration. In recent years there have been significant efforts in Virginia to develop systems of care for children and adolescents as well as systems of care for infants and children 0-5; nevertheless, services for children continue to be fragmented. Not only are services not coordinated between child serving agencies and systems but these systems don't effectively address the natural transitions as children age from one system to the next. Virginia needs a coordinated approach that provides seamless services for children across agencies and systems as they age from early childhood to school age to young adulthood. When appropriate behavioral health services provided by qualified professional staff are not available, other systems e.g. health care, schools and juvenile justice are left to cope with troubled children.

All children interface with the education and health care system yet children's behavioral health care needs are often poorly coordinated or not coordinated at all within these systems. Although behavioral and emotional problems are often first recognized in school, Virginia's school systems are ill prepared to deal with children with serious emotional disorders. Relatively few Virginia schools have school-based mental health services or Student Assistance Programs that enable children with psychiatric or behavioral health disorders to remain in school and continue their education. Similarly, primary care physicians are often the first professionals to evaluate and prescribe medications for children with a behavioral health disorders; yet many lack the training to conduct these specialized evaluations.

When behavioral health services are not provided, or are inadequately provided, many children with such problems end up in the juvenile justice system. It is estimated that 50-80% of children involved in Virginia's juvenile justice system have a mental health and/or substance abuse disorder. Although behavioral health assessments and short-term treatment services are now available for all children in Virginia's detention centers, the necessary follow-up services may not be available to youth after they are discharged and return to their home community.

5. Lack of knowledge and information. Families who are seeking services for their children often do not know where to find services or how to go about accessing them. As noted earlier, behavioral health services vary from community to community, and are often fragmented and poorly coordinated within communities. Communities need to develop ways to reach, educate and inform families regarding available services and how to access them. One popular option has been to develop resource directories; however, without ongoing funding and staff to update them, directories quickly become outdated as services change. Directories are also limited in terms of the type of help they can provide. When seeking services for a child – especially one in need of intensive services - families need information as well as support and guidance as they grapple with difficult decisions. The Virginia Federation of Families (VAFOF) is one support organization which has evolved in recent years in response to families' needs. One of the services the VAFOF provides is individualized one-on-one resource/service coordination for parents and family members to help them develop the necessary skills and knowledge to navigate Virginia's system of care and advocate for their child's personal needs and obtain services. Due to its limited funding, however, VAFOF has only been able to serve 20 to 30 families and professionals each month – just a fraction of the families in need of such services.

6. Lack of family involvement. Transforming Virginia's behavioral health system requires the participation of families in the design, administration and delivery of behavioral health services for children and adolescents. In recent years, Virginia's service systems have placed greater emphasis on including families in decision making but have had limited success engaging families and youth. Few family members participate and, far too often, the same individuals are called upon to represent families. Without funding and concerted efforts to actively identify, recruit and engage affected children and families it has been difficult to obtain more extensive representation and ensure a variety of perspectives.

7. Lack of comprehensive quality standards and minimum competencies. Although Virginia has established quality standards for regulated children's psychiatric inpatient and residential facilities, the Commonwealth still lacks standards for non-facility community-based services. As a result, the nature and quality of services for children varies greatly across communities. All communities would benefit from minimum quality behavioral health service standards.

In 2008 the General Assembly required that the State Executive Council (SEC) oversee the development and implementation of mandatory uniform guidelines for intensive care coordination (ICC), a new CSA reimbursable service 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 is 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. Developing ICC standards and providing ICC training has greatly improved effective implementation of this service. Establishing comprehensive quality standards and minimum competencies for other services and providing necessary training would significantly reduce the variations that currently exist in services.

8. Lack of evidence-based programs and practices. Evidence-based programs (EBPs) and practices are services which, through repeated research, have been found to be effective in treating certain disorders. EBPs reflect state-of-the-art practice in many fields including behavioral health. Their use does not preclude the use of other treatments, such as those that have been designated as "promising", but they do provide the best-known possible treatment for particular problems at present. Not all behavioral health disorders have EBPs, but for those that do, consideration should be given to using EBPs.

Knowledge transfer and effective implementation of evidence based treatments and programs can be a costly and lengthy process. EBPs are effective only when applied to the population they are intended for and when replicated with fidelity. Not only must programs carefully weigh whether the selected EBP is appropriate for the population they serve, they also need to determine if they have the necessary staff, resources and support to implement and sustain the EBP and to assess and evaluate the fidelity of their implementation efforts. For implementation to be successful, staff must receive the appropriate training (both initially and on an ongoing basis), coaching, and supervision as well as frequent performance assessments. Organizations must also be able to provide the necessary infrastructure to support these services. For example, EBP implementation may require that programs reorganize their staff and how they deliver services. The cost of implementation involves not just training but supervision, ongoing licensure fees, manuals, evaluation expenses etc. To ensure effective implementation, communities and consumers need to be involved in the selection and evaluation of programs and practices. It is also critical that state and federal funding streams, policies and regulations support implementation and program operations.

In recent years DBHDS and other stakeholders have encouraged the adoption of EBPs and sought to educate providers regarding EBP selection and implementation. Although

Virginia providers are now more aware of EBPs and are eager to adopt them, many lack the funding necessary to implement and sustain such programs.

IV. SUMMARY OF RECOMMENDATIONS MADE TO THE GENERAL ASSEMBLY: 2003 through 2010

Over the years, this report has provided a number of recommendations to the General Assembly that address the continuum of available services as well as ways to improve access to services by children and their families. Some of these recommendations have been supported and funded by the General Assembly. Among the recommendations that failed to receive funding are a number of critical initiatives that the workgroup chose to include again in subsequent years. The following chart identifies the recommendations that were funded as well as those that were resubmitted in the hopes that funding would be available . A more complete list of the workgroups previous recommendations is available in Appendix F. Updates on the funded initiatives are available in Appendix H.

Recommendations Supported by General Assembly	**Funding Allocated**
Develop an Office of Child and Family Services within DBHDS	(No new funding)
Fund Mental Health Services in Juvenile Detention Centers	$2,040,000
Fund System of Care Demonstration Projects (4 sites)	$4,000,000
Fund Psychiatry and Psychology Fellowships (8 fellowships) (these funds were cut in SFY 2010)	$ 493,000
Recurrent Recommendations to the General Assembly	
Fund Mental Health Services in Schools	
Fund Additional Systems of Care Projects	
Fund Community based Intermediate Level Services for Children	
Fund Work Force Development	
Fund Family Support Network	
Reinstate funding for Psychiatry and Psychology fellowships	

The General Assembly has supported several other important initiatives related to children's services. In response to the Virginia Tech tragedy, the 2008 General Assembly allocated additional funds to improve Virginia's mental health system - including funds for mental health services for children. Funds were made available July 1, 2008 to support one new child and/or adolescent position at each CSB and the boards were allowed to design the position to meet their respective needs.

The 2008 General Assembly also 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 who are placed in, residential care through the Comprehensive Services Act (CSA) program. Although the General Assembly was not able to identify additional funds during the 2009 session to support workforce development, it directed CSA to develop and maintain an interagency training calendar.

V. BEHAVIORAL HEALTH ACCOMPLISHMENTS THAT DID NOT INVOLVE NEW STATE FUNDING

KNOWLEDGE AND SKILLS: Work Force Development

While state funding has not been made available for workforce development and training, workforce development has consistently been recognized as a critical component of improving services for children. DBHDS has relied heavily on federal grants and programs to fill some of this pressing need. The following are some initiatives that have been supported by federal funding.

- **Systems of Care and Evidence Based Practices**
  - **Conference Systems of Care-** held in March 2005, the conference had over 200 participants
  - **Conference Systems of Care and Evidence-Based Practices** - held in September 2007, the conference had over 600 participants
  - **Conference- Tools that Work for Children and Families: What Families and Professionals Need to Know –** held in May 2010 and attended by 100+ professionals and family members.
  - The ***Collection of Evidence-Based Treatment Modalities for Children and Adolescents with Mental Health Needs*.** The Virginia Commission on Children is revising and will soon publish the 4th edition of this guidance document,
- **Intensive Care Coordination** – a series of five workforce development meetings focused on the development of intensive care coordination services was held in 2009. These are continuing in 2010.
- **Children involved with the Juvenile Justice system** – workforce development for staff involved with the programs in juvenile detention centers have been held in each region of the state. The federal funding has helped to develop this initiative. The state funding for the programs does not include training.
- **Children with co-occurring mental health and substance abuse disorders** – the federal Co-Occurring State Incentive Grant was instrumental in improving integrated services for children with co-occurring services and their families.
- **Family Focus groups and Family Survey** – these activities help to inform professional and others about what families need and what their perspective is.
- **Training regarding Adolescent Substance Abuse Treatment** – Project TREAT, DBHDS's federal State Adolescent Coordination (SAC) grant, supported a 4 year effort to enhance provider's knowledge and skills regarding the treatment of adolescents with a substance use or co-occurring substance use and mental health disorder. The SAC grant funded EBP implementation at 16 CSBs; supported speakers at numerous conferences i.e., the Virginia Association for Community Service Boards (VACSB) Conference, the Commission on Youth and DBHDS System of Care/ Evidence Based Practice Conference, and the DBHDS Transformation Conference and funded the following training activities:
  - **Adolescent Evidence Based Practices: Knowledge Exposure Trainings** - eight regional trainings provided at "no cost" to 469 public and private adolescent treatment providers.

- **American Society of Addiction Medicine (ASAM) Adolescent Patient Placement Criteria** – three 2-day regional trainings provided at "no cost" to 273 public and private adolescent treatment providers.
- **Adolescent Track at the Virginia Summer Institute for Addiction Studies (VSIAS)** – TREAT staff developed and supported VSIAS's Adolescent Track from 2006 through 2009. The grant funded 227 VSIAS scholarships for adolescent treatment providers across systems
- **Person Centered Screening and Assessment For Co-occurring Disorders in Adolescents and Adults** Project TREAT and DBHDS Co-Occurring State Incentive Grant co-sponsored a 2-day conference in September 2008; 320 individuals participated and an additional 25 were waitlisted.

FAMILY INVOLVEMENT AND SUPPORT

Family involvement and support are important components of the system of care. Families are the experts on their children and must be empowered to be actively involved in all aspects of their child's care. When families are involved and part of the planning and implementation of their child's care, outcomes are improved. Families are able to access services more promptly, funding is used more efficiently and least restrictive environments are more likely to be used, best practices and evidence-based practices are implemented and the child is served in the most appropriate way.

Though no state funding is appropriated for family support, DBHDS, through the federal Community Mental Health Services Block Grant, funds the Virginia Federation of Families (VAFOF). Federation of Families is a statewide, family-run program of Mental Health America Virginia that provides support and education to assist families.

Families who have children with behavioral health needs require support services within their communities. Families benefit from support and guidance during stressful times and need to know who to contact when questions arise. DBHDS supports information and support resource to help families navigate through the behavioral health system in Virginia through the VAFOF.

The availability of family services and interventions rely heavily on local community resources; as a result, family support services vary considerably by locality. Although some families may benefit from funding provided by Medicaid or the Comprehensive Services Act, many children and their families are not eligible to receive Medicaid or CSA supported services. Therefore, family support is an invaluable asset to families seeking help.

VAFOF serves families of children and adolescents who have special health care needs, particularly those with mental health, 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 serves 20 to 30 families and/or professionals each month.

The VAFOF participates on many state interagency entities to represent the needs and viewpoints of children, children and their families. It assists and supports the formation of local Federation of Families 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.

During the summer and fall of 2009, the DBHDS and the Federation of Families hosted several family focus groups to gather information from families related to service needs. These focus groups were the second step in a process that began with a family needs survey distributed in May 2009. The survey received 169 responses and a total of 39 family members attended the focus group sessions. For a summary of comments from the survey and the focus groups, please see Appendix H. Information gained from the survey and the focus groups is being used to define the future direction for family involvement initiatives.

Services Provided by Virginia's Federation of Families

- Resource and service coordination support for families
- Family survey and focus groups
- Strong Roots for a Healthy Future—this is an annual conference sponsored by DBHDS, Medical Home Plus, VA-FOF, and the Capital Area Health Education Center.
- Represent the voice of parents on commissions, councils, committees, taskforces, and workgroups.

SERVICE INTEGRATION

A. Children's Services System Transformation

Between 2007 and the present, 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 children leaving foster care without a permanent home to go to, as well as contain CSA's escalating costs. The *Children's Transformation* efforts initially involved the Department of Social Services (DSS), CSA and DBHDS at both the state and local level. In its first phase the initiative was known as the Council on Reform (CORE) and involved thirteen communities which had been selected to serve as pilot sites with four common goals:

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

As of January 2009, the *Transformation* focused on expanding the success with the thirteen CORE localities statewide. Major accomplishments included:

- Development and promotion of a statewide **practice model**.
- A series of **regional input forums** in which communities were invited to hear about the transformation practice model and to share their input on local needs.
- An **Executive Team** with key staff from each of the child-serving agencies met twice each month to collaborate and guide the transformation activities.
- Development of a website at www.vafamilyconnections.com
- The **Governor's Conference on Children's Services System Transformation** was held on December 16 and 17, 2009. The conference had over 600 participants, including direct service providers, state agency staff, legislators and Executive Branch officials.
- **"Agents of Change" leadership development program –** two regional and one state cohort of children's services staff participated in this program which was funded and provided by the Annie E. Casey Foundation. This program is described in more detail below.

The Virginia Agents of Change Program is a targeted leadership development program for current and emerging leaders in the field of children's services. It was designed for state and local leaders who demonstrated leadership and commitment to furthering the goals of the Transformation and who want to provide collaborative leadership to improve the way we help at-risk children and their families to achieve;

- success in life;
- safety for children and communities;
- life in the community;
- family based placements; and
- life-long family connections.

The Agents of Change Leadership Program sought to accelerate the achievement of the Children's Transformation goals by creating and strengthening leaders at the state and local level who would lead efforts to improve outcomes for children and families in Virginia. Developed in collaboration with the Annie E. Casey Foundation, the program consisted of 5 two-day seminars, offered over six months from January-June 2010. Participants included forty individuals, representing 2 local clusters across the Commonwealth, and a state cohort of 20 professionals, selected from agencies supporting the Transformation. State agencies include: DBHDS, DJJ, DOE, DSS, OCS and the Supreme Court of Virginia. Participants were helped to:

- Increase their understanding regarding leadership and how they could provide leadership to produce improved results in their agencies for children and their families
- Gain greater confidence in their own leadership skills
- Master a set of tools/competencies that would enhance their ability to lead effectively and produce improved results
- Develop their ability to collaboratively lead in the service of achieving results.

B. Early Childhood Efforts

The Virginia early childhood system recognizes that many problems can be prevented if social-emotional development during infancy and early childhood is understood and fostered and if programs and services that support children and their families are available. Factors which put children at risk for a mental disorder include violence, intense marital discord, maternal psychiatric disorder, poverty, abuse, and neglect. When at-risk children are identified early, intervention and support can lead to better outcomes in terms of the emotional well being of the child (*Mental Health America of Indiana, 2007*). Virginia expanded its statewide strategic plan (*Virginia's Plan for Smart Beginnings*) for children birth through age five and their families to include infant and child mental health and social-emotional development.

Both the Infant and Child Mental Health Committee (ICMHC) and the Home Visiting Consortium (HVC) have adopted use of the *Pyramid Model* to guide system change for Virginia's early childhood social-emotional and behavioral health supports and services. The Pyramid Model builds upon a tiered public health approach to providing universal supports to all children to promote wellness; targeted services to those who need more support; and intensive services to those who are greatest risk. The "foundation" for the practices in the Pyramid are the systems and policies necessary to ensure a workforce able to adopt and sustain these evidence-based practices. The Pyramid Model recommends that "Universal supports" are provided for all children through nurturing and responsive relationships and high quality environments. "Prevention," the next step on the pyramid, represents those social emotional strategies targeted to prevent problems. The top of the pyramid "Intervention" is comprised of practices related to intensive interventions for individuals in need of services.

The ***Infant and Child Mental Health Committee of Virginia*** (ICMHC) was formed to implement the social-emotional and mental health goals, outcomes and strategies outlined in Goal Four of *Virginia's Plan for Smart Beginning* and to develop a comprehensive system of care for infant and child mental health services for children through 5 years of age and their families/caregivers. The ICMHC members include representatives from Virginia's Departments of Health, Education, Social Services, Medical Assistance Services, and Behavioral Health and Developmental Services; other early childhood agencies (including Head Start) at the state and local level; universities; mental health professionals and parents. Working collaboratively with the System of Care Advisory Team (SOCAT), it was determined that there was no other Virginia entity that focused specifically on the social-emotional and/or behavioral health needs unique to children birth through age five and their families. To ensure efforts to create seamless and efficient service delivery systems, strengthen intervention efforts, and strategize over initiatives, practices, partnerships and policies members of the ICMHC and SOCAT became active members in each others' committees.

The ICMHC seeks to develop a system of care for children 0 -5 and their families which:

- Engages parents as partners;
- Provides high quality supports and services to families;

- Is grounded in developmental knowledge;
- Includes family and child centered practice and policy;
- Includes cultural and linguistic competence;
- Is infused into natural settings and services;
- Is relationship-based;
- Utilizes evidence-based practices;
- Is linked to the substance abuse system, domestic violence services and programs and the court system;
- Assures comprehensive mental health services for infants and toddlers in foster care; and
- Assures comprehensive services to the highest risk/most vulnerable infants and young children and their families in Virginia.

The ICMHC is seeking to implement a “competency-based endorsement system” to ensure that early childhood behavioral health providers are qualified to work with this very young population. They plan to purchase a license agreement to use Michigan’s competencies which provide best practice standards for professionals working with or on behalf of very young children and their families. Utilizing “one-time funds” from DBHDS’ Infant & Toddler Connection of Virginia, the ICMHC will develop an endorsement system that will verify that an applicant has attained the required level of education, participated in ongoing specialized in-service trainings, worked with guidance from mentors or supervisors and acquired knowledge to promote the delivery of high quality, culturally sensitive, relationship-focused services to infants, toddlers, preschoolers, parents, other caregivers and families. Once this endorsement system is in place, the ICMHC plans to establish a network of endorsed Early Childhood Mental Health Consultants that will be available to Virginia agencies, physicians and childcare providers that work with children birth through five and their families. This will be the first step in assisting Virginia to build a pool of qualified professionals (capacity) by developing an endorsement system to identify them.

Virginia’s Home Visiting Consortium (HVC) is a collaboration of 8 statewide early childhood home visiting programs that serve families of children from pregnancy through age 5. Like the ICMHC, the Consortium reports to the Early Childhood Advisory Council and is a partner in Virginia’s Plan for Smart Beginnings. The HVC consists of the State Coordinators for Healthy Families (Stop Child Abuse Now); Project LINK (DBHDS); Part C Early Intervention (DBHDS) ; the Resources Mothers Program (VDH); Virginia Healthy Start /Loving Steps (VDH); the Comprehensive Home Investment Project (CHIP) of Virginia ; Early Head Start/Head Start (DOE); Early Childhood Special Education (ECSE); Baby Care (DMAS) and Virginia Medicaid Managed Care (DMAS). The mission of the HVC is *“To ensure that children grow up healthy and ready to learn by reaching all children and their families where they live.”*

The Consortium has been meeting since 2006 to identify ways to improve the quality, efficiency and effectiveness of early childhood home visiting services in Virginia through interagency collaboration and has focused on five areas:

- State policies and procedures;

- Technical assistance to local coalitions and communities;
- Core training for all early childhood home visitors;
- Interagency efforts to improve screening, data collection and evaluation processes; and,
- Collaborative programs with medical providers and child care providers.

The HVC believes that program efficiency and effectiveness can be increased through quality supervision and well-trained staff. They have identified 12 core trainings for all home visitors, as well as 9 additional trainings that include enrichment topics and supervisor training. The HVC partners have utilized their collective resources to ensure that all Virginia early childhood home visitors are trained on the core topics - either through webinars or face-to-face sessions - by the end of 2011 and have provided funding and/or resources to make this happen. The VDH has partnered with James Madison University to develop and offer trainings for home visitors and to create a website (http://homevisitingva.com) to keep them informed regarding training opportunities and initiatives.

ACCESS

In December 2009, statewide advocates made a concerted effort to make mental health services more available and accessible to the children in Virginia who need them. In April and May of 2010, the same advocates co-sponsored a series of regional forums on children's mental health. The purpose of the forums was to hear from stakeholders about their concerns and ideas and engage citizens. The information gathered in the forums will be used to shape the advocacy community's future policy recommendations.

QUALITY STANDARDS

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 who 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 and developed the following products:

- Development of a Toolkit for Intensive Care Coordinators that is posted on the Department of Behavioral Health and Developmental Services (DBHDS) 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 DBHDS 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 thirty CSBs offer ICC services and ten of these have more than one ICC position. Per the CSA dataset 194 children received ICC services for FY09.

Also in 2009, DBHDS and OCS collaborated to facilitate five ICC Network meetings. The average attendance at these meetings was 41 participants. While most of the participants at these meetings have been Intensive Care Coordinators and their supervisors, there has been some participation by CSA Coordinators, FAPT and CPMT members. A popular agenda item at these meetings is the sharing of case studies as a way for different localities to share and learn from each other's experiences. In addition to the ICC Network meetings, the DBHDS and the OCS facilitated an ICC Learning Forum in March 2010. This forum was designed to build competency around the development of community-based wraparound services to support ICC. It was very well received with 47 participants present. Intensive Care Coordinators worked in teams composed of at least one CSA team representative and one private provider to discuss challenges and strategies related to the development of services. Four more learning forums are planned for summer 2010.

EVIDENCE BASED PRACTICES

Implementation of Evidence Based Programs and Practices for Substance Using Youth

Research indicates that substance use disorders begin during adolescence and that children require specialized substance abuse treatment services based on their developmental needs. DBHDS applied for and received a 3-year ($1.2 million dollar) Substance Abuse

Coordination (SAC) grant in 2005 from the Substance Abuse and Mental Health Services Administration (SAMHSA) to develop and improve the coordination of substance abuse treatment for adolescents across the Commonwealth. Project TREAT (Training and Resources for Effective Adolescent Treatment) funded an Adolescent Coordinator and Adolescent Trainer, an interagency collaboration process, and workforce development efforts in an effort to create a system of care across agencies that supported services for adolescents with a substance use or co-occurring substance use and mental health disorders. A major focus of the SAC grant was to address workforce development and funds were set aside to support education and training activities for CSB staff and adolescent providers across Virginia's other children serving systems. Funding provided by Project TREAT enabled DBHDS to offer affordable, easily accessible, intensive, high quality behavioral health training for adolescent providers. When the grant ended in July 2009 Virginia lost a valuable training resource.

In addition to the education and training activities previously noted, Project TREAT provided specialized technical assistance and training funds to 16 community service boards to help them implement EBPs for substance using children. OCFS' Project TREAT staff helped each of the 16 boards select an EBP that was appropriate to their needs, staffing and resources; identify a skill development training process as well as an implementation process adapted to their system. Project TREAT funding supported both initial and follow-up training, required licensure fees and training materials for each CSB. When Project TREAT funding ended in July 2009, 16 boards had successfully implemented and were providing the following EBPs:

EBP Technical Assistance and Funding Supported by Project TREAT

Seven Challenges
1. Alexandria Community Service Board
2. Chesterfield Community Service Board
3.Virginia Beach Community Service Board
Dialectical Behavior Treatment (DBT)
4. Central Virginia Community Service Board
5. Blue Ridge Behavioral Health Care
6. New River Valley Community Service Board
Motivation Enhancement Therapy/Cognitive Behavioral Treatment (MET/CBT 5)
7. Eastern Shore Community Service Board
8. Richmond Behavioral Health Care
9. Piedmont Community Service Board
10. Rappahannock- Rapidan Community Service Board
11.Portsmouth Community Service Board
Motivational Interviewing (MI)
12. Mt Rogers Community Service Board
13. Planning District 1 Community Service Board
14. Colonial Community Service Board 15. Rockbridge Community Service Board
16. Henrico Community Service Board

The developers of the Seven Challenges were so impressed by Virginia Beach CSB's success implementing the Seven Challenges Program that they recommended the CSB present on their efforts at the 2010 National Joint Meeting on Adolescent Treatment Effectiveness (JMATE) Conference which will be held in December 2010.

The Project TREAT grant also supported EBP implementation initiatives within the Department of Juvenile Justice (DJJ) and the Department of Education (DOE).

- **Motivational Interviewing (MI) Training** - in partnership with the Mid-Atlantic Addiction Technology Center (ATTC), Project TREAT coordinated and funded MI training for 30 DJJ staff in 2007 and provided refresher training for the same staff the following year.

- **Student Assistance Programs -** Project TREAT helped fund 5 regional trainings in 2008 on implementing Student Assistance Programs; 183 individuals participated in these trainings.

Education and training is an ongoing need as new staff enter the field, programs experience staff turn over, and new research influences treatment theory. For the past three years DBHDS and its partners have sponsored conferences which have addressed the Systems of Care model as well as the implementation of evidence based programs and practices. As a result of these efforts, Virginia's programs and providers are now better educated regarding EBPs, and the merits of implementing them but lack the necessary support, funding and resources to train staff and implement new services. While there is greater interest and concern about developing Virginia's workforce, the lack of funding to support training across our youth serving systems is a major concern. A major challenge for Virginia in these difficult economic times will be to identify resources to support ongoing training for behavioral health care staff.

Substance Use Screening and Brief Intervention

In 2008, Virginia was one of 10 states that authorized reimbursement for structured substance abuse screening and brief intervention services. Initially, Virginia's Department of Medical Assistance (DMAS) limited reimbursement to the use of two screening tools, the Drug Abuse Screening Test (DAST) and the Alcohol Use Disorder Identification Test (AUDIT). Concerned that many good screening tools had been omitted – including ones designed for specific population - DBHDS requested that DMAS expand their list of approved screening tools. DMAS agreed and invited DBHDS to submit recommendations; it also encouraged DBHDS to provide guidance for providers regarding screening and brief intervention services. DMAS approved DBHDS' recommendations that included standardized instruments for four populations: adults, adolescents, pregnant women, and older adults. In spring 2010, DBHDS posted information to its website which addresses the special needs of each population, identifies approved screening tools and provides guidance regarding screening, brief intervention and referral concerns particular to the respective population. The adolescent section includes adolescent instruments that screen for substance abuse as well as ones which screen for co-occurring substance use and

mental health issues and also provides guidance regarding legal issues that pertain to screening adolescents.

VI. MOVING FORWARD: DIRECTIONS FOR THE FUTURE

As detailed in this report, much has been accomplished over the past decade to improve the services system for children, yet much more remains to be done. Virginia, like the rest of the nation, has struggled with economic crisis over the past two years. New initiatives have not been funded and many existing programs have been reduced. While new initiatives are not feasible in the current economic environment, the workgroup remains committed to the recommendations below for consideration when new funding becomes possible. The SOCAT workgroup strongly believes that interagency coordination has been strengthened through the collaboration of its membership and supports an interagency approach in every aspect of services to children. Each year since the workgroup was founded, it has made certain recommendations members believe are essential to transforming Virginia's behavioral health care system for children. When funding is available, the workgroup recommends that the following initiatives be implemented:

1. **Fund community systems of care and increase community service capacity.** There needs to be a basic array of services that are available uniformly across the Commonwealth. This is the most essential and most consistently repeated recommendation.

2. **Fund efforts to provide behavioral health services in school settings.** Trained mental health professionals need to be on site in schools to help children stay in their community school. Medicaid covers day treatment services for children in schools, but there is no funding to support these services for children who are not Medicaid-eligible.

3. **Fund workforce development for child behavioral health professionals.** A comprehensive workforce development program is recommended that would include training targeted to professionals at all levels. This could be accomplished through a partnership between the DBHDS and a Virginia public university.
4. **Reinstate funding for fellowships.** When funding is available, fellowships for professions such as psychiatry, psychology, social work, and other behavioral health disciplines should be made available. There should be an emphasis on fellowships for professionals who will make a commitment to work in rural and understaffed areas.

APPENDIX A
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APPENDIX B
ACKNOWLEDGEMENTS

The Department of Behavioral Health and Developmental Services sincerely acknowledges the contributions and input of all members of the System of Care Advisory Team.

These individuals, and the agencies and organizations they represent, have brought together significant expertise and progress in children's services.

In particular, those who served on the writing committee deserve very special thanks and acknowledgement for their work.

Much more remains to be done and ongoing collaborative work on behalf of children will not be possible without these members and agencies.

The workgroup especially wishes to acknowledge the contributions and commitment of Shirley Ricks
1951 - 2009

APPENDIX C

Virginia Reports on Child and Adolescent Services Previously Referenced in this Report

Reports from 2006 through 2009 [8]

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 (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

[8] *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)*

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

Reports from 1988 - 2000

Recommendation/Content Summary from Appendix E, House Document 23[9]

YEAR	TITLE	PRIMARY AUTHOR	TOPIC ADDRESSED AND/OR RECOMMENDATIONS
1988	Investing in Virginia's Future: A Continuum of Care for our Adolescents at Risk	Interagency Conference Proceedings, DMHMRSAS	A memorandum of agreement by the Secretariats and department heads and in interagency budget initiative for the 1988-1990 Biennium. The agreement created an Interagency Funds Pool to help localities meet the needs of Seriously Emotionally Disturbed (SED) children and criteria for eligibility of funding.
1991	Improving Care for Trouble and At-Risk Youth and Their Families	The Council on Community Services for Youth and Families	Set forth the plan for what is now known as the Comprehensive Services Act for At-Risk Youth and Families. This report included: 1) Preliminary findings from the demonstration projects; 2) A long-range plan for phasing in community-based nonresidential services across the Commonwealth; 3) An interagency plan for redirecting current funds and identifying new revenue resources for funding community-based services, including consideration of Medicaid; and 4) Any proposed legislation necessary for implementation.
1989	The Invisible Children's Project	Mental Health Association of Virginia	1) Treatment and care should be through a comprehensive array of services that is community-based and family focused; 2) There should be collaboration in all planning, funding, and implementation strategies; 3) Early identification and intervention 4) Use of a case manager for each child 5) Recognition of the special needs of families of children with multiple disabilities; 6) The needs of the child and family should dictate the types and mix of services provided with families as full participants in service planning and delivery; 7) There should be effective advocacy and protection of rights for emotionally disturbed children; 8) Services for children and their families should be available within the least restrictive, most normalizing environment that

[9] *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 329-F, 2003 Appropriations Act) July 1, 2003- July 30, 2004

YEAR	TITLE	PRIMARY AUTHOR	TOPIC ADDRESSED AND/OR RECOMMENDATIONS
			is clinically appropriate; and 9) Services should be provided without regard to race, religion, etc. and should be sensitive to cultural differences.
1990	A Study of Children's Residential Services	Virginia Department of Planning and Budget	1) The current service delivery system for children with emotional and behavioral problems and their families requires significant change in order to be consistent with the goals of family preservation, individualized services in the least restrictive setting; 2) Expenditures of children in residential care should be tracked, in an effort to control costs and an interagency tracking and reporting system should be developed; 3) Consolidation of funds in social services and juvenile justices systems used for residential placements; 4) Funding of residential placements should be shared by the placing locality; 5) Other sources of funding for children's services needs to be explored; 6) Community-based services for children and their families need to be expanded; 7) DMHMRSAS should prioritize services for those children at imminent risk of residential placement by other agencies; 8) State funds saved from increased usage of community based options should be reinvested in developing increase community-based services capacities; and 9) DSS, DMHMRSAS, DSS and DOE should develop a process to evaluate the appropriateness and effectiveness of selected residential placements.
1990	Community Service Model for Troubled Children and Their Families in Virginia	The Council on Community Services for Youth and Families	Selected findings: 1) Children and their families are best served by a system that is comprehensive, coordinated, and responsive to needs; 2) Each child's service program has to be tailored to his/her individual needs rather than attempting to fit the child into a pre-structured program; 3) Comprehensive care in conjunction with early recognition and preventative care; 4) Available resources and funding should be pooled; 5) Communities are diverse and faced with needs and problems with varying levels and types of resources available to youth; and 6) Localities should be able to choose from an array of core services to meet the local needs of youth and their families.
1992	Virginia Child and Adolescent Service System Program (CASSP)	DMHMRSAS	Sought to: 1) Identify and empower constituencies of advocates, parents, families, consumers, and providers to promote and guide state level system development for children and adolescents; 2) Promote interagency coordination in the planning, funding and

YEAR	TITLE	PRIMARY AUTHOR	TOPIC ADDRESSED AND/OR RECOMMENDATIONS
	Demonstration Project		delivery of services to SED children and adolescents; 3) Develop a responsive service system for SED children and adolescents that includes those services necessary to effectively meet their complex needs; and 4) Provide training to community services boards and local interagency service projects to ensure community-based service development and implementation are guided by state-of-the-art knowledge.
1992	The Council on Community Services for Youth and Families Demonstration Projects: Technical Report on Evaluation	Commonwealth Institute for Child and Family Studies	Selected findings of demonstration projects conducted to identify how to improve services and control costs: 1) Youth in demonstration projects were significantly less likely to be placed in a residential setting; 2) Youth in the demonstration projects were significantly more likely to have received advocacy, case management, financial assistance, in-home services, and transportation services; 3) Interagency teams were central to the projects, and in all cases, the teams were expanded either in number of participants or frequency of meetings; 4) The availability of more resources and local service alternatives was a major positive outcome expressed by local personnel; 5) Changes in structure were seen as positive, but concern expressed over increased staff time demands attending meetings and staffing of cases; 6) Responses to consumer satisfaction questionnaires were consistently positive; and 7) Data suggested that on average, the use of residential care changed very little.
1994	Comprehensive Services for At-Risk Youth and Families: Demonstration Projects SFY '93 Evaluation Report	DMHMRSAS	New Services Developed: 1) Intensive probation 2) Therapeutic Respite Care 3) Parent and Student Aide Programs 4) Day Treatment Programs 5) After School Programs 6) Therapeutic Summer Programs 7) Pre-school Prevention Programs 8) Transition Classrooms Major Explorations: 1) Who are the youth being served by the Demonstration Projects? 2) What evidence is there of increased identification and intervention with younger children at risk of developing emotional and behavioral problems? 3) How have the communities' capacities for providing community-based alternatives to residential services changed through the Demonstration Projects? 4) How have local child serving agencies cooperated and collaborated in the planning and provision of services to youth

YEAR	TITLE	PRIMARY AUTHOR	TOPIC ADDRESSED AND/OR RECOMMENDATIONS
			with SED and behavioral problems? 5) How satisfied are the youth, families and service providers with the services being received through the project? 6) To what extent has the use of residential services changed as indicated by the number of youth placed out of the home and the expenditures for those services?; and 7) To what extent have the youth served changed as the result of services received through the Demonstration Projects?
1994	The Impact of the Downsizing of Virginia's State Psychiatric Hospitals for Children Without Increased Community Care Options	Community Services Board Planning Committee	Selected findings: 1) Each CSB should have or be able to purchase a flexible array of eight basic services; 2) Capacity of the CSBs to provide these eight foundation services needs to be expanded as needed in that locality; and 3) To provide the needed services, the estimated increase in funding needed is $47.830, 600.00.
1994/5	Comprehensive Services Act Implementation Assessment	Research and Evaluation Center of the DMHMRSAS	Recommendations: 1) Improve information available to decision makers through the development of a CSA Management Information System; 2) Provide incentives and/or assistance to localities to develop community-based services which foster family preservation and cost savings; 3) Identify and correct financial disincentives which may encourage localities to utilize out-of-home placements, instead of community-based services; 4) Explore potential mechanisms by which non-mandated youth could have adequate access to CSA services, and project costs to the state and localities; 5) As recommended by the CSA Forecasting Task Force, request the Department of Planning and Budget re-establish the technical forecasting group to project the future demand for CSA services and their associated costs; 6) Continue state financial assistance to localities for CSA administration; and 7) Create or find ways to reduce the local administrative burden. 8) Identify specific problems CSA teams may encounter with local courts and aggressively seek solutions; 9) Continue to monitor the capacity of Family Assessment and Planning Teams to engage parents to participate in service planning and implementation; 10) Establish more formal private/public partnerships to lay the groundwork and provide incentives for developing a full array 11) f children's services consistent with the intentions of CSA; 12) Request the DPB repeat its study of private provider fees; 13) Publicly recognize local CSA participants for their accomplishments in making CSA a reality;

YEAR	TITLE	PRIMARY AUTHOR	TOPIC ADDRESSED AND/OR RECOMMENDATIONS
			14) Request that the State Executive Council (SEC) assume responsibility for the coordination of prevention/early intervention activities within the framework of CSA; 15) Publicize Virginia's experiences with CSA.
1995	Non-Mandated Youth: History and Potential Fiscal Approaches	State Management Team	1) A large number of localities are not using the protection provided by the SEC to assure that some non-mandated youth in their locality receive services; 2) There is a decreasing reliance on residential and private service, suggesting that community efforts to build capacity may be realized; 3) There is mixed success regarding the CSA non-mandated funds; 4) Two distinct types of spending patterns are exhibited by localities: "Want more" and "Don't spend"; 5) Any approach to resolve funding issues must address both types of patterns in order to create improvements on a statewide basis;
1995	Evaluation of the Comprehensive Services Act	Secretary of Health and Human Resources, Secretary of Public Safety, and the Secretary of Education	1) Implementing CSA is costly in terms of staff time, administrative support, and actual expenses; 2) Most localities believe that CSA is meeting its goals of stronger interagency collaboration and family participation; and 3) Non-mandated children do not receive the services they need.
1998	Review of the Comprehensive Services Act	Joint Legislative Audit and Review Commission	1) The General Assembly may wish to require that the SEC develop a mandatory uniform assessment instrument process to be used by all localities that identifies the appropriate level of care for various levels of risk; 2) The General Assembly may wish to require all cases for which treatment services (not foster care maintenance) are requested to appear before a multi-agency team at the locality; 3) The General Assembly may wish to require the Department of Medical Assistance Services to amend its state plan to include Medicaid payment for residential care and therapeutic foster care; and 4) The General Assembly may wish to require that non-mandated cases where children have displayed acute or recent risk by afforded sum-sufficient funding.
1998	A Study of Service for Children Who are Not Included in the Mandated Populations of the Comprehensive Services Act for	The Office of the Executive Secretary, Supreme Court of Virginia: Under the direction of the Comprehensive Services Act State Executive Council	1) Further study needs to be done; 2) Further inquiry could comprehensively distinguish existing services and funding source and, most importantly, identify gaps in these areas; and 3) Examination of these issues should be undertaken by of the Secretaries of Education, Health and Human Resources, and Public Safety. A broad-based policy review is required, not unlike the original effort that resulted in the development of legislation and policy for the CSA.

YEAR	TITLE	PRIMARY AUTHOR	TOPIC ADDRESSED AND/OR RECOMMENDATIONS
	At-Risk Youth and Families		
1999	Educational Needs of Emotionally Disturbed Students with Visual and Hearing Impairments	Department of Education and the Disability Commission	1) Adopt a Massachusetts program for use at the Virginia School for the Deaf and Blind; and 2) Creation of a program on the campus of the residential school so it is in the community and among educators/residential specialists who have experience working with the deaf and blind population.
1999	Continuum of Care for Children and Adolescents	Child and Family Task Force of the Virginia Association of Community Service Boards (VACSB)	Services that, on a nationally recognized idea of a system of care, comprise what is thought of as a "system of care" for children and adolescents: 1) Family Support 2) Crisis Intervention 3) Case Management 4) Outpatient 5) Intensive Community Based Treatment 6) Specialized Vocational Programs; and 7) Community-Based Residential Programs
1999	Keeping Our Kids at Home (KOKAH) Project: A Study of the Feasibility, Efficacy, and Cost-Effectiveness of Expanding the Project Statewide	DMHMRSAS	1) A model of KOKAH should be implemented in each of the Health Planning Regions of the state; 2) The KOKAH model should be modified to include less reliance on local inpatient hospitalization, a broader array of community-based and step down services, and standards for hospital utilization rates; 3) A grant of flexible dollars should be given to each site, to purchase or implement an array of services, with an emphasis on community-based treatment—including the purchase of local inpatient treatment; and 4) The development of a standardized risk assessment and clinical guidelines to support decision-making regarding the use of local private facilities and state inpatient facilities.
1999	Virginia's Continuing Policy to Take Away State Psychiatric Hospitals for Children Without Increasing Community Service Options	Child and Family Services Council of the Virginia Association of Community Service Boards	1) Sufficient funding for community service development has been shown to reduce the number of hospitalizations of children, who could benefit from less restrictive, but very intensive services; 2) Transfer state funds to develop services close to communities; 3) The funds saved from downsizing institutional care should be made available to the community to provide follow-up care; and 4) Virginia must begin to plan services for children and adolescents, and should include in its comprehensive planning families, advocates, community service providers and the DMHMRSAS.
2000	Report of the Joint Subcommittee to Evaluate the Future Delivery of Publicly Funded Mental Health, Mental Retardation and	House Document 101, 2000 General Assembly Session	A feasibility study examining the impact of a carve-out of Medicaid financed mental health, mental retardation and substance abuse services from any managed care contracts negotiated with HMOs, and of contracting out the administration of all Medicaid-covered mental health, mental retardation, and substance abuse services to DMHMRSAS. 1) CSBs to function as care coordinators, and as the single point of entry into the services system. Care coordination is the central service function of CSBs in a managed system of care,

YEAR	TITLE	PRIMARY AUTHOR	TOPIC ADDRESSED AND/OR RECOMMENDATIONS
	Substance Abuse Services: A Report to the Governor		and it would be provided exclusively by the CSBs and behavioral health authorities; and 2) The Chair of the State Executive Council, supported by the Office of Comprehensive Services, shall examine the potential for the use of the underutilized state property under the control of the DMHMRSAS to determine if the use of this property, if leased to vendors, would reduce the cost of services in the provision under the CSA. Every attempt should be made to locate these treatment facilities, if deemed feasible, in an appropriate geographic distribution across the state that allows children and families to have reasonable access to services.

APPENDIX D

System of Care Children's Services Consistently Referenced in National and State Reports

Service	Service Array Reference Document	Needed in VA?	State Document Citing Need for Service
Assessment & Evaluation	Pires[10], Stroul et al[11], DHHS[12], CCT[13], OIG[14]	Yes	SOCAT, CSA
Outpatient/Office-based (Group, Individual, Family)	Pires, Stroul et al, DHHS, CCT, OIG	Yes-SA only	CCT, OIG
Medication Management/ Psychiatry	Pires, Stroul et al, DHHS	Yes	SOCAT, CCT, OIG
Day Treatment (School-based or Alternative Ed)	Pires, Stroul et al, DHHS, SOCAT[15]	Yes	SOCAT, OIG, CSA
Crisis Stabilization/Outreach	Pires, Stroul et al, DHHS, CCT, SOCAT	Yes	SOCAT, OIG, CSA
Inpatient (Acute, Res Treatment, Group Home)	Pires, Stroul et al, DHHS, CCT	Yes-acute care	SOCAT, CCT, CSA
Case Management/Care Coordination (including ICC)	Pires, Stroul et al, DHHS, CCT, SOCAT	Yes-ICC	SOCAT, OIG, CSA
School-based MH Services	Pires, Stroul et al, SOCAT	Yes	OIG
Respite	Pires, Stroul et al, SOCAT	Yes	SOCAT, OIG, CSA
Educational Support for Families	Pires, Stroul et al, CCT, OIG[16]	Yes-skills training	SOCAT, CSA
Intensive SA Services	OIG	Yes	SOCAT, CSA

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[10] Building Systems of Care: A Primer, by Sheila A. Pires

[11] Stroul et al.= Financing Structures and Strategies to Support Effective Systems of Care, by Beth A. Stroul, M.Ed., Sheila A. Pires, M.P.A., Mary I. Armstrong, Ph.D. , Jan McCarthy, M.S.W., Karabelle Pizzigati, Ph.D., & Ginny M. Wood, B.S.

[12] DHHS=U.S. Department of Health and Human Services, October 2001.

[13] CCT= State and Community Consensus Team Report, December 15, 2009

[14] OIG=Office of Inspector General Report 149-08 Survey of Community Service Board Child and Adolescent Services, Office of the Inspector General September 19, 2008

[15] SOCAT= System of Care Advisory Team 2007, 2009 Reports under Appropriations Items #311E and 315E

[16] CSA=FY08 and FY09 Comprehensive Services Act Critical Service Gap Survey

APPENDIX E

SFY 2009 Statewide Service Gaps

Top 20 Service Gaps Ranked by CSA Census*

1. Crisis Intervention and Stabilization
2. Intensive Substance Abuse Services
3. Emergency Shelter Care
4. Acute Psychiatric Hospitalization
5. Regular Foster Care/Family Care
6. Parenting/Family Skills Training
7. Transportation
8. Psychiatric Assessment
9. Respite
10. Family Assessment
11. After Schools Recreational
12. Alternative Ed Day Programs
13. Supervised Ind. Living
14. Substance Abuse Prevention
15. Child & Family Advocacy
16. Parent & Family Mentoring
17. Short-term Diag. Assess
18. Developmental Prevention
19. Wraparound Services
20. Special Populations Housing

APPENDIX F
UPDATE ON INITIATIVES SUPPORTED BY THE GENERAL ASSEMBLY

A. Initiatives Recommended by the Workgroup

1. DBHDS Office of Child and Family Services

In response to the workgroup's recommendation, DBHDS created the Office of Child and Family Services (OCFS) in April, 2004. Previously, the focus on children was dispersed across existing offices of Mental Health, Mental Retardation and Substance Abuse Services. The OCFS now integrates services and initiatives for children birth through 17 as well as services for pregnant and parenting women that use substances. Regrettably, the past two budget years have resulted in some reduction of staff, but the integrated approach to policy, planning, funding and service development continues.

2. System of Care Demonstration Projects

With $2 million in funding from the General Assembly, DBHDS 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 DBHDS 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 children 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 DBHDS 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) and Dialectical Behavioral Therapy (DBT). The FFT program at Planning District One had to be terminated in January 2010 due to the FFT Supervisor moving out of state. The plans are to use funding to enhance crisis stabilization services and to provide the evidence-based practice cognitive behavioral therapy (CBT). 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. Intensive Care Coordination

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 and issues have been identified about the feasibility of recovering costs of some 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.

3. CSB Services in Juvenile Detention Centers

Children with behavioral health problems who are involved with the juvenile justice system are an important target population for DBHDS. Through this initiative, CSBs provide short-term behavioral health services to children 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 children 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, DBHDS received a Juvenile Accountability Block Grant funding that enabled CSBs to provide mental health screening, assessment services, and community based referrals for children in five 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 DBHDS 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 children annually. DBHDS provides technical assistance and support to the 23 programs to assist them in addressing the challenges of serving children 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. A series of regional networking meetings were held in April 2010. Staff from both Juvenile Detention Centers and Community Service Boards attended.

During the first two quarters of FY10 **2,563** children received a mental health service while in detention. Services include:

- Case management: **459** children
- Emergency services: **123** children
- Early intervention services: **507** children
- Assessment and evaluation services: **705** children

4. Child Psychiatry and Psychology Fellowships

As part of the 2008 budget, funds ($483,000) were allocated 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 DBHDS's Request for Applications (RFA) and were awarded funds on the basis of their applications.

As part of the reductions necessary to balance Virginia's budget, funding for the fellowships was cut from the 2010 budget. As a result of these cuts, funding for Eastern Virginia Medical School and MCV was discontinued as of June 30, 2009; however DBHDS was able to identify alternate funds to support MCV's psychiatry fellow until he graduated in June of 2010.There continues to be a significant shortage of child psychiatrists in both the private and public sector in Virginia and the loss of these funds pose a serious concern for children's services. 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.

APPENDIX G
Workgroup's Recommendations to the General Assembly: 2003 - 2009

Budget Item 315-E (June, 2009)			Budget Item 311-E(June, 2008)			Budget Item 311-E (June, 2007)		
Request	Funds Requested	Dollars Funded	Request	Funds Requested	Dollars Funded	Request	Funds Requested	Dollars Funded
Increase Continuum of Services for Youth and/ or Increase Service Capacity								
When funds become available: 1)Fund 20 School-based MH Clinicians	2,000,000	0	Fund 20 School-based MH Clinicians	2,000,000	0	Fund 20 School-based MH Clinicians	1,800,000	
2)Fund 12 SOC projects	3,600,000	0	Fund 12 SOC projects	3,600,000	0	Fund 12 SOC projects	3,600,000	0
3)Increase support for intermediate service capacity	unspecified	0				Fund Intermediate community- based services	20,000,000	0
						Fund MR. Family Supports	2,500,000	0
						Fund MR Waiver slots	6,000,000	0
						Supplement Part C funds	1,730,000	0
						Fund 3 new Project LINK sites for pregnant substance using women	375,000	0
						Fund Outpatient Adol SA Tx	3,000,000	0
Workforce Development for Providers that Serve Youth								
When funds become available 1)Reinstate child psychiatry & psychology positions	483,000	0				**Fund 4 psychiatry & 2 psychology fellows**	**1,036,000**	**483,000**
2)Fund 3 teaching Centers of Excellence	700,000	0	Fund 3 teaching Centers of Excellence	700,000	0	Fund 3 teaching Centers of Excellence	700,000	0
Support & sustain state wide training system to assist CSBs and CSA serve youth & families								
Family Support								
When funds become available Family support	125,000	0	Fund Family Support Network	125,000	0	Fund Family Support Network	100,000	0
State Level Infrastructure in Support of Behavioral Health Services for Youth								
Continue Special Advisor on Children's Services position;	0	0	**Support Core's Efforts**	0	0	Fund additional OCFS staff responsible for monitoring & oversight	990,000	0

APPENDIX G

Workgroup's Recommendations to the General Assembly: 2003 – 2009

Budget Item 315-E (June, 2009)			Budget Item 311-E (June, 2008)			Budget Item 311-E, (June, 2007)		
Request	**Funds Requested**	**Dollars Funded**	**Request**	**Funds Requested**	**Dollars Funded**	**Request**	**Funds Requested**	**Dollars Funded**
Continue to develop 6 building blocks of Children's Services System Transformation	0	0	GA to recommend that CORE address behavioral health needs of ALL youth	0	0			
Clarify Code of Virginia language to directs CSBs to provide case management for all youth in need	0	0	GA to encourage CORE to support CSBs as public providers of services to CSA youth	0	0			
Recommend CSBs develop and provide 4 core services for youth: 1) emergency services; 2) care coordination; 3) home based services and 4) intensive care coordination (ICC)	0	0	Develop process to ensure each CSB allocates new funding to support a new child positions	0	0			
When funds become available Fund additional positions in child serving agencies to provide oversight and guidance	0	0	Fund OCFS position to oversee these 40 new child positions	75,000	0			
Request CSA Service Gap Survey explore reasons for gaps	0	0	Increase Medicaid Community Mental Health rate	13,000,000	0			
Support the 6 Building Blocks of the Children's Services System Transformation	0	0						
Total Funds Requested	**6,908,000**			**19,500,000**			**41,831,000**	
Total Funds Approved		**0**			**0**			**483,000**

APPENDIX G

Workgroup's Recommendations to the General Assembly: 2003-2009

Budget Item 330F (June, 2006)			Budget Item 330F (June, 2005)			Budget Item 329-F (July, 2004)		
Request	**Funds Requested**	**Dollars Funded**	**Request**	**Funds Requested**	**Dollars Funded**	**Request**	**Funds Requested**	**Dollars Funded**
Increase Continuum of Services for Youth and/or Increase Service Capacity								
Fund MH services in remaining juvenile detention centers that do not have them	**1,200,000**	**1,140,000**	**Add 4 detention center projects & fund outcome evaluation for all sites**	**240,000**	**900,000**	DMHMRSAS should resubmit budget request to fund a continuum of behavioral youth services for youth	0	0
Fund school based MH clinicians in 20 schools	1,800,000	0	Fund 20 school- based MH projects & evaluate them	1,800,000	0	DMHMRSAS should resubmit budget request to fund a determined number of dedicated CSB youth case management services	0	0
Fund 4 new SOC pilot projects	**2,000,000**	**1,000,000**	**Continue 2 and add 6 new MST/FFT Systems of Care demonstration projects & evaluate them**	**4,000,000**	**1,000,000**	DMHMRSAS should resubmit request pool of flexible funds for program startup	0	0
Workforce Development for Providers Across Systems that Serve Youth								
Fund 4 psychiatry & 4 psychology fellows	493,000	0 (Funded as of SFY 2009	Fund 4 psychiatry & 4 psychology fellows		0 (Funded as of July 1,2008)	DMHMRSAS should continue to explore existing resources that could support training. Agencies in Education, HHR and Public Safety should cooperate	0	0
Fund a university based Child Center of Excellence	300,000	0		1,700,000	0	DMHMRSAS should work with CSBs to provide cross training other agencies	0	0
Fund child & adolescent training for BH clinicians	200,000	0	Train behavioral health care providers regarding child & adolescent behavioral health care		0	DMHMRSAS should provide training on Systems of Care to CSBs and interested stakeholders	0	0
Fund child & adolescent training for medical providers	200,000	0	Train health care providers regarding child & adolescent behavioral health care					

APPENDIX G
Workgroup's Recommendations to the General Assembly: 2003 – 2009

Budget Item 330F (June, 2006)			Budget Item 330F (June, 2005)			Budget Item 329- F (July, 2004)		
Request	**Funds Requested**	**Dollars Funded**	**Request**	**Funds Requested**	**Dollars Funded**	**Request**	**Funds Requested**	**Dollars Funded**
Family Support								
Fund statewide family education, information and support network	150,000	0	Fund a Family Support Coalition	500,000	0	OCFS should build ways to link family members with other child serving agencies & network to develop a statewide parent/Family network	0	0
State Level Infrastructure in Support of Behavioral Health Services for Youth								
Fund a web based psychiatric bed reporting system	75,000	0				Continue to build OCFS infrastructure so that it may provide leadership in improving services for youth	0	0
Conduct Medicaid Rate study to determine if behavioral health care rates are sufficient	0	0				OCFS should develop a State Advisory Committee for Child and Family Services	0	0
Adopt children's behavioral health as a very high priority	0	0				DMHMRSAS should develop an interactive website	0	0
Use CSA funding flexibly and creatively to develop additional services	0	0				DMHMRSAS should identify gaps in policies & procedures & develop an integrated approach to serving youth & their families to promote consistency	0	0
Study the possibility of suspending rather than ending Medicaid benefits for juveniles who enter juvenile justice facilities	0	0				DMHMRSAS should review State Board policies & make recommendations re: youth services develop an interactive website	0	0
DMHMRSAS should coordinate and lead the planning for children's behavioral health	0	0						
Total Funds Requested	**6,418,000**			**8,240,000**			**0**	
Total Funds Approved		**2,140,000**			**1,900,000**			**0**

APPENDIX G

Workgroup Recommendations to the General Assembly: 2003 – 2009

Budget Item 329-G (June, 2003)			Child and Adolescent Special Populations Workgroup Final Report (August 2004)		
Request	**Funds Requested**	**Dollars Funded**	**Request**	**Funds Requested**	**Dollars Funded**
Increase Continuum of Services for Youth and/or Increase Service Capacity					
DMHMRSAS should initiate a budget request to fund a continuum of behavioral youth services	0	0	Fund 4 system of Care demonstration projects	2,500,000	**(Funded in SFY 2006 & SFY 2007)**
DMHMRSAS should initiate a budget request to fund a determined number of dedicated CSB case management services for youth	0	0	Fund behavioral health services provided by CSBs in detention centers	3,500,000	0
DMHMRSAS should submit a request for pool of flexible funds to support startup costs for programs for youth & establish an agreement with a state university to evaluate the efficacy of such programs	0	0			
Workforce Development					
DMHMRSAS should explore existing state & federal to provide statewide training for youth providers across disabilities as related to the recommended continuum of services	0	0	**Fund slots for psychiatry fellows and psychology interns**	$60,000 per fellow and $26,000 per intern	**(Funded in SFY 2008)**
			Fund 6 regional trainings on Systems of Care	$500,000	0
			Fund MST & FFT capacity building (inc training & licensure) Conduct statewide training on EBPs, best practices and Promising Treatments for Youth Provide cross state and agency training re: System of Care model	2,500,000 0 $200,000	0 0
Family Support					
DMHMRSAS should seek ways to build & link the network of parents of children & adolescents with disabilities	**0**	**0**	Fund a Parent/Youth Involvement Network	500,000	0

APPENDIX G
Workgroup Recommendations to the General Assembly: 2003-2009

June, 2003			Child and Adolescent Special Populations Workgroup Final Report August 2004		
Request	**Funds Requested**	**Dollars Funded**	**Request**	**Funds Requested**	**Dollars Funded**
Family Support					
			Encourage partnerships between parents, providers and stakeholders	0	0
State Level Infrastructure in Support of Behavioral Health Services for Youth					
DMHMRSAS should establish an integrated organizational unit that merges existing staff that provide child, adolescent and family services	**0**	**(Created April, 2004)**	Maximize all resources to build capacity that included prevention, early intervention & intensive therapeutic services	0	0
DMHMRSAS should establish a state advisory committee to support	0	Created	**a) Add substance abuse services to DMAS state plan**	**0**	**(Funded SFY 2008)**
DMHMRSAS should create, publish and fund an interactive website to enable improved access to services, providers, resources and supports	0	0	b) Increase Medicaid rates for day treatment		
			c) Conduct rate study to expand community based services	0	0
			DMHMRSAS should recommend possible code, regulatory changes and budget initiatives to the SEC & GA that support Systems of Care	0	0
			Include prevention and early intervention services in Virginia's System of Care model	0	0
			State agencies should continuously braid and blend funding to meet the service needs of youth	0	0
			Support the Systems of Care model	0	0
			Merge the Child & Adolescent Special Populations group with the workgroup for Budget Item 330F	0	**(Merged August 2004)**
Total Funds Requested	**0**			**0**	
Total Funds Approved		**0**			**0**

APPENDIX H
Summary of Family Needs Survey and Family Focus Group Responses

Most Requested Service Needs

- In home
- Community based
- School services to include mental health services in school, assistance with Individualized Education Program (IEP), tutoring
- Autism/Applied Behavioral Analysis
- 24/7 crisis stabilization services
- Respite/Child Care
- Child psychiatrists
- Medicaid providers
- Medicaid waiver slots

Comments on Funding

- No support for middle class, insurance limits coverage for services; middle class couples often do not qualify for Medicaid
- Insurance companies often only pay for high intensity services
- Services too expensive
- Lack of funding for service development
- Providers may choose not to provide a service due to lack of funding
- Funding may be provided for a service but then there are not enough providers to provide the service or not enough qualified providers to provide the service

Comments on Schools

- Need better training for school personnel on how to focus on children's strengths as opposed to their deficits, especially those with mental or physical health needs
- Level of IEP (Individualized Education Program) services often correlates with whether or not the school budget allows for provision of the services
- Would like support for creating appropriate IEPs for children with special needs
- Teachers may not be knowledgeable about the extent of a child's needs particularly if the child has a learning disability, mental health diagnosis or other special needs issues; educators are not trained to understand mental health and behavioral issues
- Education staff and IEP team do not recognize that mental health issues can effect a children's ability to learn; they say the mental health service is not required for the children's education so they do not put it in the IEP
- Private day placements are difficult to get because professionals do not realize that some children require a low stimulus environment in order to learn
- Would like to see schools as gateway to receiving mental health services and also other special needs like developmental disabilities and learning disabilities

- Need for more communication between school and parents especially for children with mental health issues or disabilities
- Often schools deny that there is a problem when it comes to their involvement with children that have mental health issues or disabilities; they do not see this as a priority for them

Comments on Service Availability and Access to Services

- Waiting lists for many services at CSBs and options are not offered or available while waiting
- Not enough MR waiver slots
- Times services are offered not feasible for the family
- System is hard for families to navigate; families need education about what services are available and how to access them; there is no central information source
- Need case managers, peer families, or family organizations that can assist with navigation of the system
- Parents need to know who to contact in order to get services as opposed to getting "bounced" around the system
- Families need a central link to the system; need continuity; one person they can call when they need help with system navigation issues

Training/Education of Professionals

- Need more professionals including school personnel that understand brain development issues in children
- Need more professionals that can provide in depth mental health assessments to guide service planning
- High turnover of staff often results in inexperienced and less knowledgeable staff
- Lack of consistent quality case management across CSBs
- Child serving agencies should be better integrated to enhance collaboration; should collaborate together within communities to determine how best to provide more services to more children
- Need more consistency with case workers, i.e. ability for family to keep same case worker over entire service period
- Need for case managers to focus on child's possibilities as opposed to their deficits; need case managers that will partner with families and recognize the families' strengths as opposed to their challenges

APPENDIX I

Introduction

To ensure effective and coordinated Smart Beginnings for all of Virginia's young children, many partners have contributed to a comprehensive plan, with the purpose of building and sustaining a system in Virginia to support parents and families as they prepare their children to arrive at kindergarten healthy and ready to succeed. The plan is designed to provide practical guidelines, including

- ✓ Prioritized goals, measurable objectives and strategies;
- ✓ Outcomes to measure progress;
- ✓ Clear accountability and communication of results.

Guiding principles

The development of this plan was guided by several key principles:

- ✓ Virginia's plan is for *all* children and families, regardless of income, geographic location, race, ethnicity, language, or special needs.
- ✓ Parents and families are the most influential people in a child's life and must be supported by communities and included as primary partners at every level.
- ✓ Families should be partners with stakeholders and service providers in coordinating and evaluating services and supports.
- ✓ Programs and supports must be developmentally, culturally, and linguistically appropriate.
- ✓ Preventive approaches are more economical and effective than costly remediation later in life.
- ✓ Utilization of best practices to deliver high quality early childhood services and programs helps ensure that children are ready to succeed in school and in life.
- ✓ Partnership across all sectors of the community, both public and private, is necessary to ensure the effectiveness and impact of services.
- ✓ It is essential that strengthening and improving the early childhood system proceed collaboratively at both the state and local level, with flexibility to support local decision-making and priorities.
- ✓ Successful transitions into elementary school and beyond sustain the foundation of healthy early childhood development.
- ✓ Virginia's plan is proactive, anticipating the need to address dynamic forces that bring both opportunities and unexpected obstacles and impact future policy goals.