COMMONWEALTH of VIRGINIA

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November 1, 2024

To: Governor Glenn A. Youngkin
The Honorable L. Louise Lucas, Chair, Senate Finance & Appropriations Committee
The Honorable Luke E. Torian, Chair, House Appropriations Committee

From: Nelson Smith, Commissioner, Department of Behavioral Health and Developmental Services

RE: Item 301.G, 2024 Special Session I Appropriations Act

Item 301.G of the 2024 Special Session I Appropriations Act directs the Department of Behavioral Health and Developmental Services (DBHDS) to identify alternative placements for children who would otherwise be served at the Commonwealth Center for Children and Adolescents (CCCA). The language reads:

> *G. The Department of Behavioral Health and Developmental Services, in consultation with other relevant state and local agencies, shall identify existing and develop new, if necessary, alternative placements that are effective, safe, and therapeutic for children and youth who would otherwise be admitted to the Commonwealth Center for Children and Adolescents (CCCA) and report findings to the Governor and the Chairs of the House Appropriations and the Senate Finance and Appropriations Committees by November 1, 2024. The report shall include information on (i) the types and locations of alternative placements identified, (ii) the number and treatment needs of children and youth who could be admitted at each placement type identified, (iii) the cost and funding sources for each placement type, and (iv) steps that remain to be taken to identify a sufficient number of appropriate alternative placements for all children and youth who would otherwise be admitted to CCCA.*

In accordance with this item, please find enclosed the report for Item 301.G. DBHDS staff are available should you wish to discuss this request.

cc: Secretary Janet V. Kelly

DBHDS
Virginia Department of Behavioral Health and Developmental Services

Report on Commonwealth Center for Children and Adolescents (CCCA) Alternative Placements

(Item 301.G, Special Session I of the 2024 Appropriations Act)

November 1, 2024

DBHDS Vision: A Life of Possibilities for All Virginians

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Preface

Item 301.G of the 2024 Special Session I Appropriations Act directs the Department of Behavioral Health and Developmental Services (DBHDS) to identify alternative placements for children who would otherwise be served at the Commonwealth Center for Children and Adolescents (CCCA). The language states:

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Executive Summary

The purpose of this report is to provide a summary and recommendations regarding effective, safe, and therapeutic alternatives to hospitalization at the Commonwealth Center for Children and Adolescents (CCCA). These recommendations are based on information gathered from a variety of stakeholders that are involved in Virginia's system of behavioral healthcare for children, including Community Services Boards (CSBs), the Department of Social Services (DSS), Children's Services Act (CSA), private inpatient facilities, private providers, CCCA, families, the Department of Medical Assistance Services (DMAS), DBHDS Central Office, and others.

CCCA has experienced significant changes in the population it serves, as well as the number of individuals served each year, since the Bed of Last Resort law was implemented in 2014 (SB260, 2014). Since 2021, CCCA has seen increasing average lengths of stay for individuals admitted. While there appear to be multiple reasons for this change, the most frequent reason cited was the number of children admitted to CCCA who are in the custody of local Department of Social Services (DSS) agencies, who do not have identified appropriate step-down or foster care placements at the time of clinical readiness for discharge. However, the number of annual admissions to CCCA has decreased dramatically (over 75 percent) in the past five years to a record low of 260 admissions in FY 2024. This averages to less than one admission per day.

- While some of the services recommended in this report already exist in the community, the providers of these services often report an unwillingness or an inability to serve some of the individuals admitted to CCCA, due to the complexities of managing the social and psychiatric needs of these children.
- Many other states contract with private inpatient providers in lieu of operating a state psychiatric hospital for children. While DBHDS has attempted to contract with private inpatient providers to relieve the pressure on CCCA, there has been limited interest from private inpatient providers in this area.
- Additional inpatient bed availability is needed for children and adolescents, specifically in Southwest Virginia. Currently, Carilion Clinic in Roanoke is the children's inpatient unit that is the furthest southwest in Virginia, which leaves a significant geographic area of the state without any locally available options for children's inpatient treatment.
- Additional investments and development are needed for community services that provide prevention and step-down levels of care, including community crisis programs, behavioral assessment/applied behavior analysis (ABA)/behavioral consultation services, intensive community-based services such as partial hospitalization programs, intensive in-home services, coordinated specialty care, and high-fidelity wraparound services, among others. It is essential that intensive services are immediately available resources for families, caregivers, and foster care providers to access when crisis behaviors begin.
- Additional comprehensive Assessment and Diagnostic services/programs are needed, particularly for children who exhibit the most complex psychiatric and behavioral symptoms.

- Specialty inpatient programs for children and adolescents with developmental disabilities and challenging behavior and/or co-occurring mental illness are needed in Virginia.
- Out of home placements that provide specialized care are needed to prevent admissions to CCCA. These may include therapeutic group homes (including those for children with intellectual/developmental disabilities), sponsored residential placements with a focus on mental health training/interventions, specialized foster care providers, and psychiatric residential treatment facilities. While for some youth, congregate care may be needed, this should not be the first resort for children and adolescents and every effort should be made to decrease the length of time that youth spend in a congregate care setting and improve the quality of care in those settings.
- It would be beneficial to expand access to evidence-based mental health treatments that decrease long-term morbidity due to mental illness via services such as Coordinated Specialty Care, a program for individuals who have experienced first episode psychosis.
- There is a need to increase systemic coordination by directing resources to expand the availability of resources and support to foster care providers, particularly those that are serving children with intensive behavioral health needs.
- The lack of availability and accessibility of community-based therapeutic services, specifically trauma-based therapies, attachment-based therapies, and child psychiatry, and family support and respite, impact the ability to maintain individuals in the community with their families, rather than seeking psychiatric inpatient admission.
- CCCA staff and culture would benefit from an orientation to the Kin First philosophy. This training would help staff with a primary background in mental health better understand and align with the goals of child welfare workers, ultimately enhancing CCCA's ability to serve youth across different system, particularly youth in DSS custody hospitalized a CCCA.

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Introduction and Background

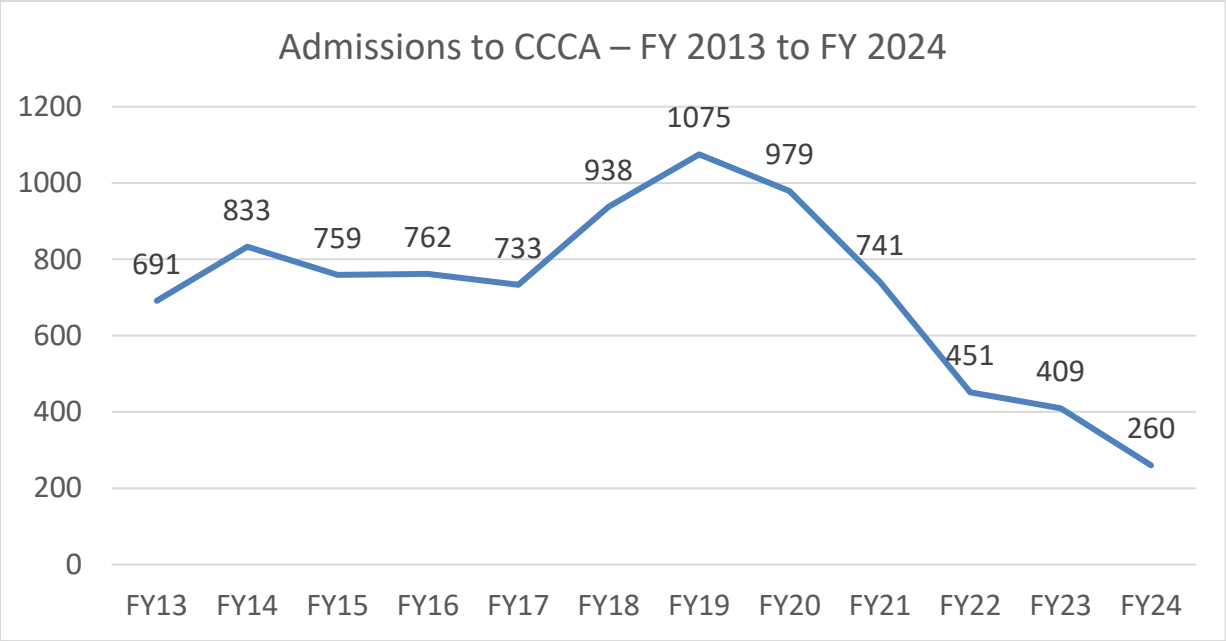
The purpose of this report is to provide a summary and recommendations regarding effective, safe, and therapeutic alternatives to hospitalization at the Commonwealth Center for Children and Adolescents (CCCA). These recommendations are based on information gathered from a variety of stakeholders that are involved in Virginia's system of behavioral healthcare for children, including Community Services Boards (CSBs), the Department of Social Services (DSS), Office of Children's Services (OCS), Department of Juvenile Justice, private inpatient facilities, private providers of behavioral health services, CCCA, families, the Department of Medical Assistance Services (DMAS), DBHDS Central Office, advocates and others.

The Commonwealth Center for Children and Adolescents (CCCA) is the only state hospital for children and adolescents in Virginia. State hospitals have historically served individuals who are uninsured, underinsured, or have multi-system involvement with long term behavioral health needs. However, due to the widespread insurance coverage for youth being able to cover a range of behavioral health supports and the build out of community services the majority of other states have reduced the capacity or completely eliminated their state psychiatric hospital for children. However, in Virginia, CCCA continues to experience pressure to meet the acute behavioral health crisis needs of children.

CCCA has experienced significant changes in the population it serves, as well as the number of individuals served each year, since the Bed of Last Resort law was implemented in 2014 (SB260, 2014). While historically, CCCA had served in a residential treatment center capacity, this law change and the need to almost exclusively serve children under Temporary Detention Orders (TDOs) forced CCCA to convert to an acute psychiatric care model. Admissions to CCCA grew between FY 2014 and FY 2019, with CCCA experiencing a record high of 1,075 admissions in 2019. Beginning in 2020, admissions to CCCA began to decrease for a variety of reasons. First, the COVID-19 pandemic resulted in periods of time in which CCCA was forced to slow or stop admissions, due to outbreaks of COVID within the facility. Second, CCCA began to experience drastic staff shortages, particularly among nursing and direct care staff. Due to the ongoing struggles in recruiting and retaining nursing staff, CCCA has been unable to operate their full capacity of beds (48) since 2021. CCCA currently operates 24 beds.

The changes in operational capacity, among other factors, has had a dramatic effect on the number of admissions to CCCA. As previously mentioned, in FY 2019, CCCA had 1,075 admissions. By comparison, in FY 2024, CCCA had 260 admissions – an over 75 percent decrease in the number of annual admissions. Table 1 shows admissions to CCCA from FY 2013 to FY 2024.

Figure 1.



Since 2021, CCCA has seen increasing average lengths of stay for individuals admitted. In FY 2019, the average length of stay for individuals admitted to CCCA was 9.7 days. By comparison, in FY 2024, it was 31 days.

While there appears to be multiple reasons for this change, the most frequent reason cited was the number of children admitted to CCCA who are in the custody of local Department of Social Services (DSS) agencies, and do not have identified foster care or kinship placements, or appropriate therapeutic step-downs, such as residential treatment facilities or therapeutic group homes, at the time of clinical readiness for discharge. Children in DSS custody experience extended stays at CCCA for days or even months past when they are considered clinically ready to step down to a lower level of care. In FY 2024, at any given time, an average of eight of the 24 individuals at CCCA were children in DSS custody. Of those individuals, an average of over half (five) were considered to no longer require inpatient psychiatric care at any given time, but remained at CCCA because the resources and care they needed to discharge were not available in the community. On average, three of the 24 children at CCCA at any given time were children in DSS custody who had been considered clinically ready to leave CCCA for 30 days or more, but were unable to leave, again due to the required services not being available in the community. In some situations, children in DSS custody have remained at CCCA for over two years due to complex psychosocial circumstances and inability for the community to meet the child's needs. While children in DSS custody accounted for approximately 21 percent of all admissions to CCCA during FY 2022-24, they have also accounted for 30 to 35 percent of all bed days used at the facility.

CCCA exclusively serves acute, involuntary admissions. Based on admission data from fiscal years 2022 through 2024, approximately 70 percent of children admitted to CCCA have Medicaid. The majority of individuals admitted to CCCA (76 percent) are between the ages

of 13 and 17, with the average age at admission being 15. In addition, there are racial disparities that exist among the population of children admitted to CCCA: 39 percent of children admitted to CCCA are Black; however, only 21 percent of children in Virginia are Black. Additionally, 58.8 percent of admissions to CCCA are male. Thirty-eight percent of the children admitted to CCCA have confirmed or suspected diagnoses of intellectual disability, autism, or developmental disabilities.

Individuals who are admitted to CCCA are more likely to come from certain geographic areas/CSB catchment areas in Virginia than others. Although there are 40 CSBs in the Commonwealth, individuals admitted to CCCA from the ten CSB catchment areas in Table 1 account for more than 50 percent of all admissions:

Table 1.

CSB	Catchment Area	% of admissions to CCCA
Horizon	City of Lynchburg; Amherst, Appomattox, Bedford, and Campbell Counties	7.3%
Rappahannock Area	City of Fredericksburg; Caroline, King George, Spotsylvania, and Stafford Counties	6.1%
Hampton-Newport News	Cities of Hampton and Newport News	6%
Blue Ridge	Cities of Roanoke and Salem; Botetourt, Roanoke, and Craig Counties	5.8%
Norfolk	City of Norfolk	5.4%
Fairfax-Falls Church	Cities of Falls Church and Fairfax; Fairfax County	4.3%
Northwestern	City of Winchester; Frederick, Clarke, Warren, Shenandoah, and Page Counties	4.2%
Henrico	Henrico, Charles City, and New Kent Counties	4%
Chesterfield	County of Chesterfield	4%
Prince William	Cities of Manassas and Manassas Park; Prince William County	3.8%

In 2023, the Joint Legislative Audit and Review Commission (JLARC) issued a report based on a year-long study of Virginia's state hospitals. A portion of the report was dedicated to CCCA. The

report cited findings that CCCA had significantly higher rates of restrictive behavioral interventions, such as seclusion and restraint, than national averages for children; that CCCA had higher readmission rates than national averages for children's inpatient facilities; and that CCCA had the highest rates of peer-to-peer aggression and patient self-injurious behavior of all the state hospitals in Virginia. Ultimately the report recommended closure of CCCA; however, prior to considering that action, the Commonwealth must still address how to serve children and adolescents with serious emotional and behavioral disturbances and serious mental illness. Even prior to the 2023 JLARC report, CCCA had initiated a series of significant actions regarding stabilizing staffing, and decreasing the use seclusion and restraint; however, the facility has still been unable to operate beyond 24 beds, and during peak times of demand that correlate with the academic school year, still experiences a waitlist.

The goal of this report is to identify trauma-informed, least restrictive alternatives for children who would otherwise be admitted to CCCA, including identifying treatment needs, types of placements, potential costs and funding sources for placements, and steps that would need to be taken to identify and develop these placements.

The vision for Virginia's behavioral health system as stated in the Governor's *Right Help, Right Now Plan*, is that all Virginians will be able to access behavioral health care when they need it, have prevention and management services personalized to their needs, particularly for youth, know who to call, who will help, and where to go when in crisis, and have paths to reentry and stabilization when transitioning from crisis. When the community continuum of care does not include comprehensive, easily-accessible, and evidence-based care that is available to everyone who needs it when they need it, the system will continue to see a high reliance on restrictive and institutional based modalities of care, such as CCCA.

Previously, a legislatively mandated workgroup took place in 2019-2020 that was tasked with a similar report as the one included here. While the COVID-19 pandemic and its subsequent impacts on the healthcare system, specifically the behavioral healthcare system, cannot be overstated, many of the recommendations in that report are the same as those shared by stakeholders during the development of this report. Of note, that report stated "Virginia must better meet the behavioral health needs of children. Combined effort across the child-serving systems of Virginia will ensure that children's mental health remains a priority". These statements are truer in 2024 than ever before, especially considering the number of children in DSS custody who experience long lengths of stay at CCCA when they do not require that level of psychiatric care.

Primary Findings

- The number of annual admissions to CCCA has decreased dramatically (over 75 percent) in the past five years to a record low of 260 admissions in FY 2024. This averages to less than one admission per day.
- While some of the services recommended in this report already exist in the community, the providers of these services often report an unwillingness or an inability to serve some of the individuals admitted to CCCA, due to the complexities of managing the social and psychiatric needs of these children.
- Many other states contract with private inpatient providers in lieu of operating a state psychiatric hospital for children. While DBHDS has attempted to contract with private inpatient providers to relieve the pressure on CCCA, there has been limited interest

from private inpatient providers in this area.

- Additional inpatient bed availability is needed for children and adolescents, specifically in Southwest Virginia. Currently, Carilion Clinic in Roanoke is the children's inpatient unit that is the furthest southwest in Virginia, which leaves a significant geographic area of the state without any locally available options for children's inpatient treatment.
- Additional investments and development are needed for community services that provide prevention and step-down levels of care, including community crisis programs, behavioral assessment/applied behavior analysis (ABA)/behavioral consultation services, intensive community-based services such as partial hospitalization programs, intensive in-home services, coordinated specialty care, and high-fidelity wraparound services, among others. It is essential that intensive services are immediately available resources for families, caregivers, and foster care providers to access when crisis behaviors begin.
- Additional comprehensive Assessment and Diagnostic services/programs are needed, particularly for children who exhibit the most complex psychiatric and behavioral symptoms.
- Specialty inpatient programs for children and adolescents with developmental disabilities and challenging behavior and/or co-occurring mental illness are needed in Virginia.
- Out of home placements that provide specialized care are needed to prevent admissions to CCCA. These may include therapeutic group homes (including those for children with intellectual/developmental disabilities), sponsored residential placements with a focus on mental health training/interventions, specialized foster care providers, and psychiatric residential treatment facilities. While for some youth, congregate care may be needed, this should not be the first resort for children and adolescents and every effort should be made to decrease the length of time that youth spend in a congregate care setting and improve the quality of care in those settings.
- It would be beneficial to expand access to evidence-based mental health treatments that decrease long-term morbidity due to mental illness via services such as Coordinated Specialty Care, a program for individuals who have experienced first episode psychosis.
- There is a need to increase systemic coordination by directing resources to expand the availability of resources and support to foster care providers, particularly those that are serving children with intensive behavioral health needs.
- The lack of availability and accessibility of community-based therapeutic services, specifically trauma-based therapies, attachment-based therapies, and child psychiatry, and family support and respite, impact the ability to maintain individuals in the community with their families, rather than seeking psychiatric inpatient admission.
- CCCA staff and culture would benefit from an orientation to the Kin First philosophy. This training would help staff with a primary background in mental health better understand and align with the goals of child welfare workers, ultimately enhancing CCCA's ability to serve youth across different system, particularly youth in DSS custody hospitalized a CCCA.

Alternatives to CCCA – Service and Placement Recommendations

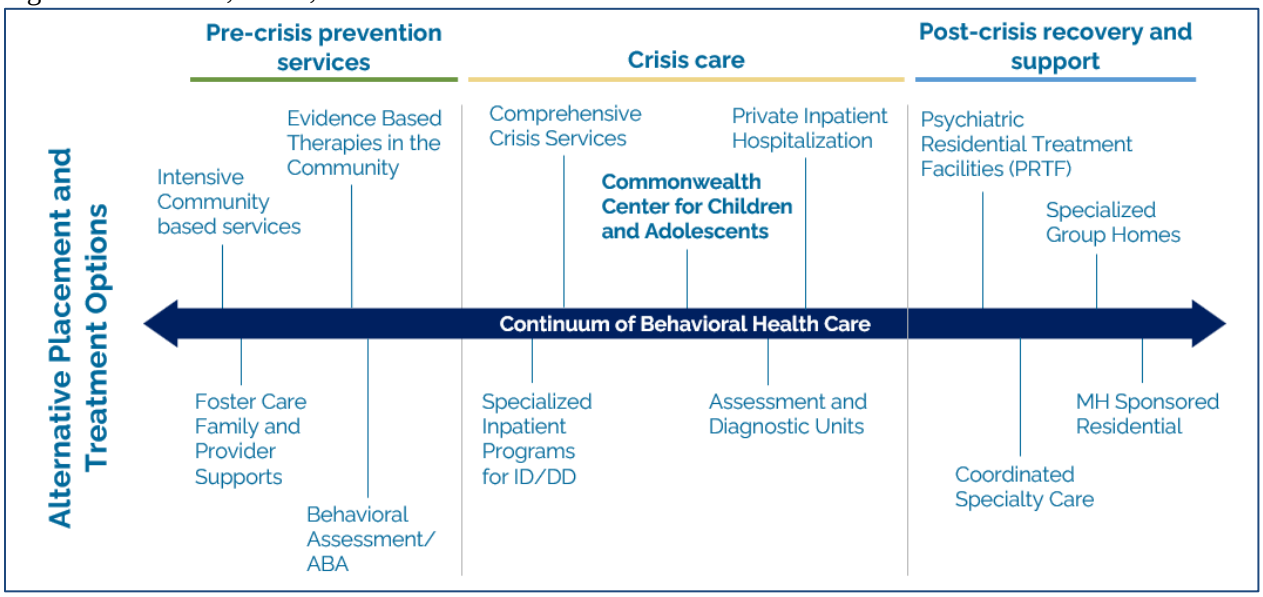
Specifically, DBHDS was charged with reporting the following information by Item 301.G. of the 2024 Special Session I Appropriations Act:

- Types and locations of alternative placements identified
- The number and treatment needs of children and youth who could be

admitted at each placement type identified
- The cost and funding sources for each placement type
- Steps that remain to be taken to identify a sufficient number of appropriate alternative placements for all children and youth who would otherwise be admitted to CCCA

Youth admitted to CCCA are those who are experiencing an acute behavioral health crisis, however, may experience a longer length of stay due to limited step-down treatment options that would prevent rehospitalization. While a full continuum of services is needed for youth, this report focuses exclusively on alternatives to CCCA. Figure 1 depicted below illustrates a continuum of pre-crisis, crisis, and post-crisis services that could serve as alternatives, which are further described in the report.

Figure 1. Pre-crisis, Crisis, and Post-Crisis Services for Youth at CCCA



Private/Non-State Inpatient Options

As stated previously, many states no longer operate a state hospital for children and adolescents, due to the widespread availability of insurance coverage for youth, thus being able to receive a broad range of services in the community as an alternative to state hospitalization. Often, in lieu of a state hospital, states will contract with private/community inpatient hospitals/units to serve individuals that would otherwise be served by a state hospital. Per the 2023 JLARC Report, sufficient psychiatric bed capacity is available in the Commonwealth, and the report reinforces what DBHDS has experienced with respect to accessing available beds – there is a reluctance by the private facilities to serve certain populations. For several years after the Bed of Last Resort law was implemented, DBHDS has attempted to contract with private/community inpatient beds, specifically for children and adolescents. The success of these contracts has varied. The current contract is with UHS and includes five inpatient facilities in Virginia (Newport News, Petersburg, Norfolk, Leesburg, and New Kent) that serve children and adolescents. The contract is utilized by CCCA to divert individuals who have been referred for admission to CCCA, and has had some success; however, UHS is not required to accept any of the individuals referred to them. DBHDS provides funding to UHS to cover the costs of care of individuals who are uninsured, as well as covering the costs of care when Medicaid/insurance will no longer pay for the patient's stay. The contract includes enhanced rates for individuals with developmental and intellectual disabilities, as well as rates for

individuals who may require 1:1 staffing during their inpatient stay.

Despite the current contract success, overall, there have been challenges associated with attempts to contract with private/non-state inpatient providers. These have included:

- An inability to supplement Medicaid/insurance rates that are paid to these facilities
- Contracted/private facilities are unwilling to serve the most behaviorally challenging individuals, or individuals that the hospitals perceive may be challenging to discharge (such as children in DSS custody)
- Lack of inpatient providers willing to partner with DBHDS

Private/non-state inpatient providers have identified that they would benefit from specialized staff training, higher staff to patient ratios, separate units, specialized therapeutic programs, and, in very severe situations, the use of seclusion and restraint, which many non-state inpatient programs currently do not use primarily by refusing to accept youth who they are concerned may have aggressive behaviors.

Additionally, while there are multiple children's psychiatric inpatient programs in Virginia, there are none in far Southwest Virginia. This means that children and adolescents who live south of Roanoke must travel across the state to receive inpatient care, when needed. Similarly, there are no crisis stabilization units or crisis receiving centers for youth, other than Mount Rogers CSB and New River Valley CSB which has a small number of chairs/beds and therefore is not a reliable option for diversion and step-down from state hospitalization.

Recommendations:

- Establish a child and adolescent inpatient psychiatric unit in Southwest Virginia with up to 16 beds. This unit would be dedicated to serving children and adolescents under a temporary detention order (TDOs). Consider ongoing funding to assist the facility with the needs associated with serving behaviorally challenging individuals, including enhanced staffing, specialized staff training, and specialized therapeutic programs. This unit could serve an estimated 500 patients per year.
    - Estimated costs: $5 million start-up costs; $1 to 2 million, ongoing
        - To incentivize this program and support this program to serve more challenging individuals, may want to consider ongoing financial support, at least during the first several years of operation.

In the experience of DBHDS, it is mostly system issues, rather than funding, that are the barriers to contracting with established private inpatient units. Specialized programming, staffing, and the appropriate environment should be considered in the development of such a unit with rates that match the model of care.

Assessment and Diagnostic Services

One of the challenges identified for some individuals who are admitted to CCCA is the lack of a clear diagnosis. Since CCCA currently operates on an acute care model, they do not perform the psychological testing and assessments needed to provide

assessment and diagnostic services, as these can take 30 days or more for some individuals. Unfortunately, the lack of a clear diagnosis supported by assessments and testing can be a barrier to establishing a comprehensive treatment plan to receive needed community services, as well as qualifying for programs, such as the developmental disability (DD) waiver, that fund these services.

In Virginia, there are currently both inpatient and outpatient assessment and diagnostic programs. Many of these programs have long waitlists to receive these services. Additionally, for individuals who may require inpatient assessment and diagnostic services, the current programs do not serve individuals with complex psychiatric and behavioral symptoms, or may only focus on certain diagnoses, such as autism. The current lack of this resource for children presenting with certain needs and behaviors can result in a cycle of frequent inpatient admissions, due to the inability to access appropriate services in the community.

Recommendations:

- Establish an assessment and diagnostic program that serves individuals with complex and challenging psychiatric behaviors, specifically a residential inpatient program. Some options to consider are partnerships with current children's behavioral health providers, such as the Virginia Treatment Center for Children (VTCC); or partnership with an out of state provider who may be willing to provide specialty psychiatric services in Virginia. Establishing the program at CCCA may also be an option. Depending on the size of the unit and the average length of stay of individuals in these programs, an estimated 60 to 80 individuals could be served by these programs. This was also a recommendation of the Safe and Sound Task Force.
    - Estimated costs: $3 to 4 million, one-time; $1 to 2 million, ongoing. This includes start-up costs to hire staff, develop the program, purchase supplies, etc.

Specialized Inpatient Programs for Individuals with Intellectual and Developmental Disabilities

As stated above, 38 percent of children admitted to CCCA have a confirmed or suspected diagnosis of an intellectual and/or a developmental disability. Often, an acute psychiatric inpatient hospital that serves a variety of populations may not be the most optimal setting for individuals with these diagnoses. The presentation of mental health conditions in individuals with intellectual and developmental disabilities may be significantly different than other individuals, and, at times, the developmental disability itself may manifest as psychiatric symptoms and behaviors. The development of resources and services for individuals with these diagnoses, including programs that have staff with specialized training and skills, is needed in Virginia. One model that may be considered is the Neurobehavioral Programs provided at Kennedy Krieger Institute in Baltimore, Maryland. These programs offer a continuum of care for children and adolescents with neurobehavioral disorders and challenging behaviors, including inpatient care, intensive outpatient care, and outpatient care. Throughout the continuum of care, these programs utilize applied behavior analysis, an emphasis on safety, caregiver involvement and education (including paid providers and school systems), and collaboration with all the entities/agencies involved in each individual's care. Specifically, the goal of these programs is to move beyond the management of

challenging behaviors, to the treatment of challenging behaviors.

The development of a program that is similar to those at Kennedy Krieger Institute would require significant investment of resources, including costs to start up a highly specialized inpatient unit; the hiring and intensive training of qualified staff; and ongoing costs associated with any elements of the program that are not covered by insurance. Often the length of treatment in these inpatient programs are significantly longer than traditional psychiatric inpatient programs (up to five months or more), and this may require subsidizing of the program with funds to allow the program to be successful. This program could serve up to 100 individuals annually, depending on the service and size of the inpatient program.

Recommendations:

- Develop a specialized neurobehavioral program in Virginia, similar to the program at Kennedy Krieger Institute
    - Estimated costs: $15-20 million, one-time; $5 million, ongoing

Comprehensive Crisis Services for Youth
The availability of community crisis services for children in Virginia is currently limited; however, there are multiple programs operating and in development, including through Mount Rogers CSB, Western Tidewater CSB, Northwestern CSB, Henrico CSB, and Prince William CSB.

Community crisis programs could serve as a point of early intervention for children who would otherwise be admitted to CCCA. Of particular interest are mobile crisis teams/programs. These teams could serve as supports not only for the children and adolescents in crisis, but for their families, service providers, foster care providers, and others within their systems of support. *Right Help, Right Now*, with support of the General Assembly has directed significant funding for the crisis system, and more specific services are being developed for youth.

Intensive Community Based Services
Another possibility for consideration is mobile support teams that provide intensive wraparound supports to children and adolescents who may need this, of which mobile crisis would be one service. Ideally, these teams would be available to the children and adolescents they serve 24 hours per day, seven days per week. These teams could provide caregiver support, care coordination/case management, therapeutic services, peer support, and crisis intervention. The services provided would be flexible, person-centered, and adjust to the needs of the individual being served. There are two evidence-based models available in Virginia, that have proven effectiveness in decreasing out-of-home placements for youth - Multisystemic Therapy and Functional Family Therapy. There are currently fifteen MST teams in Virginia. Another program in the Commonwealth that offers some of these services is intensive in-home (IIHT), however IIHT services are much more variable in regard to what each provider offers.

Partial hospitalization (PHP) and Intensive Outpatient Programs (IOP) are other short-term, facility based, intensive services that may be beneficial to a child or

adolescent experiencing a behavioral health crisis. Multiple Virginia hospitals and CSBs currently offer these services to children, and the service is reimbursable by Medicaid. While these programs may not be appropriate for children in highly acute crisis that cannot be cared for safely in the home setting, they may be utilized for individuals beginning to experience a crisis, for individuals whose behaviors do not require placement outside of the home, and for children who are stepping down from an inpatient stay.

High-fidelity wraparound (HFW) is a model of intensive care coordination for children and adolescents that encompasses a team approach and involves providing individualized care for children and adolescents with behavioral health challenges and their families. It includes collaborative planning and has the goals of meeting the needs of the child and their family, improving the child and their family's ability to manage their own supports, developing the child and their family's natural support system, and to integrate all the child and family's providers and natural supports into one cohesive plan. Virginia is engaged in efforts to support communities in utilizing this evidence-based model of care through the Virginia Wraparound Implementation Center (VWIC). Currently this service is not reimbursable by Medicaid and is primarily funded in Virginia through CSA funding attached to individuals receiving this service.

While Virginia already has some of the services listed here, they are not available statewide, and many are not equipped to serve individuals with some of the most challenging behaviors and there is a lack of child mental health professionals in the state to meet the need. A major limitation to utilizing these programs, particularly for youth in DSS custody, is that they need to have a stable home environment.

Recommendations:

- Expand community crisis programs for children and adolescents, which requires start-up funding, typically state general funds. Consider development of intensive community-based services and focus development on the ten catchment areas with the highest admissions to CCCA (pp. 5-6). Ten new mobile support teams could serve up to 600 children annually.
    - Estimated costs to develop 10 mobile support teams: $12 million, one-time; up to $500,000, ongoing (depending on Medicaid reimbursement availability)
- Explore making high-fidelity wraparound a Medicaid reimbursable service (currently being considered under Medicaid Behavioral Health Redesign)
- Work with current PHP and IOP providers regarding what resources they may need to serve individuals with more challenging behavior presentations, including family supports to be able to utilize these programs while the youth remains at home.
- Provide dedicated funding for workforce development for child mental health service providers to be able to expand much needed services in the Commonwealth.

Coordinated Specialty Care

Some adolescents are admitted to CCCA due to their first episode of psychosis. Research indicates that early intervention programs for adolescents and young adults experiencing first episode psychosis can result in higher remission rates, improvement in symptoms, increases in social and vocational functioning, and decreases in inpatient hospitalizations. First episode psychosis programs focus on bridging any gaps between adolescent and adult behavioral health services, utilizing a team-based and recovery-oriented approach, a comprehensive approach to pharmacological treatments, cognitive and behavioral skills training, peer support, case management, family support and education, and education and employment support.

Currently in Virginia, there are 11 Coordinated Specialty Care programs, which is an evidence-based model of care that provides first episode psychosis interventions.

- Alexandria CSB
- Arlington CSB
- Blue Ridge Behavioral Healthcare
- Encompass CSB
- Fairfax CSB
- Henrico CSB
- Highlands CSB
- Loudon County CSB
- Mountain Rogers CSB
- Prince William CSB
- Western Tidewater CSB

While these programs have shown successful outcomes, they are not available to everyone in the state and are currently supported by federal and state funding.

Recommendations:

- Develop a rate for Coordinated Specialty Care to be a billable service through Medicaid and other insurance, which is currently being considered under Medicaid Behavioral Health redesign.
- Expand the availability of these services to other areas of the state through additional state general funds that can be awarded to CSBs and private providers who are interested in providing these services.

Foster Care Provider and Family Support

Stakeholder input indicates that there is a lack of consistency in support to foster care families in Virginia, and that the availability and quality of these supports often vary by locality, DSS agency, or even the individual foster care worker. Especially when becoming a provider of foster care to individuals with intensive mental health needs and challenging behavior, the value of support to the foster care providers cannot be overstated. These supports may include education and training for providers on the child's mental health needs, management of challenging behaviors and available resources; access to immediate assistance and crisis care; peer support; assistance with navigation of the mental health service system and the school system; behavioral consultation, behavioral support plans; financial support that enables foster care providers to not have to obtain/continue outside employment; respite care options that are easily accessible; and mental health and self-care support for foster care providers and other family members and professional foster parents. Professional foster parents are specially trained and supported by a team of professionals to manage the complex needs of children in foster care. Professional foster parents receive specialized training in areas such as

trauma informed care, behavioral management, and de-escalation techniques. In best practice models, including a previous pilot in Virginia, one foster parent may take a leave of absence from paid employment to provide full-time care, ensuring stability and minimizing disruptions. Professional foster parents aim to prevent placement in congregate care settings or long-stays in hospitals, focusing on stabilizing the child's situation and developing an effective wraparound plan. The goal is to facilitate a smooth transition to a more permanent placement, such as reunification with parents, foster care, or placement with kin relatives.

While Children's Services Act (CSA) funds are already used for foster care provider support, decisions regarding the use of these funds are made at the local level and this can result in a lack of consistency within the Commonwealth.

Recommendations:

- Development of specialized foster care family programs to serve children and adolescents with current or historical psychiatric inpatient hospitalizations, challenging behaviors, individuals assigned to the Safe and Sound Taskforce, and other children who are considered "high acuity".
- Appropriate funding specifically for this purpose, and establish consistency in how the funds are allocated, managed, and utilized, by CSA in collaboration with DSS.
- Estimated cost: $10-15 million, ongoing

Evidence Based Therapeutic Community Services

Many, if not all, of the children served by CCCA have experienced trauma in their young lives, and often the behavioral challenges exhibited that result in hospitalization are a reaction to this trauma. Unfortunately, while there are multiple evidence-based therapies to treat trauma related conditions, they are not available in every community and/or trauma providers already have full caseloads. Even accessing traditional psychotherapy for children can take weeks or months.

Specific community services that are needed for children who would otherwise be served by CCCA include child psychiatry, trauma and attachment-based treatments, high quality/intensive case management/care coordination (such as high-fidelity wraparound), intensive in-home services (which may include MST), functional family therapy, and applied behavioral analysis/behavioral consultation.

The proposed evidenced-based practice updates for STEP-VA includes many specific evidence-based practices that encompass the services listed above.

Recommendations:

- Consider evaluation of current Medicaid rates for these services to incentivize providers to provide evidence-based therapies and ensure programs are sustainable and able to meet the needs of children with the most intensive behavioral needs.
- Continue to develop a continuum of community-based services for youth through Medicaid redesign.

Behavioral Assessment, Therapy and Consultation/Applied Behavioral Analysis

Most children who are admitted to CCCA present with a complex psychiatric presentation that may include maladaptive behaviors as a reaction to trauma, mood disorders, psychosis, developmental disabilities, or conduct disorders. This is often

difficult to determine, and a comprehensive behavioral assessment is not readily available consultation in the community. Many of the programs that operate in Virginia have waiting lists, and services aren't available in all areas. In addition, there is a shortage of Applied Behavior Analysts, and at times, it can be challenging to get private insurance programs to cover the service, especially for the adolescent population. ABA can be especially beneficial for children diagnosed with autism and challenging behaviors, and recently there is growing evidence that it can benefit youth with serious emotional and behavioral disturbances. Additionally, there are barriers of accessing ABA across treatment settings, such that outpatient providers cannot provide continuity of care if a youth is admitted into a residential or inpatient psychiatric setting.

Recommendations:

- Develop the workforce in this area.
- Consider a Medicaid rate structure for ABA providers who are willing to serve children with the most intensive behavioral needs across treatment settings.

Enhanced Sponsored Residential Services

Sponsored residential services are services, typically provided in a home or home-like setting, that provide skill-building, routine supports, general support, supervision, and safety supports in the homes of families or other individuals. Sponsor home providers are licensed by DBHDS. This is a service that is currently primarily covered by Medicaid under the DD waiver; however, CSA does fund some sponsored residential services for children and adolescents who meet eligibility and are approved for CSA funds.

For some children who are admitted to CCCA, especially those in the custody of a local DSS, sponsored residential services with a focus on mental health and behavioral supports may be an appropriate option for placement; however, these types of sponsored residential programs are not readily available in Virginia, due to most sponsored providers being licensed under the developmental disability license (as opposed to also being licensed for Mental Health), a need for robust mental health training for sponsored homes, lack of identified providers and for mental health sponsored residential homes, the main funding source being CSA.

Under the DD waiver, sponsored residential services are reimbursed at a rate of anywhere from $195.20/per day to $551.45 per day, depending on the individual's assessed needs and the part of the state where the sponsored residential provider is located. Children who currently require care at CCCA are likely to have the most intensive behavioral support needs, and to compensate providers adequately, reimbursement for more specific services may be needed beyond the base level reimbursement of $551.45.

In the proposed model, providers would be highly trained in mental health and behavioral support, and also have access to intensive community supports, including appropriate respite providers.

Recommendations:

- Consider piloting this type of sponsored residential service in areas of the state that utilize CCCA the most for children in DSS custody – Blue Ridge Behavioral Health (Roanoke area), Horizon Behavioral Health (Lynchburg area); and Region Ten CSB (Charlottesville area).
- Currently, unless an individual has a DD waiver, this service is not covered by any type

of insurance; therefore, the mental health sponsored residential service would either need to become one covered by Medicaid, or these services will need to funded by CSA (for eligible children and adolescents) or state general funds.
    - Estimated cost: $4 million, ongoing; $200,000 to $300,000 per child, annually.
- It is estimated that these programs could serve up to 30 children and adolescents annually.

Specialized Group Homes

While congregate living settings, such as group homes, are not the preferred placement option for individuals, in certain situations these services may be the most appropriate, specifically for children and adolescents who require highly specialized care. Therapeutic group homes and DD group homes already exist for children; however, the ones currently in existence are often unable or unwilling to serve children who are admitted to CCCA. Similar to sponsored residential settings, the development of group homes for children that provide specialized behavioral health care are needed. Current Medicaid rates for these homes may not be sufficient to recruit providers, or to enable providers to provide the level of services needed.

Recommendation:

- Consider developing a rate structure for group homes that are equipped to serve children with highly specialized behavioral and mental health needs that reflect the additional services and supports beyond the base rate. Value based payment models should be considered to also ensure the quality of care and outcomes are met.

In-State Psychiatric Residential Treatment Facilities (PRTF)

CCCA data from FY 2022-24 indicates that there was a subset of children served at CCCA who were discharged to out of state PRTFs (approximately 5%). This was typically because in-state facilities were unable or unwilling to serve these children or could not meet their behavioral needs. Stakeholders report that some in-state PRTFs indicate that they are more likely to accept children from outside of Virginia because of other state's willingness to pay higher rates for services. Additionally, children in Virginia are, at times, being placed at residential treatment facilities in other states at significantly higher per diem rates that Medicaid reimburses in state PRTFs, with CSA or DBHDS funding these placements. For example, the ceiling for Medicaid rates for PRTFs in Virginia is $568.48 per day, and in some situations, CSA or DBHDS is funding out of state placements at over $1,000 per day. While reimbursement is one factor to consider, Virginia's youth should be served by Virginia providers and there should be a comprehensive look to determine what financial, regulatory, policy, and practice changes are needed to achieve this.

Residential treatment facilities are a critical component of a comprehensive continuum of services for youth and more work is needed to ensure that when this level of care is needed, that youth are again not staying there for longer than is clinically necessary, they receive high quality treatment, and families are able to be supported and engaged to ensure transition to the community. Psychiatric residential treatment and group homes continue to be the only youth service that is carved out of the Medicaid Managed care plans. This means that the youth is only covered in through fee-for-service Medicaid and therefore does not receive any care coordination or oversight by the MCO with respect to utilization management or quality of the provider, as with other mental health services. MCOs have the ability to reimburse higher than the Medicaid floor, create value-based payment options, and shape the quality of their network, but cannot use these tools when the service is carved out.

Recommendation:

- Include care coordination for PRTF into Medicaid managed care to improve care coordination, explore carve-in of the service and value based payment options for providers to serve children assessed to require the most intensive level of support, and ensure that the rates match the quality of care received by the youth.
- Establish a provider development plan to ensure that staff at residential facilities have access and are trained in evidence-based, trauma-informed care, and consider the development of specialty providers that can better meet the needs of youth.

Funding Sources

The majority of children currently admitted to CCCA are enrolled in Medicaid or are Medicaid-eligible, and many of the services referenced in this report are covered by Medicaid; however, the current reimbursement structure may not be adequate to support the level of care needed for these children, which in turn may deter providers of these services from being willing to serve children and adolescents with intensive behavioral health needs. Additionally, the Bed of Last Resort legislation that was enacted in Virginia in 2014 has resulted in a system in which community providers and non-state inpatient providers are not required to be equipped to serve individuals with the most challenging behavioral needs. To create a system in which children and adolescents who would typically be admitted to CCCA are served by other providers, providers would need to be developed who are willing and able to serve children and adolescents with the highest level of needs. This will require adequate training, education, resources, and compensation. To further develop or build out the services recommended, significant investment of funding would be required.

Children's Services Act (CSA) Funds

Due to the current restrictions of CSA funding to ensure that it is not used as a workaround to Medicaid reimbursement, it is not possible to allocate a certain portion of that funding to these services and programs. Decisions on whether CSA funding would be used to support individuals receiving these services (for children who are eligible for CSA funding) would be made at the local and individual level. CSA has the ability to pay for services to meet the youth's needs however lack of standardization and availability of services in each community create variable access to high quality services and supports that CSA can pay for.

Medicaid Reimbursement

Based on data from CCCA and information from stakeholders, Medicaid rates and use of value based payment structures for the following services are recommended to equip providers to serve children who would otherwise be admitted to CCCA, including the ability to recruit and retain qualified staff:

- Psychiatric inpatient
- Comprehensive crisis services
- Multisystemic Therapy
- Family Functional Therapy
- Partial hospitalization
- Applied Behavior Analysis
- Therapeutic group homes
- Evidence Based Therapies
- Psychiatric residential treatment facilities

Additionally, it is recommended that changes are made to allow the following services to become covered by Medicaid:

- Mental health sponsored residential services
- High fidelity wraparound
- Coordinated specialty care

Of note, part of the work that is being done through Behavioral Health Redesign is the development of a continuum of youth services and the evaluation of Medicaid rates that reflect the quality and outcomes needed.

State General Funds

DBHDS currently is appropriated $7.6 million for use to support services for children who are being diverted from or discharged from CCCA; however, at this time, all of these funds are allocated to existing initiatives. Additional appropriations of general funding would be required to develop and implement the services needed to support children who would otherwise be served at CCCA.

To develop and implement the needed services, additional staff resources would also be required at DBHDS to oversee and monitor these services, and to ensure that they are serving the target population of children and adolescents.

CCCA's current budget consists of $19 million in state general funds. As programs are developed that can serve children who are typically admitted to CCCA, these funds could be reappropriated to these programs; however, it should be noted that it is essential that there is a significant period of time in which both these programs are developed/operational, and CCCA or similar level of care is still available for children across the Commonwealth.

The Role of CCCA in a Comprehensive System of Behavioral Health Care for Children

In the past, CCCA served longer-term, residential, and a mix of involuntary and voluntary cases with complex behavioral health needs. In this role, CCCA often served as the tertiary level of care for children with the most extensive behavioral health needs, accepting transfers from private/non-state inpatient units of patients who required complex, longer-term treatment. Currently, the role of CCCA is defined by the Bed of Last Resort law. The development of new services in the community, and the enhancement of existing services, may allow stakeholders, including behavioral health and developmental disability providers, families, other child agencies, and children and adolescents themselves, to describe what is needed in Virginia to meet the needs of youth with behavioral health needs, and within this, what the role of the state should be in this continuum of care. The system of care for youth is different from an adult model and careful consideration is needed to align the services with the practice model to see the outcomes improve for youth.

Conclusion

Children and adolescents with behavioral health disorders, specifically those who present with

complex psychiatric symptoms and behaviors, are a distinct population that require individualized care to address the complex interplay of their social, emotional, academic, and developmental needs. It is clear from previous workgroups and studies, as well as the feedback received from stakeholders, that Virginia needs a comprehensive continuum of behavioral health services for children, ranging from prevention to acute treatment and recovery. Services are missing, not fully developed, or not accessible to those who need them most, resulting in significant gaps that CCCA has been left to fill in times of acute crisis.

Fortunately, the growing evidence base for effective, high intensity services for children is becoming more available, and the next step forward is to ensure they are accessible to all children who need it. This includes addressing availability, workforce, training, and financial sustainability. To immediately target the behavioral health needs of children in acute crisis and those who are post crisis who are currently being served by CCCA, the priority investments should be supporting the expansion and enhancement of existing providers and establishing a best-in-class model of behavioral health care to better meet the needs of youth and families.