

# Commonwealth of Virginia



## 2008 MHBG Implementation Report

November 25, 2008

Virginia Department of Mental Health, Mental  
Retardation and Substance Abuse Services

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# **FY 2008 Implementation Report Summary**

## **Areas Identified as Needing Improvement**

The approved plan for FY 2008 identified a need for improvement in three important areas:

- Forging and supporting partnerships with community services boards, state facilities, local private providers, consumers, family members and advocates;
- Strengthening the department's policy leadership with other state entities, such as the Department of Medical Assistance Services (the state Medicaid agency), the Office of Comprehensive Services and others; and
- Creating and supporting recovery-focused services.

Virginia is engaged in a process of transforming its mental health system to a recovery-oriented system. Supporting this process, the state has been fortunate to have the Community Mental Health Services Block Grant that has strengthened efforts to establish a comprehensive community-based mental health service system focused on the needs of consumers. Virginia is pleased to be part of the movement to achieve the promise of the President's New Freedom Commission and recognizes the importance of the CMHS Block Grant and performance partnership planning as part of Virginia's overall implementation strategy.

Virginia's public mental health, mental retardation and substance abuse services system is comprised of forty community services boards (CSBs) and sixteen state facilities. The CSBs and state facilities serve children and adults who have or who are at risk of mental illness, serious emotional disturbance, mental retardation, or substance use disorders.

## **Significant Events that Impacted the Mental Health System**

This is an exciting time of transition and transformation for Virginia's services system. The Department is continuing to implement restructuring initiatives to develop and to enhance community-based care for individuals who would best be served in community settings. Our system has received, in the most recently approved budget, a down payment for investing in this work. Specifically, DMHMRSAS has received funding to support a significant number of new waiver slots and money for Olmstead initiatives such as private bed purchase money, Discharge Assistance Plans (DAP), and Programs of Assertive Community Treatment (PACT).

In addition, DMHMRSAS has a new Vision that focuses on self-determination, empowerment, recovery and resilience. Virginia's system will not be restructured appropriately until we fully understand, fully embrace, and fully implement the concepts of self-determination, empowerment and recovery. The Department's Vision is an essential component of an Integrated Strategic Plan, which was developed in the fall of 2005 and incorporated recommendations of the Regional Partnerships, the Special Populations Work Groups and the Mental Health Planning Council. In addition, a new Governor was elected in November, 2005 and he retained the current

Commissioner and thus maintained continuity in leadership and vision for the transformation effort.

## System Mission and Overview

The Department of Mental Health, Mental Retardation and Substance Abuse Services is committed to improving the quality of life and self-sufficiency of people with serious mental illnesses, serious emotional disturbances, mental retardation, developmental delays, and alcohol and other drug addiction or abuse problems and to preventing, to the greatest extent possible, the devastating personal, social, and economic consequences of mental disabilities and substance abuse.

Community mental health, mental retardation, and substance abuse services are provided in Virginia by community services boards (CSBs), behavioral health authorities, or local government departments with policy-advisory CSBs. These organizations function as:

- the single point of entry into the publicly-funded mental health, mental retardation, and substance abuse services system, including access to needed state facility services through pre-admission screening, case management, and coordination of services;
- service providers, directly and through contracts with other providers;
- advocates for consumers and individuals in need of services;
- community educators, organizers and planners;
- advisors to the local governments that established them; and
- the primary locus of programmatic and financial accountability.

In addition to its comprehensive system of community and facility mental health services, Virginia has a number of initiatives and planning activities to assure that training is provided for staff and providers of emergency health services and medical and dental services. These initiatives focus on educating emergency health services and medical and dental service providers on the mental health needs of children and adults. DMHMRSAS works with the Virginia Hospital and Healthcare Association and the College of Emergency Physicians to identify, treat and stabilize the medical conditions of individuals prior to their admission to state psychiatric hospitals. CSB case managers actively work to identify medical and dental services for indigent consumers and make referrals to medical and dental service providers.

This report includes the Uniform Reporting System data tables (Section 4.). Much of the data has been gathered by a new system, the Community Consumer Submission (CCS), which extracts data directly from Community Services Boards' individual management information systems. CCS was developed in response to Block Grant and other reporting needs. This is a very important accomplishment for Virginia, resulting in the capacity to provide unduplicated client counts and a reduced reporting burden on CSBs.

## **State Selected Performance Measures**

Listed below are the performance measures selected by the state for this implementation report with the percentage to which each goal was achieved:

### **Adult Services**

#### **CRITERION 1: Comprehensive Community-based Mental Health Service Systems**

- Readmission rate:
  - within 30 days of discharge mental illness (110%)
  - within 180 days of discharge mental illness (97%)
- Number of Evidence Based Practices offered in Virginia (100%)
- Number of adults receiving Evidence Based Practices (142%)
- Positive consumer perceptions of outcomes on MHSIP survey (105%)

#### **CRITERION 2: Mental Health System Data Epidemiology**

- Number of adults served by the public system (107%)
- The percentage of adults with a serious mental illness who receive public mental health services from community services boards during the fiscal year (102%)

#### **CRITERION 3: Applies only to Children's Services**

#### **CRITERION 4: Targeted Services to Rural and Homeless Populations**

- The composite score will be reported on PATH consumers who receive mental health services, shelter, and housing services (159%)

#### **CRITERION 5: Management Systems**

- Percent of state mental health agency-controlled resources distributed to community services boards (98%).

## **Children's Services**

### **CRITERION 1: Comprehensive Community-Based Mental Health Service Systems**

- Readmission rate for children/adolescents at state facilities:  
within 30 days of discharge mental illness (94%)  
within 180 days of discharge mental illness (63%)
- The rate per 100,000 population of admission to the state mental health facilities of youth under the age of eighteen (106%)
- Number of children and adolescents receiving therapeutic foster care (78%)

### **CRITERION 2: Mental Health System Data Epidemiology**

- The number of children who receive mental health services from CSBs during the fiscal year (114%)
- The percentage of children with serious emotional disturbance who receive mental health services from CSBs during the fiscal year (131%)

### **CRITERION 3: Children's Services**

- Percentage of consumer's care givers who report satisfaction with staff sensitivity to cultural/ethnic background (98%)
- Percentage of consumer's care givers who report positive perceptions of outcomes (100%)

### **CRITERION 4: Targeted Services to Rural and Homeless Populations**

- Children with serious emotional disturbance in rural areas receiving mental health services (119%)

### **CRITERION 5: Management Systems**

- State mental health agency-controlled resources distributed to CSBs Specifically for children's mental health services (115%)

## **Block Grant Expenditures, Recipients and Funded Activities**

A detailed expenditure report for the FFY 2008 Block Grant is included on page 5. The block grant monies supported community mental health services for children with serious emotional disturbance and adults with serious mental illness, consumer-run programs, recovery programs, consumer and family education and other contractual programs and state administrative expenses. Block Grant funds have made an immeasurable difference in the midst of recent state budget shortfalls and transformation. Block Grant funds have enabled Virginia to support new recovery-oriented initiatives and to empower consumers through consumer education and employment. The recipients of CMHS block grant funds are detailed in Table 10 of the URS tables.

## **Mental Health Planning Council Review**

This implementation report has been submitted to the Mental Health Planning Council for review. Comments from the review will be submitted later in December (see the enclosed letter from the Mental Health Planning Council president on page 4).



**COMMONWEALTH of VIRGINIA**

ALISON HYMES  
PRESIDENT

**MENTAL HEALTH PLANNING COUNCIL**

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November 19, 2008

Ms. Lou Ellen M. Rice  
Grants Management Office  
Division of Grants Managements, OPS  
Substance Abuse and Mental Health  
Services Administration (SAMHSA)  
1 Choke Cherry Road  
Room 7-1091  
Rockville, Maryland 20857

**Re: Virginia Implementation Report 2008**

Dear Ms. Rice,

As President of the Mental Health Planning Council of Virginia, I would like to thank you for the opportunity to comment on the implementation report for the block grant funding, which the Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) has prepared for you.

Unfortunately, due to the lack of time between the implementation report and our next full Mental Health Planning Council meeting on December 3, 2008, the Mental Health Planning Council will be unable to review and comment by the December 1, 2008 deadline.

Therefore, this letter is to inform you that we will be reviewing the Implementation Report over the next month and will provide comments by December 31, 2008.

Thank you once again for the opportunity to provide comments.

Sincerely,

Alison Hymes, President  
Mental Health Planning Council of Virginia

**Virginia MH Block Grant: Project 50137  
Expenditure Period: 10/01/06 – 9/30/08**

<b>FFY 08 Award</b>	<b>10,238,437</b>
<b>Set-Aside Requirements for FFY05</b>	
<b>Children</b>	<b>1,501,623</b>
<b>Admin Allowance 5% maximum</b>	<b>511,922</b>

**SFY08  
Expenditures  
7/01/07 to 09/30/08**

<b>Administrative:</b>			
<b>Salaries/Fringes &amp; Operating</b>			<b>465,565</b>
<b>Program Evaluation - (Non-Admin)</b>			<b>85,596</b>
<b>CSB Funding:</b>			
<b>Children</b>			<b>2,094,352</b>
<b>Adults</b>			<b>2,682,422</b>
<b>SW Va Mental Health</b>			<b>84,375</b>
<b>PACT</b>			<b>787,501</b>
<b>Geriatric HPR II &amp; V Pilots</b>			<b>834,519</b>
<b>Children - One Time</b>			<b>401,866</b>
<b>Adults - One Time</b>			<b>826,406</b>
<b>Consumer Run Programs - One-Time</b>			<b>141,570</b>
<b>Msc One-Time Projects</b>			<b>109,336</b>
<b>Total CSB Funding</b>			<b>7,962,347</b>
<b>Consumer Run Programs:</b>			
<b>Middle Peninsula-Northern Neck CSB</b>			<b>36,712</b>
<b>Fairfax Opportunities/Srv Source</b>			<b>89,769</b>
<b>On Our Own - Charlottesville</b>			<b>89,781</b>
<b>On Our Own - Roanoke</b>			<b>27,387</b>
<b>Mt Rogers CSB</b>			<b>11,675</b>
<b>Additional Funding for Consumer Run Programs - One-Time</b>			<b>418,937</b>
<b>Total Consumer Run Programs</b>			<b>674,261</b>
<b>Consumer &amp; Family Education, Training Support:</b>			
<b>VHST - Region 10 CSB</b>			<b>65,625</b>
<b>Emergency Services Conference (CSB - fiscal agent)</b>			<b>17,000</b>
<b>VOCAL COOP</b>			<b>53,626</b>
<b>VOCAL - REACH</b>			<b>40,000</b>
<b>VOCAL - NETWORK</b>			<b>64,126</b>
<b>VOCAL - Mgmt &amp; Admin Infrastructure</b>			<b>83,333</b>
<b>Family Education - NAMI</b>			<b>50,000</b>
<b>MH Planning Council (Operating Budget)</b>			<b>20,000</b>
<b>Parent Support</b>			<b>87,500</b>

<b>Consumer and Family Education Trng</b>			-
<b>VAPRA Conference - Consumer Education</b>			-
<b>CELT - Leadership Academy - MHAV</b>			<b>140,000</b>
<b>Children's Services Conference</b>			<b>25,000</b>
<b>ILPPP - Mental Health Law Reform Study - One-Time</b>			<b>152,500</b>
<b>Consumer &amp; Family Education - One-Time Projects</b>			<b>251,958</b>
<b>Total Consumer &amp; Family Education</b>			<b>1,050,668</b>
<b>Total Expenditures</b>			<b>10,238,437</b>

# Introduction and Background Narrative for Virginia

## Excerpted portions from: Comprehensive State Plan

### I. INTRODUCTION

Section 37.2-315 of the *Code of Virginia* requires the Department of Mental Health, Mental Retardation and Substance Abuse Services (the Department) to develop and update biennially a six-year Comprehensive State Plan for mental health, mental retardation, and substance abuse services. This plan must identify the services and supports needs of persons with mental illnesses, mental retardation, or substance use disorders across Virginia; define resource requirements; and propose strategies to address these needs. That *Code* section also requires that the plan be used in the preparation of the Department's biennium budget submission to the Governor.

The Department's initial Comprehensive State Plan for 1985-1990 proposed a "responsible transition" to a community-based system of services. In 1986, the plan was expanded to cover a six-year time frame, with updates corresponding to the Department's biennium budget submissions. These updates continued until 1995, when agency strategic planning efforts replaced the 1996-2002 Comprehensive State Plan. Biennial updates to the Comprehensive State Plan were reinstated in 1997 with the completion of the 1998-2004 Plan.

The Department's Comprehensive State Plan has evolved to serve a number of purposes. The plan:

- Establishes services system priorities and future system directions for the public mental health, mental retardation, and substance abuse services system;
- Describes strategic responses to major issues facing the services system;
- Identifies priority service needs;
- Defines resource requirements and proposes initiatives to respond to these requirements; and
- Integrates the agency's strategic and budget planning activities.

The 2000-2006 Comprehensive State Plan introduced an individualized database to document service needs and characteristics of individuals on community services board (CSB) waiting lists. This biennial survey continues to be used to document community service needs. CSB waiting lists include individuals who have sought but are not receiving CSB services and current recipients of CSB services who are not receiving the types or amounts of services that CSB staff have determined they need. The CSB waiting list database provides demographic and service need information about each individual identified as needing community services or supports. Also included in the database are the

CSBs' average wait times for accessing specific types of services and prevention service priorities.

In addition to CSB waiting list information, the Department maintains state facility "ready for discharge" lists. These include patients in state hospitals whose discharges have been delayed due to extraordinary barriers and residents of state training centers who, with their authorized representative or family member, have chosen to continue their training and habilitation in the community instead of at a training center.

The 2008-2014 Comprehensive State Plan continues to build on the recommendations of the Department's Integrated Strategic Plan (ISP). Additionally, key initiatives in this Plan also are incorporated in the Agency Strategic Plan (ASP) and associated Service Area Plans prepared as part of the 2008-2010 biennium budget submission to the Department of Planning and Budget.

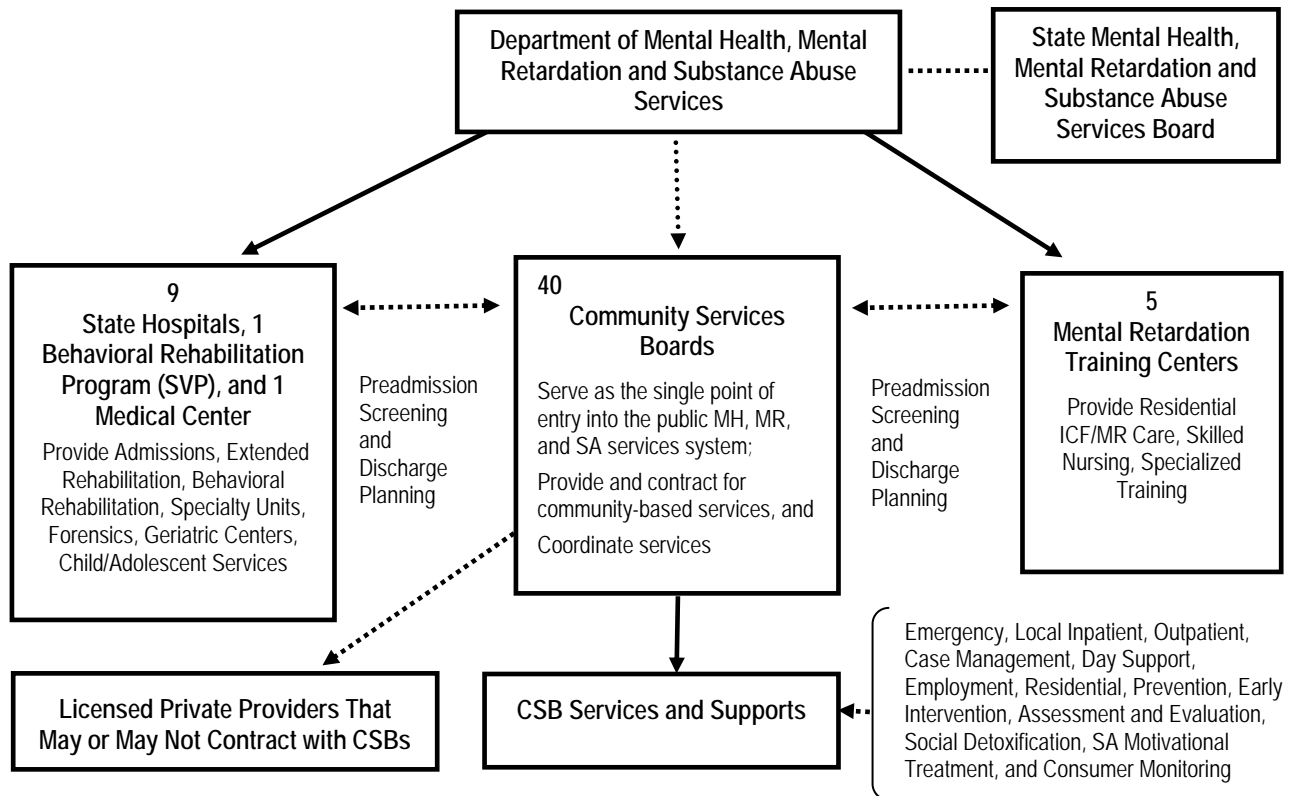
- The ISP is the product of a two-year strategic planning process that has involved hundreds of interested citizens. The ISP provides a framework for transforming Virginia's publicly funded mental health, mental retardation, and substance abuse services system.
- Using a uniform structure and cross-agency taxonomy of state programs and activities provided by the Department of Planning and Budget, the Department's ASP is intended to align the Department's vision, goals, services, objectives, and resource plans with the guiding principles, long-term vision, and statewide objectives established by the Council for Virginia's Future. The Council was established by §2.2-2684 of the *Code of Virginia* to advise the Governor and the General Assembly on the implementation of the Roadmap for Virginia's Future process.

## II. SERVICES SYSTEM OVERVIEW

### Services System Structure and Statutory Authority

Virginia’s public services system includes the Department, the State Mental Health, Mental Retardation, and Substance Abuse Services Board (the State Board), 16 state operated hospitals and training centers operated by the Department, and 39 community services boards and one behavioral health authority (referred to as CSBs) that provide services directly or through contracts with private providers. Maps of CSB service areas and the locations of state facilities are contained in Appendix A.

The following diagram outlines the relationships between these services system components. Solid lines depict a direct operational relationship between the involved entities (e.g., the Department operates state facilities). Broken lines depict non-operational relationships (e.g., policy direction, contracting, or coordination).



Title 37.2 of the *Code of Virginia* establishes the Department as the state authority for mental health, mental retardation, and substance abuse services. By statute, the State Board offers policy direction for Virginia’s services system.

The mission of the Department’s central office is to provide leadership and service to improve Virginia’s system of quality treatment, habilitation, and prevention services for individuals and their families whose lives are affected by mental illness, mental retardation, or substance use disorders (alcohol and other drug dependence or abuse). The central office

seeks to promote dignity, choice, recovery, and the highest possible level of participation in work, relationships, and all aspects of community life for these individuals.

Responsibilities of the Department include:

- Providing leadership that promotes strategic partnerships among and between CSBs, state facilities, and the central office and effective relationships with other agencies and providers;
- Providing direct care, treatment, and habilitation services in state hospitals (civil and forensic) and training centers;
- Supporting the provision of accessible and effective community mental health, mental retardation, and substance abuse treatment and prevention services through the network of CSBs;
- Assuring that public and private mental health, mental retardation, and substance abuse services providers adhere to licensing standards; and
- Protecting the human rights of individuals receiving mental health, mental retardation, or substance abuse services.

### **Characteristics of Community Services Boards and Trends**

Community services boards (CSBs) function as the single points of entry into publicly-funded mental health, mental retardation, and substance abuse services, including access to state hospital and training center (state facility) services through preadmission screening, case management and coordination of services, and discharge planning for individuals leaving state facilities. Community services boards:

- provide services, directly and through contracts with other providers;
- are the local focal points of programmatic and financial responsibility and accountability for publicly-funded services;
- are community educators, organizers, and planners and serve as advocates for individuals receiving CSB services and persons in need of services; and
- serve as advisors to the local governments that established them.

The private sector is a vital partner with CSBs in serving people with mental illnesses, mental retardation, or substance use disorders. In addition to serving many individuals through contracts with CSBs, private providers also serve other individuals directly, for example through various Medicaid programs such as the mental retardation home and community-based waiver (MR waiver), with plans of care case managed by CSBs, and mental health clinic and inpatient psychiatric treatment services.

Section 37.2-100 of the *Code of Virginia* defines three types of CSBs: operating CSBs, administrative policy CSBs, and policy-advisory CSBs with local government departments (LGDs). Chapter 6 in Title 37.2 of the *Code* authorizes certain localities to establish behavioral health authorities (BHAs). In this Plan, CSB or community services board means CSB, BHA, and local government department with a policy-advisory board.

### Combined Classification of Community Services Boards

CSB Classification	Functions as LGD	Cities and/or Counties Served		Total CSBs
		One	Two or More	
Administrative Policy CSBs <sup>1</sup>	7	7	3	10
LGD with Policy-Advisory CSB	1	1	0	1
Operating CSB <sup>2</sup>	0	2	26	28
Behavioral Health Authority <sup>2</sup>	0	1	0	1
<b>TOTAL CSBs</b>	<b>8</b>	<b>11</b>	<b>29</b>	<b>40</b>

<sup>1</sup> Seven of these CSBs are city or county departments; even though 3 CSBs are not, all use local government employees to staff the CSB and deliver services.

<sup>2</sup> Employees in these 28 CSBs and in the BHA are board, rather than local government, positions.

CSBs are not part of the Department. The Department's relationships with all CSBs are based on the community services performance contract, provisions of Title 37.2 of the *Code of Virginia*, State Board policies and regulations, and other applicable state or federal statutes or regulations. The Department contracts with, funds, monitors, licenses, regulates, and provides consultation to CSBs.

#### ***CSB Mental Health Services***

In FY 2006, 118,732 individuals received CSB mental health services. This represents an unduplicated count of all individuals receiving any mental health services. Numbers of individuals receiving CSB mental health services by core service follow.

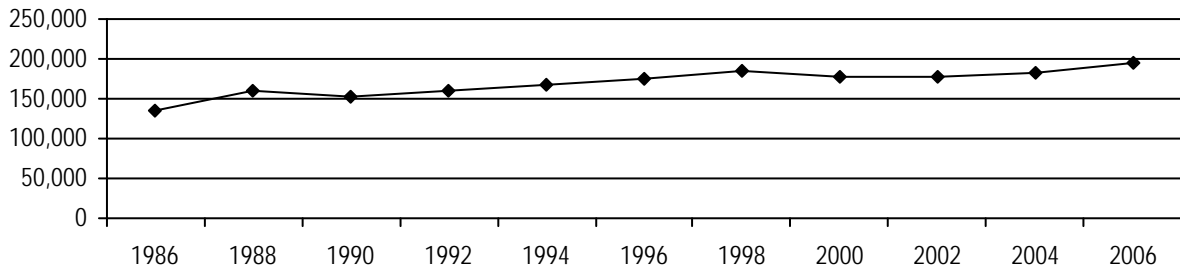
#### **Number of Individuals Receiving CSB Services by MH Core Service in FY 2006**

Core Service	# Served	Core Service	# Served
Emergency Services	43,830	Highly Intensive Residential	1,040
Local Inpatient Services	2,787	Intensive Residential	339
Outpatient Services	76,443	Supervised Residential	1,489
Assertive Community Treatment	1,401	Supportive Residential	4,812
<b>TOTAL Outpatient Services</b>	<b>77,844</b>	<b>TOTAL Residential Services</b>	<b>7,680</b>
Case Management	47,972	Early Intervention Services	552
Day Treatment/Partial Hospitalization	2,902	Motivational Treatment Services	3
Rehabilitation Services	5,608	Consumer Monitoring Services	1,891
<b>TOTAL Day Support Services</b>	<b>8,510</b>	Assessment and Evaluation Services	3,826
Sheltered Employment Services	53	<b>TOTAL Limited Services</b>	<b>5,720</b>
Supported Employment - Group Models	38	<b>TOTAL Individuals Served</b>	<b>195,794</b>
Individual Supported Employment	808	<b>TOTAL Unduplicated Individuals</b>	<b>118,732</b>
<b>TOTAL Employment Services</b>	<b>899</b>		

Source: FY 2006 Community Services Performance Contract Annual Reports, Department.

Between FY 1986 (the first year that annual performance contract data was submitted by CSBs) and FY 2006, the numbers of individuals receiving various CSB mental health services grew from 135,182 to 195,794, an increase of 45 percent. Trends in the numbers of individuals receiving mental health services from CSBs are displayed on the following graph.

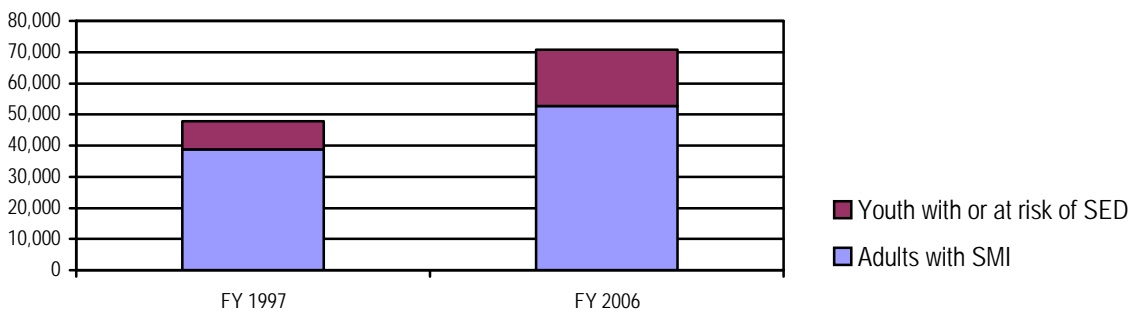
**Trends in Numbers of Individuals Receiving MH Services From CSBs  
FY 1986 - FY 2006**



These numbers are duplicated counts of individuals receiving services because they are derived from CSB community services performance contract annual reports that display numbers of people receiving services by core service categories.

CSBs continue to serve more consumers with more severe disabilities. In FY 1997, CSBs served 38,787 adults with serious mental illness (SMI) and 8,922 youth with or at risk of serious emotional disturbance (SED); in FY 2006, CSBs served 52,799 adults with SMI and 17,955 youth with or at risk of SED. This represents a 36 percent increase in the numbers of adults with SMI and a 101 percent increase in the numbers of youth with or at risk of SED served by CSBs between FY 1997 and FY 2006.

**Numbers of Adults with SMI and Youth with or At-Risk of SED Served by CSBs  
FY 1997 and FY 2006**



Between FY 1997 and FY 2006, the percent of adults with SMI and youth with or at risk of SED increased from 41.4 percent to 59.9 percent of the total number of individuals with mental illnesses served by the CSBs.

## Characteristics of State Hospitals and Training Centers and Trends

### *State Hospitals*

State hospitals provide highly structured intensive inpatient services, including a range of psychiatric, psychological, psychosocial rehabilitation, nursing, support, and ancillary services. Specialized programs are provided for geriatric, child and adolescent, and forensic individuals. The Joint Commission for Accreditation of Healthcare Organizations (JACHO) has accredited all state hospitals.

Child and adolescent services provided by the Southwestern Virginia Mental Health Institute (SVMHI) and the Commonwealth Center for Children and Adolescents (CCCA) are licensed under the CORE regulations for residential children's services.

The Hiram Davis Medical Center (HDMC) provides medical and skilled nursing services to individuals receiving state facility services.

The Virginia Center for Rehabilitative Services (VCBR) provides individualized rehabilitation services in a secure facility to individuals who are civilly committed as sexually violent predators.

Operating (staffed) bed capacities on July 5, 2007 and FY 2007 average daily census for the state hospitals follow.

### Mental Health Facility Operating Capacities and Average Daily Census

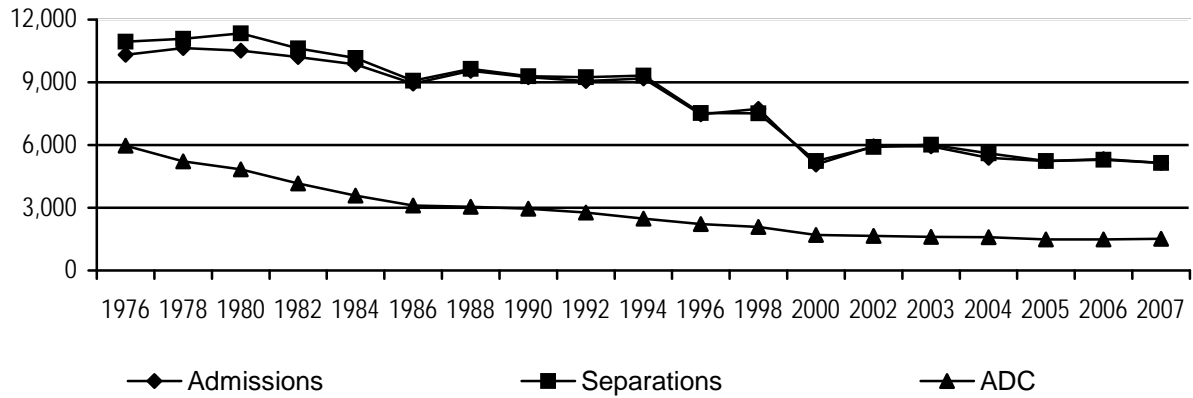
MH Facility	Beds	ADC	MH Facility	#Beds	ADC
Catawba Hospital	120	107	Piedmont Geriatric	135	120
Central State Hospital	277	240	Southern VA MHI	74	69
CCCA	48	34	Southwestern VA MHI	172	151
Eastern State Hospital	456	427	Western State Hospital	260	241
Northern VA. MHI	129	122	Total Operating Capacity (Beds) and ADC	1,671	1,511

Note: HDMC, with an operating capacity of 87 beds and an ADC of 58 and VCBR, with an operating capacity of 94 beds and an ADC of 38 are not included in this table.

Between FY 1976 and FY 1996, the average daily census at state hospitals, excluding the Hiram Davis Medical Center, declined by 3,745, or 63 percent (from 5,967 to 2,222). Between FY 1996 and FY 2007, the average daily census declined by 32 percent (from 2,222 to 1,511). Between FY 1996 and FY 2007, excluding the HDMC and VCBR, admissions declined by 31 percent (from 7,468 to 5,146) and separations (discharges) declined by 32 percent (from 7,529 to 5,149). In FY 2007, VCBR experienced 19 admissions and 2 separations.

Admission, separation, and average daily census trends (FY 1976 - FY 2007) for state hospitals, excluding the HDMC and VCBR, follow.

**MH Facility Admissions, Separations, and Average Daily Census (ADC) Trends: FY 1976 - FY 2007**



Note: Includes the Virginia Treatment Center for Children through FY 1991, when it transferred to the Medical College of Virginia.

**Training Centers**

Training centers provide highly structured habilitation services, including residential care and training in areas such as language, self-care, independent living, socialization, academic skills, and motor development for individuals with intellectual disabilities. All training centers are certified by the U.S. Centers for Medicare and Medicaid (CMS) as meeting Medicaid Intermediate Care Facility for the Mentally Retarded (ICF/MR) standards of quality. In addition, Central Virginia Training Center provides skilled nursing services. Operating (staffed) bed capacities on July 5, 2007 and FY 2007 average daily census for each training center follow.

**Training Center Operating Capacities and Average Daily Census**

Training Center	Beds	ADC	Training Center	Beds	ADC
Central Virginia Training Center	577	509	Southside Virginia Training Center	359	311
Northern Virginia Training Center	200	172	Southwestern Virginia Training Center	215	209
Southeastern Virginia Training Center	200	187	Total Operating Capacity (Beds) and ADC	1,551	1,389

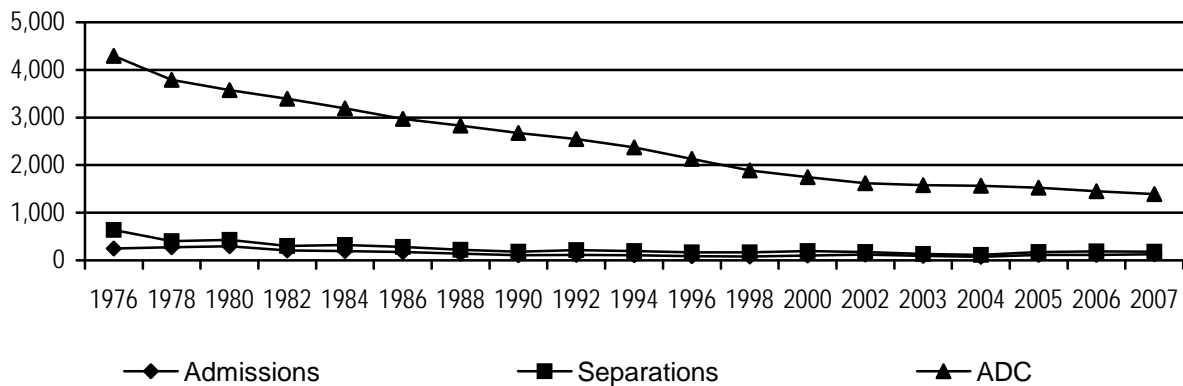
Between FY 1976 and FY 1996, the average daily census at training centers declined by 2,161, or 51 percent (from 4,293 to 2,132). Between FY 1996 and FY 2007, the average daily census declined by 35 percent (from 2,132 to 1,389). Between FY 1996 and FY 2007, training center admissions increased by 47 percent (from 87 to 128). Between FY 1996 and

FY 2007, training center separations (discharges) decreased by 18 percent (from 223 to 182).

Admission to a training center is governed by §37.2-806 of the *Code of Virginia* (regular admission through the judicial certification process) and by §37.2-2.807 and regulations promulgated under that statute (emergency and respite admission for up to 21 days). Applicants must have a diagnosis of mental retardation and deficits in at least two of seven areas of adaptive functioning. Applications are made through the CSB in the locality where the applicant resides. Applicants who meet the criteria for admission to an ICF/MR must be offered the choice of receiving services in an ICF/MR or through the MR waiver.

Admission, separation, and average daily census trends (FY 1976 – FY 2007) for training centers follow.

Training Center Admissions, Separations, and Average Daily Census (ADC) Trends:  
FY 1976 - FY 2007

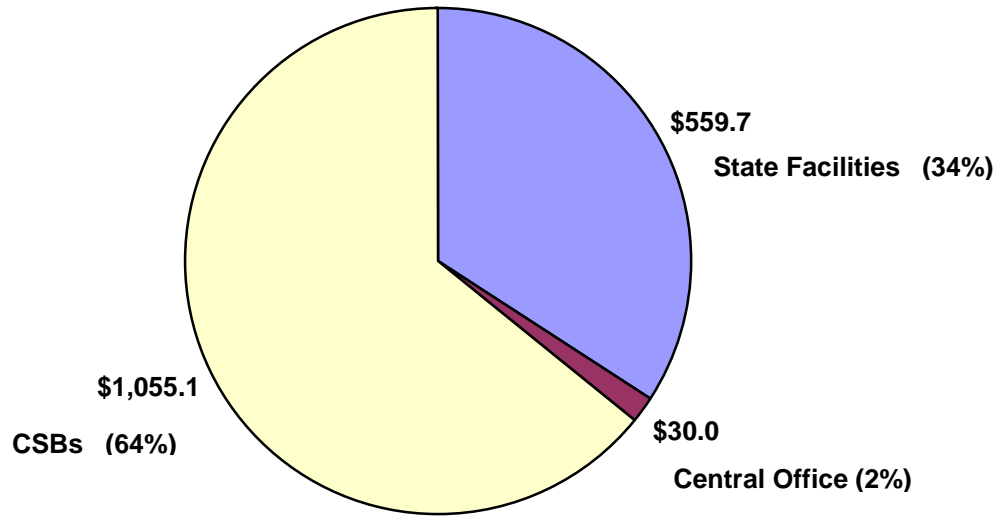


Appendix C contains detailed information on state facility utilization, including the numbers served, average daily census, admissions, separations, and utilization, by CSB.

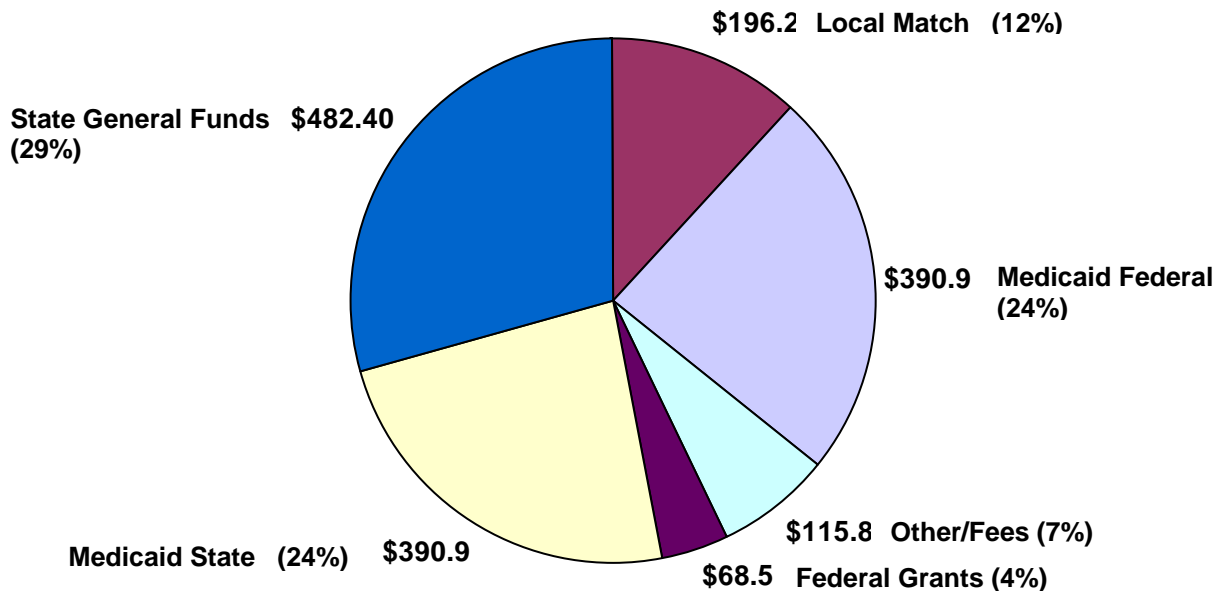
## Services System Funding and Trends

Charts depicting the services system's total resources for **FY 2006** from **all sources** (rounded and in millions), including the Department's final adjusted appropriation, local matching funds, all fees, and Medicaid MR waiver payments to private vendors, follow.

### FY 2006 Total Services System Funding \$1.6448 Billion



**FY 2006 Total Services System Funding  
\$1.6448 Billion**



Dollars in the Charts Above Are in Millions

## Funding Trends

Between FY 2000 and FY 2006, total services system funding grew by 49 percent from \$1,106.3 million to \$1,644.8 million. The following table depicts funding by source (in millions) for this time period.

### Total Services System Funds by Source FY 2000 – FY 2006

	FY 2000	FY 2002	FY 2004	FY 2006
State General Funds	399.9	408.2	408.7	482.4
Federal Grants	56.2	72.2	78.7	68.5
Medicaid - State	209.0	256.9	302.1	390.9
Medicaid - Federal	223.2	273.3	303.7	390.9
Other/Fees	102.0	92.8	99.0	115.8
Local Match	115.9	149.3	166.2	196.2
Total	\$1,106.3	\$1,252.7	\$1,358.4	\$1,644.8

Dollars above are in millions

# Summary of Areas Needing Attention

## CSB Waiting Lists

The following table displays the number of individuals who were on CSB waiting lists for community mental health, mental retardation, or substance abuse services during the first four months of 2007.

### Numbers of Individuals on CSB Waiting Lists for Mental Health, Mental Retardation, or Substance Abuse Services: January - April 2007

Populations of CSB Waiting Lists	Numbers Who ARE Receiving Some CSB Services	Numbers Who Are NOT Receiving Any CSB Services	Total Numbers on CSB Waiting Lists
<b>CSB Mental Health Waiting List Count</b>			
Adults with a Serious Mental Illnesses	3,418	611	4,029
Children and Adolescents With or At Risk of Serious Emotional Disturbance	1,224	456	1,680
Total MH	4,642	1,067	5,709
<b>CSB Mental Retardation Waiting List Count</b>			
Individuals on CSB Waiting Lists for MR Waiver and Non-Waiver Services	4,852	1,114	5,966
<b>CSB Substance Abuse Waiting List Count</b>			
Adults with Substance Use Disorders	1,565	616	2,181
Adolescents with Substance Use Disorders	144	90	234
Total SA	1,709	706	2,415
<b>Total CSB Mental Health, Mental Retardation, or Substance Abuse Services Waiting List Count</b>			
Grand Total on All CSB Waiting Lists	11,203	2,887	14,090

During the time period during which the CSB mental retardation waiting lists were completed, 1,745 persons on these lists also were on the MR waiver urgent waiting list, 1,617 were on the waiver non-urgent list, and 569 were on CSB waiver planning lists.

To be included on the waiting list for CSB services, an individual had to have sought the service and been assessed by the CSB as needing that service. CSB staff also reviewed their active cases to identify individuals on their active caseloads who were not receiving all of the amounts or types of services that they needed. This point-in-time methodology for documenting unmet service demand is conservative because it does not identify the number of persons who needed services over the course of a year.

Appendix E depicts numbers of individuals on waiting lists for mental health, mental retardation, and substance abuse services by CSB.

Diagnostic information and special conditions and risk factors of individuals on waiting lists for CSB mental health, mental retardation or substance abuse services follow.

### Numbers of Individuals on CSB Mental Health Services Waiting Lists

#### Diagnostic Information January – April 2007

Diagnosis	Adult	C&A	Diagnosis	Adult	C&A
Serious Mental Illness (SMI)	2,761		Co-occurring MI/MR	123	35
Serious Emotional Disturbance (SED)		1,135	Co-occurring MI/MR/SUD	18	1
Any Other MI Diagnosis	498		Developmental Disability (Not MR)	45	26
Any Other ED or MI Diagnosis		281	Not Known at This Time	315	262
Co-occurring MI/SUD	910	59			

#### Special Conditions or Risk Factors January – April 2007

Special Condition or Risk Factor	Adult	C&A
Deafness or Hearing Loss	67	8
Blindness or Visual Impairment	78	12
Non-ambulatory or Major Difficulty in Ambulation	139	3
Unable to Communicate with Verbal Speech	23	12
Traumatic Brain Injury	94	12
Dementia	87	
High or Extensive Behavioral Challenges	688	704
High or Extensive Physical or Personal Care Needs	336	53
Concurrent Major Medical Condition or Chronic Health Problem	1,152	51
Limited English Proficiency (National Origin)	106	23
At Risk of Being Homeless or Out of Home Placement	736	316
Current Residence Is Not Satisfactory or Appropriate to Individual's Needs	462	98
Current Residence Is Satisfactory But Supports Provided are Inadequate	510	335
Currently Unemployed or No Day Support Options	1,783	
Receiving Special Education		472
Currently Truant, Expelled, Suspended, or School Drop Out		167
Social Supports Are Limited or Lacking	2,020	625
Aging Care Giver	186	105
Care Giver Illness or Disability	74	

Special Condition or Risk Factor	Adult	C&A
Care Giver Is Unable or Unwilling to Provide Support		127
No Guardian or Legally Authorized Representative	194	6
Family Has Petitioned to be Relieved of Custody to Receive Services		8
Aging Out of CSA or Foster Care Financing for Residential Services		21
Social Services/Juvenile Justice System Involvement		362
In Jail, Correctional Facility, or Criminal Justice Involvement	287	
Lacks Transportation	1,073	130
No Special Conditions or Risk Factors	241	135
Special Conditions or Risk Factors Not Known at This Time	493	280

### Numbers of Individuals on CSB Mental Retardation Services Waiting Lists

#### Diagnostic Information January – April 2007

Diagnosis	Total	Diagnosis	Total
Mental Retardation	4,960	Co-occurring MR/MI/SUD	29
Cognitive Developmental Delay	331	Autism	486
At Risk for Cognitive Developmental Delay	33	Developmental Disability (Not MR or Autism)	235
Co-occurring MR/MI	616	Not Known at This Time	65
Co-occurring MR/SUD	14		

#### Special Conditions or Risk Factors January – April 2007

Special Condition or Risk Factor	Individuals
Deafness or Hearing Loss	241
Blindness or Visual Impairment	389
Non-ambulatory or Major Difficulty in Ambulation	758
Unable to Communicate with Verbal Speech	1,178
Traumatic Brain Injury	79
Dementia	29
High or Extensive Behavioral Challenges	1,263
High or Extensive Physical or Personal Care Needs	1,090
Concurrent Major Medical Condition or Chronic Health Problem	1,068
Limited English Proficiency (National Origin)	133
At Risk of Being Homeless	253
Current Residence Is Not Satisfactory or Appropriate to Individual's Needs	278

Special Condition or Risk Factor	Individuals
Current Residence Is Satisfactory But Supports Provided are Inadequate	1,658
Currently Unemployed or No Day Support Options	623
Social Supports Are Limited or Lacking	1,689
Aging Care Giver (Caregiver is 55 or older)	1,338
Care Giver Illness or Disability	883
Family Has Petitioned to be Relieved of Custody to Receive Services	19
No Guardian or Legally Authorized Representative	1,071
An Application for Training Center Placement Has Been Initiated	6
Aging Out of CSA or Foster Care Financing for Residential Services	76
Aging Out of Special Education	659
In Jail, Correctional Facility, Juvenile Detention Facility, or Criminal Justice Involvement	33
Lacks Transportation	910
No Special Conditions or Risk Factors	467
Special Conditions or Risk Factors Not Known at This Time	370

## Other Indicators of Community-Based Services Needs

In addition to individuals on waiting lists for CSB mental health, mental retardation, or substance abuse services, there are additional disability-specific, community-based service needs that are significant and compelling.

- Virginia Department of Education counts made on December 1, 2006, identify 11,621 students with a primary disability (as defined by special education law) of emotional disturbance and 10,986 students with mental retardation who are receiving special education services. As these students age out of special education services, many will require community-based treatment or habilitation services to maintain the skills they learned in special education. Virginia schools are presently serving 7,910 children under the age of six who are diagnosed with a developmental disability and 583 children under the age of six with Autism Spectrum Disorder.
- In August 2007, there were 3,791 individuals on the Statewide Waiting List for MR Waiver Services (1,931 on the urgent needs wait list and 1,860 on the non-urgent needs wait list). While over 1,354 community slots have been allocated since 2004, over 1,500 new names have been added to the urgent needs list alone. This means that the urgent needs component of the waiting list has been growing at a greater than one individual per day.
- In January 2006, communities across Virginia participated in a statewide one-day point-in-time count and found over 9,600 homeless persons. The count found 2,000 individuals (21 percent of all persons who were homeless) had been homeless for a year or longer or had been homeless at least three times in the previous four years and also had a disabling condition (i.e., meeting the HUD definition of chronic homelessness).
- CSBs serve a large number of infants and toddlers in programs funded through the Part C program. In 2006, 10,704 infants, toddlers, and their families were served, indicating that the trend will continue upward for the number of children served in 2007, due in part to better outreach and case finding. The current data system allows for reporting the number of children in the system by annualized count (December 2-December 1, one-year period) and by point-in-time (December 1 of each year). The annualized count provides a much more accurate picture of the total number of children served.
- The 2003 National Survey on Drug Use and Health estimated that, nationwide, 9.8 percent of pregnant women drank alcohol during their pregnancy and 4.3 percent of pregnant women used an illicit drug. Of the 104,488 infants born in Virginia in 2005, it is estimated that 10,234 were exposed to alcohol in utero and 4,492 to an illicit substance.
- The 2005 National Survey on Drug Use and Health estimates that there are 136,000 Virginians needing, but not receiving treatment for illicit drug use in the past year and 422,000 needing, but not receiving treatment for alcohol use in the past year. Patterns of

drug use reflect an increased prevalence of prescription drug and methamphetamine abuse and dependence.

- According to the 2005 National Survey on Drug Use and Health, among adolescents ages 12 to 17, the rate of illicit drug use in the past year was higher among those who received mental health treatment or counseling in the past year than among those who did not (29.1 vs. 17.2 percent). This pattern was also observed for marijuana, cocaine, heroine, hallucinogens, inhalants, and the non-medical use of prescription –type psychotherapeutics.
  - Adolescents aged 12 to 17 who received mental health treatment or counseling in the past year were more likely to use alcohol in the past year than those who did not receive treatment or counseling (39.7 vs. 31.5 percent).
  - Adolescents receiving mental health treatment or counseling in the past year also were more likely to have smoked cigarettes in the past year (25.8 vs. 14.9 percent).
  - In 2005, among adolescents who received mental health treatment or counseling in the past year, 14.2 percent were dependent on or abused illicit drugs or alcohol in the past year, higher than the 6.3 percent who did not receive treatment or counseling.

## CRITICAL ISSUES AND STRATEGIC RESPONSES

### *Transforming Virginia's System of Care*

#### **Integrated Strategic Plan for Virginia's Services System**

The Department's Integrated Strategic Plan (ISP), *Envision the Possibilities: An Integrated Strategic Plan for Virginia's Mental Health, Mental Retardation, and Substance Abuse Services System*, (2005) continues to provide a framework for transforming Virginia's publicly funded mental health, mental retardation, and substance abuse services system to:

- Fully implement self-determination, empowerment, recovery, resilience, and person-centered core values at all levels of the system through policies and practices that reflect the unique circumstances of individuals with one or more of the following: mental illnesses, mental retardation, or substance abuse disorders.
- Incorporate the principles of inclusion, participation, and partnerships into daily operations at all levels.
- Expand services and supports options needed to support individual and family choice, community integration, and independent living.
- Provide sufficient capacity to meet growing individual needs so that individuals with mental illnesses, mental retardation, or substance use disorders, wherever they live in Virginia:
  - Receive the levels of services and supports they need,
  - When and where they need them,
  - In appropriate amounts, and
  - For appropriate durations.
- Promote the health of individuals receiving services, families, and communities.
- Increase opportunities for collaboration among state and community agencies.
- Align administrative, funding, and organizational processes to make it easier for individuals and families to obtain the services and supports they need.
- Monitor performance and measure outcomes to demonstrate that services and supports are appropriate and effective, promote services system improvement, and consistently report on the transformation process.
- Provide stewardship and wise use of system resources, including funding, human resources, and capital infrastructure, to assure that services and supports are delivered in a manner that is efficient, cost-effective, and consistent with evidence-based and best practices.

#### **Vision for the Future Services System in Virginia**

The Department is committed to implementing the vision “of a consumer-driven system of services and supports that promotes self-determination, empowerment, recovery, resilience,

health, and the highest possible level of individual participation in all aspects of community life, including work, school, family and other meaningful relationships” (State Board Policy 1036 (SYS) 05-3).

### **Services and Supports Principles and Practices**

Individuals with mental illnesses, intellectual disabilities, or substance use disorders are members of the community in which they live and should enjoy the same opportunities for quality of life. The overarching goal of the services system is to provide or assist individuals in obtaining services and supports based on informed choice that would enable them to:

- Attain their highest achievable level of health and wellness;
- Live as independently as possible, with children living with their families;
- Engage in meaningful activities, including school attendance or work in jobs that they have chosen; and
- Participate in community, social, recreational, and educational activities.

**Consumer and Family Member Participation:** Consumers and family members must be actively involved in all aspects of service planning, implementation, and monitoring and must be afforded multiple opportunities to participate in planning and policy development activities at the state and community levels. The perceptions and life experiences of consumers and family members also are important drivers for system transformation activities, particularly in areas such as:

- Overcoming stigma and advancing public awareness of the many contributions and successes of individuals with disabilities; and
- Promoting and supporting self-advocacy and individual wellness, growth and development.

In 2006, the State Mental Health, Mental Retardation and Substance Abuse Services Board adopted Policy 1040 (SYS) 06-3 Consumer and Family Member Involvement and Participation. This policy articulates the importance of consumer and family member involvement and participation and identifies ways in which the Department, state facilities, and CSBs can support the involvement and participation of consumers and family members as partners in the design, operation, and evaluation of the public services system. Activities identified in the policy include:

- Analyzing, formulation, and implementing policies;
- Planning services and designing programs;
- Providing direct services;
- Advocating for resources and fulfilling unmet needs for services;
- Monitoring and evaluating services, providers, and the services system; and
- Providing accountability and engaging in quality improvement activities.

The policy calls on the Department, state facilities, and CSBs to support consumer and family involvement and participation on committees, work groups, task forces, and other planning or deliberative bodies. It encourages CSBs to work closely with the boards of supervisors or city councils and county administrators or city managers of their local governments to help them appoint consumers and family members who are knowledgeable about the services system to community services boards.

**Services and Supports Values:** The ISP identifies the following values as underpinning the design and operation of services and supports:

- Services and supports are person-centered. Individuals receiving services and family members have access to information, are involved in service planning, and have decision-making power over the types of services and supports they need and use. The specific needs of each individual are at the center of service planning and care coordination.
- The services system is designed to intervene early to minimize crises through early screening and assessment, appropriate interventions that keep individuals receiving services connected to their families and natural supports, and seamless access to services.
- Services and supports are available and delivered as close as possible to an individual's home community and in the least restrictive setting possible, are culturally and age sensitive and appropriate, and are fully integrated and coordinated with other community services.
- Adults and children requiring services and supports from multiple agencies are provided care that is coordinated across agencies.
- Services and supports are flexible, allow for the greatest amount of individual choice possible, and provide an array of acceptable options to meet a range of individual needs.
- A consistent minimum level of types and amounts of services and supports is available across the system, with timely access to needed services.
- Prevention, early intervention, and family support services are critical components of the services system.
- Services are universally and equally accessible regardless of the individual's payment source.
- Services are of the highest possible quality and are based upon best and promising practices, where such practices exist.
- Services are provided in an efficient and cost-effective manner to enhance service quality and continuity of care and to take advantage of technologies that provide appropriate access to properly protected information.
- Emphasis is placed on continuous quality improvement at the provider and system levels, with performance and outcome measures focused on self-determination, empowerment, recovery, resilience, and community integration.

- Integrated and flexible public funding of mental health, mental retardation, and substance abuse services promotes person-centered and recovery-oriented service and supports.
- Public funding is adequate to meet individual needs and includes cost inflators to sustain capacity and address the total costs of service delivery.
- The services system is committed to state facility and community workforce training, retraining, development, retention, and expansion to needed staffing levels.

**Wide Front Door:** The ISP envisions Virginia’s services system as having a wide “front door” for screening and assessing the needs of individuals who seek publicly funded mental health, mental retardation, or substance abuse services or supports. It states that referrals to this “front door” should come directly to the CSB or through referrals to CSBs from local hospital emergency rooms or other local agencies. All individuals and families seeking services and supports should receive timely and thorough initial screening and state-of-the-art assessments provided by well-qualified and highly trained staff. Assessment results should determine the types, levels, and amounts of needed services and supports depending upon the complexity of the individual’s condition or his level of functioning.

Following assessment, services and supports choices should be identified for each individual. These choices should be flexible and provided as close to the individual’s home and natural supports as possible. Regardless of where an individual lives in Virginia, individuals and their families should have access to a broad array of services and supports that promote independence and enable individuals to live in their own homes or natural environments wherever possible, and when not possible, with other family members.

**Collective Responsibility for and Flexible Implementation of Safety Net Services:** The ISP describes the public safety net and serves as the conceptual basis for State Board Policy 1038 (SYS) 05-5 The Safety Net of Public Services. This policy states that the Department and CSBs, as partners in the mental health, mental retardation, and substance abuse service system, are jointly responsible for assuring to the greatest extent practicable the provision of a safety net of appropriate public services and supports in safe and secure settings for individuals with serious mental illnesses, mental retardation, substance use disorders, or co-occurring disorders who:

- Are in crisis or have severe or complex conditions;
- Cannot otherwise access needed services and supports because of their level of disability, their inability to care for themselves, or their need for a highly structured or secure environment; and
- Are uninsured, under-insured, or otherwise economically unable to access appropriate service providers or alternatives.

The policy directs that public safety net services shall be available to the greatest extent possible on a 24 hours per day and seven days a week basis within clinically reasonable time periods to anyone who needs them. It identifies the following as safety net services: local emergency services, in-home assistance and support or out-of-home respite care, non-

hospital based crisis stabilization or detoxification services, acute stabilization in local hospital psychiatric or substance abuse inpatient or medical detoxification services, and specialty services provided in state facilities or a regional or statewide basis. The policy defines the public safety net to include services delivered by private inpatient and community service providers under contract to CSBs or state facilities. It also affirms the responsibility of CSBs to serve as the single points of entry into the safety net of public services, to screen and assess individuals, and to manage and review access to and utilization of public safety net services.

The policy states that the specific array or extent of public safety need services may differ among localities, and individual programs may reflect differences in design and operation. However, it asserts that some services, such as emergency or crisis stabilization services, should be provided as close to a person's home and natural supports as possible. When these local services are not available or appropriate or more specialized or intensive services are needed, the policy directs CSBs or the Department with the responsibility for assuring the availability of these safety net services on a sub-regional, regional, or statewide basis.

**Services and Supports Reflect the Core Values of Self-Determination, Recovery, Resilience, and Person-Centered Planning.** The ISP calls for the expansion of recovery and resilience-oriented and person-centered services, training, and supports provided by and for peers and families, including:

- Individual and family education and support,
- Services provided by peer specialists,
- Family resource centers,
- Individual wellness recovery planning, and
- Peer-run programs such as peer-to-peer drop-in centers.

Every locality would have the capacity to provide, either locally or through regional arrangements, crisis access and response 24 hours per day and seven days a week. Crisis access and response services include:

- Locally provided emergency services;
- In-home assistance to stabilize a crisis;
- Non-hospital crisis stabilization and detoxification; and
- Acute stabilization in local hospitals.

Access to and continuation in the most intensive services would be rigorously screened and continuously reviewed to assure services are provided in the most integrated and least intrusive setting appropriate to the acuity and complexity of the individual's condition or his level of functioning. Referrals to emergency and crisis services would be immediate. Referrals to non-emergency services provided by the CSBs, peer-run organizations, local agencies, or other providers would be within a reasonable period of time based on individual need. Services utilization, including hospitalization, would be managed by the CSBs in

collaboration with other providers, as appropriate, for the period suitable to the needs of the individual.

At the local level, CSBs would provide, directly or through contracts with other community providers, the following core array of recovery and resilience-oriented and person-centered services:

- Prevention and early intervention services,
- Infant and toddler intervention,
- Respite care,
- In-home services, including intensive in-home therapy by licensed clinicians,
- Care coordination and case management,
- Medication and medication education services,
- Outpatient treatment provided by trained clinicians using best and promising practices,
- Integrated treatment for persons with co-occurring MI/SUD, MI/MR, or MR/SUD diagnoses,
- Supported employment and vocational training,
- Rehabilitation and day support services,
- Day treatment provided in schools or clinics,
- Supervised and supportive residential services, and
- Intensive community treatment, training, and transitional services.

In addition, a system of care for children and adolescents would be available. This system of care would include cross-agency planning and coordination at the local level with child-serving agencies and the Comprehensive Services Act teams; with family involvement; respite care services; family supports; behavioral health support for schools, court services, health departments, and social services; and early intervention services through local schools, behavioral health, and other health care clinics.

While it is preferable in most instances to provide services and supports in an individual's home community, there may be situations where needed services are beyond the capacity of most localities to provide. These services and supports would be provided at the regional level through specialized teams, regional programs, or utilization of emerging technologies such as teletherapy or teleconsultation. These services and supports may include:

- Regional MR/MI behavioral consultation teams;
- Regional MI/SUD consultation teams;
- Expert consultation teams for nursing homes and assisted living facilities; and
- Specialty clinical services (e.g., extensive assessments for medical and psychiatric needs, child and family therapy, and medical and dental supports).

The following specialty services would be available statewide or at the regional level.

- Intermediate treatment and rehabilitation and intensive treatment for individuals with severe or complex conditions, or both, requiring care in state hospitals;

- Intensive short-term acute inpatient crisis intervention, stabilization, and treatment for children and adolescents with high acuity or high complexity behavioral health conditions, or both;
- Intensive medical (to include skilled nursing), behavioral, or other specialized supervision and therapeutic interventions for individuals with mental retardation;
- Secure forensic and not guilty by reason of insanity (NGRI) services; and
- Behavioral rehabilitation services for sexually violent predators.

In 2006, the State Board adopted Policy 1039 (SYS) 06-2, Availability of Minimum Core Services. This policy recognizes the importance of intervening early to minimize crises through early screening and assessment; delivering services and supports that are appropriate and age and culturally sensitive as close to the individual's home community as possible; and providing a consistent minimum level of services and supports with timely access to needed services across Virginia. The policy defines the minimum array of services and supports as follows:

- Minimum safety net services, as described in State Board Policy 1038;
- Outpatient treatment services, including intensive in-home services, medication and medication education services, and assertive community treatment;
- Case management and care coordination;
- Day treatment provided in schools or other sites and rehabilitation services;
- Supported employment services;
- Supervised residential services, including in-home respite care, and supportive residential services, including respite care;
- Prevention and early intervention, including infant and toddler services; and
- Services managed and provided by consumers, including peer-to-peer drop-in centers, individual wellness recovery planning, peer-run programs, family resource centers, and consumer and family member education and support.

The ISP states that, to the extent possible, funding should follow the individual and not a specific provider or service. Integrated funding, with cost of living escalators, would reduce existing funding complexity and provide flexibility needed to create choices among services and supports that promote self-determination and person-centered planning, empowerment, recovery, and resilience for individuals receiving services.

## **Critical Success Factors**

Seven critical success factors described below are required to transform the current services system's "crisis-response" orientation to one that provides incentives and rewards for implementing the vision of a recovery and resilience-oriented and person-centered system of services and supports. Successful achievement of these critical success factors will require the support and collective ownership of all system stakeholders.

1. Virginia successfully implements a recovery and resilience-oriented and person-centered system of services and supports.
2. Publicly funded services and supports that meet growing mental health, mental retardation, and substance abuse services needs are available and accessible across Virginia.
3. Funding incentives and practices support and sustain quality care focused on individuals receiving services and supports, promote innovation, and assure efficiency and cost-effectiveness.
4. State facility and community infrastructure and technology efficiently and appropriately meet the needs of individuals receiving services and supports.
5. A competent and well-trained mental health, mental retardation, and substance abuse services system workforce provides needed services and supports.
6. Effective service delivery and utilization management assures that individuals and their families receive services and supports that are appropriate to their needs.
7. Services and supports meet the highest standards of quality and accountability.

### **Implementation of the Governor's Transformation Initiative**

In late 2005, Governor Warner proposed and incoming Governor Kaine supported a multi-year plan to transform Virginia's mental health, mental retardation, and substance abuse services system through:

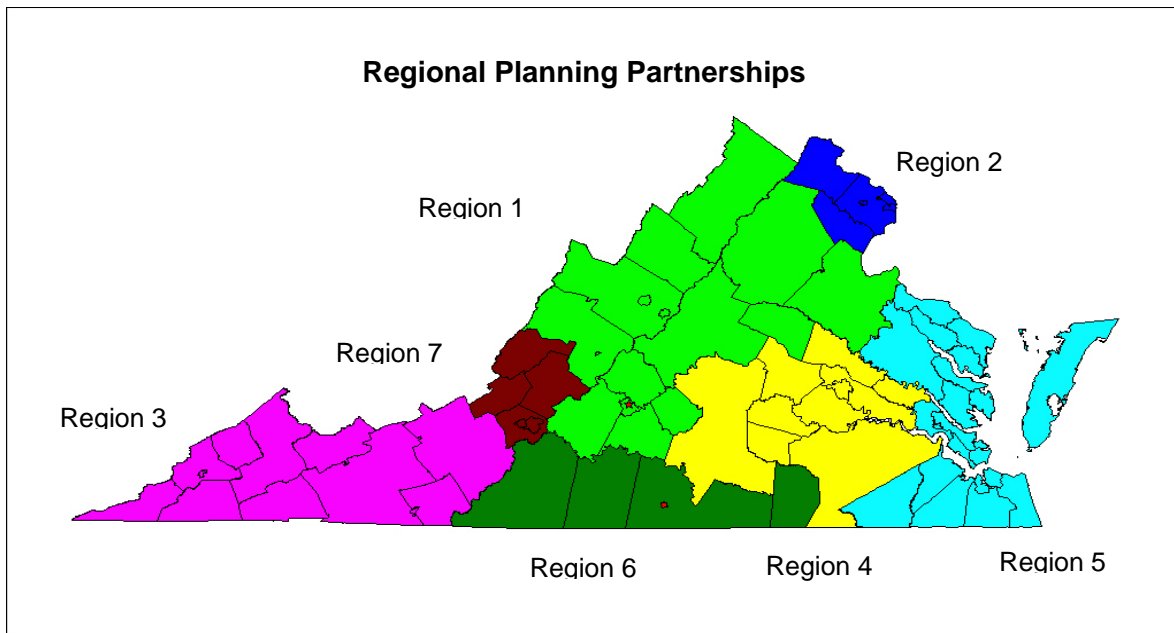
- Investment in community services and supports to reduce state facility utilization, and
- Redesign and replacement of two state hospitals (Eastern State Hospital and Western State Hospital) and two training centers (Southeastern Virginia Training Center and Central Virginia Training Center) to address current and future clinical needs more efficiently and appropriately.

During the 2006 session, the General Assembly amended, expanded, and approved the Governor's Transformation Initiative. This initiative represents a historic opportunity to make a positive difference in the lives of individuals with serious mental illnesses, co-occurring mental illnesses and substance use disorders, or mental retardation who receive publicly-funded services and supports.

For the 2006-2008 biennium, the Transformation Initiative provided just over \$187.5 million in state general and Medicaid funds for a wide array of community investments, including:

- Expansion of community mental health services, including:
  - recovery and peer supports, including consumer-operated services and programs, consumer peer specialists and recovery coaches, recovery education and training, consumer stipends and employment and training scholarships, and deaf peer support;
  - community crisis stabilization, including in-home and residential crisis stabilization and diversion
  - crisis response and referral services, including outpatient crisis response and crisis intervention teams, regional flexible funding for regional crisis services and mobile crisis team stipends, expanded crisis staff, clinicians with co-occurring expertise, and crisis prevention services;
  - psychiatric services, including expanded psychiatric time, psychiatric nursing, medical consultation, and psychiatric support services;
  - intensive case management and hospital liaison services,
  - residential services, and
  - forensic and jail-based services;
- Funding for new discharge assistance plans for civil and not guilty by reason of insanity patients currently in state facilities;
- Funding to provide mental health services for children and adolescents in six additional juvenile detention centers and through two new systems of care projects;
- Investments in community mental health services associated with the redesign and replacement of Eastern State Hospital and Western State Hospital;
- MR waiver rate increases; expansion of waiver slots, including 214 slots for individuals on the waiver's urgent waiting list, 110 slots for children under the age of six, and 149 slots for Southeastern Virginia Training Center and Central Virginia Training Center residents; and provision of waiver start-up funds;
- Support for mental retardation guardianship services for training center residents or individuals who are at risk of training center placement;
- Expansion of Part C early intervention services for infants and toddlers; and
- Funding for substance abuse opiate treatment and jail diversion services.

The seven Regional Planning Partnerships are coordinating implementation of community services and supports funded through the Transformation Initiative. With guidance provided by the Department that focused on implementing the Vision and values of recovery, resilience, self-determination, person-centered planning, and community integration, each Regional Planning Partnership established services and supports priorities that were tailored to that region's needs. The Partnerships provide quarterly implementation progress reports to the Department.



***Implementation of Community Adult MH and MH/SA Services:***

The following table provides a listing of individuals who have received community-based services through the Transformation Initiative.

**Community Adult Mental Health and Co-Occurring MI/SA Services**

Service	# Served in FY 2007	Service	# Served in FY 2007
Emergency Services	1,956	Individual Support Employment	16
Acute Psychiatric Inpatient Services	41	Highly Intensive Residential	34
Community-Based SA Medical Detox Inpatient Services	655	Residential Crisis Stabilization Services	939
Outpatient Services	4,246	Intensive Residential Services	203
Peer-Provided Outpatient Services	51	Supervised Residential Services	89
Opioid Detoxification Services	6	Supportive Residential Services	277
Case Management Services	3,059	Peer-Provided Supportive Residential Services	76
Peer-Provided Case Management Services	51	Consumer Monitoring	15
Day Treatment/Partial Hospitalization	50	Discharge Assistance Project Plans	114

Service	# Served in FY 2007	Service	# Served in FY 2007
Ambulatory Crisis Stabilization Services	10	Consumer-Run Services	637
Rehabilitation	326	Totals	13,074
Peer-Provided Rehabilitation	223		

### ***Implementation of Child/Adolescent Services***

*Systems of Care Demonstration Projects:* Four systems of care demonstration projects are providing an array of services, including evidence-based practices, to children and adolescents throughout Virginia. These projects were first funded in FY 2006 (Richmond Behavioral Health Authority and Planning District 1) and later in FY 2007 (Alexandria and Cumberland Mountain). In FY 2007, 194 children and adolescents had been referred and 84 enrolled and were receiving services. For 53 children and adolescents, the treatment team, the consumer and their family have agreed to end services because desired clinical outcomes had been achieved.

*Juvenile Detention Center Services:* Programs are operational and ongoing in 14 juvenile detention centers. In each program, CSBs have placed clinical and case management staff on-site in the center. Services provided include screening and assessment, short-term treatment, case management and referral to community-based services. In FY 2007, of the 2,209 youth admitted to juvenile detention centers, 2,060 received mental health screening and assessment during detention center intake, 808 youth received case management services, 814 received individual face-to-face therapy, 16 were admitted to state hospitals, and 394 were released to community with an aftercare plan for individual face-to-face therapy.

*Part C Early Intervention Services:* All appropriated funds were allocated to local early intervention systems (local lead agencies) for Virginia's Part C Early Intervention System for infants and toddlers with disabilities. In FY 2007, 5,559 new children, ages 0-3 were served in the part C system. A total of 10,408 children were served during the fiscal year.

### ***Virginia's Experience With EBPs***

Virginia has made significant progress in implementing selected evidence-based practices. For example, Programs of Assertive Community Treatment (PACT) have been developed in 15 CSB areas, and Multi-Systemic Therapy for adolescents is offered at several other CSBs. Most individuals have access to the "new generation" medications, whether in CSB or state

facility programs. Outcome data from the PACT initiatives have shown dramatic reductions in state hospital usage, increased stability in living situations for individuals, and reduced involvement with criminal justice agencies. The Department also supports family psycho-education through its contracts with family support groups and the Southwest Virginia Behavioral Health Board. Most individuals receiving services in the public mental health system, however, do not have consistent access to such services. In addition, the Department supports EBP's such as Supported Employment, Supported Housing, and Integrated Treatment for Co-occurring Disorders (MH/SA).

The Department also funds 12 science-based prevention programs for families, including services for new parents, for Head Start children and their parents, and families with children and adolescents. Program directors are working closely with program developers and university faculty to evaluate the programs. Thus far, program evaluation data indicate that children gained in their awareness of drug harm and increased their levels of cooperation and social skills. Evaluation results for parents show fewer inappropriate parental expectations and increased overall parenting and monitoring skills. Evaluation of the families showed an increase in communication skills and family interaction.

### ***Strengthening Evidence-Based Practices for the Future***

The Department, CSBs, individuals receiving services and families, and others continue to recognize the importance of working together to develop, disseminate, and support evidence-based service models and uniform clinical practices that will promote positive individual outcomes. Such efforts would include defining the extent and quality of "evidence" necessary for services and interventions to qualify as evidence-based practices (e.g., multiple randomized clinical trials, quasi-experimental research, qualitative evidence, etc). Adoption of uniform clinical practices by the CSBs would also help promote consistency across services throughout the state and permit clear identification of service system gaps where they exist. While still allowing for local variation and innovation, a core set of evidence-based clinical practices for community services across the state also would help ensure informed individual choices and ease of movement from one service area to another. The Department must increase its focus on adopting evidence-based practices for persons with mental illness, mental retardation and substance use disorders to effectively achieve its mission.

Today, advances in communication technology greatly enhance the dissemination and transfer of information to practitioners and can make the most current research and other information readily accessible to most practitioners, allowing them to integrate this information into their daily practice. Opportunities exist to strengthen Virginia's mental health, mental retardation, and substance abuse services system through this technology.

To effectively adopt evidence-based practices, several ingredients must be in place, including

- Commitment of leadership at each level (state, local, program),
- Education and skill building for practitioners,
- Supportive administrative practices,

- Incentives and rewards,
- Feedback mechanisms (e.g., measurement of outcomes), and
- Stable, long-term financial support for EBPs.

Additional resources continue to be needed to raise awareness of evidence-based practices, enhance competency among providers, and to develop and sustain programs and services.

### ***Recovery Orientation of Virginia's Public Mental Health System***

Virginia has revised its vision statement to be:

*Our vision is of a consumer-directed system of services and supports that promotes self-determination, empowerment, recovery, resiliency, health, and the highest possible level of consumer participation in all aspects of community life including work, school, family and other meaningful relationships.*

In addition to the Department's new vision statement emphasizing a commitment to self-determination, empowerment, resiliency and recovery, Virginia provides funding for several consumer initiatives including a statewide Consumer Network, Recovery Education and Creative Healing (a consumer run program that provides education and training on recovery and wellness for adults with mental illness using WRAP), Consumer Empowerment and Leadership Training (CELT) (training designed to give mental health consumers important tools for successful leadership and advocacy) and VOCAL (Virginia Organization of Consumers Asserting Leadership). The Path Finders CELT was developed this year geared toward veterans. VOCAL is a consumer run organization that is dedicated to developing a diverse state-wide coalition of consumers, providing a voice for individual empowerment and fostering a consumer-driven mental health system. The Department also funds the Virginia Human Services Training academy (VHST) that trains consumers to work as Peer Facilitators.

In SFY 2008, the consumer run programs and organizations supported by the Department served the following:

- VOCAL programs served over 1000 consumers and hosted a conference in June, 2008 with over 300 consumers in attendance, offering an array of workshops and support programs aimed at recovery and peer training.
- Ninety-five consumers received CELT.
- One hundred twenty-three WRAP classes were offered throughout Virginia and graduated 488 consumers graduating.

# COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT 2008 IMPLEMENTATION REPORT

## ADULT SERVICES

### CRITERION 1: Comprehensive Community-based Mental Health Service Systems

#### Performance Measures for Criterion 1

Five performance measures have been selected for Criterion 1:

1. The state facility readmission rate within 30 days (and 180 days) of discharge

The percent of consumers readmitted to state mental health facilities within 30 days of discharge decreased from 9.2% in SFY2007 to 7.5% in SFY2008. The re-admission rate of 7.5% exceeds the goal of 8.3% (lower is better). Goal achieved.

The percent of consumers readmitted to state mental health facilities within 180 days of discharge decreased from 21.5% in SFY2007 to 20.3% in SFY2008. The re-admission rate of 20.3% does not meet the goal of 19.6% (lower is better). Goal not achieved.

2. The number of evidence-based practices provided by the SMHA

Currently in Virginia, the following evidence based practices are offered in the public system for adults: Supported Housing, Supported Employment, Assertive Community Treatment, and Integrated treatment for co-occurring disorders (MH/SA). This represents four of the six CMHS defined EBPs. Goal achieved.

3. The number of adults receiving evidence-based practices provided by the SMHA

The number of adults receiving EBPs dropped slightly from 2643 last year to 2414 in SFY2008. The majority of consumers are receiving the service Program of Assertive Community Treatment (PACT). Goal Achieved.

4. Positive consumer perceptions of outcomes

Virginia has been surveying consumers' opinions of their satisfaction with services for over 10 years. Consumers' perceptions of outcomes have remained relatively stable. In SFY 2007, satisfaction was 75% and in SFY2008, it was 73.0% (approximately a 4% improvement). Goal Achieved.

These measures and the sources of data for collecting each one are described in detail on the following pages.

**STATE PLANNING & MONITORING  
MENTAL HEALTH PERFORMANCE INDICATOR**

*Goal:* To reduce number of re-admissions to state mental health facilities within 30 days of discharge.

*Population:* Adults Diagnosed with a Serious Mental Illness

*Criterion 1:* Comprehensive Community-based Mental Health Service Systems

*Brief Name:* Re-admission Rate 30 and 180 days

*Indicator 1:* Rate of re-admissions within 30 and 180 days of discharge from state mental health facilities.

*Measure:* Numerator: Number of non-forensic patients readmitted to state mental health facilities within 30 days (and 180 days) of discharge during the fiscal year.

Denominator: Number of discharges from state facilities within fiscal year.

*Sources of Information:*

Numerator: AVATAR Information System

Denominator: AVATAR Information System

*Special Issues:*

Significance: Reduction in the percentage of individuals discharged from state mental health facilities who are readmitted within 30 and 180 days reflects more effective discharge planning and improved coordination between community programs and state facilities.

**STATE PLANNING & MONITORING  
MENTAL HEALTH PERFORMANCE INDICATOR**

*Goal:* To track the number of evidence-based practice services provided by the state mental health authority (SMHA).

*Population:* Adults with Serious Mental Illness

*Criterion 1:* Comprehensive Community-Based Mental Health Service Systems

*Brief Name:* Number of Evidence-based Practices

*Indicator 2:* Evidence-based practice services provided by the SMHA

*Measure:* Number of evidence-based practice services provided by the SMHA

*Source of Information:* Survey

*Significance:* Evidence-based practices (EBPs) represent practices that have research supporting their efficacy. Use of EBPs should result in better patient outcomes.

*Special Issues:* Data for this measure was collected from a self-report survey. While we provided CMHS definitions of the EBPs to survey respondents, we do not currently check fidelity.

**STATE PLANNING & MONITORING  
MENTAL HEALTH PERFORMANCE INDICATOR**

*Goal:* To track the number of adults who receive evidence-based practice services (EBPs).

*Population:* Adults with serious mental illness

*Criterion 1:* Comprehensive Community-Based Mental Health Service Systems

*Brief Name:* Number of adults receiving EBPs

*Indicator 3:* Evidence-based Practice Services

*Measure:* Number of adults receiving EBPs

*Source(s) of Information:* Survey of CSBs

*Significance:* Evidence-based practices represent practices that have research supporting their efficacy. Use of EBPs should result in better patient outcomes.

*Special Issues:* Data for this measure was collected from a self-report survey. While we provided CMHS definitions of the EBPs to survey respondents, we do not currently check fidelity.

**STATE PLANNING & MONITORING  
MENTAL HEALTH PERFORMANCE INDICATOR**

*Goal:* To maintain or increase the percent of persons who report positive perceptions of outcomes on the MHSIP Adult Consumer Survey

*Population:* Adults with serious mental illness

*Criterion 1:* Comprehensive Community-Based Mental Health Service Systems

*Brief Name:* Positive Perceptions of Outcomes

*Indicator 4:* Client Perception of Care

*Measure:* Percent of clients reporting positively about outcomes (Number of Clients Reporting Positively About Outcomes) on the MHSIP Adult Consumer Survey.

Numerator: Number of positive responses reported in the outcome domain on the MHSIP Adult Consumer Survey.

Denominator: Total number of respondents to the outcome domain on the MHSIP Adult Consumer Survey.

*Source(s) of Information:* MHSIP Adult Consumer Survey

*Significance:* It is important to know what consumers think about the effectiveness of service delivery.

**FY 2008 STATE MENTAL HEALTH IMPLEMENTATION REPORT  
PERFORMANCE INDICATORS**

**Population:** *Adults with Serious Mental Illness*

**Criterion:** *Comprehensive Community-based Mental Health Service Systems*

***State Fiscal Year***

Performance Measures (1)	FY06 Actual/Goal (2)	FY07 Actual/Goal (3)	FY08 Actual/Goal (4)	% Attain (5)
1. Re-admission Rate – 30 days (Brief Name)				
Value:	7.6%/8.7%	9.2/8.5%	7.5/8.3%	110%
if rate:				
Numerator	268	316	316	
Denominator	3,510	3,442	3,442	
1. Re-admission Rate – 180 days (Brief Name)				
Value:	19.0%/19.40%	21.5/19.80%	20.3/19.6%	97%
if rate:				
Numerator	669	740	740	
Denominator	3510	3,442	3,442	
2. Number of EBPs				
Value:	4/4	5/5	4/4	100%
3. Number of adults receiving EBPs				
Value:	2133/1500	2643/1600	2414/1700	142%
4. Positive consumer perceptions of outcomes				
Value:	71/69.1%	75%/69.1%	73%/69.5%	105%
if rate:				
Numerator	3695			
Denominator	5207			

## **CRITERION 2: Mental Health System Data Epidemiology**

### **◆ Performance Measure for Criterion 2**

The quantitative target for 2008 focuses on maintaining or increasing the rate of treated prevalence of serious mental illness. It is encouraging that larger numbers of adults with serious mental illness have been served in recent years and a larger percentage all consumers treated are adults with serious mental illness; however a much higher penetration of the prevalence rate is desirable.

It is important to note that Virginia's definition of SMI is narrower than the criteria in the federal definition. This will cause the CSB penetration rates to be lower than they would be if the federal definition were applied, since the prevalence rates are based on the federal definition. While part of the discrepancy between prevalence and treated prevalence may be accounted for by the broader nature of the federal definition of serious mental illness relative to the State Board's, increasing CSB penetration rates continues to be an important goal of this plan. This measure has been a particular focal point for the Mental Health Planning Council and considerable emphasis will be placed on monitoring this data over the next few years.

Data from the SFY 2008 reports from community services boards indicate that the number of adult consumers with serious mental illness served increased from SFY 2007 for a 107% goal attainment figure. There continues to be significant efforts by community providers to focus resources on the needs of the consumers who are seriously mental ill. We are hopeful that progress is being made in reaching individuals with serious mental illnesses and that services are being provided in a manner that positively supports recovery and empowerment.

**STATE PLANNING & MONITORING  
MENTAL HEALTH PERFORMANCE INDICATOR**

*Goal:* To maintain or increase the number of adults who receive mental health services from the state mental health authority (SMHA).

*Population:* Adults

*Criterion 2:* Mental Health System Data Epidemiology

*Brief Name:* Number of adults served by the SMHA

*Indicator 1:* Increased Access to Services

*Measure:* Count of adults who receive mental health services from either a CSB or a state mental health hospital during the fiscal year.

*Sources of Information:* Community Consumer Submission (CCS); Hospital Information Systems (AVATAR).

*Special Issues:* This indicator does not include data about persons receiving services through private providers.

*Significance:* It is important to provide treatment to as many individuals with mental illness as possible.

**STATE PLANNING & MONITORING  
MENTAL HEALTH PERFORMANCE INDICATOR**

*Goal:* To maintain or expand access to mental health services for the population of persons who have a serious mental illness.

*Population:* Adults with Serious Mental Illness

*Criterion 2:* Prevalence and Treated Prevalence of Mental Illness

*Brief Name:* Treated Prevalence of Serious Mental Illness

*Indicator 2:* The percentage of adults with a serious mental illness who receive public mental health services from community services boards during the fiscal year.

*Measure:* Numerator: Number of adults who have a serious mental illness (as defined by the priority populations) and who have received mental health services from community services boards during the fiscal year.

Denominator: Federal estimates of the number of adults who annually have a serious mental illness in the State.

*Sources of Information:*

Numerator: Community Consumer Submission (CCS)

Denominator: Estimate of prevalence of serious mental illness (e.g., State estimates of prevalence prepared for CMHS by NRI (URS Table 1 for 2008).

*Special Issues:*

This indicator does not include data on individuals receiving services through private providers.

*Significance:*

Setting quantitative targets to be achieved for the numbers of adults with serious mentally illness to be served by the public mental health system is a key requirement of the mental health block grant law. Penetration of the population affected by serious mental illness is a critical building block of the community-based care system.

**FY 2008 STATE MENTAL HEALTH PLAN & IMPLEMENTATION REPORT  
PERFORMANCE INDICATORS**

**Population:** *Adults*

**Criterion:** *Prevalence and Treated Prevalence of Mental Illness*

Performance Measures (1)	<i>State Fiscal Year</i>			% Attain (5)
	FY06 Actual/Goal (2)	FY07 Actual/Goal (3)	FY08 Actual/Goal (4)	
1. Number of adults served by the SMHA				
Value:	92,776 /84,000	94,077/85,000	92,931/87,000	107%
2. Treated Prevalence of Serious Mental Illness (Brief Name)				
Value:	15.78/14.75	15.6/15%	15.9/15.5%	102%
if rate:				
Numerator	47,690	48,022	49,760	
and				
Denominator	302,203	307,612	311,383	

**CRITERION 3: Applies only to Children’s Services**

**CRITERION 4: Targeted Services to Rural and Homeless Populations**

□ **Performance Measure for Criterion 4**

A performance measure related to Virginia's Projects to Assist Transition from Homelessness (PATH) Program was selected for criterion 4. Data on PATH consumers who received mental health services, shelter, and housing services indicated that 3,318 clients were served out of an estimated PATH identified population of 2,073 in SFY 2008. Virginia was successful in exceeding the goal of 90% and actually served 159%. The percent of goal attainment was 176%. Goal Achieved.

**STATE PLANNING & MONITORING  
MENTAL HEALTH PERFORMANCE INDICATOR**

*Goal:* To maintain the level of shelter, housing, mainstream resources and mental health services to homeless adults with serious mental illness.

*Population:* Adults with Serious Mental Illness

*Criterion 4:* Targeted Services to Homeless and Rural Populations

*Brief Name:* PATH Performance and Outcome Measurements

*Indicator 1:* Composite score for PATH mental health services and mainstream resources + shelter & housing assistance.

*Measure:*

Numerator: Composite Score, Mental Health and Mainstream Resources + Shelter and Housing Services

Denominator: Number of PATH clients identified during the year

*Sources of Information:*

Numerator: PATH Mental Health Services and Mainstream Resources + Shelter and Housing Services

1. PATH Mental Health Services  
Clients placed in mental health services  
Clients connected to mainstream resources
  
2. PATH Shelter and Housing Services  
Clients placed in shelter  
Clients placed in housing

Denominator: Number of PATH clients identified during the year

*Special Issues:*     Significance: Accessing and maintaining these services is critical to homeless adults with serious mental illness.

**FY 2008 STATE MENTAL HEALTH PLAN & IMPLEMENTATION REPORT  
PERFORMANCE INDICATORS**

**Population:** *Adults with Serious Mental Illness*

**Criterion 4:** *Target Services to Rural and Homeless Populations*

Performance Measures (1)	State Fiscal Year			% Attain (5)
	FY 06 Actual/Goal (2)	FY 07 Actual/Goal (3)	FY 08 Actual/Goal (4)	
1. PATH Performance and Outcome Measurements (Brief Name)				
Value: if rate:	105%/80%	135%/80%	159%/90%	176%
Numerator and Denominator	2,327  2,226	2492  1,845	3,318  2,076	

## **CRITERION 5: Management Systems**

### **□ Performance Measure for Criterion 5**

DMHMRSAS is the primary funding source for public mental health services in Virginia. Other revenues include Medicaid, other third-party payments, Federal grant funds and local tax revenues. The community mental health system is underfunded to provide all needed community-based services. This fact underlines the significance of the Community Mental Health Services Block Grant funds as part of the total resources used for community services.

In Virginia, a community mental health center (CMHC) is defined as a local entity through which comprehensive community mental health services are provided. These services are provided within the framework of the Commonwealth's core services, and within the structure of the Code of Virginia ( 37.1-194-202.1) establishing the community services boards (CSBs). Mental Health block grant funds are allocated to Virginia's community services boards and to consumer-operated, community-based programs.

In determining the allocation of CMHS block grant funds for community-based mental health services, DMHMRSAS uses the following principles:

1. Priorities for program funding will be consistent with the establishment and maintenance of a coordinated system of community-based services and the statewide implementation of core community-support services.
2. Priorities for program funding will be consistent with Virginia's Mental Health Plan, to include priority for providing services for adults with serious mental illness.
3. Although emphasis has been placed upon maintaining services currently supported by these federal funds, DMHMRSAS will support new programs with CMHS block grant funds that are consistent with its Mental Health Plan and the provisions of P.L. 102-321.
4. Funding under the block grant will be through the CSBs and other appropriate, qualified community programs as defined by P.L. 102-321. CSBs may provide services directly or under contractual arrangements.

Mental Health Block Grant funds are primarily used in Virginia to support and develop services through CSBs. These services are restricted to non-residential and outpatient services and supports in accordance with P.L. 102-321. CSBs use the Block Grant funds, in conjunction with other state and local funds, to maintain and expand the array of community-based services for adults with serious mental illness.

Support to community-based adult services was maintained in SFY 2008, essentially meeting the target of 30%. Funds have been targeted to specific initiatives that support CMHS Block Grant priorities, such as increasing the number of PACT teams in areas of high hospital utilization, providing funds to CSBs for children's services and initiatives to

transition consumers from state facilities to their home communities. Again this year, MHBG funds were also targeted to make sure that psychiatric medications would be available for consumers.

**STATE PLANNING & MONITORING  
MENTAL HEALTH PERFORMANCE INDICATOR**

*Goal:* To maintain or increase the percentage of SMHA-controlled expenditures used to support community programs.

*Population:* Adults with Serious Mental Illness

*Criterion 5:* Management systems

*Brief Name:* Support for Community Programs

*Indicator 1:* Percent of SMHA-controlled resources distributed to community services boards

*Measure:*

Numerator: SMHA-controlled resources distributed to community services boards for adult services.

Denominator: Total SMHA-controlled resources (for Central Office, State Facilities, CSBs - includes state general funds, federal block grant, Medicaid, Medicare)

*Sources of Information:*

Numerator: State financial management system

Denominator: State financial management system

*Special Issues:*

The amount for adult service is calculated by taking the total for expenditure for each core service category, multiplying it by the proportion of clients served in that core service who are 18 or older, and summing this figure across all core service categories.

Significance: Adequate funding is essential to building the community-based system of care. Measuring the proportion of SMHA-controlled resources supporting community programs is one indicator of progress.

**FY 2008 STATE MENTAL HEALTH PLAN & IMPLEMENTATION REPORT  
PERFORMANCE INDICATORS**

**Population:** *Adults with Serious Mental Illness*

**Criterion 5:** *Management Systems*

Performance Measures (1)	<i>State Fiscal Year</i>			% Attain (5)
	FY 06 Actual/Goal (2)	FY 07 Actual/Goal (3)	FY 08 Actual/Goal (4)	
1. Support for Community Programs (Brief Name)				
Value: if rate:	29%/29%	30.5/30%	29.4/30%	98%
Numerator and Denominator	173.3M  597.3M	191.3  627.1	201.6  685.3	

# COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT 2008 IMPLEMENTATION REPORT

## CHILDREN'S SERVICES

**CRITERION 1** The plan provides for the establishment and implementation of an organized community-based system of care for such individuals.

□ **Performance Measures for Criterion 1**

Three performance measures have been selected for Criterion 1:

1. Percentage of children and adolescents re-admitted to a state facility within 30 days and 180 days. Goal was not achieved for 30 day and 180 day re-admission.
2. The rate per 100,000 population of patient bed days of service provided in state mental health facilities to youth under the age of eighteen. Goal achieved.
3. The number of children receiving the evidence based practice of Therapeutic Foster Care. Goal achieved.

These measures and the sources of data for collecting each one are described in detail on the following pages.

The ability to provide for the establishment and implementation of a community-based system of care for children and their families is critical to a statewide mental health plan. During FY 2008, Virginia has been successful in implementing the children's mental health plan.

Analysis of SFY 2008 data indicates a decrease in bed day utilization rates for children and adolescents to 760 bed days per 100,000 population. However, this is still better than the performance target of 800 bed days per 100,000 population. The number of re-admissions within 30 decreased from 57 in SFY 2007 to 45 in SFY 2008 out of 646 discharges. However, readmissions within 180 days of discharge increased during this same reporting period from 114 in SFY 2007 to 135 in SFY 2008 out of 648 discharges. Virginia is experiencing extreme budget reductions which is affecting the capacity of communities to fund appropriate placements for children. While it is the intention of the state to reduce unnecessary reliance on inpatient care, critical care needs and safety of children with serious emotional disturbance cannot be overlooked when hospitalization appears to be necessary.

The number of children receiving the evidence-based practice of Therapeutic Foster Care was 24 in SFY2008, and therefore we technically missed our previously stated goal of 31. However, we have discovered that eight of these 31 consumers that have been counted in recent years have been reported erroneously in this category by local providers as they have technically aged out of the program..

**STATE PLANNING & MONITORING  
MENTAL HEALTH PERFORMANCE INDICATOR**

*Goal:* To maintain or reduce the rate of readmissions to State Psychiatric Hospitals within 30 days and 180 days.

*Population:* Persons under the age of 18.

*Criterion 1:* Comprehensive Community-based Mental Health Service Systems

*Brief Name:* Re-admission Rate (within 30 and 180 days)

*Indicator 1:* Rate of re-admissions within 30 & 180 days of discharge from state mental health facilities.

*Measure:* Numerator: Number of patients readmitted to state mental health facilities within 30 and 180 days of discharge during fiscal year

Denominator: Number of discharges from state facilities within fiscal year.

*Sources of Information:*

Numerator: AVATAR Information System

Denominator: AVATAR Information System

*Special Issues:*

Significance: Reduction in the percentage of individuals discharged from state mental health facilities who are readmitted within 30 and 180 days reflects more effective discharge planning and improved coordination between community programs and state facilities.

**STATE PLANNING & MONITORING  
MENTAL HEALTH PERFORMANCE INDICATOR**

*Goal:* To maintain the utilization of state mental health facility beds for children.

*Population:* Children and adolescents diagnosed with serious emotional disturbance

*Criterion 1:* Comprehensive Community-based Mental Health Service Systems

*Brief Name:* Bed Day Utilization Rate

*Indicator 3:* Number of patient bed days of service provided in state mental health facilities per 100,000 population 17 years of age or younger.

*Measure:* Numerator: Number of patient bed days of service provided in state mental health facilities during the fiscal year to children and adolescents.

Denominator: 2007 Census data on population (estimate) under 18 years of age.

*Sources of Information:*

Numerator: Avatar Information System

Denominator: 2007 Census data, Weldon Cooper Center for Public Service, University of Virginia.

Special Issues:

Significance: An increase in resources for community-based services for children and adolescents with serious emotional disturbance may help to maintain the current level of utilization of inpatient services in state mental health facilities.

**STATE PLANNING & MONITORING  
MENTAL HEALTH PERFORMANCE INDICATOR**

*Goal:* To track the number of children and adolescents who receive therapeutic foster care.

*Population:* Children and Adolescents with Serious Emotional Disturbance

*Criterion 1:* Comprehensive community-based mental health service systems

*Brief Name:* Therapeutic foster care

*Indicator 2:* Number of children and adolescents receiving therapeutic foster care

*Measure:* Count of the number of persons receiving evidence-based practice services.

*Source of Information:* Survey.

*Significance:* Evidence-based practices represent practices that have research supporting their efficacy. Use of EBPs should result in better patient outcomes.

*Special Issues:* Data for this measure was collected from a self-report survey. While we provided CMHS definitions of the evidence-based practices to survey respondents, we do not currently check fidelity.

**FY 2008 STATE MENTAL HEALTH PLAN & IMPLEMENTATION REPORT  
PERFORMANCE INDICATORS**

**Population:** *Children with serious emotional disturbance*

**Criterion 1:** *Comprehensive Community-based Mental Health Service Systems*

Performance Measures (1)	State Fiscal Year			% Attain (5)
	FY 06 Actual/Goal (2)	FY 07 Actual/Goal (3)	FY 08 Actual/Goal (4)	
1a. Readmission Rate for Children (30 days) (Brief Name)				
Value:	9.0%/6.3%	8.8/6.3%	6.9/6.5%	94%
if rate:				
Numerator	53	57	45	
and				
Denominator	583	648	646	
1b. Readmission Rate for Children (180 days) (Brief Name)				
Value:	15.9%/11.90%	17.6/11.90%	20.8/13%	63%
if rate:				
Numerator	93	114	135	
and				
Denominator	583	648	646	
2. Bed Day Rate/100,000 (Brief Name)				
Value:	.76k/.94k	.76/.94k	.75/.80k	106%
if rate:				
Numerator	14.2k	14.2k	14.0k	
and				
Denominator	1.86M	1.88M	1.85M	
3. Number Receiving Therapeutic Foster Care (Brief Name)				
Value:	*31/31	31/31	24/31*	100%

\*4 of the participants are over 17, but receive this service

\*8 of the participants are over 17, but receive this service

\*Goal based on incorrect figures From previous years.

## **CRITERION 2** Mental Health System Data Epidemiology

### **□ Performance Measure for Criterion 2**

1. The number of children who receive mental health services from CSBs in the fiscal year. (Achieved)
2. The percentage of children with serious emotional disturbance who receive mental health services from CSBs during the fiscal year. (Achieved)

The quantitative target for criterion 2 focuses on increasing the rate of treated prevalence of serious emotional disturbance in youth under the age of eighteen. It is important to note that the current DMHMRSAS definition of serious emotional disturbance is more exclusive than the federal definition. This is significant because it will cause the CSB penetration rates to be lower than they would be if the federal definition were applied. However, given that this definition is consistently used from year to year, the goal of increasing the numbers of children with serious emotional disturbance served remains valid.

Assuring that all potential service recipients have access to a service delivery system is essential to the success of a state mental health plan. The CSBs continue involved in a number of activities that continue to maintain and expand access to mental health services for the population of children with serious emotional disturbance. Such activities have included an increase in service provision in the public school system and co-locating services in multi-purpose service centers providing “one stop shopping” for children and families. This increased visibility and blending with the community provides for an increased number of children who are identified as having serious emotional disturbance. Moreover, Virginia’s Comprehensive Services Act (CSA) has allowed for ongoing child-serving agency collaboration and a consequent increase in serving a greater number of children with serious emotional disturbance.

As reported in the following data descriptions, the Commonwealth of Virginia has successfully achieved the stated goal of increasing the total number of children treated for serious emotional disturbance. Our data reporting system indicates that in SFY 2008, the Commonwealth of Virginia community programs served 28592 children with serious emotional disturbance (1,630 more than in the prior year). Over the past four years, Virginia has consistently increased the number of children served who have a serious emotional disturbance. This year’s data represents a 114% attainment of the goal set for Criterion 2. Goal Achieved.

The treated prevalence of Serious Emotional disturbance was 16,350 children out of an estimated prevalence of 63,753 in the state. The goal was to treat at least 19.5% and 25.6% were served for a 131% attainment of the goal -- Goal Achieved.

**STATE PLANNING & MONITORING**  
**MENTAL HEALTH PERFORMANCE INDICATOR**

*Goal:* To increase the number of persons under the age of 18 served.

*Population:* Children and adolescents diagnosed with a serious emotional disturbance

*Criterion 2:* Mental Health system Data Epidemiology

*Brief Name:* Children and Adolescents Served

*Indicator 1:* Count of the number of persons under the age of 18 who are served by the state mental health authority.

*Measure:* Number of children with serious emotional disturbance who have received mental health services during the fiscal year.

*Sources of Information:*

Community Consumer Submission (CCS); AVATAR

*Special Issues:*

*Significance:* It is important to provide treatment to as many individuals with mental illness as possible.

**STATE PLANNING & MONITORING**  
**MENTAL HEALTH PERFORMANCE INDICATOR**

*Goal:* To maintain or expand access to mental health services for the population of children with serious emotional disturbance (SED)

*Population:* Children with serious emotional disturbance

*Criterion 2:* Mental Health system Data Epidemiology

*Brief Name:* Treated prevalence of serious emotional disturbance

*Indicator 2:* The percentage of children with serious emotional disturbance who receive mental health services from CSBs during the fiscal year.

*Measure:* Numerator: Number of children with SED who have received mental health services during the fiscal year.

Denominator: The number of children who have SED in the State.

*Sources of Information:*

Numerator: Fourth Quarter Performance Contract

Denominator: Federal estimate of prevalence of serious emotional disturbance Level of Functioning score = 50 and utilizing the upper limit value.

*Special Issues:*

Significance: Setting quantitative goals to be achieved for the numbers of children with serious emotional disturbance to be served in the public mental health system is a key requirement of the mental health block grant law. Penetration of the population affected by serious emotional disturbance is a critical building block of community-based systems of care.

**FY 2008 STATE MENTAL HEALTH PLAN & IMPLEMENTATION REPORT  
PERFORMANCE INDICATORS**

**Population:** *Children with serious emotional disturbance*

**Criterion 2:** *Prevalence and treated prevalence of serious emotional disturbance*

Performance Measures (1)	<i>State Fiscal Year</i>			% Attain (5)
	FY 06 Actual/Goal (2)	FY 07 Actual/Goal (3)	FY 08 Actual/Goal (4)	
	1. Number of Children Served			
Value:	25,529/22,200	26,962/22,400	28,592/25,000	114%
2. Treated Prevalence of Serious emotional disturbance (Brief Name)				
Value:	21%/18%	23.5/19%	25.6/19.5%	131%
if rate:				
Numerator	13,543	14,977	16,350	
and				
Denominator	64,808	63,792	63,753	

\* Utilizing the data from the Upper Limit of the Level Of Functioning = 50 in the Federal estimate of SED for Virginia in 2007.

### **CRITERION 3** Provision of Children's Services

#### **Performance Measures for Criterion Three**

Two performance measures have been selected for Criterion 3:

1. Percentage of consumer's care givers who report satisfaction with staff sensitivity to cultural/ethnic background. Goal Achieved.
2. Percentage of consumer's caregivers who report positively about their child's outcomes. Goal Achieved

In the provision of children's mental health services, the Commonwealth of Virginia recognizes the continuing need to ensure that services are delivered in a manner that respects the uniqueness of all ethnic/cultural groups represented in Virginia. Over the past several years, the DMHMRSAS has encouraged local providers of children's mental health services to implement policies and procedures that support cultural competence that is tailored to the communities they serve. Effective cultural competency in mental health service provision should integrate an awareness of individuals and groups of people into specific standards, service approaches and treatment strategies. DMHMRSAS has identified two main strategies to increase cultural competency at CSBs: first, the completion of a formal organizational self-assessment and second, the development of formal cultural competence plans. The target for performance indicator #1 was nearly reached at 98% (The target was 86% and the actual was 83.9%). The target for the percentage of caregivers who report positively about their child's outcomes was 48% and FY 2008 results were 48.3% for a 100% attainment of the goal.

STATE PLANNING & MONITORING  
**MENTAL HEALTH PERFORMANCE INDICATOR**

*Goal:* Maintain cultural competency of Community Service Boards

*Population:* Children with serious emotional disturbance

*Criterion 3:* Provision of children's services

*Brief Name:* Cultural Competency Self-assessment

*Indicator 1:* Percentage of consumer's care givers who report satisfaction with staff sensitivity to cultural/ethnic background.

*Measure:* Numerator: Total number of respondents with average scale score >3.5 on the cultural sensitivity subscale.

Denominator: Total number of respondents.

*Sources of Information:*

Numerator: Youth Services Survey for Families (YSS-F)

Denominator: Youth Services Survey for Families (YSS-F)

*Special Issues:*

The YSS-F is being refined through a national effort in which Virginia is participating. The survey was administered initially in Virginia in FY2000.

Significance: The cultural competency of a program increases the likelihood that members of minority groups will successfully engage in treatment.

**STATE PLANNING & MONITORING  
MENTAL HEALTH PERFORMANCE INDICATOR**

*Goal:* To maintain or increase the percent of caregivers reporting positively about their child's outcomes.

*Population:* Persons under the age of 18.

*Criterion 3:* Children's Services

*Brief Name:* Positive perceptions of outcomes.

*Indicator 1:* Perception of Care

*Measure:* The percent of caregivers reporting positively about their child's outcomes on the Youth Services Survey for Families (YSS-F).

Numerator: Total number of respondents with average scale score >3.5 on the outcomes subscale.

Denominator: Total number of respondents to the outcome domain on the YSS-F

*Sources of Information:* Youth Services Survey for Families

*Significance:* It is important to know what consumers think about the effectiveness of service delivery.

**FY 2008 STATE MENTAL HEALTH PLAN & IMPLEMENTATION REPORT  
PERFORMANCE INDICATORS**

**Population:** *Children with serious emotional disturbance*

**Criterion 3:** *Provision of Children's Services*

Performance Measures (1)	<i>State Fiscal Year</i>			% Attain (5)
	FY 06 Actual/Goal (2)	FY 07 Actual/Goal (3)	FY 08 Actual/Goal (4)	
<b>1. Cultural Competency Self-Assessment</b>				
Value:	85%/86.3%	85.4%/86.6%	83.9%/86%	98%
Numerator	1357	1215	1264	
Denominator	1592	1422	1507	
<b>2. Positive perceptions of outcomes</b>				
Value:	*51%/47.5%	49.3%/48%	48.3%/48%	100%
Numerator	832	706	733	
Denominator	1597	1432	1517	

\* Corrected figures from previous reports

**CRITERION 4** Targeted Services to Homeless and Rural Populations

**Performance Measures for Criterion 4**

1. The number of children with serious emotional disturbance served in rural community services boards Goal achieved

The availability of services for children with serious emotional disturbance residing in rural catchment areas has been selected as a performance measure for Criterion 4. The Virginia Department of Mental Health, Mental Retardation, and Substance Abuse Services designates areas as rural based on a population of less than 120 per square mile. Currently the Commonwealth of Virginia has 40 CBSs of which 17 are designated as urban and 23 are designated as rural. The 40 CBSs provide services to residents of all 135 counties in Virginia.

The number of seriously children with serious emotional disturbance who received services at the state's 23 rural CBSs has varied over each of the last three years, with a total of 8,320 served in SFY 2008. As shown in the data table, this number of children with serious emotional disturbance served represents 119% of the goal that was set for Criterion 4. Goal Achieved.

**STATE PLANNING & MONITORING  
MENTAL HEALTH PERFORMANCE INDICATOR**

*Goal:* To maintain or increase the availability of mental health services for children with serious emotional disturbance in rural areas.

*Population:* Children with serious emotional disturbance

*Criterion 4:* Targeted Services to Homeless and Rural Populations

*Brief Name:* Rural mental health services

*Indicator 1:* Services to children with SED in rural areas

*Measure:* Number of children with SED served in rural community services boards

*Sources of Information:*

Community Consumer Submission (CCS) data reporting from Community Services Boards.

**FY 2008 STATE MENTAL HEALTH PLAN & IMPLEMENTATION REPORT  
PERFORMANCE INDICATORS**

**Population:** *Children with serious emotional disturbance*

**Criterion 4:** *Targeted Services to Homeless and Rural Populations*

	<i>State Fiscal Year</i>			
Performance Measures	FY 06	FY 07	FY 08	% Attain
(1)	Actual/Goal	Actual/Goal	Actual/Goal	(5)
(2)	(3)	(4)		
1. Rural Mental Health Services				
Value:	6549/6,400	7,248/7,000	8320/7,000	119%

**CRITERION 5**      Management Systems

□      **Performance Measures for Criterion 5**

One performance measure has been selected for Criterion 5:

1. Support for child mental health programs

This measure and the sources of data for collecting each are described in detail on the following pages.

Within the past 13 years, through the Comprehensive Services Act and other strategies, Virginia has made significant efforts to improve parent involvement in service planning. In many localities, parents are required to participate in all assessment team meetings and to document their involvement in the plan of care. In Virginia, we have placed particular emphasis on the inclusion of parents/families of children with serious emotional disturbance at all levels of decision-making. Parental involvement is improving.

Our estimate of the funding for community mental health children's services for SFY2008 is \$63.7 million. The target goal of at least 8% of all mental health expenditures was exceeded (actual achievement of 9.2%) and a 115% attainment of the target was achieved. Goal Achieved.

**STATE PLANNING & MONITORING  
MENTAL HEALTH PERFORMANCE INDICATOR**

*Goal:* Increase percentage of funding expended for child and adolescent mental health services.

*Population:* Children with serious emotional disturbance

*Criterion 5:* Management Systems

*Brief Name:* Support for Child Mental Health Programs

*Indicator 1:* Percentage of SMHA-controlled resources distributed to community services boards specifically for child mental health services.

*Measure:*

Numerator: SMHA-controlled resources distributed through grants to community services boards for child mental health services\*.

Denominator: Total SMHA-controlled resources (for Central Office, State Facilities, community services boards, including state general funds, federal block grant, medicaid, medicare)

*Sources of Information:*

Numerator: State financial management system

Denominator: State financial management system

*Special Issues:*

Significance: Increased funding for the child and adolescent component of the state mental health system will increase the ability of CSBs to develop foundation services for children.

\* The percent of state funding to community programs for child mental health programming was estimated by applying the percent of unduplicated CSB clients that the children/adolescents represent and allocating that percent of the community funding.

**FY 2008 STATE MENTAL HEALTH PLAN & IMPLEMENTATION REPORT  
PERFORMANCE INDICATORS**

**Population:** *Children with Serious Emotional Disturbance*

**Criterion 5:** *Management Systems*

Performance Measures (1)	<i>State Fiscal Year</i>			% Attain (5)
	FY 06 Actual/Goal (2)	FY 07 Actual/Goal (3)	FY 08 Actual/Goal (4)	
1. Support for Community Programs				
Value: if rate:	8.0%/7.4%	8.4%/7.5%	9.2%/8.0%	115%
Numerator and Denominator	47.7M 597.3M	53.3M 627.1M	63.7M 685.3M	