DBHDS

Virginia Department of Behavioral Health and Developmental Services

Item 304.M. – Final Report:

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

To the Chairs of the House Appropriations and Senate Finance Committees

November 1, 2011

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October 24, 2011

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

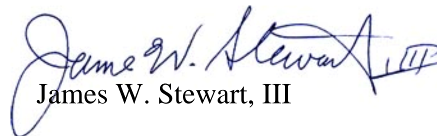
Dear Senator Colgan:

Pursuant Item 304.M. of the 2011 *Appropriation Act*, enclosed is the final 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 and that clarifies the role of the Commonwealth Center for Children and Adolescents.

This final report includes the findings from the interim report (Report Document 240, 2010) and reflects the input of expert panels made up of state agency representatives, service providers, family members and advocates.

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 24, 2011

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 2011 *Appropriation Act*, enclosed is the final 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 and that clarifies the role of the Commonwealth Center for Children and Adolescents.

This final report includes the findings from the interim report (Report Document 240, 2010) and reflects the input of expert panels made up of state agency representatives, service providers, family members and advocates.

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

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EXECUTIVE SUMMARY

Item 304.M. of the *Appropriation Act* directs 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.*

In October 2010, the Interim Report was submitted that provided information on the planning process, the recommended comprehensive service array and the current status of the system. This Final Report identifies by community services board, the specific needs to reach both the base level of services and the full comprehensive service array statewide.

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 includes 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 the Commonwealth Center for Children and Adolescents (CCCA) for the foreseeable future, and until more adequate community-based services are in place.**

5. **Establish quality management mechanisms 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 FY2012. **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.

Introduction

Item 304.M. of the *Appropriation Act* directs 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.

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 prior initiatives 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 have been administered separately at the state level. Recent organizational changes by the administration 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 includes funding from the following sources: the state General Fund, federal mental health block grants, local government, Medicaid, and 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, Education, CSBs, CSA, and the well-developed network of privately operated, publicly-funded children's services. The need for collaboration among 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-serving agencies about the goals, principles, and vision of an expanded and effective "system of care" for children and families. 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.

I. Plan Development Process

In the spring and summer of 2010, DBHDS prepared an Interim Report for presentation to the General Assembly as required by Item 304.M. The Interim Report was submitted on October 1, 2010 and is appended to this Final Report. DBHDS used an input gathering process that included all of the stakeholders named in the *Appropriation Act*. A thorough review was conducted of many prior studies and plans. 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 Reports, 2010 and 2011
- 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 to review these plans and form a consensus about current needs and priorities:

- ***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

The fundamental characteristic of an adequate system of services for children and families is that the services should be coordinated and complementary. 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 planned service growth. It is the intention of this document to provide that planning framework.

During the first year of the planning process, national system of care and state reports were researched and compared. As a result of that analysis, consensus was achieved on a children's behavioral health comprehensive service array for Virginia. The Interim Report included a full description of each service and the comprehensive service array is appended to this Final Report (Appendix B.) The comprehensive service array is also summarized by the table below. The services in the comprehensive service array 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 are arrayed in ascending levels of intensity, cost, and interruption of home-based, family life.

Children's Behavioral Health Comprehensive Service Array
Assessment & Evaluation
Outpatient or Office Based Services • Child psychiatry • Medication management • Office based mental health therapy • Office based substance abuse treatment • Educational support for families, skills training
Case Management • Children's case management • Intensive care coordination
Home and Community Based Services • Home based family therapy services • Intensive in-home services • Mental health support services • Behavioral therapy and supports for families • Independent living supports for youth/young adults • School based 1:1 therapy: • School based 1:1 behavioral specialists • School based therapeutic day treatment (mainstream) • School based therapeutic day treatment (self contained) • School based after school therapeutic day treatment • Summer programs for special education/behavioral challenges • Services in juvenile detention centers
Intensive Community Supports • In home family supports (ongoing • Respite • Sponsored placements – specialized foster care; therapeutic foster care
Community Crisis Response Services 24/7 on-call specialized children's emergency service access • Mobile child crisis response service (to schools, home) • In-home crisis stabilization support services • Emergency respite care placement service • Crisis stabilization unit for children

Residential – Group homes and residential treatment
Inpatient • Acute Inpatient Care • Substance abuse detoxification or SA residential treatment

V. Current Status of the System

In the time available before the publication of the Interim Report, DBHDS relied on existing sources of data to define current service capacity in communities and document needs. This process supported a set of preliminary findings and recommendations that were presented in the Interim Report.

Report Findings and Data

1. All communities have an incomplete array of services.

Interim Report Findings and Data - The data available for the Interim Report showed that many Virginia communities had very few of the services that make up the comprehensive array. Still others with excellent service systems were seen to 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 had excellent service systems that provide many of the services listed in the comprehensive continuum, 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 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:

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**

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.

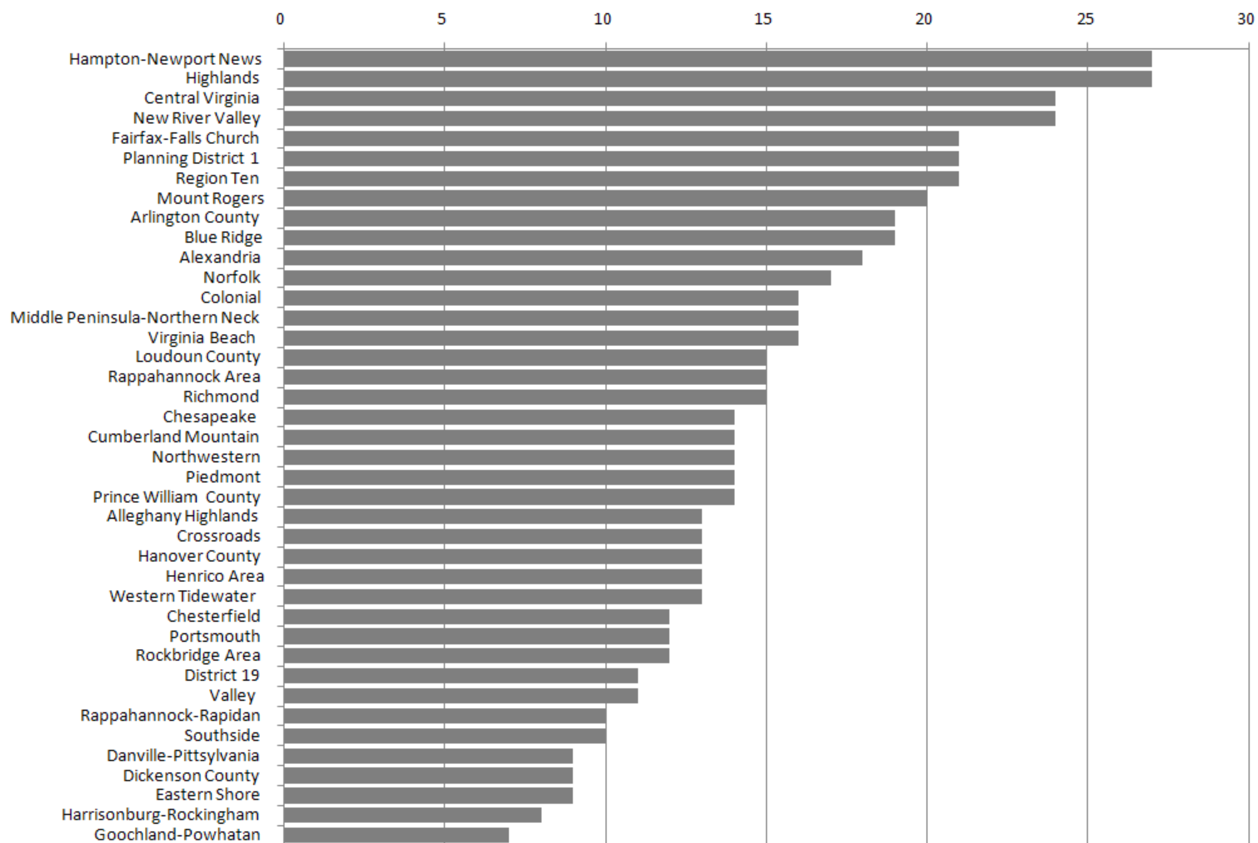
Final Report Findings and Data - In preparing this Final Report, DBHDS conducted a comprehensive survey of children's services. The purpose of the survey was to bring the findings and data up to date and test the validity and provide actual data to support the Interim Report's recommendations.

The survey consisted of a 37- item questionnaire that was distributed to each of the 40 Virginia CSBs by DBHDS' partner in this research effort, the Child and Family Services Council of the Virginia Association of Community Services Boards. The survey was conducted from November 2010 to January 2011, with all final responses from the 40 CSBs completed in January 2011.The survey assessed the array of services available from each CSB in 2011.

Table 1, *"Number of Service Types Provided by CSBs"*, provides data from the survey to show the extent to which the CSBs provide the services in the comprehensive service array. There are a total of 37 services in the comprehensive service array. Table 1 shows how many of the 37 services in the comprehensive service array are provided by each CSB. The CSBs are listed in order of how many of the services they provide.

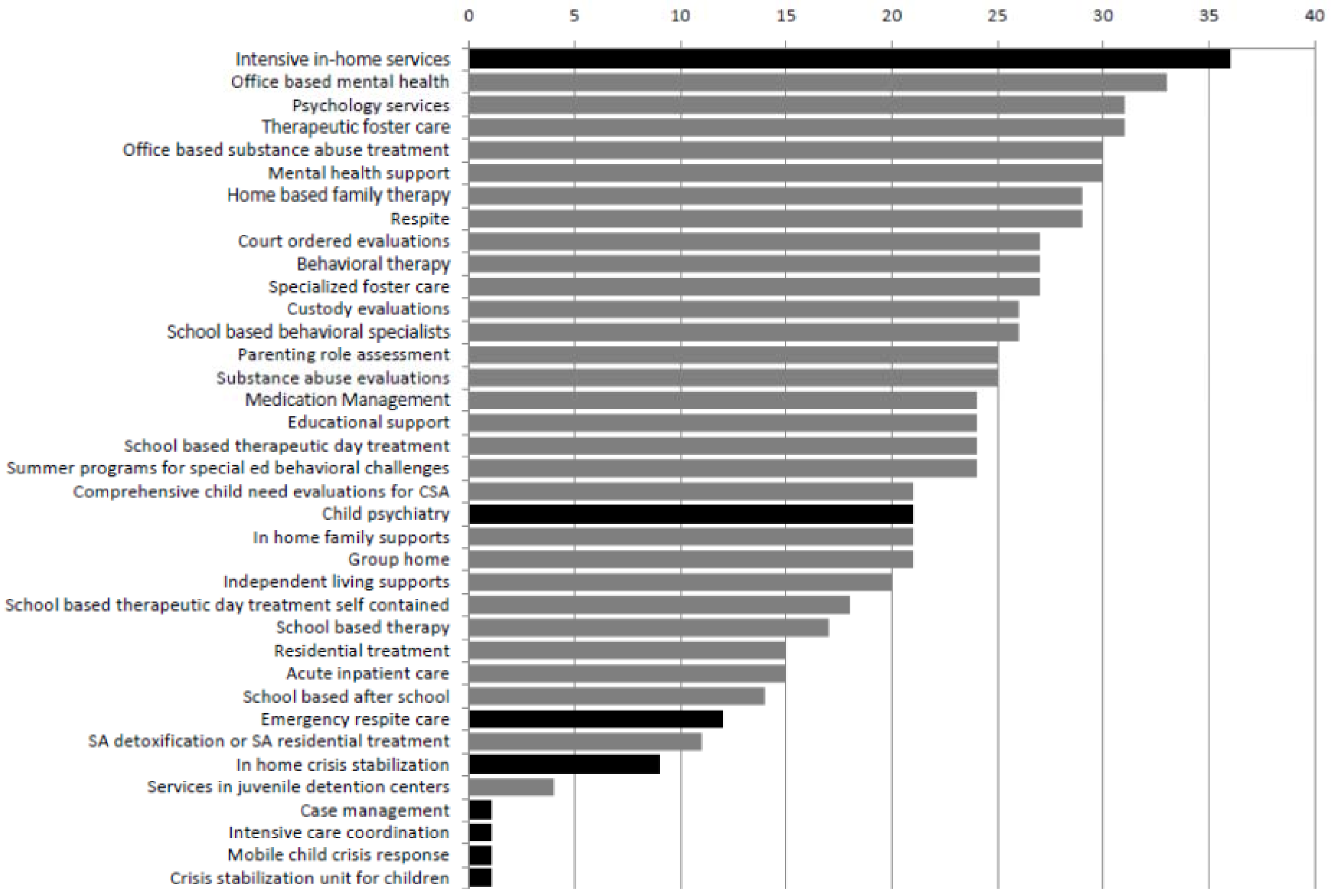
The data show that no CSB provides all 37 services, but two CSBs, Hampton-Newport News and Highlands, provide almost all of the services. Central Virginia and New River Valley provide 24 of the services. But many other CSBs have large gaps in their service array, leaving them with fewer alternatives to meet the needs of children and families. Having an array of services allows for targeting the best package of services for the child and family, rather than plugging children into service "slots" because they are the only thing available. The survey data confirmed and quantified challenges discussed in the Interim Report: an incomplete array of services in all communities and a lack of consistency of service availability across the state. Considerable growth must occur before the full comprehensive service array is consistently available in all Virginia Communities.

Table 1



In addition to CSB services, the available array of services across the state includes significant services provided by private agencies. The survey asked CSBs to indicate for each service in the comprehensive array whether it was provided in the CSB catchment area by a private provider. This data is reflected in Table 2, *"Number of CSBs with Private Providers in Catchment Area"*, showing by service the number of CSBs that reported the service as being available through a private provider in their catchment area. Again the data confirmed the inconsistency of service availability, with intensive in-home services provided by a private provider in 36 CSB catchment areas contrasted with crisis stabilization and mobile crisis response provided privately in only 1 CSB catchment area.

Table 2



2. **In many of the services that are available, there is inadequate capacity or limitations on access, which result in children and families waiting for services or being denied them altogether.**

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. Where larger systems of services have been developed, the majority of these services are funded by Medicaid. The 2008 OIG report showed that 54.1% of children's services provided at CSBs are funded by Medicaid. This is especially true of CSBs that have been able to develop larger and more complete systems of services – in these communities Medicaid funding is 83%. The extraordinary growth of intensive in-home services and therapeutic day treatment services provided by private agencies (from $178,953,309 in 2007 to $295,416,358.40) has been almost entirely funded by Medicaid. DMAS reports that 97% of intensive in home services and approximately 74% of therapeutic day treatment services are provided by private agencies. While this growth has brought needed services to tens of thousands of children and families, it is important to note that only 27 % of children under 18 have Medicaid (or FAMIS). 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. Lack of services for children without Medicaid was a major need cited by stakeholders in the 2008 OIG survey and by the DBHDS Expert Panel.

Even when services are present, in most communities there is not sufficient capacity for all the children that need them. Services are often full or in short supply. Most CSBs were found to have a waiting list for services (DBHDS waiting list data for the Interim Report from a 2009 survey of CSBs (DBHDS Comprehensive State Plan 2010-2016). Waiting lists data from that survey showed waits of 3 to 12 weeks for access to key services. According to the 2008 OIG report, "child and adolescent services at CSBs were mostly full to capacity, resulting in long waiting periods for new persons to access services. The average wait for all services from all CSBs that reported was 26 days". Data from the 2011 DBHDS survey (provided in Table 3, below) show that very few services, even when available, are judged by CSBs to have adequate capacity to meet local needs.

3. There is inconsistency across the state in the availability and capacity of "Base Services."

With the very inconsistent distribution of service availability among Virginia communities, DBHDS recommends that a system of priorities and guidance is needed to provide a rational and effective way to grow services availability in a step-by-step way. Earlier reports recommended defining and establishing a "base" or foundational set of services that every community should have to begin to meet the needs of children and families. The 2008 OIG and the 2010 Report of the System of Care Advisory Team recommended that a consistent base level of services be made available in every community.

The OIG Survey of Community Service Board Child and Adolescent Services (OIG, 2008) identified 5 highly specialized, high-impact services that, according to stakeholders and CSB staff in a survey of child service leaders in 2008, offer the most promise in serving children with severe needs and help reduce the need for more intensive placements such as residential treatment:

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

In the 2010 Interim Report only two CSBs offered all five of these specialized intensive services, as shown by data available at that time.

The DBHDS Expert Panel, giving input for the 2010 Interim Report, recommended a further refinement and definition of a base system of services. These services are described in detail in Section VII.

- Crisis Stabilization Unit for Children
- Emergency Respite Care
- In Home Crisis Stabilization
- Mobile Child Crisis Response
- Psychiatric Services
- Case Management
- Intensive Care Coordination
- Intensive In-Home Services

As part of its 2011 survey of current needs, DBHDS asked about the availability of these base services. The following tables show the availability and gaps in these fundamental services.

Table 3

Base Service Capacity by CSB

CSB Code	CSB	Crisis Stabilization Unit for Children	Emergency Respite Care	In Home Crisis Stabilization	Mobile Child Crisis Response	Psychiatric Services	Case Management	Intensive Care Coordination	Intensive In-Home Services
001	Alexandria	○	○	○	○	●	●	●	●
003	Alleghany-Highland	○	○	○	○	◑	●	○	●
005	Arlington County	○	○	○	○	◑	◑	◑	○
067	Blue Ridge	○	○	●	○	◑	◑	●	●
007	Central Virginia	●	○	◑	◑	◑	◑	◑	●
009	Chesapeake	○	○	○	○	◑	◑	◑	○
011	Chesterfield	○	○	○	○	◑	◑	○	◑
013	Colonial	○	○	○	○	●	●	●	●
015	Crossroads	○	○	○	○	◑	●	●	○
017	Cumberland Mountain	○	○	○	●	●	●	●	●
019	Danville-Pittsylvania	○	○	○	○	◑	◑	●	○
020	Dickenson County	○	○	○	○	○	◑	◑	○
053	District 19	○	○	○	◑	◑	●	●	○
021	Eastern Shore	○	○	●	○	●	●	○	○
023	Fairfax-Falls Church	◑	○	◑	◑	◑	◑	◑	○
025	Goochland-Powhatan	○	○	○	○	◑	●	○	○
027	Hampton-Newport News	○	○	●	●	◑	◑	◑	◑
029	Hanover County	○	○	○	○	◑	◑	◑	◑
031	Harrisonburg-Rockingham	○	○	○	○	◑	◑	●	○
033	Henrico Area	○	○	○	○	◑	◑	◑	◑
035	Highlands	○	●	●	●	◑	●	●	◑
037	Loudoun County	○	○	○	○	◑	◑	○	◑
039	Middle Peninsula-NN	●	○	●	○	◑	●	●	◑
041	Mount Rogers	○	○	○	○	◑	●	●	◑
043	New River Valley	○	○	●	◑	◑	◑	●	●
045	Norfolk	○	○	○	○	●	●	●	●
047	Northwestern	○	○	○	○	◑	●	●	●
049	Piedmont	○	○	○	○	◑	●	◑	◑
051	Planning District I	○	○	◑	○	◑	●	◑	◑
055	Portsmouth	○	○	○	○	●	●	●	○
057	Prince William County	○	●	○	○	◑	◑	◑	◑
059	Rappahannock Area	○	○	○	○	●	●	●	◑
061	Rappahannock-Rapidan	○	○	○	○	◑	◑	◑	○
063	Region Ten	○	○	◑	○	◑	◑	◑	◑
065	Richmond	○	○	○	○	◑	◑	○	◑
069	Rockbridge Area	○	○	○	○	◑	●	○	○
071	Southside	○	○	○	○	◑	◑	●	◑
073	Valley	○	○	○	○	◑	●	○	◑
075	Virginia Beach	○	○	○	○	●	●	●	○
077	Western Tidewater	○	○	○	○	◑	◑	◑	○

● Adequate Service Capacity ◑ Inadequate Service Capacity ○ Service Not Available

Table 4

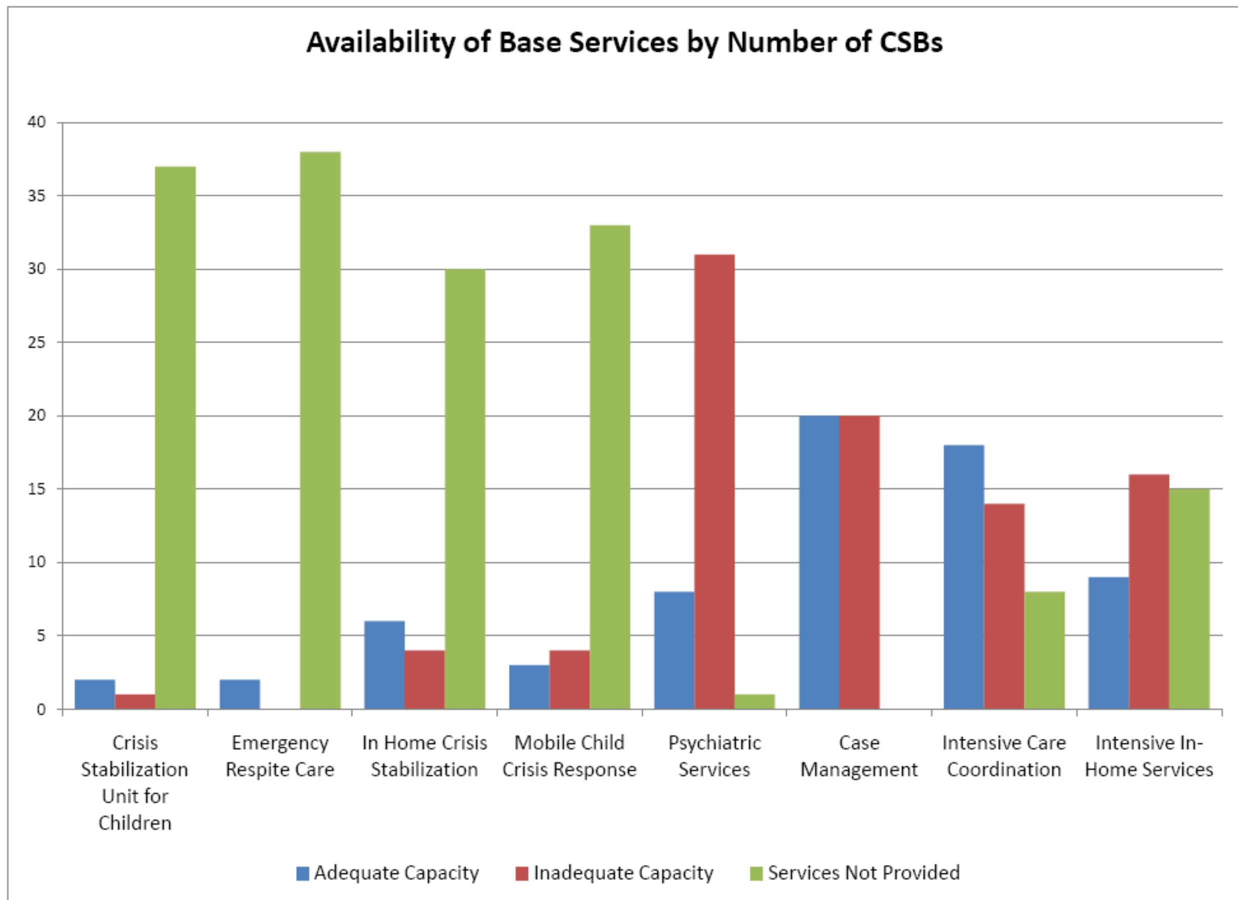


Table 5

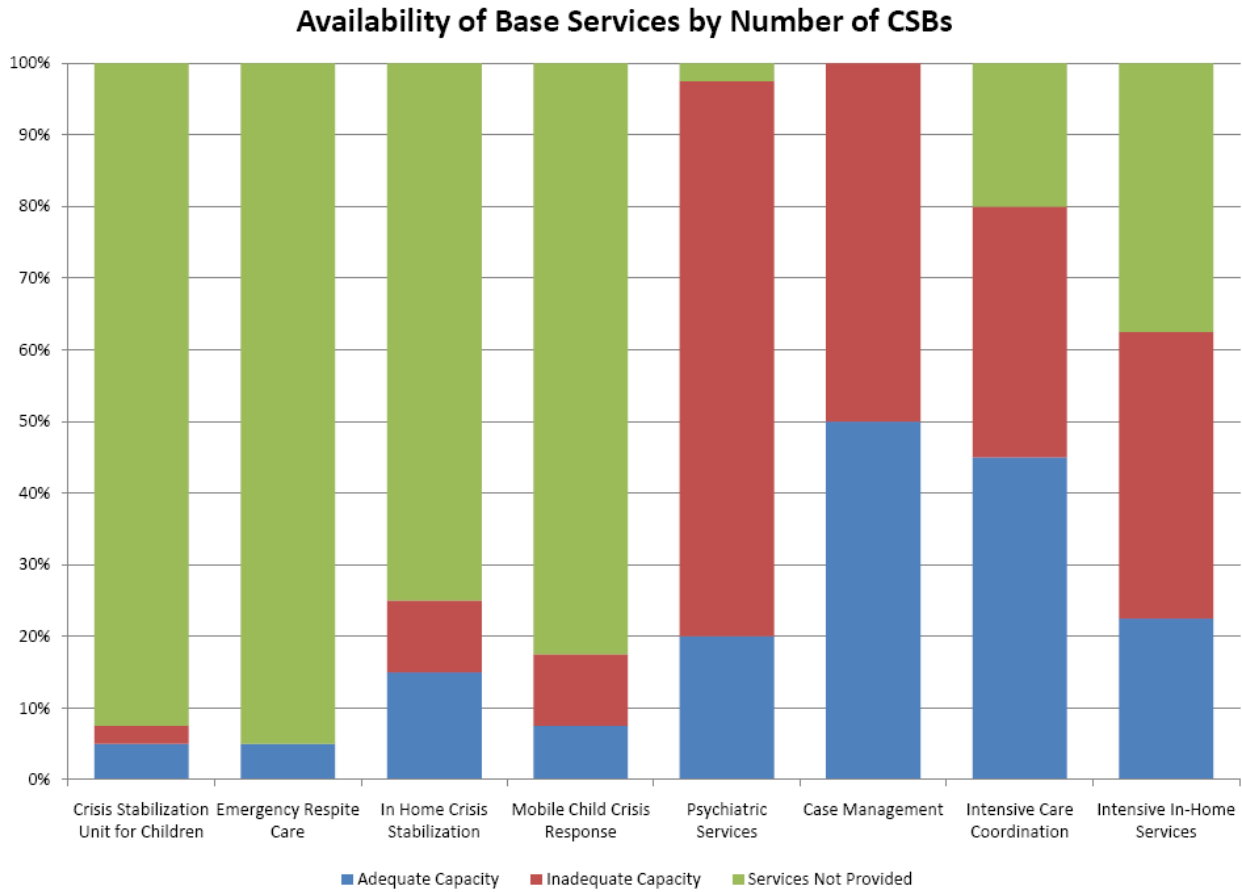


Table 6

Base Service	Adequate Capacity	Inadequate Capacity	Services Not Provided
Crisis Stabilization Unit for Children	5%	3%	93%
Emergency Respite Care	5%	0%	95%
In Home Crisis Stabilization	15%	10%	75%
Mobile Child Crisis Response	8%	10%	83%
Psychiatric Services	20%	78%	3%
Case Management	50%	50%	0%
Intensive Care Coordination	45%	35%	20%
Intensive In-Home Services	23%	40%	38%

The CSB survey data show the expected wide variability in availability and capacity of CSB services, especially the base services. The Crisis Response category has the most significant gaps and largest number of CSBs that do not provide these services at all. This category includes crisis stabilization units, emergency respite care

and in-home crisis stabilization. Even case management, a service that is required within available resources and reimbursed by Medicaid, is only provided with adequate capacity at 50% of the CSBs. Though almost every CSB reported providing psychiatric services, 80% indicated that their capacity for psychiatric services was inadequate. To complete the picture of base service availability, the following table, Table 7. *"Base Services Available through CSBs and/or Private Providers"*, shows by CSB the base services that are available by the CSB and by private providers.

Table 7

Base Services Available through CSBs and/or Private Providers

	Child psychiatry		Case management		Intensive care coordination		Intensive in-home services		Mobile child crisis response		In home crisis stabilization		Emergency respite care		Crisis stabilization unit for children	
CSB	CSB	PP	CSB	PP	CSB	PP	CSB	PP	CSB	PP	CSB	PP	CSB	PP	CSB	PP
Alexandria	●	○	●	○	●	○	●	●	○	○	○	○	○	○	○	○
Alleghany-Highland	●	○	●	○	○	○	●	○	○	○	○	○	○	○	○	○
Arlington County	●	●	●	○	●	○	○	●	○	○	○	○	○	○	○	○
Blue Ridge	●	●	●	○	●	○	●	●	○	○	●	●	○	●	○	○
Central Virginia	●	●	●	○	●	○	●	●	●	○	●	○	○	○	●	○
Chesapeake	●	○	●	○	●	○	○	●	○	○	○	○	○	○	○	○
Chesterfield	●	●	●	○	○	○	●	●	○	○	○	○	○	○	○	○
Colonial	●	●	●	○	●	○	●	●	○	○	○	○	○	○	○	○
Crossroads	●	○	●	○	●	○	○	●	○	○	○	○	○	○	○	○
Cumberland Mountain	●	●	●	○	●	○	●	●	●	○	○	○	○	○	○	●
Danville-Pittsylvania	●	○	●	○	●	○	○	●	○	○	○	○	○	○	○	○
Dickenson County	○	○	●	○	●	○	○	●	○	○	○	○	○	○	○	○
District 19	●	●	●	○	●	○	○	●	●	○	○	○	○	○	○	○
Eastern Shore	●	○	●	○	○	○	○	●	○	○	●	●	○	○	○	○
Fairfax-Falls Church	●	●	●	○	●	○	○	●	●	○	●	●	○	●	●	○
Goochland-Powhatan	●	○	●	●	○	○	○	●	○	○	○	●	○	○	○	○
Hampton-Newport News	●	○	●	○	●	○	●	○	●	○	●	○	○	○	○	○
Hanover County	●	●	●	○	●	●	●	●	○	○	○	○	○	○	○	○
Harrisonburg-Rockingham	●	●	●	○	●	○	○	●	○	○	○	○	○	●	○	○
Henrico Area	●	●	●	○	●	○	●	●	○	○	○	○	○	○	○	○
Highlands	●	●	●	○	●	○	●	●	●	○	●	○	●	●	○	○
Loudoun County	●	●	●	○	○	○	●	●	○	○	○	○	○	●	○	○
Middle Peninsula-NN	●	○	●	○	●	○	●	●	○	○	●	○	○	●	●	○
Mount Rogers	●	●	●	○	●	○	●	●	○	○	○	○	○	○	○	○
New River Valley	●	○	●	○	●	○	●	●	●	○	●	○	○	●	○	○
Norfolk	●	●	●	○	●	○	●	●	○	○	○	○	○	○	○	○
Northwestern	●	○	●	○	●	○	●	○	○	○	○	○	○	○	○	○
Piedmont	●	○	●	○	●	○	●	●	○	○	○	○	○	○	○	○
Planning District I	●	○	●	○	●	○	●	●	○	○	●	○	○	○	○	○
Portsmouth	●	○	●	○	●	○	○	○	○	○	○	○	○	○	○	○
Prince William County	●	●	●	○	●	○	●	●	○	○	○	●	●	○	○	○
Rappahannock Area	●	●	●	○	●	○	●	●	○	○	○	●	○	○	○	○
Rappahannock-Rapidan	●	●	●	○	●	○	○	●	○	○	○	○	○	●	○	○
Region Ten	●	●	●	○	●	○	●	●	○	○	●	○	○	○	○	○
Richmond	●	●	●	○	○	○	●	●	○	○	○	●	○	●	○	○
Rockbridge Area	●	○	●	○	○	○	○	●	○	●	○	○	○	○	○	○
Southside	●	○	●	○	●	○	●	●	○	○	○	○	○	○	○	○
Valley	●	○	●	○	○	○	●	●	○	○	○	○	○	●	○	○
Virginia Beach	●	●	●	○	●	○	○	●	○	○	○	●	○	●	○	○
Western Tidewater	●	○	●	○	●	○	○	●	○	○	○	●	○	●	○	○

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 to not 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. A fully developed and widely available 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.

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

Even if funding were available to expand services, finding 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.

DBHDS has reviewed workforce development needs and sought input from the Expert Panels convened for this children's behavioral health planning process and others. This analysis and input 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.

An additional challenge is that, for some services, capacity is sufficient but quality is a significant concern. DMAS, as part of its ongoing responsibilities and its participation in the Expert Panel, documented concerns about provider qualifications, appropriateness of services provided for children and families, and marketing practices. The focus of concern was on Medicaid-reimbursed Intensive In-home services and Therapeutic day Treatment services. These services are available statewide and are provided by both private and CSB providers, and have rapidly grown over the past few years. Medicaid provider audits have revealed problems with many providers and services. In 2010 DMAS introduced significant revisions of provider qualification and service provision standards in the Provider Manual for these services. A need was indicated 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 Day Treatment services is a strong focus area of DMAS and DBHDS, particularly through its Office of Licensure.

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.

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

A specific requirement of the language of Item 304.M. was that the plan should "*define the role that the Commonwealth Center for Children and Adolescents will play…*" 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 or community living arrangements for stabilization and/or family respite.
- Intensive community support services – services that "wrap around" a child and family to meet their individual needs.

For the Interim Report, bed utilization by CSB and region was calculated for the combined 64 beds at CCCA and SWVMHI by CSB region for FY09 and FY10. Complete data for this period is available in the Interim Report in the online version of this plan (website). For this Final Report, the following summary data are presented for FY09-FY11:

Table 8

Bed Utilization at CCCA and SWVMHI

FY 09 (July 1, 2008 – June 30, 2009)		
Facility	***Bed capacity***	***Average Daily Census***
CCCA	48	33.7
SWVMHI	16	6.3

FY 10 (July 1, 2009 – June 30, 2010)		
Facility	***Bed capacity***	***Average Daily Census***
CCCA	48	26.8*
SWVMHI	16	7.7*

FY 11 (July 1, 2010 – June 30, 2011)		
Facility	***Bed capacity***	***Average Daily Census***
CCCA	48	37.1

Table 9

CCCA Admissions: FY2008- FY 2011 YTD (July 1, 2010-April 2011)

FY 2008 Admissions	605
FY 2009 Admissions	605
FY 2010 Admissions	564*
FY 2011 Admissions (YTD)	**646**

**Notes:*
During FY 10, CCCA was evacuated to WSH for 5 months and only had 24 operational beds during this time. SWVMHI was closed effective 6/30/10.

Unless the comprehensive community service array can be expanded over the next four to eight years in many communities, the need for public inpatient services can be projected to continue at current levels.

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.**

DBHDS has achieved this recommendation. As recommended, the Comprehensive Service Array as published in the interim report has been shared publicly as the goal and standard for children's behavioral health services in every community in Virginia. It is posted on the DBHDS website and will be used in all communications as the guide for development of appropriate services for the target population (Appendix B).Further, the comprehensive service array was used to create and analyze the 2011 survey of CSBs called for in the Interim Report (reported above) and will be used on an ongoing basis to define the needed services system. If all of these services were available in most Virginia communities, children would be served closer to home. Earlier and more robust 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.

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 was cited as a finding in the Interim Report, the Final Report, and has also been cited in previous reports and studies. 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 planned, 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 would bring each community to a base level floor of the most needed and useful evidence-based services. This could be accomplished through state general funds and Medicaid funding over the next two biennia. Any new funding appropriated should be used to support the development and spread of base services across Virginia, before funding would be provided for other 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 are required by code to 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. **Mobile child crisis response service** (to home, school, community): *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, DJJ or other community location. Such teams ideally have a psychiatrist.*
   ii. **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.*
   iii. **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).*
   iv. **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.*

b. ***Case Management and Intensive Care Coordination*** - CSB case management, while a "mandated" service that all CSBs must provide, is currently only required "as funds are available." The 2011 DBHDs survey showed that all CSBs provide children's case management service, but 20 do not have adequate capacity. 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.

   A more intensive form of case management - Intensive Care Coordination, designed to provide close support and community return for certain children placed in or at-risk of residential care through CSA - is provided by 32 of 40 CSBs. Beginning in 2009, *Appropriation Act* Item 283 #2c required local Community Policy and Management Teams and Community Services Boards to work collaboratively to implement this service, which is reimbursable by CSA. This service is

not appropriate for all children; the Family Assessment and Planning Team has the role of referring those children for whom it will be beneficial..

c. ***Psychiatric Services*** – greater availability of child psychiatrists, nurse practitioners, and medication management. This need exists in an environment of scarcity concerning availability of child psychiatrists. Rather than recommending an across the board increase in funding for child psychiatry time for all CSBs that indicate a need, DBHDS is recommending development of regional demonstration projects in which highly qualified child psychiatrists are hired, one per region, to not only provide direct services to children and families, but to extend their services through consultation and training activities with general practitioners, nurse practitioners, and other community health providers. Expanded use of telemedicine and collaboration with medical schools will further extend the reach of the regional specialists. Development of collaborative physician networks between psychiatrists, pediatricians and primary care providers on a regional basis will extend the limited availability of child psychiatric resources.

d. ***In-Home Services*** – this service is widely available statewide for children who are Medicaid recipients, but there are significant issues with quality. Medicaid data indicates that 26 CSBs were reimbursed $3,936,947.71 in FY11 for providing this service. Private providers were reimbursed $125,400,083.73 in for this service in FY11. DMAS introduced regulatory and rate changes designed to reduce costs and assure greater quality of this service in October, 2010. At the time of this report, DMAS is working with DBHDS, the CSBs, and private providers to develop care coordination requirements for certain Medicaid-funded services that were approved by the General Assembly and signed by Governor McDonnell in the 2011 session (*2011 Appropriation Act*). These care coordination measures include requirements that CSBs complete an independent clinical assessment of children referred for Intensive In-Home, Therapeutic Day Treatment, Mental Health Supports, and Residential A and B services by all providers, public or private, prior to the initiation of these services. It is expected that these care coordination activities, joined with the regulatory reforms introduced by DMAS in 2010, will serve to improve service quality and reduce growth in costs. As one of the four base services, intensive in-home services should also be available to children who are not Medicaid recipients.

Funding Priorities

Table 10, *"Capacity and Cost Estimates for Statewide Availability of Base Services",* below shows the base services, the capacity of CSBs for each service, cost methodology and cost estimates for improving statewide availability of the base services.

Table 10

Capacity and Cost Estimates for Statewide Availability of Base Services

Base Service	# of CSBs with Adequate Capacity*	#of CSBs with Inadequate Capacity	# of CSBs that do not Provide Service	Cost Methodology	Estimated Cost
Crisis Response Services					
Crisis Stabilization Unit for Children	2	1	37	Cost information from model for crisis stabilization unit for children. Proposal: Five site demonstration program ($1.265 million X 5 Health Planning Regions to provide one unit per region.)	$6.326 Million
Mobile Child Crisis Response	3	4	34	Cost information from Wrap-Around Milwaukee's Mobile Urgent Treatment Team. The team is multidisciplinary and provides 24 hour crisis intervention services to families. Proposal: Five site demonstration program ($2 million x 5 HPR regions, one unit per region.)	$10 Million
Psychiatric Services	8	31	1	Proposal: Five site demonstration program ($275,675 est. average psychiatrist salary X 5 HPR regions to establish a regional child psychiatry position in each region.)	$1.4 Million
Case Management	20	20	0	Proposal: Expand CSB children's case management services to all CSBs (20 case managers X est. average case manager salary, fringe, and support costs of $80,000.)	$1.6 Million
Intensive Care Coordination	18	14	8	No additional funding is required. A funding stream exists as this is a CSA-reimbursable service.	N/A
Intensive In-Home Services	9	16	15	No additional funding is required at this time. Service is provided by CSB or private providers in all but one CSB area. Quality improvement mechanisms are needed to assure effective services.	N/A
Total					**$19.326 Million**

*CSBs that reported having the crisis response services with no wait time and the other services with no more than 5 days wait time.

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

DBHDS has reviewed workforce development needs, including the results of a survey conducted with the assistance of the Virginia Partnership for People With Disabilities. An online survey to determine the type of professional development and family support needed in Virginia was completed in May 2010. A total of 527 individuals completed the survey. Their responses, along with the input from the Expert Panels pointed to the needs detailed in this recommendation.

Even if funding were available to expand services, finding 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 pockets of training expertise in Virginia, including that provided through very limited federal funds by DBHDS, 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. The following are the detailed recommendations and funding needs to address the need for workforce development.

a. ***Fund and implement a statewide children's behavioral health best practice workforce development initiative:***

- DBHDS should administer this initiative in collaboration with public and private service providers.
- The workforce development initiative should be guided by this comprehensive plan and be focused on teaching best practices in children's services.
- 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 the Virginia Community College System would enhance the expertise available to implement the initiative.
- 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 development 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 may include:

- Collaboration with other state agency partners, DSS, DJJ, DOE, OCS, DMAS, and private agencies 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;
- Internship, fellowship and residency opportunities for behavioral health professionals, including social workers, psychologists, case managers, child psychiatrists and pediatricians.
- Continuing education should be documented and certificates issued upon completion.

Cost Estimate for the Workforce Development Initiative: $500,000 per year. This funding should be used to contract with one or more entities, such as a public or private universities or the community college system, to assist DBHDS with the workforce development initiative. A portion of the funding would support staff time in the DBHDS Central Office to establish the initiative, convene and work with the advisory group, oversee the contract and assure that all workforce development activities meet the evolving needs of DBHDS and Virginia's service providers for children with behavioral health problems.

Estimated expenditure break-out:

Contract with university for workforce development support and logistical coordination	@ $210,000
DBHDS Workforce Development Coordinator position - salary and fringe benefits	@ $90,000
Child Psychiatry fellowships – X fellowships @ 100,000 each	$200,000
	TOTAL $500,000

4. **Continue the current role of the Commonwealth Center for Children and Adolescents (CCCA) for the foreseeable future, and until more adequate community-based services are in place.**

Among the charges of the appropriations language to DBHDS as part of this planning process was to define the role that the Commonwealth Center for Children and Adolescents should play in the overall system of care for children. This role was considered extensively in the first year of the planning process and included considerable input from the expert panels. Recommendation #4 reflects the consensus on the role and current status of CCCA. CCCA should continue to provide high quality acute inpatient services for the most challenged and traumatized children in Virginia and work with communities to return them to their homes in the shortest clinically feasible time.

5. **Establish quality management mechanisms 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. Possible initiatives could include:
        - A quality assurance process to include monitoring to assure that funding appropriated for children's behavioral health services remains fully designated for that purpose in CSB budgets.
        - An expanded role for children's services case managers. The role of the case manager is the key to assure quality management at the individual case level for publicly funded services. The current DMAS process to establish an independent assessment process for children receiving services should be considered in this expansion.
        - Improvement of the quality, accuracy and completeness of CSB data collection and reporting. This would provide the information that is critical to a quality assurance process.
    - DBHDS should continue active involvement with DMAS on initiatives to improve quality and accountability in the provision of Medicaid services. Specifically Intensive In-Home, Therapeutic Day Treatment, Mental Health Supports and Residential A and B services are being analyzed for

opportunities to improve quality through regulatory and other policy changes (see item d., page 20). Other collaborative efforts are needed between the state agencies and private providers to address service quality challenges. No new funding is required for this.

- In addition, recruitment is under way for a DBHDS Medical Director/Director of Quality Management who will lead future initiatives that will support this recommendation.

Cost Estimate for the Quality Management Initiative: Planning for a comprehensive quality management system is complex and expensive. In order to accomplish this recommendation, considerable planning will need to be done once the DBHDS Director of Quality Management is hired. A comprehensive quality management system will have some costs that have not been quantified yet. Additional staff would be needed in order to increase licensing focus specifically on children's services. Data experts would be needed to interface between IT and the program planning staff to analyze and produce user-friendly reports using CSB service and funding data. These reports would inform the quality monitoring process, allowing quality management staff to use the data to identify patterns, outliers and other indicators for further investigation. To begin this quality management initiative, DBHDS is initially estimating that funding for two additional staff would be needed. These staff would be focused on the quality monitoring and data initiatives described above. 2 FTEs @ $80,000 = $160,000.

Overall funding needed to support the recommendations that require funding is summarized in Table 11 below, "*Summary of Cost Estimates to Support the Recommendations"*.

Table 11

Summary of Cost Estimates to Support the Recommendations

Base Service	# of CSBs with Adequate Capacity*	#of CSBs with Inadequate Capacity	# of CSBs that do not Provide Service	Cost Methodology	Estimated Cost
Crisis Response Services					
Crisis Stabilization Unit for Children	2	1	37	Cost information from Region IV's proposed plan for developing a crisis stabilization unit for children. $1.265 million X 5 Health Planning Regions to provide one unit per region	$6.326 Million
Mobile Child Crisis Response	3	4	34	Cost information from Wrap-Around Milwaukee's Mobile Urgent Treatment Team. The team is multidisciplinary and provides 24 hour crisis intervention services to families. $2 million x 5 HPR regions	$10 Million
Psychiatric Services	8	31	1	$275,675 est. average psychiatrist salary X 5 HPR regions to establish a regional child psychiatry position in each region	$1.4 Million
Case Management	20	20	0	20 case managers X est. average case manager salary of $80,000	$1.6 Million
Intensive Care Coordination	18	14	8	No additional funding is required. A funding stream exists as this is a CSA-reimbursable service.	N/A
Intensive In-Home Services	9	16	15	No additional funding is required at this time. Service is provided by CSB or private providers in all but one CSB area. Quality improvement mechanisms are needed to assure effective services.	N/A
Workforce Development				Contractual services @ $210,000 DBHDS Workforce Development Coordinator position - salary and fringe benefits @ $90,000 Child Psychiatry fellowships – 2 fellowships @ 100,000 each = $200,000	$500,000
Quality Management				2 FTEs @ $80,000	$160,000
Total					**$19.986 Million**

*CSBs that reported having the crisis response services with no wait time and the other services with no more than 5 days wait time.

Funding Priorities

The General Assembly might consider gradual funding of these recommendations over successive fiscal years, beginning with FY2012. **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 keep children in their home communities and to reduce unnecessary reliance on inpatient and residential care.

Appendices

Appendix A: Resource Documents

Children's Services Special Populations Workgroup Report. Department of Mental Health, Mental Retardation and Substance Abuse Services. 2005.

"Children's Service System Development: Training Needs for Professionals and Parents". Report of survey conducted by Virginia Department of Behavioral Health and Developmental Services. June 2010.

Collection of Evidence-based Practices for Children and Adolescents with Mental Health Treatment Needs. Virginia Commission on Youth. http://vcoy.virginia.gov/collection.asp. Retrieved June 10, 2011.

Commission on Mental Health Law Reform. Chief Justice of the Supreme Court of Virginia. 2007-2010. http://www.courts.state.va.us/programs/cmh/home.html

Comprehensive Services Act Critical Service Gap Survey. FY08, FY09. http://www.csa.virginia.gov/publicstats/featured.cfm?export_fyqtr=20103

Medicaid Facts Virginia. American Academy of Pediatrics. June 2011. http://www.aap.org/advocacy/washing/medicaid/Virginia.pdf. Retrieved June 7, 2011.

Pires, Sheila A. *Building Systems of Care: A Primer*. Spring 2002. https://gushare.georgetown.edu/ChildHumanDevelopment/CENTER%20PROJECTS/WebSite/PRIMER_CompleteBook.pdf

State and Community Consensus Planning Team 2009. *Report Regarding Acute Psychiatric Services for Children and Adolescents Appropriations Item # 315.BB.2*. December 15, 2009. http://leg2.state.va.us/dls/h&sdocs.nsf/By+Year/RD4272009/$file/RD427.pdf

Stroul, Beth; Blau, Gary; Friedman, Robert. Issue Brief, *Updating the System of Care Concept and Philosophy*. Washington, DC: Georgetown University Center for Child and Human Development, National Technical Assistance Center for Children's Mental Health. 2010.

Stroul, B., & Friedman, R. M. (1986 rev ed). *A system of care for children and adolescents with severe emotional disturbances*. Washington DC: Georgetown University Center for Child Development, National Technical Assistance Center for Children's Mental Health.

Stroul, Beth A.; Pires, Sheila A.: Armstrong, Mary I.; McCarthy, Jan; Pizzigati, Karabelle; Wood, Ginny. *Effective Financing Strategies for Systems of Care: Examples from the Field*. March 2008. http://rtckids.fmhi.usf.edu/rtcpubs/hctrking/pubs/Study03-exp-fr-field.pdf

System of Care Advisory Team. Reports prepared in response to the Policy and Plan Appropriations Items #329G, 330F, 311E, and 315E. 2002-2010.

http://www.dmhmrsas.cov.virginia.gov/documents/reports/CFS-329GReport.pdf

http://www.dmhmrsas.cov.virginia.gov/documents/reports/CFS-330FReport.pdf

http://www.dbhds.virginia.gov/documents/CFS/CFS-329AnIntegratedPolicyAndPlan330F2006Report.pdf

http://www.dbhds.virginia.gov/documents/reports/CFS- IntegratedPolicyPlan311E2007Report.pdf

http://www.dbhds.virginia.gov/documents/reports/CFS- IntegratedPolicyPlan311E2008Report.pdf
http://www.dbhds.virginia.gov/documents/reports/CFS-330FReport.pdf

U.S. Department of Health and Human Services. *Children's Systems of Care.* October 2001.
http://www.namhpac.org/PDFs/childrens_systems.pdf

Virginia Office of the Inspector General for Mental Health, Mental Retardation and Substance Abuse Services. Office of the Inspector General Report 149-08 *Review of Community Services Board Child and Adolescent Services*. September 19, 2008. http://www.oig.virginia.gov/documents/SS-CACM-149-08.pdf
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

Appendix B: Comprehensive Service Array

Children's Behavioral Health Comprehensive Service Array

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 that describe system of care services.)*

Appendix C: Survey of Community Services Boards

Instructions

Please complete the survey as accurately as possible so that a comprehensive picture of the types of services needed and service capacity can be established. For definitions of the services listed in the survey, see the Children's Behavioral Health Service Array on pages 4-6 of this document. Report as available only those services that are consistently offered by your CSB, i.e. not a one time occurrence. Also, where the survey asks for you to report on capacity, adequate capacity means the service can be provided without a wait. For CSB Services, column 3, if possible, identify the number of additional service slots needed. Example:

	CSB Services 1	2	3	4	**Private Services**	
Survey of Children's Services and Capacity	**Service is available from the CSB; capacity is adequate**	**Service is not available from the CSB**	**Service available from the CSB, but "x" additional capacity is needed**	**Estimated Wait Time (in days) for the service**	**Service is provided in the CSB catchment area by private providers**	
					YES	**NO**
Assessment and Evaluation						
Court-ordered evaluations			Yes, unknown	5		X
Case Management						
Children's case management	Yes					X
Intensive care coordination			Yes, 10 slots	14		X

Survey results should be sent to Sandy Bryant, Chair, Child and Family Council, Virginia Association of Community Services Boards at sandy.bryant@cvcsb.org.

Survey of Children's Services and Capacity	CSB Services 1 Service is available from the CSB; capacity is adequate	2 Service is not available from the CSB	3 Service available from the CSB, but "x" additional capacity is needed	4 Estimated Wait Time (in days) for the service	Private Services: Service is provided in the CSB catchment area by private providers	
					YES	**NO**
Assessment and Evaluation						
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 of DSS						
Psychology services (IQ testing for intellectual disabilities (ID, behavioral, etc.)						
Substance abuse evaluations for schools, families, etc.						
Outpatient or Office Based Services						
Child psychiatry						
Medication Management						
Office based mental health therapy						
Office based substance abuse treatment						
Educational support for families, skills training						
Case Management						
Children's case management						
Intensive care coordination						
Home and Community Based Services						
Home based family therapy services						
Intensive in-home services						
Mental health support services						
Behavioral therapy and supports for families						
Independent living supports for youth/young adults						
School based 1:1 therapy						
School based 1:1 behavioral specialists						
School based therapeutic day treatment (mainstream)						

School based therapeutic day treatment (self-contained)						
School based after school therapeutic day treatment						
Summer programs for special education/behavioral challenges						
Services in juvenile detention centers						
Intensive Community Supports						
In home family supports (ongoing)						
Respite						
Specialized foster care						
Therapeutic foster care						
Community Crisis Response Services						
Mobile child crisis response service (to schools, home)						
In-home crisis stabilization support services						
Emergency respite care placement service						
Crisis stabilization unit for children						
Residential						
Group home						
Residential treatment						
Inpatient						
Acute inpatient care						
Substance abuse detoxification or SA residential treatment						

Appendix D: Children's Behavioral Health Services Planning Process: Expert Input Panels

Children's Behavioral Health Services Planning Process

Expert Input Panels

State Interagency Panel	Service Provider Panel	Family and Advocacy Panel
1. John Pezzoli *Department of Behavioral Health and Developmental Services* 2. Paul McWhinney *Department of Social Services* 3. Scott Reiner *Department of Juvenile Justice* 4. Cynthia Cave *Department of Education* 5. Charlotte McNulty *Office of Comprehensive Services* 6. Karen Lawson *Department of Medical Assistance Services*	1. Don Roe *Commonwealth Center for Children and Adolescents - Public* 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 *Virginia Coalition of Private Provider Associations* 8. Betty Long *Virginia Hospital and Healthcare Association- Private*	1. John Morgan *Voices for Virginia's Children* 2. Colleen Kraft *American Academy of Pediatrics-Virginia Chapter* 3. Paula Price *Family/Mental Health America Virginia* 4. Carol Obrochta *Family* 5. Naomi Verdugo *Family/National Alliance on Mental Illness* 6. Clare Nugent *Family* 7. Alisa Cowen *Family/National Alliance on Mental Illness* 8. Margaret Nimmo-Crowe *Voices for Virginia's Children* 9. Karin Addison *Virginia Chapter – American Academy of Pediatrics*