

**An Integrated Policy and Plan  
to Provide and Improve Access  
to Mental Health, Mental Retardation and Substance Abuse  
Services for Children, Adolescents and Their Families  
July 1, 2008- June 30, 2009**

**To the Governor and Chairmen of the House Appropriations  
and Senate Finance Committees of the General Assembly**

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

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

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## Executive Summary

### General Assembly Guidance

Since 2002, the General Assembly has approved *Appropriation Act* language (Items 329-G, 330-F, 311-E, and 315-E respectively) directing the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) to convene stakeholders to study ways to improve access to services for children and their families across disabilities. The language also requires DMHMRSAS to report the plan to the Chairmen of the Senate Finance and House Appropriations Committees as follows:

*“The Department of Mental Health, Mental Retardation, and Substance Abuse Services, the Department of Juvenile Justice and the Department of Medical Assistance Services, in cooperation with the Office of Comprehensive Services, Community Services Boards, Court Service Units, and representatives from community policy and management teams representing various regions of the Commonwealth shall develop an integrated policy and plan, including the necessary legislation and budget amendments, to provide and improve access by children, including juvenile offenders, to mental health, substance abuse, and mental retardation services. The plan shall identify the services needed by children, the cost and source of funding for the services, the strengths and weaknesses of the current service delivery system and administrative structure, and recommendations for improvement. The plan shall also examine funding restrictions of the Comprehensive Services Act which impede rural localities from developing local programs for children who are often referred to private day and residential treatment facilities for services and make recommendations regarding how rural localities can improve prevention, intervention, and treatment for high-risk children and families, with the goal of broadening treatment options and improving quality and cost effectiveness. The Department of Mental Health, Mental Retardation, and Substance Abuse Services shall report the plan to the Chairmen of the Senate Finance and House Appropriations Committees by June 30<sup>th</sup> of each year.”*

DMHMRSAS convenes the interagency Systems of Care Advisory Team (SOCAT) – previously known as the Child and Family Behavioral Health Policy and Planning Committee (CFBHPPC) - to study children’s services and advise it and the General Assembly regarding necessary changes in services. In June 2008, DMHMRSAS submitted its sixth consecutive report, *A Policy and Plan to Provide and Improve Access to Mental Health and Substance Abuse Services to Children, Adolescents and Their Families*. This report delineated recommendations to improve access to services for children and their families. The report included recommendations to address unmet service needs, funding, infrastructure, and system issues.

Over the past seven years there has been considerable interest in the children’s behavioral health services system and numerous reports and studies have been generated. Besides DMHMRSAS, several state executive and legislative agencies have generated reports and

recommendations related to mental and behavioral health services needed by youth. These include the Office of the Inspector General (OIG), the Virginia Commission on Youth (COY), the Joint Legislative Audit and Review Committee (JLARC), and the Virginia Commission on Mental Health Law Reform (CMHLR). Independent legislative committees, such as the Joint Subcommittee to Study Strategies and Models of Substance Abuse Treatment and Prevention (SJR 77), have also been asked to study special areas of concern. In total, at least 18 reports or studies have been issued in the past 2 years directly addressing or pertaining to Virginia's behavioral health care system for children. These reports have identified similar findings, including:

- Lack of service capacity;
- Limited access to care;
- Lack of a full continuum of community-based care;
- Shortage of child and adolescent psychiatrists and psychologists;
- Fragmentation of services;
- Families unaware of available services;
- Lack of family and youth involvement;
- Lack of statewide evidence-based treatments; and
- Reliance on other systems to provide care.

The numerous reports, initiatives and activities described in this and previous reports have laid a helpful foundation for ongoing change. As Virginia continues its efforts to develop a broader range of services and supports for children and adolescents across the Commonwealth, stakeholders are working to address unmet needs and ensure that providers have the required skills and knowledge to provide better-coordinated services for children and their families.

In recent years multiple efforts to transform behavioral health care services for children, adolescents and adult services have been implemented. DMHMRSAS continues its Transformation Initiative to reform the community behavioral health system by implementing a vision that includes consumer- and family- driven services promoting resilience in children and the highest possible level of participation in community life including school, work, family and other meaningful relationships. Through an ongoing collaboration and coordination process across child-serving agencies, focus has expanded into a comprehensive, cross-agency effort that includes Medicaid, juvenile justice, social services, education and comprehensive services.

DMHMRSAS participated in two federal grants to effect system transformation – one to address services for adolescents with a substance use or co-occurring mental health disorder; the other to transform services for adolescents and adults who have co-occurring mental health and substance use disorders. Two other state-directed initiatives, the *Children's Services System Transformation* and *Smart Beginnings*, have emerged in Virginia. Both are large, complex, interagency efforts aimed at changing how services are delivered to children and their families across the Commonwealth; however, those initiatives focus on different populations.

The SOCAT offers recommendations in the following areas for FY 2010:

- **Improving the Availability of Child and Adolescent Behavioral Health Services Available across Virginia's Communities**
- **Future Funding (as state budget conditions improve)**

The recommendations are detailed on pages 22 through 25.

# An Integrated Policy and Plan to Provide and Improve Access to Mental Health, Mental Retardation and Substance Abuse Services for Children, Adolescents and Their Families

## Introduction and Background

Since 2002, the General Assembly approved *Appropriation Act* language (Items 329-G, 330-F, 311-E, and 315-E respectively) directing the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) to convene stakeholders to study ways to improve access to services for children and their families across disabilities. The language also requires DMHMRSAS to report the plan to the Chairmen of the Senate Finance and House Appropriations Committees as follows:

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## The Role of the Systems of Care Advisory Team (SOCAT)

Since its inception, the System of Care Advisory Team (SOCAT, formerly named CFBHPPC) has focused on identifying strategies to develop a more comprehensive system of care for youth within the Commonwealth. In order to provide the General Assembly with a comprehensive overview and recommendations for improving this system, DMHMRSAS has sought input from public and private agencies and partnerships annually.

In 2006 at the request of the Secretary of Health and Human Resources, the workgroup and the department developed a 10-year strategic plan to enhance Virginia’s service system for children and their families. SOCAT has assessed system strengths and challenges; explored the range of services needed by children and adolescents; and identified strategies to enhance coordination and collaboration among key agencies. The workgroup is currently revising and updating this plan. This report includes an overview of the status of Virginia’s system of care for youth and recommendations for improving this system<sup>1</sup>.

Many recommendations have been implemented and a number of initiatives requiring funding have been supported by the General Assembly. These include:

- Part C Early Intervention Funds (2003: \$7,200,000)
- System of Care/Evidence Based Practice Demonstration Projects (2006: \$1,000,000; 2007: \$1,000,000)
- Juvenile Detention Centers Projects Mental Health Screening and Assessment Services (2006: \$1,140,000; 2007: \$900,000)
- Child Psychiatry / Child Psychology Fellowships (2007: \$483,000)
- Web Based Reporting of Hospital Beds (2008: \$25,000)
- CSB Child and Adolescent positions (2008: \$2,800,000)

Progress updates on these initiatives are provided in Appendix A.

Along with the work of the System of Care Advisory Team, many reports in recent years have sought to address services for youth who have a mental, behavioral and/or developmental disability.

<b>Reporting Entity</b>	<b>Date of Report</b>
<b>Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS)</b>	
<i>An Integrated Policy and Plan to Provide and Improve Access to Mental Health, Mental Retardation and Substance Abuse Services for Children, Adolescents and Their Families (Budget Item 311-E, 2007 Appropriations Act) July 1, 2007- June 30, 2008</i>	June 30, 2008
<i>An Integrated Policy and Plan to Provide and Improve Access to Mental Health, Mental Retardation and Substance Abuse Services for Children, Adolescents and Their Families (Budget Item 311-E, 2006, Appropriations Act) July 1, 2006- June 30, 2007)</i>	June 30, 2007
<i>A Report on Virginia’s Part C Early Intervention System (Budget Item 312 K.2, 2006 Appropriations Act) July 1, 2006 – June 30, 2007</i>	June 30, 2007
<i>State Facility Bed Use for Children and Adolescents: Report to the Department of Mental Health, Mental Retardation, and Substance Abuse Services and the Child and Family Behavioral Health Policy and Planning Committee</i>	2006
<b>Office of the Inspector General (OIG)</b>	

<sup>1</sup> Copies of previous reports may be accessed on the Virginia General Assembly’s Legislative Information System website (<http://legis.state.va.us>) under Reports to the General Assembly

<i>Inspection of the Commonwealth Center for Children and Adolescents Report – November 2008 #167-08</i>	December 10, 2008
<i>Review of Community Services Board Child and Adolescent Services Report March – April # 149-08</i>	September 19, 2008
<i>Survey of Community Services Board Child and Adolescent Services Report- October 2007 # 148-07</i>	March 31, 2008
<b>Commission on Youth (COY)</b>	
<i>Guide to Local Alternative Education Options for Suspended and Expelled Students in the Commonwealth (RD 144)</i>	April 2008
<i>Collection of Evidence-Based Practices, 3<sup>rd</sup> Edition (HD 21)</i>	January 2008
<i>Alternative Education Options (RD 194, Interim Report)</i>	April 2008
<i>Establishment of an Office of Children’s Services Ombudsman (RD 117 Final report)</i>	March 2008
<i>Establishment of an Office of Children’s Services Ombudsman (Interim Report)</i>	January 2007
<i>At-Risk Youth Served in Out-of-State Residential Facilities (RD 353)</i>	July 2006
<b>Joint Legislative Audit Review (JLARC)</b>	
<i>Mitigating the Costs of Substance Abuse Services</i>	June 2008
<i>Evaluation of House Bill 83: Mandated Coverage of Autism Spectrum Disorders</i>	September 2008
<i>Follow Up Report: Custody Relinquishment and the Comprehensive Services Act</i>	March 2007
<b>Legislative Committees</b>	
<i>Executive Summary of the Study by the Joint Legislative Audit and Review Commission of Autism Services in the Commonwealth</i>	2009
<i>Senate Document 8 Executive Summary of the Joint Subcommittee to Study Strategies and Models of Substance Abuse Treatment and Prevention (SJR 77)</i>	2008
<b>Comprehensive Services Act</b>	
<i>Residential Services for Children in the Comprehensive Services Act; Utilization, Length of Stay and Expenditures Statewide and by Locality; Program Year 2008</i>	December 2008
<i>FY08 Critical Service Needs Gaps</i>	January 8 , 2009
<i>Commonwealth of Virginia Commission on Mental Health Law Reform Progress Report on Mental Health Law Reform December 2008</i>	December, 2008

### **Unmet Behavioral Needs of Virginia’s Children**

According to the most recently available prevalence data, the estimated number of Virginia youth ages 9 to 17 who had a serious emotional disturbance (level of functioning score of 60) in 2005 was between 84,923 and 103,794.<sup>2</sup> . The National Survey of Drug Use and Health (NSDUH)<sup>3</sup> further estimated that during 2005-2006, 47,000 youth ages

<sup>2</sup> Estimate obtained utilizing methodology published by the U.S. Center for Mental Health Services (CMHS) of the Substance Abuse and Mental Health Services Administration (SAMHSA) in the Federal Register, Volume 63, No. 137, Friday, July 17, 1998. and applied to prevalence rates of the 2005 Estimated Population data.

<sup>3</sup> Trends in Substance Use, Dependence or Abuse, and Treatment among Adolescents: 2002 to 2007, NSDUH December 4, 2008

12-17 (7.53%) and 162,000 Virginia youth age 18-25 (19.88%) abused or were dependent on illicit drugs and/or alcohol in Virginia. In addition, the NSDUH estimated that 56,000 youth were estimated to have had experienced a major depressive episode in the past year during the survey period.

In 2008, Virginia’s CSBs provided services to a portion of these youth. Less than 45% of those believed to have a serious emotional disturbance and less than 10% estimated to have a substance use disorder obtained services at a CSB. The same year, 737 youth received acute care services in a DMHMRSAS inpatient psychiatric facility – a significant increase over the preceding year. It is not known why outpatient services for youth 12 – 25 declined from FY 2007 to FY 2008, why hospitalizations increased and if the two might even be related.

Disability Area	CSB Services				DMHMRSAS Acute Care
	# Served 0 – 11 yrs	# Served 12 -17 yrs	# Served 18 - 25	Waiting List 1/1 -4/1/07	# Served
<b>Mental Health</b>					
2007	12,617	17,430	16,185	1680	513
2008	12,608	14,961	9,659	NA	737
<b>Substance Use</b>					
2007	572	6,697	11,755	234	
2008	320	4,069	9,659	NA	

Despite recent gains, Virginia’s child and adolescent behavioral health system still requires improvement in order to meet the needs of many children and adolescents. Improvements are needed in regard to a comprehensive continuum of care and increased service capacity, particularly in rural areas. According to the OIG’s 2007 survey of CSB child and adolescent services, of those children and adolescents who do receive services, most receive basic services - emergency services, case management, office based treatment and sometimes medication management. Even when communities are able to offer more comprehensive services, access may be limited by funding restrictions.

Five recent surveys have attempted to assess available services and/or identify gaps:

- CSA’s 2008 Survey of Critical Service Gaps;
- OIG’s Survey of Community Services Board Child and Adolescent Services - October 2007;
- DMHMRSAS’ CSB Survey of Services for Adolescent Substance Use and Co-Occurring Disorders (2007) and Private Provider Survey of Services for Adolescent Substance Use and Co Occurring Disorders (2008); and, the
- Virginia Federation of Families’ Family Services Survey (2009).

Each year CSA surveys stakeholders to identify perceptions of service gaps at the community level. Data is analyzed both regionally and statewide. The top 10 statewide service gaps identified through CSA’s FY 2008 survey were, in order of priority:

1. Crisis intervention

2. Intensive substance abuse services
3. Intensive care coordination
4. Wraparound services
5. Parent/family skills training
6. Alternative education day services
7. Transportation
8. Psychiatric assessment
9. Substance abuse prevention
10. Respite care services

The OIG's report, *Review of Community Service Board Child and Adolescent Services*, drew on both survey and interview findings and provides considerable detail regarding funding and services for youth across the disability areas as well as information regarding the interface between CSB and CSA services. The OIG report provided these observations regarding child and adolescent services available through the CSBs:

- “Whether measured by expenditures, staffing, or percentage of child population served, the availability of mental health services for children and adolescents offered by CSBs varies widely among communities”<sup>4</sup>
- “Few CSBs offer a large array of child and adolescent services sufficient to meet the needs of their community. Many CSBs have very limited services available to children. A few have virtually no service system designed especially for children”<sup>5</sup>

The OIG found that 32 CSBs provide mental health services to children and adolescents within a dedicated specialized unit and 8 CSBs serve children along with adults. Many of the OIG's findings focused on the lack of child and adolescent services across Virginia's public behavioral health services system<sup>6</sup>:

- Only 2 CSBs offer all of the 5 highly specialized, high impact services (children's emergency services, crisis stabilization, home-based therapy, school-based day treatment, and local residential services) that are considered by stakeholders, CSB staff, and the OIG to offer the most promise to serve children with severe needs and help prevent residential placement. The average number of intensive services offered by all CSBs is 1.7.
- Access to services for uninsured families and those that are not eligible for a dedicated source of funding for children and adolescents is extremely limited.
- Child and adolescent services at many CSBs are full to capacity - resulting in long waiting periods. The average wait for all youth services at a CSB was 26 days
- Stakeholder agencies are concerned that CSBs do not offer an adequate array of services, CSB services for youth with substance abuse needs or autism spectrum disorders are inadequate and that wait times in general are too long.

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<sup>4</sup> OIG *Review of Community Service Board Child and Adolescent Services March-April 2008*

<sup>5</sup> Ibid.

<sup>6</sup> Ibid.

DMHMRSAS' Project TREAT grant surveyed CSBs and licensed residential providers regarding the nature and availability of services for youth with substance use or co-occurring substance use and mental health disorders. Survey responses revealed that CSBs work primarily with youth who abuse alcohol and marijuana and have co-occurring substance use and mental health disorders and identified that:

- CSBs lack supervisory staffs that have expertise in treating adolescents with substance use or co-occurring disorders.
- Almost 40% of the CSBs do not use standardized instruments to screen adolescents and 42% do not use standardized instruments to assess adolescents for substance use or co-occurring disorders.
- Few CSBs implement evidence based practices (EBPs).
- Almost three-fourths do not offer or plan to offer: Multi-systemic Family Therapy, Multidimensional Family Therapy, Functional Family Therapy, Contingency Management, Seeking Safety, ACRA, or Seven Challenges.
- Just over half implement motivational treatment services or Cognitive Behavioral Treatment (CBT).

Of those CSBs that do offer EBPs:

- Almost a quarter do not have supervisors trained in that modality who oversee staff.
- The majority do not monitor fidelity to the model.
- Due to the lack of funds, few CSB are able to access residential substance abuse treatment services for youth.

The OIG's survey went one step further than either the TREAT or CSA survey and asked respondents to also identify those factors that "hinder" the development of children's services. Depending upon the disability referenced the responses they received varied.

The impediments most frequently cited related to children's mental health services were:

- Lack of flexible funding for non-CSA mandated children,
- Lack of flexibility in Medicaid for ineligible services and ineligible family members,
- Lack of children's health insurance coverage,
- Lack of prevention funding, and
- Difficulty recruiting and retaining qualified child mental health staff.

The explanations provided for not developing adolescent substance abuse services were:

- Lack of state funding for children's substance abuse services; and
- Lack of support for outpatient services.

SOCAT's findings and recommendations have been remarkably consistent with the numerous reports referenced on page 7-8 of this report. There appears to be general consensus that Virginia's current child and adolescent services system needs:

- A full continuum of services;
- Increased service capacity;
- Improved access to care;
- Greater access to child and adolescent psychiatrists and psychologists;
- Ongoing education and training opportunities to ensure that providers achieve and maintain the necessary skills and expertise to provide services;

- Mechanisms to address transitions between services and ensure continuity of services;
- Adequate service information and support for families including how to access services;
- Greater involvement of family and youth in service development; and,
- Increased use of evidence-based treatments (EBTs) for children and adolescents across the Commonwealth.

## **Initiatives for Serving Children and Adolescents in Virginia**

### **Adoption of National Initiatives that Address the “Whole Child”**

It is broadly recognized that serving the needs of youth involves multiple systems, and, individuals are best served when there is a high degree of service coordination focusing on the “whole child” and the family. Virginia has adopted three national initiatives that address the needs of Virginia’s children in crisis:

- *Communities in Schools* is a national school dropout prevention program primarily active in the Richmond metropolitan area.
- *Coordinated School Health* is a multi-systemic approach to attending to the bio-psycho-social-spiritual needs of children promoted by the Center for Disease Control. This approach has been embraced by Student Services staff at the Virginia Department of Education.
- *Systems of Care* can trace its origins to the Institute of Mental Health’s Child and Adolescent Service System Program (CASSP). Initially developed for children with serious disorders, the “system of care” concept has since been extended to include all children. The “systems of care” concept has been embraced by DMHMRSAS, the Comprehensive Services Act (CSA) and Virginia’s Children’s Services Transformation Initiative.

Each of these national initiatives recognizes the need to serve the “whole child” and the importance of addressing children’s need for nurturance, education, and healthcare. All three maintain focus on the psychological well-being of the child, while simultaneously addressing other areas of need, and also invite public and private agencies to collaborate in problem-solving for the children they serve.

### **State Initiatives that Address the Needs of the Whole Child**

In recent years, two state initiatives aimed at transforming children’s services, the *Children’s Services System Transformation* (formerly CORE) and *Smart Beginnings*, have emerged in Virginia. Both are large, complex efforts designed to change how services are delivered, but focus on different populations.

#### ***Children’s Services System Transformation***

In 2007, the Annie E. Casey Foundation assessed Virginia's foster care services and offered technical assistance to the Commonwealth to develop a child-centered, family-focused, collaborative system of community-based services for young people and design permanent family connections for older children in foster care or at risk of entry into the foster care system. The Casey Foundation's efforts have been targeted at helping to reduce the number of youth leaving foster care without a permanent home to go to, as well as contain CSA's escalating costs. Originally known as the Council on Reform (CORE), the *Children's Transformation* efforts initially involved the Department of Social Services (DSS), CSA and DMHMRSAS at both the state and local level. Thirteen communities were selected as pilot sites with four common goals:

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

In January 2009, the newly named *Children's Services System Transformation*, expanded its transformation efforts statewide, and invited the Department of Juvenile Justice (DJJ), the Department of Education (DOE) and other stakeholders to participate in its efforts to effect change within local systems of care for all youth.

In mid-fall 2008, the *Children's Services System Transformation* invited SOCAT to participate more directly in its efforts. In December, DMHMRSAS and SOCAT facilitated an interactive "round robin" presentation on systems of care efforts in 8 localities to the participating *Transformation* sites. Each of the 8 localities described their respective initiatives and responded to audience questions about interagency collaboration and other elements of community-based systems of care. The featured localities included the four recipients of DMHMRSAS' ongoing systems of care demonstration project grants which had been recommended by SOCAT and funded by the General Assembly in previous years. SOCAT continues to collaborate with the *Children's Transformation* initiative through CSA, and SOCAT members now serve on several of the *Transformation* subcommittees.

### ***Smart Beginnings: Home Visiting Consortium and the Infant Mental Health Work Group***

The *Smart Beginnings* initiative is designed to improve services for children 0 to 5 and ensure that they enter school ready to learn. Smart Beginnings is coordinated by two organizations - the Virginia Early Childhood Foundation (a public-private partnership founded in 2005 to implement long-term strategies for improving school-readiness for all young children age's birth to 5), and the Governor's Working Group on Early Childhood Initiatives.

The *Smart Beginnings Initiative* consists of 5 workgroups that address the following overarching goals: governance and financing; parent support and education; early care and education; public engagement and health.

The *Initiative's* Health Workgroup is tasked with building and sustaining a system that ensures all families of children prenatal to 5 years of age have access to a full range of medical, dental and behavioral health care. The workgroup includes two subgroups - the Home Visiting Consortium and the Infant Mental Health Workgroup - which address the continuum of prevention, early intervention, treatment and support services for Virginia's youngest citizens.

- The Home Visiting Consortium (HVC) brings together 10 different state supported home visiting programs which serve children 0 to 5 and their families and includes representatives from VDH, DOE, DSS, DMAS and DMHMRSAS. The Consortium's efforts to enhance and coordinate services, develop uniform standards and address workforce development for this population received national attention this year.
- The Infant Mental Health Workgroup focuses on services for children 0 to 5 at risk for or in need of mental health services and their families. Like the HVC, it brings together a cross-section of agencies and organizations to take a comprehensive approach to increasing access to behavioral and developmental services for youth 0 to 5 years and developing training for the staffs that serve them.

Each of these *Smart Beginnings* workgroups addresses professional development/parent education, service delivery/practice, system collaboration and policy. SOCAT has invited the chairs of the Home Visiting Consortium and the Infant Mental Health Workgroup to update SOCAT on their respective efforts and explore how the groups might interface with one another.

The *Children's Services System Transformation* and the *Smart Beginnings Initiative* both work independently across systems to develop and implement recommendations regarding service development, provider training, data collection, funding polices and procedures for the respective populations they serve.

### **DMHMRSAS's Grant Funded System Transformation Efforts: Mental Health and Substance Abuse Services**

Since 2004, DMHMRSAS has participated in two federal grant-funded initiatives aimed at implementing major system transformation. In 2004, DMHMRSAS received a Co-occurring Systems Integration Grant (COSIG) from the Substance Abuse and Mental Health Services Administration (SAMHSA) to provide integrated mental health and substance abuse services for both adults and adolescents. The Virginia System Integration Project (VASIP) has focused its efforts on transforming CSB and DMHMRSAS facility services to ensure they are "co-occurring capable" and able to deliver effective services to youth and adults who have co-occurring disorders.

DMHMRSAS was awarded a three-year State Adolescent Treatment Coordination (SAC) grant from SAMHSA in 2005 to enhance infrastructure to support substance abuse services for adolescents. Project TREAT (Training and Resources for Effective Adolescent Treatment) was required by SAMSHA to hire an Adolescent Substance Abuse Coordinator, convene an interagency workgroup to identify and address barriers at the state and local level which impede the delivery of adolescent substance abuse treatment services, and complete a financial map that identified public expenditures for substance abuse and mental health services across all youth serving systems. TREAT's interagency workgroup functions as a subgroup of SOCAT and provides input to SOCAT for this report. Grant efforts focused on collaboration, funding, family involvement, workforce development, and implementation of evidence based practices (EBP). TREAT has also worked closely with VASIP/COSIG to develop services and infrastructure for youth who have co-occurring mental health and substance use disorders. TREAT funds supported a wide variety of cross-system workforce development activities.

Grant-funded activities also included providing technical assistance, guidance, and support to 16 CSBs to support implementation of an evidenced based practice (EBP) intended for youth who have a substance use, or substance use and another, co-occurring disorder. Each board was aided in the selection of an EBP suited to its needs and resources, and funding was provided to train their staff. Three CSBs were trained in Dialectical Behavior Treatment (DBT), 3 in the Seven Challenges EBP; 5 chose Motivational Enhancement Therapy/ Cognitive Behavioral Therapy (MET/CBT) and 5 selected Motivational Interviewing (MI); 1 CSB received additional training in Contingency Management. In order to sustain the activities of the Project TREAT grant and continue efforts to enhance services for youth with substance use and co-occurring disorders, DMHMRSAS will retain the Adolescent Coordinator position after grant funding ends July 30, 2009.

In summary, a number of initiatives have focused on enhancing interagency or multi-system collaboration and have sought to coordinate activities with other efforts. Other efforts have proceeded more independently or have only recently begun to explore how they might work with existing groups. This increased focus on children's services is positive but brings with it the potential for duplication of effort. In order to maximize the Commonwealth's resources and expenditures, SOCAT would like to see greater coordination between the different efforts to transform our system of care for youth.

## **Recent Legislative Efforts to Improve Service for Youth**

The 2008 General Assembly was an active session for behavioral health initiatives and children's initiatives. In response to the Virginia Tech tragedy, the 2008 General Assembly addressed the disclosure of necessary information between parties providing services to youth who may be dangerous to themselves or others. As precautionary measures, public universities were required to implement threat assessment teams and early warning systems and to require sharing of information between high schools and universities. In response to concerns regarding the under-funding of the

Commonwealth's public mental health system, funds were identified to support additional staff statewide – including funds to support one additional youth position at each of the 40 community service boards.

In the same year, the legislature approved the following measures to support efforts to transform CSA services:

- Increasing payments to foster and adoptive families.
- Allowing Temporary Assistance to Needy Families (TANF) payments to be made to family members of a child in custody.
- Requiring enhanced and increased training for foster care workers.
- Requiring the State Executive Council to develop and establish uniform guidelines for intensive care coordination for children in, or at-risk, of residential placement through the Comprehensive Services Act (CSA)

An update regarding Virginia's progress with implementing intensive care coordination services is provided in Appendix B.

Lastly, in 2008 the legislature approved the renaming of DMHMRSAS. This measure was an effort to support the department's mission, and to move away from the stigma associated with the term "mental retardation." The 2009 General Assembly unanimously approved the new name, Department of Behavioral Health and Developmental Services (DBHDS), and it is scheduled to go into effect July 1, 2009.

The 2009 Session addressed issues related to services for autism spectrum disorders (ASD). Following extensive study and consideration begun in 2005, responsibility and oversight of ASD services was assigned to DMHMRSAS where a lead office will be developed to address developmental disabilities. The legislature also resumed consideration of House Bill 83, introduced in 2008, which proposed mandating insurance coverage for the diagnosis and treatment of ASD in individuals under 21. The revised version, House Bill 1588, received much attention from both opponents and supporters. No action was taken on the bill by the House Commerce and Labor Committee during the 2009 General Assembly Session.

## **Impact of Recent State Budget Cuts**

Understandably, a good portion of the 2009 General Assembly Session focused on Virginia's budget deficit and efforts to meet a three billion dollar revenue shortfall. As a result of this fiscal reality, few behavioral health initiatives and, more specifically, few children's services initiatives were funded. Funds were not available to implement the Office of Children's Services Ombudsman approved during the 2008 session.

However, although budget concerns dominated the most recent session, the legislature did address several important issues related to mental and behavioral health services for children and adolescents. Legislation was approved in 2008 regarding mandatory outpatient treatment for adults but not adolescents, but in 2009, the legislature took up this issue and sought to close the loop for adolescents. Other legislation was approved that allows a family member to transport an individual under emergency custody.

Due to the dire fiscal situation, the 2009 legislature was unable to fund any new services for youth and, in another cost saving measure, cut funding for the child psychiatry and psychology fellowships previously funded in 2007. In addition, the Governor's budget recommended closing the Commonwealth Center for Children and Adolescents (CCCA) and the Adolescent Unit at Southwest Virginia Mental Health Institute (SVMHI). However, this budget item was modified by the General Assembly and DMHMRSAS was directed to convene a state and community planning team to develop a plan regarding the future role of the Commonwealth and the private sector in providing acute care services to children, adolescents, and their families. As part of the new group's discussion, DMHMRSAS' role as the "safety net" for children and their families and ensuring that all youth have access to appropriate services must be addressed and resolved.

Necessary CSBs budget reductions also resulted in hiring freezes and community concerns that delayed some of the boards from filling the community-based child and adolescent behavioral health positions funded in 2008.

## **Family Involvement**

Families who have children with behavioral health needs require support services within their communities. The availability of family services and interventions rely solely on local community resources; as a result, family support services vary considerably by locality. Although CSA funding is available to all communities for children who are mandated to receive services, many youth and their families are not eligible to receive CSA supported services. Therefore, there are gaps in the funding stream structure for these children and adolescents.

Support, guidance and assistance for families are currently provided by the Virginia Federation of Families (VA-FOF). VA-FOF is a statewide, family-run program affiliated with Mental Health America (MHA) and funded by DMHMRSAS through the federal Community Mental Health Services Block Grant. These federal funds support one staff person and limited operating expenses; additional assistance is provided through the use of volunteers. VA-FOF serves families of children and adolescents who have special health care needs - particularly those with mental, emotional and behavioral challenges. They provide one-on-one resource/service coordination and trainings for parents and family members to help them develop the necessary skills and knowledge to navigate Virginia's system of care, advocate for their child's personal needs and obtain services. The Federation routinely serves 20 to 30 families and/or professionals each month.

VA-FOF participates on many state-level committees, councils, commissions, taskforces and workgroups to help represent the needs and viewpoints of children, youth and their families. It assists and supports the formation of local Federation of Family chapters and support groups across the Commonwealth and through those chapters provides pertinent information to families, professionals and service providers in localities through brown

bag luncheons, seminars, conferences and trainings. The Federation has reached out to groups of various sizes - anywhere from 10 to 400 individuals – to:

- Discuss the importance of the work underway for families;
- Explain how to engage and assist other families; and
- Share how interested participants can become involved.

In conjunction with DMHMRSAS, VA-FOF surveyed family members and caregivers in May 2009 regarding their needs and experiences obtaining services for children with special needs. As part of the survey, responders were also invited to indicate if they wished to participate in VA-FOF activities. DMHMRSAS received 169 responses to the survey and plans to disseminate the results after analysis is completed.

In partnership with Medical Home Plus, DMHMRSAS and other child-serving agencies, VA-FOF coordinates a conference each year for families and professionals that focuses on issues confronting families of children and adolescents who have special health care needs. The 4<sup>th</sup> Annual “*Strong Roots for a Healthy Future*” Conference will be held in Roanoke this summer.

DMHMRSAS has sought to transform Virginia’s community behavioral health system and implement a vision that includes consumer-and family-driven services that promote resilience in children and the highest possible level of participation in community life including school, work, family and other meaningful relationships. Families benefit from support and guidance during stressful times and need to know who to contact when questions arise. DMHMRSAS supports the idea of an information and support resource to help families navigate through the behavioral health system in Virginia

## **Current Status of Children’s Services**

As previously stated, the numerous reports, initiatives and activities described in this and previous reports have laid a helpful foundation for ongoing change. Virginia must continue its efforts to develop a range of services and supports for children and adolescents across the Commonwealth that address the unmet needs identified in these reports. The *Children’s Services System Transformation* and *Smart Beginnings* have created momentum to address some of these issues and it is imperative that we continue their efforts. It is also critical that the Commonwealth support ongoing education and training opportunities for youth service providers as a means of ensuring that they have the necessary skills and knowledge to appropriately serve Virginia’s children and their families.

Also referenced earlier, Virginia is experiencing significant economic problems which hinder the availability of either additional enhancements to current services or support of new initiatives in the next biennium. However, this year’s report offers recommendations that require little or no new funding and are in line with recommendations from past reports. Budget limitations notwithstanding, the recommendations below are designed to

help develop strategies to create a long-term plan for the effective use of funds as they become available.

## **Policy Perspective**

DMHMRSAS is mandated by the *Code of Virginia* to perform three very essential roles relative to children in need of mental health services. First, in §37.2-315, the *Code* stipulates that DMHMRSAS “*in collaboration with CSBs, behavioral health authorities, state hospitals and training centers, consumers, consumers’ families, advocacy organizations, and other interested parties*” is responsible for providing the state with a Comprehensive State Plan that is updated on a biennial basis. The plan must identify “*the needs and resource requirements for providing services and supports to persons with mental illness, mental retardation, or substance abuse across the Commonwealth.*” This aggregate needs assessment data is used by the state for system-wide planning processes and resource development.

Second, the department is expected to exercise a system leadership role that involves coordinating the development of “*strategies*” to address the identified mental health, intellectual disability, and substance abuse needs of children in Virginia (also in § 37.2-315). As such, DMHMRSAS is responsible for promoting and facilitating the development of appropriate and effective behavioral health care services for children. The department establishes performance contracts and allocates state funding to the local community services boards/behavioral health authorities (§37.2-508, 37.2-509), and works collaboratively with other state agencies, private providers, and consumers/families to facilitate the development and provision of needed services.

Lastly, the department fills an essential “safety net” role and, according to the *Code of Virginia*, is the governmental entity responsible for ensuring that all children in Virginia have access to acute psychiatric care when this level of service is clinically indicated. The vast majority of children in Virginia are appropriately and effectively served through locally operated community-based mental health systems of care and do not require hospitalization. However, inpatient psychiatric hospitalization is required for those children who, in acute situations, cannot be safely served in less restrictive community settings. Many of these children are appropriately treated in privately operated community psychiatric hospitals; others have been unable to access services from a private facility due to their co-occurring forensic, behavioral, medical and/or developmental conditions. In recognition of this situation, the *Code* (§16.1-345) requires that DMHMRSAS assume responsibility for securing the clinically required inpatient care needed for these children. Specifically, it is mandated that children in need “*be placed in a mental health facility designated by the Commissioner of the Department of Mental Health, Mental Retardation and Substance Abuse Services.*” when no other local willing facility can be located. The state’s responsibility to secure hospitalization when needed is reiterated in several other sections of the Code.

The system of care model policy recognizes that children with serious behavioral health problems are served by multiple systems and may enter through any door. The model is

based on the belief that services must be individualized and tailored to the needs of each child and their family and provided in a planned, thoughtful and coordinated manner. In order to provide services that are truly integrated and coordinated however, these services - as well as the policies, procedures, and regulations which accompany them - must themselves be developed and implemented in a coordinated manner at both the local and state level. This requires a shift in how Virginia's youth serving systems work.

## **Critical Issues**

### **Community Service Board Child and Adolescent Behavioral Health Services**

SOCAT recommends that additional services for children and adolescents, e.g. emergency services/crisis stabilization, case management/care coordination, intensive in-home/home based services, and intensive care coordination be added to the required core. Presently, the *Code of Virginia* requires in §37.2-500 and §37.2-601 that CSBs provide emergency services and, subject to the availability of funds, case management services. As previously stated, services vary amongst localities, with some CSBs providing a more extensive array of services and others currently providing only those which are mandated.

Best Practices recommend that children are best served when a continuum of services is available to meet their respective clinical needs. The *FY08 Comprehensive Services Act Critical Service Gaps Survey*, which was completed by 70% of the Community Policy and Management Teams (CPMTs) across the state, identified the following statewide gaps in child and adolescent services:

- Crisis intervention,
- Intensive substance abuse services,
- Intensive care coordination,
- Wraparound services, and
- Parenting skills training.

Virginia's *Children's Services System Transformation* initiative is currently seeking ways to reduce out-of-home placements which are both costly and not always in the best interest of the child. CSB's have identified the following services as amongst those which could prevent out-of-home placement:

- Case management or intensive care coordination;
- Crisis stabilization;
- School based therapeutic day treatment, and
- Increased access to psychiatric services.

### **Acute Psychiatric Services for Children and Adolescents**

#### ***Background and Concerns***

Since the early 1970s, both CCCA and the Adolescent Unit at SWVMHI have been part of the statewide array of public mental health services for children and adolescents (including child and adolescent services at Eastern State Hospital and the Virginia

Treatment Center for Children, and adolescent services at Central State Hospital). As such, these facilities provided the public behavioral health safety net for children and their families who were not served elsewhere. Now, only two public facilities for this population remain.

The need for inpatient care for high risk children and adolescents in the Commonwealth seems to be increasing. In fiscal year 2008, 605 children and adolescents were admitted to CCCA. This year CCCA is on track to serve approximately 650 youth. In the last ten years, admissions to CCCA have increased by 50%. During the same period, Virginia's community based behavioral health care services for youth have increased only moderately.

Many of the children and adolescents served at CCCA and SWVMHI are transferred there from private facilities because their insurance is exhausted; they are too violent or dangerous, or because, though seen as needing to leave the private facility, they are not seen as safe for discharge to the community or another less restrictive setting.

Over the past several decades, Virginia's public and private facilities which serve children and their families have developed positive relationships, maintained an open dialogue, and have come to recognize one another's strengths.

### *Considerations for the Study Group*

A comprehensive system of care encompasses a wide array of intervention services ranging from least restrictive to most restrictive. It is preferable that children remain in their home and receive community-based services; however, there are times when some children and their families require more intensive, specialized services that can only be provided in an acute care setting.

Outpatient, community-based treatment is necessary and ideal; however, it is not always possible. When it is not clinically appropriate to provide outpatient services there must be a reasonable alternative. Even if community-based preventative care were adequately funded, there will always be some individuals that need a more intensive level of service. Therefore, we support the work of the State and Community Consensus Planning Team reviewing these issues and the future of inpatient care as one part of the system of care for children.

Should privatization occur, the Commonwealth will need to establish mechanisms to assure that these children receive the acute psychiatric services they require. Where services are to be provided by community hospitals through the provision of state funds, it is essential that mechanisms be in place to assure that:

- Private facilities assume the safety net responsibilities currently performed by DMHMRSAS at CCCA and SWVMHI;

- Contractual arrangements clearly articulate eligibility requirements and assure that providers maintain a "no reject" policy for all children and adolescents that meet eligibility requirements; and,
- Community hospitals are not impeded by "scope of services" and zoning restrictions and are willing and able to increase their bed capacity.

Other questions that will need to be considered and addressed should CCCA and SWMHI close, include:

- Who will provide the intensive inpatient evaluations regularly ordered by the courts to guide dispositional and risk management decisions?
- What is the likelihood that the use of juvenile detention settings to house adolescents with behavioral health problems will increase and what can we do to avoid such an outcome?
- How will the safety net responsibilities for children and adolescents with behavioral health problems be assured for individuals who cannot be managed in community, juvenile detention, or juvenile correctional settings?
- Will children and adolescents with behavioral health problems who cannot be treated or managed in juvenile detention or correctional settings remain there longer or will they be released without adequate treatment into the communities?
- Who will monitor the implementation of statewide intensive inpatient services?
- What is a realistic estimate of the number of youth who may require financial support so they may receive inpatient psychiatric care services? What is a reasonable amount for the Commonwealth to set aside to treat them in a private facility?

## **Recommendations**

In these tight financial times, SOCAT and DMHMRSAS remain focused on the behavioral health needs of Virginia's children and families. The recommendations included in this report contain items that require little or no funding. This year's report also confirms support of previous recommendations from past reports that have a fiscal impact, but with the understanding that funding is not available.

### **Recommendations to Improve the Uniformity of Child and Adolescent Behavioral Health Services Available across Virginia's Communities**

- Improve clarity around the intent of the clause from §37.2-500 and §37.2-601 that states that CSBs " *shall include emergency services and, subject to the availability of funds appropriated for them, case management services*" According to the OIG's survey of CSB services for children and adolescents, not all boards provide case management services for youth across all disabilities. Clarifying the intent of the language will ensure that CSBs, at a minimum, offer both emergency and case management services to children and adolescents.
- Recommend CSBs develop and offer the following four services as the CSB core child and adolescent services:

1. emergency/crisis stabilization;
  2. care coordination (case management);
  3. intensive in-home/home-based services; and
  4. intensive care coordination.
- As part of their Critical Service Gaps Survey, request that CSA assess the reason identified service gaps are not available and/or not utilized and what actions are needed to correct the situation
  - In support of the statewide Children’s Services System Transformation, provide resources to develop and sustain a statewide training system which will assist community services boards and local CSA teams to assess family needs and develop community based continuums of care to meet those needs.
  - Require that adequate provisions are in place to assure that our “most difficult to treat youth” have access to acute care services.
  - Continue the Special Advisor on Children’s Services position that coordinates child and adolescent services system transformation activities across all child-serving agencies and consider having the position report to the Governor.
  - Continue to develop the six interconnected foundation building blocks identified by the Children’s Services System Transformation to change Virginia's approach to delivering services. These are:
    1. Practice model - This set of shared principles provides a clear structure that guides policy, practice, and behavior and drives accountability;
    2. Training - This involves retooling the state's training system by adopting a model of competency-based ongoing in-service training;
    3. Resource Family Development - This is the process of recruiting, developing, and supporting resource families, which include foster, adoptive, and kinship parents;
    4. Managing by Data - This involves developing a consistent process for capturing and using data to support decision-making, improve practice quality, track child and family progress over time, and promote accountability;
    5. Family Engagement Model - This leverages family resources and gives a stronger voice to children and families through active engagement with staff and other important stakeholders in decisions that affect a child's life; and
    6. Community Based Continuum - The family-based practice model renews commitment to expanding community-based approaches, providing incentives and building local service capacity to meet growing demand, restructuring existing services, assuring intensive care coordination, and supporting community-based alternatives to detention.
  - Review progress in other states that have been successful in transforming their children’s services system.

## Recommendations for Future Funding (when state budget conditions improve)

Over the years in numerous reports, several key areas have consistently been identified as problematic. It is unlikely we will see improvements in any of these key areas unless the Commonwealth actively seeks to address them. SOCAT realizes that it is unlikely that funding will be available to support the following services in the coming year. Nevertheless, it wishes to acknowledge these needs and encourage the General Assembly to develop a plan for identifying funds that can be dedicated to improving the system of care for Virginia's children. To paraphrase the children's writer Antoine de St Exupery, a goal without a plan is only a wish.

- 1. Problem:** Virginia lacks adequate capacity for mental and behavioral health care services for children and adolescents

**Request:** Increase support for intermediate level community based services e.g. e.g. emergency services/crisis stabilization, case management/care coordination, intensive in-home/home based services, and intensive care coordination in order to avert more costly intensive residential care.

**Rationale:** CSBs and other community programs lack sufficient staff and/or available resources to develop or enhance existing services. They will require start up funds in order to introduce new services that can become self-sustaining through 3<sup>rd</sup> party payment such as insurance, Medicaid, CSA etc.
- 2. Problem:** Virginia lacks sufficient staff to provide the level of guidance and oversight necessary to transform its children's services system as desired.

**Request:** Fund additional positions in child serving agencies to provide monitoring, oversight and technical assistance.

**Rationale:** Without additional staff, youth serving agencies will not be able to provide the necessary level of technical assistance, monitoring and oversight to implement best practice models and new services uniformly across the Commonwealth. Adding staff will enable the Commonwealth to regain capacity lost as a result of previous budget shortfalls
- 3. Problem:** Providers who serve children and adolescents lack skills and knowledge necessary to implement evidence based programs and practices and effectively coordinate services between youth serving systems.

**Request:** Enhance Workforce Capacity—Establish 3 Teaching Centers of Excellence @ \$700,000

**Rationale:** As long as new staff enter the workforce; research identifies new information and innovations are made in service delivery, providers will need to be able to readily access ongoing education and training opportunities in order to update their skills and remain proficient in their areas.
- 4. Problem:** Families lack information regarding how and where to access services.

**Request:** Provide families with information and support—Fund 2.0 FTE for a Resource/Service Coordinator and administrative support @ \$125,000

**Rationale:** The requested family support services will help parents and caregivers locate and access support services in a timely manner for children who have a mental health, substance use disorder or intellectual disability - thus averting more expensive, crisis-oriented services. Currently, Virginia relies solely on federal funds to support such services. These funds are very limited and sufficient to support only one position; additional services must be provided through volunteers. State funds would support 2 additional staff who would be available to educate the public about the needs of children with behavioral health issues; inform families regarding available services, assist families in accessing needed services for their children and adolescents and link families with the appropriate support systems. This request includes funds to support operating expenses, office supplies and printing.

5. **Problem:** Due to a shortage of providers, psychiatric assessment, psychological testing and medication follow-up services are not available to children and adolescents in a timely manner

**Request:** Reinstate psychiatry and psychology fellowships: \$483,000

**Rationale:** The Commonwealth is experiencing a significant shortage of psychiatrists and psychologists with expertise in treating children and adolescents who have a mental health or co-occurring mental health and substance use disorder and/or intellectual disability. Fellowships that stipulate service payback can serve as a valuable incentive – especially in underserved areas – to attract practitioners in training and enable the Commonwealth to increase the availability of these services.

6. **Problem:** Children and their families have difficulty accessing and coordinating behavioral health services

**Request:** Provide services where they are most accessible to youth: in school and in their community

- a. Fund 12 additional System of Care projects @ \$3.6 million
- b. Fund school-based mental health services in 20 middle schools in five regions @ \$2.0 million

**Rationale:** Children are most easily reached and served while in the school setting where they are in regular attendance. Community based services for children tend to be less disruptive and less costly than out of home care and are most effective when coordinated with other needed services. Supporting additional sites that provide mental and behavioral health services in the school will enable us to identify and serve youth more easily - before they develop more severe problems and repercussions. The system of care model supports communities efforts to develop necessary services, ensures that children and their families are able to access services and that these services are provided in a coordinated manner.

## **APPENDIX A**

### **UPDATES ON PREVIOUSLY FUNDED INITIATIVES TO IMPROVE ACCESS TO CARE**

Each year this report has included funding recommendations to enhance or provide new services. Funding for the following initiatives to expand community services for children was awarded as a result of recommendations made in past reports.

#### **SYSTEM OF CARE PROJECTS**

With \$2 million in funding from the General Assembly, DMHMRSAS continues to support four systems of care grant projects. Ongoing funds for the demonstration projects were allocated in 2006 (1 million) and 2007 (1 million). The systems of care projects emphasize a collaborative cross-agency approach to serving children and adolescents with challenging emotional issues. The initial grant guidance required the implementation of a specific evidence-based practice (EBP), either Multi-systemic Therapy (MST) or Functional Family Therapy (FFT) in each of the four projects. However, over time it became apparent to some of the grant communities that the EBP they chose was not feasible for them. These projects asked and received permission from DMHMRSAS to alter their original plans regarding the requirement of the specific EBP. In spite of the challenges associated with implementing an EBP, cumulative data from each project indicates they are benefiting through improved outcomes for youth and their families. In addition, all have benefited by increasing their ability to provide community-based services and building systems of care capacity. The target populations for the four demonstration projects initiated in FYs 06 and 07 are:

1. Children with serious emotional disturbance who are involved with the juvenile justice system;
2. Children who have co-occurring mental health and substance abuse problems; and
3. Children who will be maintained in the community or returned from residential care with appropriate community services funded by this demonstration project.

The projects report quarterly progress and data to DMHMRSAS and participate in technical assistance meetings with OCFS staff. National experts have stated that successful systems of care projects require two to four years to demonstrate success.

Current System of Care/Evidence-Based Practice Demonstration Projects:

1. Richmond Behavioral Health Authority (FY 2006)
2. Planning District One (FY 2006)
3. Cumberland Mountain CSB (FY 2007)
4. Alexandria CSB (FY 2007)

The evidence-based practices currently offered by these CSBs are Multi-systemic Therapy (MST), Functional Family Therapy (FFT), and Dialectical Behavioral Therapy (DBT). In addition to the evidence-based practices, Virginia's systems of care projects provide an array of other community services, including:

1. Intensive in-home services
2. Therapeutic day treatment in schools
3. Case management
4. Wraparound Services
5. Alternative Day Support
6. Outpatient Services
7. Intake
8. Crisis services
9. Psychiatric services
10. Family partner/Family support programs
11. Specialized family therapy
12. Foster care prevention services

The implementation challenges and lessons learned from these projects include the following:

- The staff involved in implementation of the systems of care evidence-based practices projects require special skills and capabilities;
- Retention of staff has been identified as a potential barrier to success of the projects;
- Establishing vendors' capacity and availability necessary for certifying or approving projects for the provision of services needs to occur very early in development;
- Fidelity to the treatment model occasionally conflicts with systems of care principles and sometimes is not compatible with the agency's administrative structure;
- Third party reimbursement is important in sustaining evidence-based practices in Virginia and questions and issues have been identified about the feasibility of recovering costs of the FFT programs through Medicaid and other third party insurance programs;
- The success of the systems of care projects is very dependent on establishing and maintaining collaborative partnerships among community agencies; and,

## **CSB SERVICES IN JUVENILE DETENTION CENTERS**

Through this initiative, CSBs provide short-term behavioral health services to youth while in juvenile detention and coordinate follow-up care after they leave the detention center. The Department of Juvenile Justice Services (DJJ) estimates that at least 50% of Virginia's juvenile detention population is in need of behavioral health services, and states that funding from private, federal, state, and local sources has been inadequate to

meet the needs of youth with behavioral healthcare needs placed in these local facilities. These facilities are not designed for, nor funded to provide, adequate behavioral health care services to local offenders in need. In 2003 DMHMRSAS applied for and received Juvenile Accountability Block Grant funding that enabled CSBs to provide mental health screening, assessment services, and community based referrals for youths in 5 local juvenile detention facilities. In 2006, the General Assembly provided \$1.14 million for nine new projects and picked up the federal share of funding for the others - bringing the total number of projects to fourteen. In 2007, the General Assembly provided \$900,000 in additional funding which enabled DMHMRSAS to provide mental health screening and assessment services to a total of twenty-three. Based on current data, the programs are projected to serve more than 2,500 youth annually. DHMRSAS provides technical assistance and support to the 23 programs to assist them in addressing the challenges of serving youth in this setting using a short-term intervention and case management approach.

Programs are in operation at all 23 Juvenile Detention Centers:

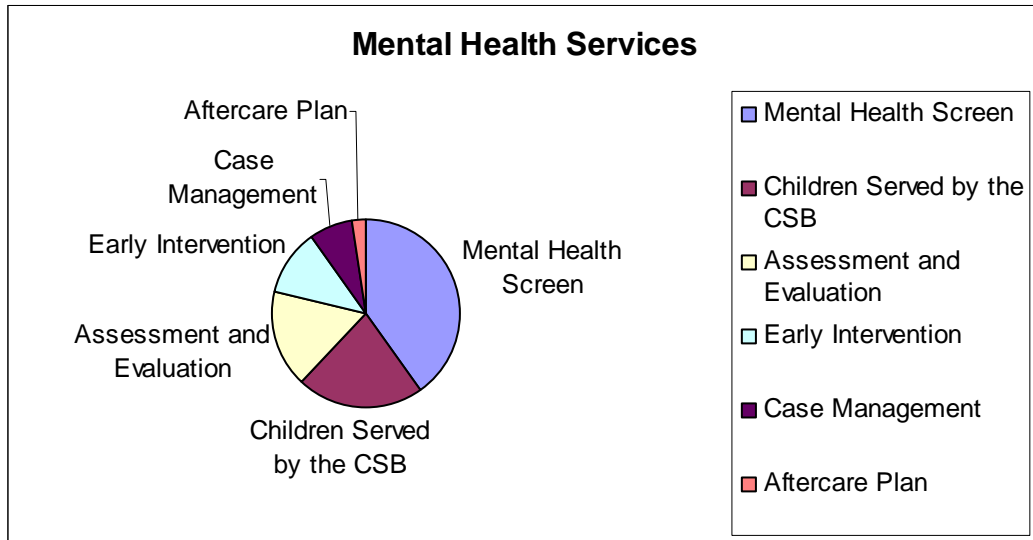
- Alexandria CSB/Northern VA Detention Home
- Blue Ridge Behavioral Health/Roanoke Detention Center
- Central Virginia CSB/ Lynchburg Detention Center
- Region 10 CSB/Blue Ridge Detention Center
- Chesapeake CSB/Chesapeake Juvenile Justice Center
- Chesterfield CSB/Chesterfield Juvenile Detention Home
- Colonial CSB/Merrimac Detention Center
- Crossroads CSB/Piedmont Juvenile Detention Home
- Danville CSB/W.W. Moore Detention Center
- District 19 CSB/Crater Juvenile Detention Home
- Fairfax-Falls Church CSB/Fairfax Juvenile Detention Home
- Hampton-Newport News CSB/Newport News Juvenile Detention Home
- Henrico CSB/Henrico Juvenile Detention Home (also serves James River Detention Center)
- Loudoun CSB/Loudoun Juvenile Detention Home
- New River Valley CSB/New River Valley Detention Center
- Norfolk CSB/Norfolk Juvenile Detention Home
- Northwestern CSB/Northwestern Juvenile Detention Home
- Planning District One Behavioral health/Highlands Juvenile Detention Home
- Prince William CSB/Prince William Juvenile Detention Home
- Rappahannock CSB/Rappahannock Juvenile Detention Home
- Richmond Behavioral Health/Richmond Juvenile Detention Home
- Valley CSB/Shenandoah Juvenile Detention Center
- Virginia Beach CSB/Virginia Beach Juvenile Detention Home

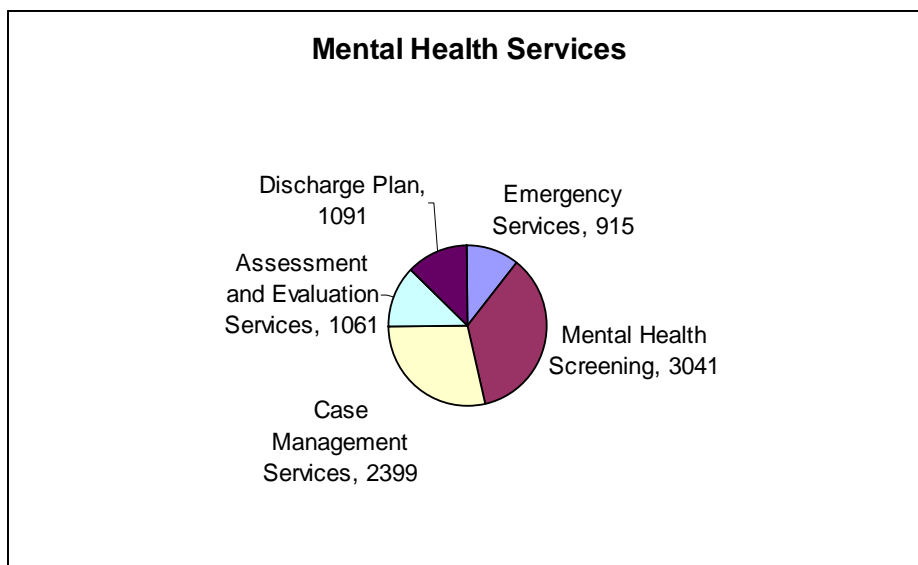
These programs serve to increase local system capacity to identify and intervene in the lives of children involved in the juvenile justice system. Some highlights of the

services that have been provided to children in juvenile detention centers include, but are not limited to:

Of the 6371 children admitted to detention centers in the first two quarters of FY09:

- 5,522 mental health screenings were completed
- 2,987 children were served by the CSB
- 1,026 youth received case management services from mental health case managers
- 1,547 youth received early intervention services with mental health clinicians
- 2,315 youth received assessment and evaluation services
- 329 discharge plans were developed





**PART C/ EARLY INTERVENTION SERVICES**

**Total Number of Infants and Toddlers Served in Each Year**

<b>Year (12/2 – 12/1)</b>	<b>Total Number Served</b>
2002	7,409
2003	9,076
2004	9,615
2005	10,212
2006	10,704
2007	11,095
2008	11,352

DMHMRSAS is the lead agency in Virginia for Part C Early Intervention Services. DMHMRSAS works with a variety of stakeholders representing providers, advocates and families to examine Virginia’s Part C system, identify the system’s unique strengths and challenges, and make recommendations about infrastructure changes to improve Virginia’s Part C system. Plans to transition Part C Early Intervention Services to the Virginia Department of Health effective July 1, 2009 were revised and it was determined that Part C services would continue to be located within DMHMRSAS. Community Services Boards serve a large number of infants and toddlers in programs funded through the Part C program. In 2008, 11,351 infants, toddlers, and their families were served, indicating that the trend will continue upward for the number of children served in 2009. This is due, in part, to better outreach and child find.

The Infant & Toddler Connection of Virginia has been working toward a transformation of Virginia's Part C System. Included in the transformation are a Medicaid Initiative in collaboration with the Department of Medical Assistance Services (DMAS);

enhancement of the Part C data system; revision of the Family Cost Participation process; and initiation of a Service Pathway approach to the provision of Part C services.

The Medicaid Initiative will result in Part C services being billed to Medicaid under Early Periodic Screening, Diagnosis and Treatment (EPSDT). This will enable providers to access payment for the additional Part C service of Special Instruction as well as a revision in the rate structure. A process is also being put in place for the training and certification of all Part C providers. This will align with both Medicaid requirements and the Office of Special Education Program's (OSEP) requirement that all Part C Systems have a Comprehensive System for Personnel Development (CSPD) in place. The Medicaid Initiative is expected to be implemented by October 01, 2009.

Updates continue to be made to the Infant and Toddler On-Line Tracking System (ITOTS) in order to better meet the reporting requirements of the Federal Government and to assist local systems in reporting data. Additional changes and improvements to the data system will occur. Collaboration is also underway related to data coordination between Part C and Medicaid related to the Medicaid Initiative.

In order to ensure a consistency to all families related to Family Cost Participation, a revision is being made to the existing Ability to Pay process. An Implementation Task Force is currently providing input on these changes.

Finally, following additional information related to federal requirements, the Part C office will be implementing a Service Pathway for the provision of Part C services. The Pathway will provide a consistent framework for local Part C systems to follow while allowing some autonomy within the process and improving the eligibility determination process.

## **PSYCHIATRY / PSYCHOLOGY FELLOWSHIPS**

Funds (\$483,000) were allocated as part of the 2008 budget to support the Child psychiatry / child psychology workforce development initiative which was implemented in SFY 2007-2008. These funds supported student fellowships for child psychiatrists and child psychologists to work in underserved areas of the Commonwealth. Two institutions of higher education, the Medical College of Virginia (MCV) and Eastern Virginia Medical School responded to a Request for Applications (RFA) and were awarded funds on the basis of their applications. In the first year (2007 – 2008), Eastern Virginia Medical School received \$138,452 and the Medical College of Virginia received \$248,439. During the first year (2007-2008), Eastern Virginia Medical School enrolled two pre-doctoral child psychology interns and the Medical College of Virginia (MCV) enrolled one child psychiatry fellow and two child psychology interns for the training year. In the initiative's second year (2008-2009) Eastern Virginia Medical School enrolled two pre-doctoral child psychology interns and one child psychology postdoctoral fellow for a total of three psychology interns. During the same training year, MCV signed a second child psychiatry fellow and two child psychology interns, for a full cohort of two child psychiatry fellows and two child psychology interns starting in July, 2008. As

part of the reductions necessary to balance Virginia's budget, funding for the fellowships were cut from the 2010 budget. As a result of these cuts, funding for Eastern Virginia Medical School will be discontinued after June 30, 2009 and MCV will receive continued funding to support the psychiatry fellow who will graduate in June of 2010.

As noted earlier in this report, the loss of these funds poses a serious concern for children's services. There continues to be a significant shortage of child psychiatrists in both the private and public sector. Many communities, particularly those in rural areas, do not have ready access to child psychiatrists and child psychologists to treat children in need of service. Without support or incentives to encourage child psychiatrist and child psychologists to work in underserved areas it will be difficult to improve children's access to psychiatric services.

### **WEB BASED TRACKING OF ACUTE CARE BEDS FOR YOUTH**

As cited in the Commission on Youth's report on *Serious Emotional Disturbed Children Requiring Out-of-Home Placement* (HD 23, 2002), clinicians' noted difficulty in locating acute psychiatric inpatient beds for children and adolescents. As a result, there may be significant delays in hospitalizing youth with serious mental illness. As of January 2009, there were 256 child and adolescent private sector acute psychiatric inpatient beds. In addition, there are 64 beds in state-operated facilities. However, the number of private beds can be misleading because not all hospitals reserve beds for adolescent use. Some hospitals use these beds flexibly for short-term acute and long-term residential care. Other facilities serve both adolescents and young children in their beds on a "first come, first served" basis". Private hospitals may not admit youth with certain diagnoses because they may be unable to serve these youth within their scope of practice. Technology can offer a solution to this problem by allowing clinicians to obtain information on bed availability at the touch of a button thus making it faster and easier to locate beds for this population.

In response to this finding, budget language was included in the 2002 Appropriation Act which directed the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS), in conjunction with Virginia Hospital and Healthcare Association and private providers, to determine "the feasibility and cost of developing a web-based system for providing daily updated information on licensed and available acute psychiatric beds for children and adolescents." This study revealed that establishing a web-based bed tracking system was both feasible and cost-effective. Benefits of establishing a web-based system are:

- a significant decrease of time spent by clinicians and case-mangers on finding an available bed for children and youth who are a danger to themselves or others, thereby increasing the safety of the children and youth of the Commonwealth;
- a significant decrease of time spent by hospital administrative staff receiving and managing repetitive requests on bed availability;
- simplification of admissions to private facilities because CSB staff, psychologists, psychiatrists, licensed clinical social workers and other

providers could quickly locate available beds appropriate for their clients needs;

- an accurate count/census of all licensed, staffed and available beds;
- Greater awareness of screen-out criteria for these beds; and
- Minimal cost with implementing the tracking system with the benefits greatly outweighing the cost.

As estimated by DMHMRSAS, the cost to develop this system is \$23,500. Annual maintenance would cost \$8,700.00. Additionally, DMHMRSAS did not find that there would be a significant burden placed on private providers in updating/maintaining the data for this system. While a recommendation was proposed for the Virginia Health Information (VHI) to develop a web-based reporting system, funding was not appropriated for this system.

In July 2003, the Joint Commission on Health Care (JCHC) revisited the issue of establishing a web-based bed reporting system. Workgroup meetings were held during the fall of 2004. In January 2005, the JCHC submitted a budget amendment for \$75,000 requiring DMHMRSAS to issue an RFP and select a vendor to develop a reporting system. The requested funding was not included in the adopted budget. In 2006, JCHC staff re-convened meetings of a stakeholder workgroup and it was again recommended that DMHMRSAS contract with VHI to develop and operate the system. Additional parameters were added to the bed-reporting system including the ability to classify available beds by type, listing the availability of adult beds, listing whether the facility had secure or non-secure units and including other restrictions such as the ability to serve aggressive patients or sex offenders. A budget amendment for \$50,000 was introduced to fund the development and operation of the proposed bed-reporting system. Funding of \$25,000 was included in the approved budget for fiscal year 2008.

At this time, the web-based reporting system for acute psychiatric beds is still in development. The Psychiatric Bed Registry Task Force has been meeting regularly to review the progress of the website development and offer suggestions for its improvement. A demo of the web-based tracking system has been created and is now being tested.

## **CHILD AND ADOLESCENT POSITIONS**

The 2008 General Assembly allocated funds to support one new child and adolescent position at each CSB. These funds became available July 1, 2008 and, as of March 2009, at least 22 CSBs indicated that they had filled their respective position. Several boards, especially those affiliated with their local government entity, noted difficulties or delays filling their positions due to budget concerns and hiring freezes imposed at the local level. Each board was allowed to design the new position to meet their respective needs. Although CSBs elected to use these funds to improve services for children in a variety of ways, several patterns emerged. A number of boards elected to focus on services for youth involved in the legal system. At least 9 boards indicated that they will be utilizing their new position to provide services to youth who are involved in the legal system i.e.

either involved with the courts or a court service unit, receiving services at a Detention Center or transitioning from detention to community care. Another 4 boards chose to hire a staff person to provide intensive care coordination (ICC) while two other boards will use their position to improve access to services. Several boards hired staff to provide specific services: 1 hired a supervisor for child and adolescent services; 2 hired clinicians to provide Multi-systemic Therapy (MST) , an evidence based program for youth with complex needs; 1 board hired a school psychologist, 1 a family therapist and 1 school based mental health and substance abuse services. The remaining boards indicated that they hired a child and adolescent clinician but did not indicate whether this individual would serve a specific population of youth or provide specialized services.

## APPENDIX B

### INTENSIVE CARE COORDINATION

The 2008 General Assembly directed the State Executive Council (SEC) to oversee the development and implementation of mandatory uniform guidelines for intensive care coordination (ICC) services for children who are at risk of entering, or are placed in, residential care through the Comprehensive Services Act (CSA) program. The purpose of ICC services are to effectively maintain, transition, or return a child home or to a relative's home, family-like setting, or community at the earliest appropriate time that addresses the child's needs. The development phase of the Guidelines occurred May 2008-August 2008 and included drafting the guidelines, broad stakeholder review and a public comment period.

On August 28, 2008, the SEC voted to endorse the Guidelines for Intensive Care Coordination (ICC) and to establish a workgroup to discuss and clarify operational aspects of the new guidelines. The SEC also approved and endorsed the following three general rules to guide the implementation:

- ICC is a reimbursable CSA service
- The local community service board (CSB) is the entity responsible and accountable for the provision and oversight of ICC. Requires the CSB to collaborate with the local community policy and management team (CPMT) in determining how best to provide the service; the CSB and local CPMT may agree to contract the service out to another provider but the CSB remains accountable for oversight of the service.
- All children in or at risk of congregate/group care are to receive ICC, but services may be phased in based on local priorities.

The multidisciplinary implementation workgroup met from September 2008 through January 2009. The group considered in depth the three general rules and also discussed how various community roles should interface to assure best practice. They also reviewed the ICC Guidelines but did not recommend any changes to them. Several products were developed as a result of the group's work. They include:

- Development of a Toolkit for Intensive Care Coordinators that was posted on DMHMRSAS and Office of Comprehensive Services (OCS) websites. The Toolkit is based on the Wraparound process and includes tools that have been endorsed by the National Wraparound Initiative, Research and Training Center on Family Support and Children's Mental Health, Portland State University, Oregon.
- Development of a Frequently Asked Questions document that is also posted on the DMHRMSAS and OCS websites.
- Table of rate information from sample localities that is included in the Toolkit.
- Role Clarification Chart

- Establishment of a statewide ICC Network for the purposes of support and ongoing technical assistance.
- Collaboration with the CSA Training workgroup associated with the Children's Services System Transformation.

Currently fifteen CSBs offer ICC services and six of these have more than one ICC position. Ten other CSBs are in discussion with their local CPMTs to work on implementation of the service. At the first ICC network meeting held in February 2009, twenty four CSBs and thirteen CSA teams were represented. Plans for the ICC Network are to meet approximately every other month rotating around the state to allow equal participation from all localities. There will also be continued technical assistance from the Office of Child and Family Services at DMHMRSAS and continued collaboration with the Children's Services System Transformation regarding training, technical assistance, and participation in regional collaboratives.

## APPENDIX C

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