DBHDS

Virginia Department of
Behavioral Health and
Developmental Services

Item 304.M. – Interim Report:

A Plan for Community-Based Children's Behavioral Health Services in Virginia

To the Chairs of the
House Appropriations and Senate Finance Committees

October 1, 2010

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October 1, 2010

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

Dear Senator Colgan:

Pursuant Item 304.M. of the *Appropriation Act*, enclosed is the interim report on the planning process to develop a comprehensive plan for Virginia's child and adolescent behavioral health services that ensures there are child-centered services, both inpatient and community-based, delivered at the community level in every Health Planning Region in the Commonwealth.

This interim report reflects the input of expert panels made up of state agency representatives, service providers, family members and advocates. The final report is due by November 1, 2011. If you have any questions, please feel free to contact me.

Sincerely,

James W. Stewart, III

Enc.
Cc: Hon. William A. Hazel Jr., M.D.
Hon. R. Edward Houck
Joe Flores
John Pezzoli
Janet Lung
Ruth Anne Walker

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October 1, 2010

The Honorable Lacey E. Putney, Chair
House Appropriations Committee
General Assembly Building
P.O. Box 406
Richmond, VA 23218

Dear Delegate Putney:

Pursuant Item 304.M. of the *Appropriation Act*, enclosed is the interim report on the planning process to develop a comprehensive plan for Virginia's child and adolescent behavioral health services that ensures there are child-centered services, both inpatient and community-based, delivered at the community level in every Health Planning Region in the Commonwealth.

This interim report reflects the input of expert panels made up of state agency representatives, service providers, family members and advocates. The final report is due by November 1, 2011. If you have any questions, please feel free to contact me.

Sincerely,

James W. Stewart, III

Enc.
Cc: Hon. William A. Hazel Jr., M.D.
Hon Harvey B. Morgan
Susan Massart
John Pezzoli
Janet Lung
Ruth Anne Walker

A Plan for Community-Based Children's Behavioral Health Services in Virginia

TABLE OF CONTENTS

		Page
	Executive Summary	1
I.	Introduction	4
II.	Plan Development Process	5
III.	The Target Population	5
IV.	The Comprehensive Service Array – A Community-Based System of Care	6
V.	Current Status of the System	9
VI.	The Future Role of the Commonwealth Center for Children and Adolescents	13
VII.	Recommendations	15
	Appendices	18
	Appendix A: Resource Documents	
	Appendix B: Expert Input Panels	
	Appendix C: Expert Input Panels Discussion Guide	

EXECUTIVE SUMMARY

Item 304.M. of the *Appropriation Act* directed the Department of Behavioral Health and Developmental Services (DBHDS), in conjunction with several other state agencies and stakeholders, to establish a planning process, develop recommendations, and report on specific steps to provide behavioral health services to children. The language states:

> *The Commissioner of the Department of Behavioral Health and Developmental Services (DBHDS) shall establish a planning process to identify concrete steps to provide children's mental health services, both inpatient and community-based, as close to children's homes as possible. The planning process will produce a comprehensive plan that ensures there are child-centered services, both inpatient and community-based, delivered at the community level in every Health Planning Region in the Commonwealth. The target populations to be addressed in this plan are children through age 17 who: (i) have a mental health problem, (ii) may have co-occurring mental health and substance abuse problems, (iii) may be in contact with the juvenile justice or courts systems, (iv) may require emergency services, or (v) may require long term community mental health and other supports. The planning process should identify the mental health and substance abuse services that are needed to help families keep their children at home and functioning in the community and should define the role that the Commonwealth Center for Children and Adolescents will play in this effort. The plan should establish and rank recommendations based on greatest priority and identify future funding associated with each recommendation. The planning process shall include input from community services boards, state and private inpatient facilities, The Department of Social Services, The Office of Comprehensive Services, The Department of Juvenile Justice, The Department of Education, The Department of Medical Assistance Services, parents of children with mental health and co-occurring substance abuse problems, advocates for child mental health and co-occurring services, and any other persons or entities the DBHDS deems necessary for full consideration of the issues and needed solutions. The commissioner shall report interim findings to the Chairmen of the House Appropriations and Senate Finance Committees by October 1, 2010 and a final report by November 1, 2011.*

A review of prior reports and recommendations on children's behavioral health helped to build the foundation for this report. Those reports represent input from parents and advocates, state agencies, and service providers. The consensus of all prior reports indicated that if children with behavioral health problems could be served earlier with high-quality treatment, the more intensive and expensive services, such as inpatient, could be used less often.

To receive input for this plan, DBHDS convened three Expert Input Panels:

- ***State Agencies*** – including each of the state child-serving agencies listed in the language above, and the Office of the Inspector General for the Department of Behavioral Health and Developmental Services (OIG).
- ***Service Providers*** – including community services boards (CSBs), private providers of community services and supports, and public and private inpatient service providers
- ***Family Members and Advocates*** – including parents and family members of children receiving services, representatives of family and advocacy organizations, and the Campaign for Children's Mental Health, which includes over 50 supporting organizations.

Focus

This plan focuses on children's behavioral health services that are funded with public dollars. Public dollars include funding from: the state General Fund, federal mental health block grants, local government, and Medicaid or CSA. The target population for this plan is identified in the budget language in Item 304.M. as children through age 17 who:

(i) Have a mental health problem; and
(ii) May have co-occurring mental health and substance abuse problems;
(iii) May be in contact with the juvenile justice or courts systems;
(iv) May require emergency services; or

(v) May require long term community mental health and other supports.

Challenges

The plan details the full comprehensive service array that is needed to support a child-centered, family-focused system of care. The plan also describes the current status of the system of care. Virginia's behavioral health services system for children faces a number of challenges, the most significant of which include:

- All communities have an incomplete array of services.
- In many of the services that are available, there is inadequate capacity resulting in children and families waiting for services.
- Families are faced with inconsistency across the state in the array and the capacity of services.
- Because of the incomplete array, inadequate capacity, and inconsistency, many children do not receive services early enough, which may mean their conditions worsen and result in delayed, more restrictive, and more costly services. Many other children, who do not meet the eligibility or service definition of the predominant funding streams – Medicaid and CSA – simply cannot find access to services to meet their needs.
- Workforce development is needed to support a comprehensive system.
- There is inadequate oversight and quality assurance for the services that do exist.

The current and future role of the Commonwealth Center for Children and Adolescents (CCCA) within a comprehensive system is addressed by this plan. At the present time, the role of CCCA is to provide high quality inpatient services for the most challenged and traumatized children and to work with communities to return the children to their homes in the shortest clinically feasible time. This service can be expected to continue until more adequate community-based services are in place. If the comprehensive community service array can be expanded over the next four to eight years, the need for public inpatient services can be projected to decline. However, if there is no growth in community services, then the role of CCCA and the demand for its services will likely stay the same.

Recommendations

Based on the information gathered from previous reports, the current status of the system and the work of the expert panels, the following recommendations are made as strategic initiatives that the General Assembly may want to consider moving forward in the future. These initiatives could be implemented in a phased manner over a number of years, as the Virginia's budget scenario improves:

1. **Define and promote through DBHDS the full comprehensive service array as the goal and standard for children's behavioral health services in every community.**
2. **Expand the array and capacity of services to assure a consistent base level of services for children and families statewide.**
3. **Establish a children's behavioral health workforce development initiative to be organized by DBHDS.**
4. **Continue the current role of CCCA for the foreseeable future, and until more adequate community-based services are in place.**
5. **Establish quality management mechanisms and metrics to improve access and quality in behavioral health services for children and families.**

Funding Priorities

The General Assembly might consider gradual funding of these recommendations over successive fiscal years, beginning with FY2013. **The priority recommendation is Recommendation #2: *Expand the array and capacity of services to assure a consistent base level of services for children and families statewide.*** The consistent availability of the base services would have the greatest potential to reduce unnecessary reliance on inpatient and residential care.

Final Report

DBHDS is gathering current, detailed information about the status of statewide service array, capacity and consistency in all communities. Based on this data DBHDS will identify, by CSB and community, the specific needs to reach both the base level of services and sufficient capacity in every community. Corresponding budget needs will be included for subsequent biennia. This final report will be presented in 2011.

I. Introduction

The purpose of this report is to describe a plan for the development of children's mental health services, both inpatient and community-based, as close to children's homes as possible. The target population for this report includes children with co-occurring mental health and substance abuse problems; thus, the term 'behavioral health' will be used in this plan to refer to all children in the target population.

Previous service planning initiatives focused on various aspects of the service system for children with behavioral health problems. Many focused on reducing the use of public inpatient services. Others have considered ways to improve access to community services. Each of these initiatives recommended that all children with behavioral health problems should be served as close to their homes as possible – and as early as possible before their conditions become worse - and called for additional community services and inpatient alternatives that are necessary in each region of the state to achieve this goal. The consensus of all prior reports indicated that if children with behavioral health problems could be served earlier with high-quality treatment, the more intensive and expensive services, such as inpatient, could be used less often.

No initiatives prior to this one were tasked with developing a comprehensive plan to serve children with behavioral health problems in both inpatient and community settings. The Community Services Boards (CSBs) and the one public inpatient facility, the Commonwealth Center for Children and Adolescents (CCCA), have operated as separate systems and administered separately at the state level. Recent significant organizational changes at the DBHDS have created a structure that treats the CSBs and the state facilities as a single system.

A Plan for Publicly-Funded, Collaborative Services

The system of services for children and families in Virginia, including mental health services, is complex, multi-faceted, and rapidly evolving. A significant number of private agencies providing residential services and an extensive offering of community-based services have developed over the past few years. The growth in these services has been almost completely supported by public funding through Medicaid and the Comprehensive Services Act (CSA). CSBs, the public provider of community mental health services, are not the largest provider of children's mental health services. In many communities the CSB is a minor participant in provision of children's services. There is a mosaic of publicly-funded children's mental health services in most Virginia communities.

This plan focuses on children's behavioral health services funded with public dollars. Public dollars include funding from: the state General Fund, federal mental health block grants, local government, and Medicaid or CSA. Services supported by these public funding sources include those operated by CSBs and CCCA. It also includes the services provided by private organizations that are funded through these public funding sources, specifically Medicaid and CSA.

These services are part of the interagency system that serves children in Virginia, including all of the state and local child serving agencies such as Social Services, Juvenile Justice and Education CSBs, CSA, and the well-developed network of privately operated, publicly-funded children's services. The need for collaboration between these agencies cannot be overstated. Children with behavioral health problems usually interface with more than one of these agencies and the extent to which collaboration exists strongly influences the success of interventions that are used.

Recent developments over the past few years strengthened the collaborative work between agencies at both the state and local levels, but much more remains to be done. Under the general heading of "Children's Services System Transformation" much progress and agreement was reached among the key child-service agencies about the goals, principles, and vision of an expanded and effective system of care for children and families. Some of the positive outcomes of the Children's Services Transformation include:

- Interagency collaboration at the state and local levels was strengthened through the work of an Executive Team that met bi-monthly to share information, establish work priorities and problem-solve and through meetings with localities every six weeks.
- A practice model was developed that described a common philosophy for serving children, focusing on child safety, keeping children in families, and collaboration between all public and private partners with the needs of the child and family always in focus.
- Thirteen "pilot" localities worked together to improve outcomes in terms of family based placements and permanent family placements for children. These outcomes were achieved with all of the local child-serving agencies working together toward these goals.
- Training was provided through a Transformation Academy. A series of training sessions focusing on core competencies needed by all members of the workforce were delivered to groups that included state and local staff from each of the child-serving agencies.
- Increased emphasis on the needs and roles of families and parents resulted in a family engagement model and greater involvement of families in decision making.
- A statewide conference was held on December 16-17, 2009 with more than 600 state and local service providers, family members, legislators, advocates and others in attendance.

While impressive service growth and good coordination now exists in some communities, in some communities this still is not the case. There also is a need to assure Virginians that public funds are being spent in the most efficient and effective manner possible. The rapid growth of some publicly funded children's mental health services has led to questions about cost-efficiency and cost-effectiveness from Medicaid, CSA, and DBHDS.

Moreover, the services that are now available are dictated primarily by the eligibility and service requirements of Medicaid and CSA – which are targeted to children with severe and well-advanced mental health conditions from low income families. Children who do not meet these eligibility requirements or who need different services from those available under these funding streams simply do not get served.

The vision of the General Assembly to require this planning process, even in this period of serious budgetary and financial challenges, demonstrates the broad support to create an environment where all children, including those with behavioral health diagnoses, can find opportunities to grow, develop, and reach their full potential.

II. Plan Development Process

DBHDS solicited input from a wide variety of stakeholders who are committed to creating a vision of progress and opportunity for Virginia's children. A process was designed that considered the work of many prior studies and plans, and solicited input from stakeholders to create a vision of progress and opportunity for Virginia's children. Previous recommendations from prior reports were compiled and reviewed, including:

- The Office of the Inspector General's Review of CSB Child and Adolescent Services, Report #149-08, September 2008
- The Office of the Inspector General's Survey of CSB Child and Adolescent Services, Report #148-07, March, 2008
- The reports prepared in response to the Policy and Plan Appropriations Items 329G, 330F, 311E, and 315E during the years 2002-2010
- The Voices for Virginia's Children Forums and Report, "Virginians Speak Out", 2010
- The State and Community Consensus Planning Team, 2009
- The Comprehensive Services Act Service Gaps Analysis, 2009
- Commission on Mental Health Law Reform - 2007-2010
- DBHDS Children's Services Special Populations Workgroup, 2005

DBHDS convened three Expert Input Panels:

- ***State Agencies*** – including each of the state child-serving agencies listed in the *Appropriation Act* language and the Office of the Inspector General for the Department of Behavioral Health and Developmental Services (OIG).
- ***Service Providers*** – including CSBs, private providers of community services and supports, and public and private inpatient service providers.
- ***Family Members and Advocates*** – including parents and family members of children receiving services, representatives of family and advocacy organizations, and the Campaign for Children's Mental Health, which includes over 50 supporting organizations.

III. The Target Population

The target population for this plan is identified in the budget language in Item 304.M. as children through age 17 who:

(i) Have a mental health problem; and
(ii) May have co-occurring mental health and substance abuse problems;
(iii) May be in contact with the juvenile justice or courts systems;
(iv) May require emergency services; or
(v) May require long term community mental health and other supports.

Many children with mental health problems (i) also experience the problems in areas (ii) through (v). This combination of factors increases the likelihood that they will need a package of intensive services that meets more serious needs. These children should be identified as early as possible through assessment and triage. Services should be available to them at the earliest possible time to avoid the need for more intensive and costly services later.

IV. The Comprehensive Service Array – A Community-Based System of Care

A Child-Centered, Family-Focused System of Care

Prior Virginia and national reports reviewed as part of this planning process endorse the "system of care" philosophy and enumerate the services that should make up the service array. At the national level, Stroul and Friedman (1986) first published a "system of care" framework, with guiding principles to support it in 1986. The system of care philosophy calls for a coordinated interagency network of services and supports that has the child and family at the center of all planning and care coordination. The sweep of Virginia and national studies and surveys over the past few decades supports the idea that the best place for children to grow and develop in a healthy manner is their own family homes – or as close to their own family homes as possible. The reports collectively conclude that, to the extent that families need help or support to meet the needs of their children, especially when the children have special mental health needs, that help or support should be child and family focused and centered. In those cases where parents encounter challenges meeting their responsibilities as caregivers and mentors, services should help them acquire the skills to meet the goal of keeping the child healthy and in his or her own family. In the rarer cases where parents are found to be unable or unwilling to care for their children, or even a danger to them, kinship-based care (finding other members of the extended family to provide care) is the next best choice. In other, still rarer cases, care must be sought in foster care or residential settings.

In every case, when a choice of care must be made, the form of care that keeps a child in his or her family or as close to it as possible has been shown in the majority of these reports to have improved outcomes. And to the extent that a graduated system of family supports with varying levels of intensity are available to families,

reliance on the most expensive and restrictive services is less needed. A consensus exists in these reports and in the expert testimony DBHDS received for this report that some residential and inpatient services may always be needed, but if a wide array of less intense, family and community based services were commonly available, the need for residential and inpatient care will likely be less than is used today.

While there is substantial agreement about the principles described above and the descriptions of the needed service system that stem from them, availability of all or even most of these services in every region of the Commonwealth has never been achieved. It is the principal recommendation of this plan that the comprehensive service array described below be made available to all children and families in all Virginia communities as soon and as comprehensively as possible.

Funding limitations, restrictions, and categories have played the largest role in the failure to develop this comprehensive system, obviously, but the lack of a clear plan or guide for the development of such a system has also limited planful service growth. It is the intention of this plan to provide that planning framework.

The services listed below are consistently referenced in national system of care and state reports that describe a comprehensive service array. They represent the full continuum of services that should be available and accessible in every community and may be offered by public or private providers. To the extent possible, the services described below are arrayed in ascending levels of intensity, cost, and interruption of home-based, family life:

Children's Behavioral Health Comprehensive Service Array

*(*Note: The numbers in parentheses correspond to the numbered resource documents in Appendix A.)*

Service

Assessment & Evaluation (3,4,5,6,7,8,9)*
• Assessments and evaluations are essential to treatment planning and include screening, triage and referral for services. Some assessments and evaluations are completed for specific purposes, including:
  • Court-ordered evaluations
  • Comprehensive child need evaluations for CSA
  • Parenting role assessment, e.g. for Child Protective Services (CPS) or possible foster care placement
  • Custody evaluations for courts or DSS
  • Psychology services (IQ testing for intellectual disabilities (ID), behavioral, etc.)
  • Substance abuse evaluations for schools, families, etc

Outpatient or Office Based Services (4,5,6,8,9) • Child psychiatry: *diagnosis, treatment, and prevention of mental and emotional disorders in children (In some areas telemedicine - the use of telecommunication equipment and information technology to provide clinical care to individuals at distant site - may be used to extend the reach of this service.) Child psychiatry should be coordinated with pediatric care.* • Medication management: *Medication management is the level of outpatient treatment rendered by a qualified physician, (or others whose scope of practice includes prescribing medication, such as a nurse practitioner), that includes the initial evaluation of the patient's need for psychotropic medications, the provision of a prescription, and, as-needed, ongoing medical monitoring/evaluation related to the patient's use of the psychotropic medication.* • Office based mental health therapy: *mental health counseling or psychotherapy that occurs with the child or family in an office.* • Office based substance abuse treatment: *substance abuse counseling or psychotherapy that occurs with the child or family in an office.* • Educational support for families, skills training: *Supports families by teaching skills to promote desired behaviors by using increased attention and reward for positive behavior, as well as clear communication, effective discipline, problem solving and limit setting. Parents learn to encourage positive social skills and reinforce positive behavior, recognize patterns of parent-child interaction and risk factors.*
Case Management (3,4,5,6,7,8,9) • Children's case management: *Assessing needs, strengths and preferences of the child and family creating a viable plan to assist in accessing, referring, and linking to needed services and supports, actively monitoring both the delivery of services and measurable outcomes. The case manager supports and assists the child and family to address unmet needs, and collaborates with other agencies to assure coordinated services..* Intensive care coordination: *assesses and assists children and their families that are at risk of or who are placed out-of home with accessing needed services that safely and effectively maintain, transition, or return them home or to a relative's home, family like setting, or community at the earliest appropriate time.* *The case manager also plays a role in assuring quality management and efficient use of services, representing an extension of the CSB's responsibilities in this area with regard to publicly funded services.*
Home and Community Based Services (3,4,6,7,8,9) • Home based family therapy services: *mental health counseling or psychotherapy that occurs with the child and family in the home.* • Intensive in-home services: *services may include crisis intervention/treatment; individual and family counseling; life, parenting, and communication skills; and 24 hour per day emergency response. By delivering the service in the home, clinicians are able to address family system issues and support parents in effective behavioral techniques* • Mental health support services: *training and support to enable adolescents with significant psychiatric functional limitations to achieve and maintain community stability and independence in the most appropriate, least restrictive*

environment.

- Behavioral therapy and supports for families: *treatment and supports that involve the family and teaches them how to utilize behavioral therapy techniques to improve family functioning. Behavioral therapy techniques involve learning how to modify maladaptive behavior patterns by substituting new responses to given stimuli for undesirable behavior patterns.*
- Independent living supports for youth/young adults: *supports and resources that maximize independence and self determination of youth and young adults so that they can live safe and productive lives in the community*
- School based 1:1 therapy: *mental health counseling or psychotherapy that occurs between youth and therapist in the school setting*
- School based 1:1 behavioral specialists: *specialists use behavioral therapy techniques in the school setting to modify maladaptive behavior*
- School based therapeutic day treatment (mainstream): *a combination of psychotherapeutic interventions combined with medication education and mental health treatment offered in the school setting. If mainstreamed the interventions occur in a setting where the children are in a regular education class room with same age peers*
- School based therapeutic day treatment (self contained*): a combination of psychotherapeutic interventions combined with medication education and mental health treatment offered in the school setting. If self contained interventions occur in a setting where the child is removed from the general school population for all academic subjects to work in a small controlled setting with a special education teacher.*
- School based after school therapeutic day treatment: *a combination of psychotherapeutic interventions combined with medication education and mental health treatment offered in the school setting during after school hours.*
- Summer programs for special education/behavioral challenges: *summer programs that offer educational, recreational and therapeutic activities for children and adolescents with special education and behavioral challenges.*
- Services in juvenile detention centers: *mental health screening, assessment and therapeutic services that are provided in juvenile detention centers*

Intensive Community Supports (3,4,5,6,7,8)

- In home family supports (ongoing): *intensive support services that occur in the home setting on a regular basis; may include mental health, physical health, social services and community resources.*
- Respite: *service that provides short term care, supervision and support to youth for the purpose of providing relief to the primary care giver while supporting the emotional, physical, and mental well-being of the youth and their family/guardian.*
- Sponsored placements
    - specialized foster care: *payment for basic maintenance care and for additional daily supervision for children who are living in a regular foster family home that has been approved by the local agency to receive special needs/specialized payments in addition to the basic maintenance payment; the additional service payment is granted due to the difficulty of care of the child; includes all services, including community-based mental health services, provided to these children while they are living in the specialized foster home.*

therapeutic foster care: *payment for basic maintenance care and therapeutic services for children who are living in a foster family home where a trained foster parent provides care through a licensed child placing agency or local agency's defined foster care therapeutic program. The family may receive mental health services such as treatment foster care for their children in this type of placement. Treatment foster care is case management services that are directed toward children or youth in foster care with a behavioral disorder or emotional disturbance; the case manager provides treatment planning, monitors the treatment plan, and links the child to other community resources as necessary to address the special identified needs of the child..*

Community Crisis Response Services (3,4,5,6,7,8,9) 24/7 on-call specialized children's emergency service access: *emergency services which includes certified pre-screeners with child-specific expertise, more staffing, 24/7 response capacity and children's specialty services*

- Mobile child crisis response service (to schools, home): *mobile team comprised of clinical and case management staff that can assess triage and provide treatment services for a child in multiple locations including, home, school, after-school program or other community location. Such teams ideally have a psychiatrist.*
- In-home crisis stabilization support services: *direct mental health care to non-hospitalized children experiencing an acute crisis of a psychiatric nature that may jeopardize their current community living situation. The goals are to avert hospitalization or re-hospitalization; provide normative environments with a high assurance of safety and security for crisis*

intervention; stabilize children in psychiatric crisis; and mobilize the resources of the community support system, family members, and others for ongoing maintenance, rehabilitation, and recovery.

- Emergency respite care placement service: *Alternative temporary home where a child can be temporarily moved in order to diffuse a crisis, stabilize the child, or offer respite to parent(s).*
- Crisis stabilization unit for children: *local or regional short-term residential crisis stabilization in a place that is staffed to provide assessment, prescreening, temporary detention, treatment and care planning.*

Residential

- Group home: *Placement of children outside of their family homes in licensed residential programs that are characterized by a supervised homelike environment in a single family residence that serves groups of children (up to 8 youth) who have behavioral/emotional difficulties and/or physical or mental disabilities. Includes placement of children in apartments located in one complex where daily substitute parental supervision is provided and the programs are licensed as residential programs. Group homes may provide social, life or vocational skills training. They may provide emergency placements. Includes all services provided to children while living in the group home (e.g., outpatient, respite care, crisis stabilization, assessment, child behavioral aides). Includes many services to the children's families that are provided in the group home and group home community.*
- Residential treatment: *Placement of children outside of their family homes in licensed residential care programs that provide 24-hour supervised care to groups of children (e.g., secure residential treatment facilities, campus-style residential programs, group homes on the campus of a residential facility, group homes that serve more than 9 youth). Programs may provide intensive treatment services such as medication management, nursing care, occupational therapy, crisis stabilization, assessment, social skills training, group therapy, individual therapy, family therapy, etc. Includes all services provided to children while living in the residential program (e.g., outpatient, respite care, crisis stabilization, assessment, child behavioral aides). Includes many services to the children's families that are provided in the residential facility and residential facility community.*

Inpatient

- Acute Inpatient Care: *services in a public or private acute care psychiatric unit of a licensed medical hospital or licensed free-standing psychiatric hospital for stabilization of harmful behaviors (to self or others) and/or mental health issues, such as psychosis.*
- Substance abuse detoxification or SA residential treatment: *addiction treatment or detoxification service that occurs outside of a child's family home in a 24 hour supervised care residential treatment setting*

*(*Note: The numbers in parentheses correspond to the numbered resource documents in Appendix A.)*

V. Current Status of the System

Virginia's behavioral health services system for children faces a number of challenges, the most significant of which follow.

1. All communities have an incomplete array of services.

Many Virginia communities have very few of the services that make up the comprehensive array. Still others with excellent service systems have major gaps. Both the OIG Report (OIG, 2008) and the annual CSA Service Gap Analysis (CSA, 2007, 2008, 2009) show the lack of a complete children's service array in all areas of the state. Some areas in Virginia have excellent service systems that provide many of the services listed in the *Children's Behavioral Health Comprehensive Service Array* table in Section VI, yet these same communities may have major gaps in service or not enough capacity (ability to meet all presented needs) of a particular service.

The Expert Input Panels formed for this planning process also noted that the quality of a service and how it is provided varies from one service provider to another. Services that are most widely found in CSBs (listed in descending order of commonality) include (OIG, 2008):

i. Case management
ii. Outpatient Therapy

iii. Home-based Therapy
iv. School-based Therapy

The FY09 CSA Service Gap Analysis (CSA, 2009) that surveyed 131 local Community Policy and Management Teams reported the following services as the top 10 service gaps:

- Crisis Intervention and Stabilization
- Intensive Substance Abuse Services
- Emergency Shelter Care
- Acute Psychiatric Hospitalization
- Regular Foster Care/Family Care
- Parenting/Family Skills Training
- Transportation
- Psychiatric Assessment
- Respite
- Family Assessment

The CSA Service Gap Analysis also provided a summary of the most significant barriers to community service availability. The most significant barriers included lack of flexible funding or program start up funds and lack of collaboration among community stakeholders. Survey respondents stated they believed they could improve the service array in their respective communities if they were able to pool resources and funding across community partners, and if they could demonstrate the need for and value of certain services to local decision makers.

2. In many of the services that are available, there is inadequate capacity resulting in children and families waiting for services.

Even when services are present, in most communities there is not sufficient capacity for all the children that need them. Most CSBs have a waiting list for services. To document existing service demands, DBHDS asked CSBs to complete a point-in-time survey of each individual identified by the CSB as being in need of specific services during the first quarter of calendar year 2009. This waiting list information includes individuals who sought service and were assessed by that CSB as needing the service.

It is important to note that this information does not fully reflect the unmet need as it does not capture the number of individuals who requested service from a CSB, but it did not follow through with the assessment process when they learned there was a waiting list for that service. Needed services and average service wait times by program area are depicted for children and adolescents (age birth through 17) on the following table. The information in the table was taken from the DBHDS Comprehensive State Plan 2010-2016.

Services Needed by Children & Adolescents on Community Services Board Waiting Lists January –April 2009

Service	Average Wait Time in Weeks
Psychiatric Services	7
Medication Management	12
Counseling & Psychotherapy	5
Case Management	3
Therapeutic Day Treatment	9

Intensive Substance Abuse Outpatient	3
Substance Abuse Outpatient	5
Substance Abuse Case Management	3

An additional challenge is that for some services capacity is sufficient but quality is a significant concern. The most notable example of this is Medicaid-reimbursed intensive in-home services. Intensive in-home services are available statewide and are provided by both private and CSB providers. This seems to indicate the need for greater quality assurance through the collaborative efforts of the state agencies. Review and control of quality, costs, and provider qualifications of Medicaid-funded Intensive In-Home and Therapeutic services is a strong focus area of DMAS and DBHDS.

3. There is inconsistency across the state in the array and the capacity of services.

The range of services varies significantly among different localities. The 2008 Office of the Inspector General (OIG, 2008) Report on CSB Child and Adolescent Services described the lack of consistency and uniformity in children's services as provided or contracted by CSBs throughout the Commonwealth. This is the most recent data on service availability available. A few communities had a significant array of services, but all systems had major gaps, especially in meeting the crisis needs of children and families and in cases where family supports have been inadequate to prevent out-of-home placements. When services were present, often there were waiting lists to gain access due to shortages or limited service capacity. Most communities reported limited ability to intervene early, before problems worsen. Some communities had virtually no mental health services for children. Families seeking services face great differences in service availability depending on where they live. The OIG and the Report of the System of Care Advisory Team recommended that a base level of services be made available in every community.

The Expert Input Panels supported this recommendation. Each CSB should have sufficient resources and be expected to provide, or promote or encourage the provision of a base level of services and supports.. These could be provided locally or, in the case of smaller and rural localities, through a regional partnership of CSBs. At present, only emergency services and case management (as funds are available) are required by the *Code of Virginia*.

It is important to note that inconsistency exists not only in the *availability of services* in different parts of the state, but in the *funding sources* that are available to families. Families are challenged in finding services for their children when they are not covered by Medicaid, or when the child is not in the CSA-mandated category. This complicates the problem of inconsistency. Even in an area of the state with a good array of services, some families may not be able to access the services because of funding limitations.

4. Because of the incomplete array, inadequate capacity, and inconsistency, many children do not receive services early enough, which may mean their conditions worsen and result in delayed, more restrictive, and more costly services. Many other children, who do not meet the eligibility or service definition of the predominant funding streams – Medicaid and CSA – simply cannot find access to services to meet their needs.

The combined factors of incomplete array of services, inadequate capacity and inconsistency across the state, and limited access cause many children not to receive services early enough. Many also do not receive the intensity of services needed. For many, the result later in the need for more restrictive treatment approaches such as inpatient and residential care.

The OIG Survey of Community Service Board Child and Adolescent Services (OIG, 2008) data showed that no CSB offers all 48 of the services listed in the survey. The survey also identified 5 highly specialized, high-impact services according to stakeholders and CSB staff that offer the most promise in serving children with

severe needs and help reduce the need for more intensive placements such as residential treatment. These services are specialized:

- Children's emergency services;
- Crisis stabilization;
- Home-based therapy;
- School-based day treatment; and
- Local residential services, such as small group homes

Yet only two CSBs offer all five of these specialized intensive services. A fully developed continuum of services and supports would reduce many communities need to rely on high cost and highly restrictive treatments. It would also allow for children to be served in settings that are either in the home or in the home community. A community-based system of care allows for earlier intervention, families to stay together, and services that are close-by in families' home communities (SOCAT, 2007).

5. Workforce development is needed to support a comprehensive system.

Even if funding were available to expand services, finding and retaining qualified providers for all parts of the Commonwealth would still be a challenge. Currently, training for professionals in the children's behavioral health field is fragmented and reliant on individuals and separate agencies to seek out the training they need on their own. In order to support quality service provision and assure consistency, training is needed to assure that service providers have the knowledge and skills that are required to be effective. Without statewide training, there is no way to assure that the comprehensive service array will be implemented according to best practice standards. There are areas of training expertise in Virginia, including some CSBs, public and private community providers, universities, the children's services transformation and the support of the Annie E. Casey Foundation, the CSA, and the CCCA. However, there is not a coordinated approach to training that could harness and share this expertise.

To better understand specific workforce development needs, DBHDS, with the assistance of the Virginia Partnership for People With Disabilities, recently conducted an online survey to determine the type of professional development and family support needed in Virginia. A total of 527 individuals completed the survey. Their responses, along with the input from the Expert Panels pointed to the following workforce development needs:

a. *A statewide children's behavioral health workforce development initiative is needed:*

- DBHDS should administer this initiative in collaboration with public and private service providers.
- The workforce development initiative should be guided by this comprehensive plan.
- DBHDS should establish a workforce and training advisory task force to develop the scope of training that should be offered.
- Collaborations with one or more universities and community colleges would enhance the expertise available to implement the initiative.
- Further, the workforce development initiative should be closely coordinated with the DBHDS Case Management initiative currently underway. Training and potential certification of case managers is part of the DBHDS case management initiative.

b. Training through the workforce development initiative should include the following topic areas, as well as others developed by the advisory task force:

- System of care philosophy, implementation and conceptual models supporting the comprehensive service array;
- Hands-on training for each of the services in the comprehensive array, with special emphasis on crisis response services and other services that reduce reliance on more restrictive and costly care;

- Special skills needed to serve children involved with the juvenile justice system;
- Case management – training on assessment and other key case management skills. Training should be coordinated with the DBHDS case management initiative and the possibility of case manager certification should be considered;
- Education and skill building for parents and families - increasing their knowledge and teaching skills to care for and access services for their children.
- Education for providers planning to develop parent education programs; and
- Other topics that support progressive implementation of this plan.

c. Training delivery approaches and mechanisms should include:

- Collaboration with other state agency partners, DSS, DJJ, DOE, OCS and DMAS to assure interagency coordination;
- Time-limited, topic specific workshops;
- Statewide conferences;
- Regional training events targeted to rural or urban service development needs;
- Training groups that meet monthly over a period of time;
- Programs that assist license-eligible staff in completing licensure requirements;
- Online web-based training venues, webinars, teleconferences and other electronic media; and
- Continuing education should be documented and certificates issued upon completion.

6. There is inadequate oversight and quality assurance for the services that do exist.

Expert panel members identified the need for quality assurance to support the children's behavioral health system. They identified the following issues:

- Quality assurance monitoring of the care of individual children is needed to assure that children in the target population receive the appropriate level and type of services to meet their needs in a timely manner.

- When new funding is appropriated for children's services, it can later be diverted for other purposes during budget reductions.

- Reliable, accurate, and consistent data about children's mental health services is not readily available to document and evaluate service efficiency and effectiveness across all providers and agencies.

- Inadequate staff in the DBHDS Office of Licensing reduces the ability of the licensing function to assure quality programs, to assist new programs in coming on-line and to implement corrective action plans when necessary.

- Collaborative efforts among the state agencies are needed to address quality issues through cross-agency coordination, e.g. the current DMAS, DBHDS, OCS, and private provider collaboration to address quality challenges in the Medicaid State Plan Option services.

- Though children with behavioral health problems often need the services of more than one agency, the agencies do not have a common metric to measure success. While each agency may strive toward a similar goal, there is no data system that would define success across behavioral health, social services, juvenile justice and education.

VI. The Future Role of the Commonwealth Center for Children and Adolescents

At the present time the role of CCCA is to provide high quality inpatient services for the most challenged and traumatized children in Virginia and to work with communities to return them to their homes in the shortest

clinically feasible time. While inpatient care is an essential component of the comprehensive service array, its restrictiveness and cost necessitate using it only when there is no other alternative. Filling gaps in community services can be expected to decrease the demand for inpatient services. Just as is the case with an under-developed array of services and supports for adults, an even greater shortage of community-based services has caused an over-reliance on inpatient and residential treatment models for children. The number of public inpatient beds for children has declined steadily over the past two decades - from over 160 in the late 1980s to 48 at the present time.

For some children, hospitalization or residential placement occurs unnecessarily, or for a longer time, because other services in the comprehensive array are not available in their home community, especially:

- Crisis response services, crisis stabilization services (either mobile or a crisis stabilization short-term bed).
- Alternative temporary foster homes for stabilization and/or family respite.
- Intensive community support services – services that "wrap around" a child and family to meet their individual needs.
- Needed service alternatives should not be dictated by the current scope of Medicaid or CSA payments. (Many children who need these services do not qualify for these programs.)

The following table summarizes utilization data of the combined 64 beds at CCCA and SWVMHI by CSB region for FY09 and FY10. Regional utilization of these public resources varies according to the availability of other options for serving children with intense service needs. For example, some regions have developed crisis stabilization services and have been able to reduce their need for public inpatient services. Region IV has a planning process currently underway to develop mobile and bed-based crisis stabilization services which promises to reduce the need for inpatient services.

Summary Data for FY 09 and FY10
(July 1, 2008 – June 30, 2010)
Commonwealth Center for Children and Adolescents &
Southwestern Virginia Mental Health Institute Adolescent Unit

Health Planning Region (HPR)*	Admitted	Discharged	Bed Days	Avg. Daily Census	Bed Days per 100K, Age 0-17 Population**
I-FY09	244	250	3,674	10.1	1,309.55
I-FY10	212	197	3,051	8.4	1,087.49
II-FY09	119	125	2,338	6.4	438.38
II-FY10	111	107	1,771	4.9	332.07
III-FY09	216	222	2,818	7.7	1,001.45
III-FY10	185	199	2,099	5.8	745.94
IV-FY09	153	127	3,082	8.4	984.95
IV-FY10	154	139	2,713	7.4	867.03
V-FY09	68	85	1,359	3.7	298.25

* ***HPR I*** *includes Central Virginia CSB, Harrisonburg-Rockingham CSB, Northwestern CSB, Rappahannock Area CSB, Rappahannock-Rapidan CSB, Region Ten CSB, Rockbridge CSB, Valley CSB*

HPR II *includes Alexandria CSB, Arlington CSB, Fairfax-Falls Church CSB, Loudoun CSB, Prince William CSB*

HPR III *includes Allegheny-Highlands CSB, Blue Ridge Behavioral Health, Cumberland Mountain CSB, Danville-Pittsylvania CSB, Dickenson County CSB, Highlands CSB, Mount Rogers CSB, New River Valley CSB, Planning District One, Piedmont CSB*

HPR IV *includes Chesterfield CSB, Crossroads CSB, District 19 CSB, Goochland-Powhatan CSB, Hanover CSB, Henrico Mental Health, Richmond Behavioral Health, Southside CSB*

HPR V *includes Chesapeake CSB, Colonial CSB, Eastern Shore CSB, Hampton-Newport News CSB, Middle Peninsula-Northern Neck CSB, Norfolk CSB, Portsmouth CSB, Virginia Beach CSB, Western Tidewater CSB*

V-FY-10	87	98	1,678	4.6	368.26
Statewide-FY09	793	792	13,271	36.4	712.03
Statewide-FY10	749	740	11,312	31.0	606.92

Population Census Source: 2008 estimate for ages 0-17; Weldon Cooper Center

The statewide average daily census shown above is 36.4 for FY09 and 31for FY10; the average daily census for CCCA alone for FY 10 was 24.7, indicating that the current capacity is adequate. (CCCA was evacuated to WSH for 5 months and only had 24 operational beds during this time.) The CCCA average daily census for July and August, 2010 (the period of time since the closure of 16 beds was fully implemented) was 30.6 beds.

If the comprehensive community service array can be expanded over the next four to eight years, the need for public inpatient services can be projected to continue to decline. However, if there is no growth in community services, then the role of CCCA and the demand for its services will likely stay the same.

VII. Recommendations

The following recommendations are made as strategic initiatives that the General Assembly may want to consider moving forward in the future. These initiatives could be implemented in a phased manner in future years, as the state's budget scenario improves.

1. Define and promote through DBHDS the full comprehensive service array as the goal and standard for children's behavioral health services in every community.

The services in the *Children's Behavioral Health Comprehensive Service Array* table in Section VI are the full continuum of services that would enable a community to appropriately, safely and effectively serve children with behavioral health problems in their homes and communities. If all of these services were available, children would be served closer to home, and earlier intervention would lessen the severity of their conditions, strengthen their family and community supports, and the need for children to be served in inpatient or residential settings would greatly diminish. Achieving this standard should be the expectation for each CSB and the communities it serves, either by directly providing or collaborating with other agencies to provide the services.

An implementation step for this plan is to gather current and accurate information from each CSB regarding the availability of the full continuum of services. DBHDS will develop and conduct an updated survey of the following information by CSB:

a. whether they provide each service
b. whether they have the service in sufficient capacity
c. how many children received the service in the fiscal year
d. expenditures for each service
e. whether the service is provided privately in their community

Data will also be gathered from CSA, DMAS and other sources to document the range and capacity of publicly-funded children's behavioral health services provided by private sector agencies. This information will be used to determine the distribution of any future funding appropriations for CSBs and to suggest targets for funding and emphasis on service development for other publicly-funded services.

2. Expand the array and capacity of services to assure a consistent base level of services for children and families statewide.

A lack of consistency and uniformity in children's behavioral health services has been cited in this and previous reports. The range of service gaps is large and varies from community to community. It is highly unlikely that widespread service growth can occur in all services, in all communities, in a rapid fashion. To

address this disparity of service availability in a planful, graduated fashion, the General Assembly may want to fund a base level of children's behavioral health services to be provided consistently across the Commonwealth. This could be accomplished through state general funds and Medicaid funding over the next two biennia. Any new funding appropriated would be used to support the base services. The services should be developed through strengthened private-public partnerships and collaboration. The base services should include:

a. ***Crisis Response Services*** – While all CSBs provide emergency services, very few provide services that actually stabilize crises and allow the child to stay in their family, or in a safe, family-like environment in their own community. Crisis stabilization services should be available as alternatives to inpatient care and to intervene early before more restrictive alternatives are necessary. In locations where it is not practical for an individual CSB to provide crisis stabilization, it could be available through a regional arrangement or contract with a private entity. The range of crisis services should include:
   i. Expanded CSB child-specific emergency services, including certified pre-screeners with child-specific expertise, more staffing, 24/7 response capacity, children's specialty services. (Few CSBs have specialized children's services emergency on-call capacity.)
   ii. Mobile crisis teams: 24/7 response to the child's home during crises
   iii. Crisis stabilization: Regional or local 24/7 availability of child and family support services provided in times of crises. Crisis stabilization may be either mobile outreach or a bed in a crisis stabilization unit, or temporary foster home.
   iv. Next day availability of psychiatric and medication evaluation after initial crisis response, including exploration of telemedicine approaches

b. ***Case Management and Intensive Care Coordination*** - CSB case management is currently required as funds are available. It is recommended that case management be available to all children with behavioral health problems without regard to funding source, and be available at the level of intensity necessary to achieve quality service coordination. While all CSBs provide some case management for children, many do not have the low caseload, intensive levels of support for high-need children and families. For intensive care coordination, the level of intensity requires a caseload of 7 to 12 children and an experienced case manager.

c. ***Psychiatric Services*** – greater availability of child psychiatrists, nurse practitioners, and medication management. This can be enhanced through expanded telemedicine technology, especially in underserved areas. Development of collaborative physician networks between psychiatrists, pediatricians and primary care providers.

d. ***In-Home Services*** – this service is widely available statewide, but there are significant issues with quality. Medicaid data indicates that 23 CSBs were reimbursed $4,394,839.22 in FY10 for providing this service. Private providers were reimbursed $172,122,251.07 in FY10 for this service. DMAS is working with DBHDS, the CSBs and private providers to develop regulatory and rate changes designed to reduce costs and assure greater quality of this service.

3. Establish a children's behavioral health workforce development initiative to be organized by DBHDS

There should be an organized, statewide workforce development initiative as described in Section VII that supports implementation of this plan by meeting the training needs of service providers, including the following:

a. Collaborative partnerships with other state agencies, private agencies, state universities and academic medical centers, and the Virginia Community College System to offer training.

b. Training events on critical topic areas that will improve the knowledge and competency of the workforce regarding serving children with behavioral health problems.

c. Information, education and skill development for families and parents.

d. Internship, fellowship and residency opportunities for behavioral health professionals, including social workers, psychologists, case managers, psychiatrists and pediatricians.
e. Expanded capacity for web-based training, including webinars, teleconferences and use of other on-line training media.

4. Continue the current role of CCCA for the foreseeable future, and until more adequate community-based services are in place.

CCCA should continue to provide high quality acute inpatient services for the most challenged and traumatized children in Virginia and to work with communities to return them to their homes in the shortest clinically feasible time.

5. Establish quality management mechanisms and metrics to improve access and quality in behavioral health services for children and families.

DBHDS in collaboration with its interagency partners, should strengthen mechanisms for quality management and quality assurance for services and funding:

a. Create a quality assurance process to include the following two types of monitoring:
   i. Monitoring of the care of individual children
   ii. Monitoring to assure that the children most in need have access to services, even if they are not Medicaid or CSA-eligible.
   iii. Monitoring to assure that funding appropriated for children's behavioral health services remains fully designated for that purpose in CSB budgets.
b. The role of the case manager should be expanded – and is the key - to assure quality management at the individual case level for publicly funded services.
c. Improve the quality, accuracy and completeness of CSB data collection and reporting. This would provide the information that is critical to a quality assurance process.
d. In order to accomplish this recommendation, DBHDS will need funding resources for:
   i. Additional licensing staff to assure appropriate oversight and quality review.
   ii. State quality assurance/child service monitoring staff.
   iii. State data experts to create the capacity to analyze and produce user-friendly reports using CSB service and funding data. These reports would inform the quality monitoring process.
e. DBHDS should play an active role in DMAS initiatives to improve quality in the provision Medicaid State Plan option services.
f. The state child-serving agencies should seek ways to develop common methods and metrics to measure success.

Funding Priorities

The General Assembly might consider gradual funding of these recommendations over successive fiscal years, beginning with FY2013. **The priority recommendation is Recommendation #2: *Expand the array and capacity of services to assure a consistent base level of services for children and families statewide.*** The consistent availability of the base services would have the greatest potential to reduce unnecessary reliance on inpatient and residential care.

Final Report

DBHDS will gather current, detailed information about the status of statewide service array, capacity and consistency in all communities. Based on this data DBHDS will identify, by CSB and community, the specific needs to reach both the base level of services and sufficient capacity in every community. Corresponding budget needs will be included for subsequent biennia. This final report will be presented in 2011.

I. Appendices

A. Resource Documents

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Report 148-07 *Survey of Community Services Board Child and Adolescent Services.* March 31, 2008. http://www.oig.virginia.gov/documents/SS-CACM-148- 07.pdf

Voices for Virginia's Children Statewide Forums. April-May 2010
http://1in5kids.org/meetings-and-events/index.html

Voices for Virginia's Children. *"Virginians Speak Out: A Report from the Campaign for Children's Mental Health".* July 2010.
http://www.1in5kids.org/meetings-and-events/forum%20report%20FINAL.pdf

B. Children's Behavioral Health Services Planning Process: Expert Input Panels

Expert Input Panels

State Interagency Panel	Service Provider Panel	Family and Advocacy Panel
1. Jim Martinez *Department of Behavioral Health and Developmental Services* 2. Paul McWhinney *Department of Social Services* 3. Scott Reiner *Department of Juvenile Justice* 4. Paul Raskopf *Department of Education* 5. Charlotte McNulty *Office of Comprehensive Services* 6. Karen Lawson *Department of Medical Assistance Services* 7. John Pezzoli *Office of the Inspector General*	1. Don Roe *Commonwealth Center for Children and Adolescents* 2. Cal Whitehead *Psychiatric Society of Virginia* 3. Chuck Hall *Hampton-Newport News Community Services Board* 4. Sandy Bryant *Central Virginia Community Services Board* 5. Deborah Warren *Alexandria Community Services Board* 6. Gina Wilburn *Blue Ridge Behavioral Health Authority* 7. Greg Peters *United Methodist Family Services, VCOPPA* 8. Betty Long *Virginia Hospital and Healthcare Association*	1. John Morgan *Voices for Virginia's Children* 2. Karin Addison *American Academy of Pediatrics-Virginia Chapter* 3. Colleen Kraft *American Academy of Pediatrics-Virginia Chapter* 4. Paula Price *Family/Mental Health America Virginia* 5. Carol Obrochta *Family* 6. Naomi Verdugo *Family/National Alliance on Mental Illness* 7. Clare Nugent *Family* 8. Alisa Cowen *Family/National Alliance on Mental Illness* 9. Margaret Nimmo-Crowe *Voices for Virginia's Children*

C. Children's Behavioral Health Services Planning Process: Expert Input Panel Discussion Guide

1. What services are needed? (Use the service array document for guidance). If you were given unlimited funds to spend on the development of services what services would you choose to include?

2. What are the concrete steps and strategies needed to create/increase this service or core array of services to reduce need for more expensive services, juvenile justice involvement?

3. What services are hardest to get? What makes them hard to get?

4. What could be done to make services easier to get and more helpful? In the community and also statewide.

5. What are the alternatives to inpatient treatment (either public or private)?

6. What should be the role of the Commonwealth Center for Children and Adolescents today? Going forward?

7. Do different families need different kinds of support? Describe the types of supports or training that would be helpful to families?

8. Recommendations. Please review the list of recommendations that have been made in previous reports over time. Do you agree with them? Are there others that are among the highest priority?

9. Rank recommendations_____1, 2, 3 in priority order. These would be recommendations that should be advanced when future funding is available.

10. Are there other comments? Are there things we haven't asked about that you want to bring out?