

## Executive Summary

Governor Kaine's budget for FY 2010 proposed the closure of the Commonwealth Center for Children and Adolescents (CCCA) and the adolescent unit at Southwestern Virginia Mental Health Institute (SWVMHI) by June 30, 2009. These two state-operated facilities provide public acute inpatient mental health services to children from all regions of the Commonwealth.

In response to public opposition, the 2009 General Assembly's final budget did not close these two facilities; however, in response to the discussion around the facilities, it required the Commissioner of the Department of Behavioral Health and Developmental Services (DBHDS), formerly the Department of Mental Health, Mental Retardation, and Substance Abuse Services<sup>1</sup>, to establish a state and community team to examine the need for public acute psychiatric services for children in Virginia.

This report provides information about the current populations served at the facilities and describes additional services required to address the needs of these populations. The report and its recommendations were developed by the State and Community Consensus Team. The Team met on May 14, June 22, and September 17 in Staunton, Richmond, and Marion, respectively, to develop the report. Team members included representatives from the DBHDS Central Office, the two state facilities, community service boards, advocates, former patients served at CCCA, parents of children treated at CCCA and SWVMHI, local government, private psychiatric care providers, and legislators (Appendix A).

The State and Community Consensus Team found that CCCA and SWVMHI's adolescent unit provide a valuable service for children, families, and localities that lack sufficient community-based services. The Team's recommendations affirm that the Commonwealth must continue to fund inpatient mental health services for children and continue to expand community-based services for youth across the Commonwealth.

The Team has several recommendations to improve the delivery of acute mental health services to children in the Commonwealth. The major recommendations of the State and Community Consensus Team are:

- ***Continue to Support Publicly-Funded Acute Inpatient Psychiatric Care.*** *The Commonwealth has the responsibility to maintain a publicly-funded safety net that includes acute inpatient services. Funding should be aligned so services are delivered in children's communities closer to home. The Team believes both CCCA and SWVMHI adolescent unit are an important part of the "safety net" the Commonwealth provides for youth who need psychiatric services. These children include those who have behavioral challenges that cannot be addressed by private psychiatric inpatient providers, children currently connected with the court system or the juvenile correctional system, and those who have no insurance or have exhausted private insurance benefits. This safety net must be maintained until acute mental health inpatient services are available in every community across the Commonwealth.*

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<sup>1</sup> The Department's name was changed on July 1, 2009.

- **Provide Additional Funding for Community Services.** Support continued expansion of home and community-based services so children can be served in their home communities with additional services and supports that currently do not exist in Virginia's localities. The Commonwealth must develop a full continuum of community-based services for youth, including crisis intervention services, crisis stabilization services, case management, intensive in-home services, intensive care coordination, day treatment in schools, respite care, and parent support programs. This will reduce admissions to inpatient care and potentially reduce readmissions after inpatient treatment.
- **Improve Coordination and Collaboration to Enhance Existing Services.** Support reduction of regulatory or other barriers so that money follows each child in Virginia's system of care. During its work, the Team identified many opportunities to improve how state facilities, private facilities, CSBs, schools, local DSS, and CSA programs work together to minimize admissions to inpatient care. In many cases, the Team felt that state or local policies created barriers to coordination and prevented the flow of dollars moving with a child throughout the services system. The Team believes more work needs to be done to minimize regulatory or other barriers and ensure that money follows each child as they move from setting to setting. This will ensure children receive the most appropriate services to meet their individual needs.
- **Improve Data Collection.** Enhance the collection of data to better understand the acute behavioral health needs of Virginia's youth. The Team recommends establishing consistent data collection processes and procedures at CCCA and SWVMHI in conjunction with VHHA (Virginia Hospital and Healthcare Association) and private facilities so that comparisons can continue to be made with private sector facilities regarding admission, lengths of stay, occupancy rate, referral source, discharge placement and payer mix.

The State and Community Consensus Team supports continued expansion of community-based services for youth in the Commonwealth. The Team believes services at CCCA and SWVMHI adolescent unit must continue until significant additional acute inpatient mental health services are provided in every region of Virginia either through additional publicly-operated institutions or public purchase of inpatient beds. Other services must also be developed to assure continuity of care and reduce admissions or readmissions, these services include additional crisis stabilization service, private acute psychiatric care, preventive services, and other intensive mental health services.

## **Introduction**

Governor Kaine's budget for FY 2010 proposed the closure of the Commonwealth Center for Children and Adolescents (CCCA) and the adolescent unit at Southwestern Virginia Mental Health Institute (SWVMHI) by June 30, 2009. These two state-operated facilities provide public acute inpatient mental health services to children from all regions of the Commonwealth.

In response to public opposition, the 2009 General Assembly's final budget did not close these two facilities; however, in response to the discussion around the facilities, it required the Commissioner of the Department of Behavioral Health and Developmental Services (DBHDS), formerly the Department of Mental Health, Mental Retardation, and Substance Abuse Services<sup>2</sup>, to establish a state and community team to examine the need for public acute psychiatric services for children in Virginia. Item #316 BB.2. of the 2009 *Appropriation Act* states:

*2. The Commissioner of the Department of Mental Health, Mental Retardation and Substance Abuse Services shall establish a state and community consensus and planning team for the purpose of developing a plan to examine the current and future role of the Commonwealth and private sector in providing acute psychiatric services for children and adolescents. The team shall consist of department staff and representatives of affected consumers, local government officials, advocates, state hospital employees, community services boards, behavioral health authorities, and public and private child and adolescent mental health service providers, and other interested persons, as determined by the Commissioner. In addition, members of the House of Delegates and the Senate representing the localities served by the hospital may serve on the state and community planning team.*

*The state and community planning team, under the direction of the Commissioner, shall*

- (i) identify the characteristics of the child and adolescent population currently served at the CCCA and SWVMHI,*
- (ii) describe the service needs of the children served at each facility,*
- (iii) determine what services are currently available, or would need to be available in the community, to adequately provide treatment for these children,*
- (iv) consider alternate approaches to delivering services appropriate for some or all of the patient population,*
- (v) define the state's continuing role and responsibility in providing inpatient services for children and adolescents,*
- (vi) identify funding trends and policies for providing public and private services,*
- (vii) report on the cost of providing public and private psychiatric services, and*
- (viii) detail other strategies to promote high quality, community-based care while maintaining a safety net for children and adolescent in need of acute psychiatric services.*

*The Commissioner shall report to the Chairmen of the House Appropriations and Senate Finance Committee on the findings of the state and community planning team no later than November 1, 2009.*

This report provides information about the current populations served at the facilities and describes additional services required to address the needs of these populations. The report and its recommendations were developed by the State and Community Consensus Team. The Team met on May 14, June 22, and September 17 in Staunton, Richmond, and

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<sup>2</sup> The Department's name was changed on July 1, 2009.

Marion, respectively, to develop the report. These meetings were preceded by two public meetings during the General Assembly session where the potential closures were discussed by stakeholders.<sup>3</sup> Team members included representatives from the DBHDS Central Office, the two state facilities, community service boards, advocates, former patients served at CCCA, parents of children treated at CCCA and SWVMHI, local and state government, private psychiatric care providers, and legislators (Appendix A).

After the June 22 meeting, the Team broke into three workgroups to allow for additional discussion and research in three categories:

**1. Role of CCCA and SWVMHI Adolescent Unit.** This workgroup examined current data about the centers and sought to identify ways to improve services, target high-need populations not served by other providers, and determine how to advance training and center of excellence models through the centers;

**2. Crisis and Alternative Services.** This workgroup used the recommendations of previous related studies and data to identify which services are needed in the community to prevent or defer admission to CCCA or SWVMHI adolescent unit; and

**3. Juvenile Justice Services.** This workgroup examined how children who are involved with the courts, in juvenile detention centers, or are in Department of Juvenile Justice (DJJ) custody utilize acute mental health services, including at CCCA and the SWVMHI unit.

These workgroups met separately between July and September to develop recommendations to the State and Community Consensus Team. Those recommendations were discussed at the Team's September 17<sup>th</sup> meeting and are reflected in this report.

## **Background**

The State and Community Consensus Team built on the significant work already underway in the Commonwealth to transform our children's services system. The work of this Team is preceded by reports from the System of Care Advisory Team (SOCAT), The Office of the Inspector General (OIG), Commission on Youth, and many others (Table 1). In total, at least 18 reports or studies have been issued in the past two years directly addressing or pertaining to Virginia's behavioral health care system for children. Each of these reports has sought to address services for youth who have a mental, behavioral and/or developmental disability.<sup>4</sup>

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<sup>3</sup> Additional information about the Team meetings are available at:  
<http://www.dbhds.virginia.gov/Children/Planning.htm>.

<sup>4</sup> Table 1 is generated from the 2009 SOCAT report: "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." Report to the General Assembly, July 1, 2008- June 30, 2009 (Appendix B).

**Table 1: Recent Studies Regarding Behavioral Needs of Youth**

Reporting Entity	Date of Report
<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>	
<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 Committee (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

The State and Community Consensus Team drew heavily from the findings and recommendations in the SOCAT report entitled, "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” (Appendix B) and two reports from the OIG.

The OIG reports were “The Inspection of Commonwealth Center for Children and Adolescents (OIG #167-08) and “Review of Community Service Board Child and Adolescent Services (OIG# 149-08) (Appendices C and D, respectively). Each of these reports documents the need for community-based services to serve youth with mental illness, substance use and/or other behavioral disorders as well as the need to create better integration between CCCA and SWVMHI’s adolescent unit and the communities they serve. These reports have identified similar findings, including:

- Lack of service capacity in the community;
- Limited access to care in the community;
- Lack of a full continuum of community-based care;
- Shortage of child and adolescent psychiatrists;
- Fragmentation of services;
- Families unaware of available services;
- Lack of family and youth involvement;
- Lack of statewide existence of 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 encourage providers to obtain the required skills and knowledge to improve access to services and to provide better-coordinated services for children and their families in all communities across the Commonwealth.

Many of the findings and recommendations in the reports described above and those in this report are being addressed through the 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 create opportunities for 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 reducing the number of youth leaving foster care without a permanent home as well as containing the Comprehensive Services Act (CSA) program’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 DBHDS 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 listed above to participate in its efforts to effect change within local systems of care for all youth.

**Current Populations Served at CCCA and SWVMHI Adolescent Unit**

The Commonwealth Center for Children and Adolescents has 48 licensed beds, serves children from ages 4 to 18 years old, and receives referrals from all 40 community service boards. Southwestern Virginia Mental Health Institute's adolescent unit has 16 licensed beds, serves children from 13 to 18 years old, and receives the majority of its referrals from community service boards in southwest Virginia. Table 2 describes the primary diagnoses of the populations served at these two facilities. Appendix E describes the populations served at these two centers in more detail.

**Table 2: Admission Profiles -FY 2008**

Primary Diagnosis	CCCA	SWVMHI Adolescent Unit
Mood Disorders	38%	40%
Co-occurring Mental Health & Substance Use Disorders	24%	26%
Primary Substance Use Disorder	1%	7%
Other	37%	27%

Source: OIG Presentation to State and Community Consensus Team, May 14, 2009

The two facilities provide comprehensive psychiatric assessments, crisis stabilization and short-term intensive treatment services using interdisciplinary treatment teams. They provide psychopharmacology, supportive counseling, therapeutic recreation, individual therapy, group and family therapy, and full-day onsite educational services. Tables 3 and 4 outline utilization data for CCCA and SWVMHI's adolescent unit, respectively.

**Table 3: Office of the Inspector General Report—  
Commonwealth Center for Children and Adolescents Inspection,  
OIG Report #167-08, December 10, 2008**

CCCA UTILIZATION DATA FOR FY04 THROUGH FY08					
	FY04	FY05	FY06	FY07	FY08
Number of Admissions	479	537	521	558	605
Number of Discharges	491	538	510	561	601
Number of Readmissions Within 30 days	42	40	45	42	48
Average Daily Census	33.4	29	31.5	34.3	33

Average LOS (days)	27.6	19.6	22.2	22.7	20.2
Median LOS (days)	15	13	15	14	13
Total Persons Served*	511	557	540	588	632
% Bed Occupancy	70%	60%	66%	71%	69%
Cost Per Bed Day	\$776.06	\$943.46	\$920.16	\$914.92	\$987.00
Total Inpatient Days	12219	10577	11514	12510	12114
# 100 Days and Over LOS	20	2	7	9	11
% of Total Discharges	4.07%	0.37%	1.37%	1.60%	1.83%
# 7 Days and Under LOS	93	133	119	135	169
% of Total Discharges	18.94%	24.72%	23.33%	24.06%	28.12%

Source: CCCA Utilization Management Database

\*Total = End of Month Census + Discharges

**Table 4: SWVMHI Adolescent Unit Data, 2008**

SWVMHI UTILIZATION DATA FOR FY04 THROUGH FY08					
	FY04	FY05	FY06	FY07	FY08
Number of Admissions	225	191	231	223	228
Number of Discharges	232	189	232	224	233
Number of Readmissions Within 30 days (% of total admissions)	8 3.6%	5 2.6%	16 6.9%	11 4.9%	15 6.6%
Average Daily Census	5.9	4.7	7.6	7.6	9.4
Average LOS (days)	9.54	9.31	12.43	13.5	16.47
Median LOS (days)	6	6	9	8	10
Total Persons Served*	236	194	237	229	233
% Bed Occupancy	36.7%	29.5%	47.4%	47.4%	58.5%
Cost Per Bed Day	\$1160.52	\$1422.52	\$1,036.09	\$1070.80	\$996.17
Total Inpatient Days	2148	1721	2768	2767	3428
# 100 Days and Over LOS	0	0	1	1	3
% of Total Discharges	0%	0%	0.4%	0.4%	1.3%
# 7 Days and Under LOS	112	111	95	90	87
% of Total Discharges	48.28%	58.73%	40.95%	40.18%	37.34%

Source: SWVMHI Utilization Management Database

\*Total = End of Month Census + Discharges

The children admitted to CCCA and SWVMHI adolescent unit have a variety of insurance resources, are uninsured, or have exhausted their existing insurance benefits. Table 5 shows the payor mix for this population. Approximately 25% of children admitted to CCCA come from local juvenile detention centers or DJJ facilities. In addition, approximately 25% are admitted at the time of having some court involvement (e.g. evaluations).<sup>5</sup>

SWVMHI adolescent unit does not admit children under the age of 13, so children requiring public care younger than 13 are admitted to CCCA. Nearly all CSBs refer children to CCCA from ages 9-12 years. Adolescents from the nine CSBs in

<sup>5</sup> CCCA Admissions Data, 2008.

southwestern Virginia are treated at SWVMHI adolescent unit. Adolescents from the remainder of the state are treated at CCCA.

**Table 5: Payor Mix**

	Medicaid	Commercial	Uninsured	Other
SWVMHI (FY2008)	70%	13%	17%	0%
CCCA (FY07-2 <sup>nd</sup> qtr FY09)	35%	12%	44%	10%

Source: SWVMHI Utilization Data and CCCA AVATAR Data.

CCCA and SWVMHI Adolescent Unit have a partnership with the Commonwealth of Virginia's Department of Education and the local school divisions where the hospitals are located. These divisions provide full-day, on-site education programs to children at the facilities. These partnerships are required by Virginia Code §22.1-7 and school services must be provided to children in both facilities. In coordination with the facility treatment team and the home school division, education is tailored to meet each individual student's needs. A minimum of 5 ½ hours a day of instruction is provided and instructors ensure that the educational services provided will allow the student to at least maintain his or her current level of academic functioning and provides a smooth transition back to previous educational settings. The instructors also ensure that all students identified as disabled have an updated Individualized Education Plan (IEP) and ensures compliance with the following federal and state regulations:

1. *Code of Virginia 22.1-7 and 22.1-214.2*
2. *Regulation Governing Special Education Programs for Children with Disabilities in Virginia, July 7, 2009*
3. *Individuals with Disabilities Education Improvement Act 2004, PL 108-446*
4. *Section 504 or the Rehabilitation Act of 1973*
5. *12VAC35-46 Regulations for Children's Residential Facilities*

These educational services are critical to assisting with treatment and ensuring smooth transition back to the child's home community. During the 2008-2009 school year, CCCA and SWVMHI Adolescent Unit had 245 special education students with active IEPs with the following disabilities (Table 6):

**Table 6: Special Education Students by Disability Category  
CCCA and SWVMHI (08-09 School Year)**

Disability Category	Frequency 08-09
Autism	17
Deaf/Blindness	0
Developmental Delay	5
Emotional Disturbance	106
Hearing Impairment/Deaf	2
Intellectually Disabled	21

Multi- Disabilities	20-
Ortho- Impairment	0
Other Health Impairment	37
Severe Disabilities	5
Specific Learning Disability	27
Speech/Language	3
Traumatic Brain Injury	2
Visual Impairment	0

### **Existing Private Provider Acute Inpatient Services**

Previous research and the work of the State and Community Consensus Team indicate that there are mental health services available in the community for children. However, the data indicates that the level and scope of services varies across the Commonwealth and is not adequate to meet the current needs of children. Data indicates that current services and the number of service providers are inadequate and would not be able to address the additional needs of children currently served by CCCA and SWVMHI's adolescent unit.

There are 12 private psychiatric providers in the Commonwealth that provide acute inpatient mental health services to children. They have a total of 250 private licensed beds to serve at-risk youth, with 218-224 currently staffed. Appendix F shows the providers and a variety of data about the facilities compared to CCCA and SWVMHI's adolescent unit. The Appendix shows the differences in the services compared to CCCA and SWVMHI. The private providers typically have shorter lengths of stay and provide fewer or no educational services. In addition, those children with commercial insurance are more likely to be admitted to a private facility.

Appendix F also shows that CCCA and SWVMHI receive referrals from these private providers when commercial insurance benefits are exhausted. Currently, these two state facilities serve as a safety net when children cannot be served by private providers because commercial or Medicaid benefits are exhausted, the child is behaviorally challenging, the child has complicated co-occurring difficulties (psychiatric, behavioral, substance abuse, legal, sexual, or medical), the child has multiple admissions, or the child exhibits other behaviors that cannot be addressed in private psychiatric settings.

### **Existing Community-Based Services**

The OIG completed an extensive review of community-based mental health services for children in April 2008.<sup>6</sup> The report found that families seeking services for children with mental health and substance abuse needs faced enormous differences in service availability depending on where they lived. In addition to this variability, the OIG found stakeholders (CSBs and families) were satisfied with services when they could receive them, but were dissatisfied with the availability, array, and types of services for children.

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<sup>6</sup> Appendix D

State general funds and local funds make up a relatively small portion of funds dedicated to children's services. The OIG's study found that Medicaid is the largest funding source in CSB budgets for children's services, even in those communities that offer a wide array of services. CSBs indicated when surveyed for the study that the leading factor in the development of an array of children's services is the fiscal support and cooperation of the local CSA Community Policy and Management Team. In addition, collaboration with other community agencies at the local level to identify and develop needed services lead to additional services for youth.

The OIG's report identified several services that, if available, could help prevent placement in residential or short-term psychiatric facilities out of the child's community. These included:

- home-based intensive wrap-around services,
- substance abuse outpatient services,
- residential options in the community,
- outpatient mental health services,
- additional types of assessment and evaluation services,
- educational support and treatment for families, and
- community-based services for children with problematic sexual behaviors.

These needs are similar to those identified by the SOCAT and this State and Community Consensus Team. The SOCAT recommended increased support for the development of emergency services/crisis stabilization, case management/care coordination, intensive in-home/home-based services and intensive care coordination. The Team endorses the recommendations of both the OIG and SOCAT for additional community-based services.

The Team also recommends a series of services specific to acute mental health needs in the "Recommendations" section of this report. These specific services address immediate needs for children who are in psychiatric crisis and could potentially prevent admission or readmission to private psychiatric facilities, CCCA, or SWVMHI's adolescent unit. They include crisis stabilization services, incentives for communities to have a basic set of community services beyond emergency services and case management, creative and flexible funding needs related to the development of a full continuum of community-based services, and additional psychiatric professionals or access to psychiatric professionals through telemedicine approaches.

The Team also identified deficits in services for children who are involved with the courts system, DJJ, or local juvenile detention centers. These children have specialized needs that are not currently addressed in the community or by psychiatric providers. These children may require long-term mental health treatment in secure settings similar to adult forensic populations. They may also require additional supports upon discharge from correctional treatment. There have been significant reductions in funding to court services units and the Virginia Juvenile Community Crime Control Act in the past several years and this has significantly reduced services to help prevent admission to care.

### State and Community Consensus Team Recommendations

The State and Community Consensus Team found that CCCA and SWVMHI's adolescent unit provide a valuable service for children, families, and localities that lack sufficient community-based services. The Team's recommendations reflect the need to maintain CCCA and SWVMHI's adolescent unit until adequate community-based services for youth can be developed across the Commonwealth, including acute inpatient mental health services in each region.

The community currently provides some private acute inpatient psychiatric care and community-based services but the OIG, SOCAT, and this group found the availability of mental health services varies widely among communities. Few communities offer an array of services with sufficient capacity to meet the needs of children and their families in their home communities. There are a variety of reasons for the variability in services, including limitations on local and state revenue sources and limited availability of service providers. Key factors that have influenced the development of a full continuum of services for youth and families include the extent to which leadership has been exercised to place a priority on the development of children's services, the development of community and interagency relationships, and the ability of communities to use creativity and skill in utilization of funding from Medicaid, grants, and CSA.

The Team has several recommendations to improve the delivery of acute mental health services to children in the Commonwealth. The Team grouped the recommendations into four broad categories. The first reflects the need for continued publicly supported inpatient care. The second and third categories are intertwined and describe needed alternate approaches to providing this inpatient care. The fourth outlines additional data and information needed to further refine strategies related to the delivery of acute services for children.

- *Inpatient Care. The Commonwealth has the responsibility to maintain a publicly-funded safety net that includes acute inpatient services. Funding should be aligned so services are delivered in children's communities closer to home.*

The Team believes both CCCA and SWVMHI adolescent unit are an important part of the "safety net" the Commonwealth provides for youth who need psychiatric services. These children include those who have behavioral challenges that cannot be addressed by private psychiatric inpatient providers, children currently connected with the court system or the juvenile correctional system, and those who have no insurance or have exhausted private insurance benefits.

The Team supports continued maintenance of critically needed inpatient "safety net" services at SWVMHI's adolescent unit and CCCA for children who are incarcerated, lack health insurance, exhaust health insurance resources, and/or exhibit behaviors that cannot be addressed in private psychiatric hospitals or until alternative approaches to provide acute inpatient mental health care can be developed. A critical service that should be developed is acute inpatient mental health services for these

youth in each region either through additional publicly-funding facilities or the public purchase of inpatient beds.

- **Funding for Services.** Support continued expansion of home and community-based services so children can be served in their home communities with additional services and supports that currently do not exist in Virginia's localities.

The Commonwealth must develop a full continuum of community services for youth, including crisis intervention services, crisis stabilization services, case management, intensive in-home services, intensive care coordination, day treatment in schools, respite care, and parent support programs.

DBHDS, with appropriate funding, could provide incentives for communities to have a basic set of community services beyond emergency services and case management. These types of services have been recommended by the SOCAT and the OIG. The growth and expansion of these community-based services will continue to develop under the Children's Services System Transformation efforts.

The focus of this report was on acute mental health services for youth. The Team agreed that it was essential to highlight critical services that are at the core of expanding access to these acute services and complement the additional community-based services being developed through the broader child transformation efforts. The development of these acute mental health services will take time and additional financing to ensure there is in each child's community, similar to the other community-based services being developed through the broader child transformation efforts. With the expansion of all of these community-based services, additional support will be necessary to ensure there is service capacity in every child's community.

The Team recommends several options that could accelerate the development of acute mental health community-based services. Each requires additional funding or resources to ensure adequate, statewide implementation:

- **Mobile Crisis Outreach Teams** - 24/7 response to the child's home during crises, to provide crisis intervention, evaluation, family support, behavioral assistance, medical evaluation, etc.
- **Crisis Stabilization Support Services** - 24/7 availability of family support services provided on an ongoing basis in times of crises. Ongoing behavioral support, family counseling, case management, etc, in the home (or foster home), extending through a period of crisis.
- **Expanded Basic CSB Emergency Services** - more staffing, back up, children's specialty services for existing CSBs to provide 24/7 emergency response capacity - the telephone/evaluation/disposition emergency service that all CSBs now offer for youth.

- **Next day Availability of Evaluations and Medication** by psychiatric personnel (psychiatrists or nurse practitioners experienced with children) after initial crisis response.
- **Support for the Virginia Child Psychiatry Access Project (VCPAP)** would support and enhance the role of the primary care provider (PCP) in the assessment and treatment of children and adolescents with behavioral health problems (Appendix G).
- **Support for Telemedicine** would support the development of additional telemedicine services to provide psychiatric care via teleconference or support regional psychiatry consortiums that provide coverage across a region.
- **Study of Children's Forensic Mental Health** -A study to determine the most appropriate methodology to establish a children's forensic mental health unit in Virginia. As noted previously, a significant percentage of incarcerated youth have mental health problems. The Department of Juvenile Justice provides mental health services to youth in state juvenile correctional centers. Local juvenile detention facilities may contract with CSBs to provide services. However, many of the adolescents seen by these professionals while incarcerated have mental health needs that would be better served in other settings. Currently, many private psychiatric facilities and private residential programs will not treat these youth because of these children's security requirements.
- **Support for Follow-Up Services to Reduce Recidivism or Relapse** - In 2006, the General Assembly made clear its intention to provide services to previously incarcerated youth through mandating Mental Health Services Transition Plans for youth released from juvenile correctional centers as well as post-dispositional detention programs. These youth, as well as the much greater number of youth on probation in the community, have needs for mental health and substance abuse services. While local detention centers and state juvenile justice centers provide mental health and substance abuse services to youth in their facilities, often there are limited resources to provide follow-up services in the community after they are released. State budget reductions have caused further deterioration of services. These services are critical in efforts to reduce recidivism. The Team recommends the following options to support community services upon discharge that could prevent readmission and/or reincarceration:
  - ◆ Continued provision of state general funds to CSBs to provide crisis intervention and discharge planning in the Commonwealth's 24 juvenile detention facilities;
  - ◆ Additional funding for the Commonwealth's 24 juvenile detention facilities for the provision of psychiatric support and treatment;
  - ◆ Elimination of the "non-mandated" Comprehensive Services Act category with the establishment of all children involved with the juvenile justice system as a "mandated" category, if sufficient local and/or funding exists;

- ◆ Elimination of any waiting period between discharge from a juvenile justice or mental health treatment facility and access to Medicaid benefits or other supportive services;
  - ◆ Funding for CSB early intervention and diversion programs that provide mental health and supportive services to divert young offenders and first-time offenders from the juvenile justice system;
  - ◆ Establish specialized programs to provide services to children with intellectual disabilities who should be, where appropriate, diverted from the juvenile justice system; and
  - ◆ Improve the availability of community-based mental health and substance abuse services for youth involved in the juvenile justice system.
- ***Coordination and Collaboration to Enhance Existing Services.*** *Support reduction of regulatory or other barriers so that money follows each child.*

During its work, the Team identified many opportunities to improve how state facilities, private facilities, CSBs, schools, local DSS, and CSA programs work together to minimize admissions to inpatient care. In many cases, the Team felt that state or local policies created barriers to coordination and prevented the flow of dollars moving with a child throughout the services system. The Team believes more work needs to be done to minimize regulatory or other barriers and ensure that money follows each child as they move from setting to setting. This will ensure children receive the most appropriate services to meet their individual needs.

The Team believes that facilities and CSBs can work more closely together on discharge plans. Hospitals could also provide more support on difficult cases by being a presence at the community meetings where discharge options are discussed to provide some back-up and support to the CSB. This includes facility presence at FAPT and CPMT. Facility staff could provide more outreach to communities about what the child needs to be successful (with specific "Needs upon discharge") and this could enhance continuity of care from hospital to community. Specifically, staff could come to the community to show community providers how to work with a given child. Mobility of state facility staff could prove to be useful – if they could be deployed to the community for a limited time period.

- **Enhance or improve existing services in state facilities** - For instance, additional expertise may need to be developed in specialties such as autism. There are also job sharing and training opportunities that can be explored between state facilities, CSBs and other community programs, public and private.
- **Encourage and support the development of a full continuum of mental health services in each community.** Provide funding and technical assistance to help communities develop and sustain a basic set of services beyond emergency services and case management.

- **Continue to dialog with Office of Comprehensive Services** to encourage communication, use of creative and flexible funding strategies, collaboration among child serving agencies and exploration of other linkages that will enhance services.
- **Develop state run facilities as centers of training and excellence-** Specific training should be included in these centers related to assessing community service needs, building relationships with community partners and families, and creative service planning including how to creatively use funding streams (Appendix H).
- **Seek greater flexibility in the use of the Psychiatric Residential Treatment** through the Medicaid program and explore strategies that other states have implemented that could be beneficial to Virginia.
- **Create regional funding opportunities/incentives for public and private providers to work together.** The state could create an incentive pool of funding that rewards communities/regions who use fewer state inpatient beds. Lessons could be learned from the Local Inpatient Purchase of Service (LIPOS) and Discharge Assistance Project (DAP) that has reduced the reliance on state inpatient services for adults. These two programs have challenges, but could serve as a general framework for approaching the purchase of local inpatient beds.
- *Improve Data Collection. Enhance the collection of data to better understand the acute behavioral health needs of Virginia's youth.*
  - **Establish consistent data collection processes and procedures-**at CCCA and SWVMHI in conjunction with VHHA (Virginia Hospital and Healthcare Association) and private facilities so that comparisons can continue to be made with private sector facilities regarding admission, lengths of stay, occupancy rate, referral source, discharge placement and payer mix. Data should also include a level of acuity, such as hours of one-to-one or continuous observation, percentage of individuals with Individualized Education Plans, percentage of individuals new to the system, and readmission data.
  - **Improve cross-agency data collection and reporting** to enable the child-serving agencies to focus on outcomes for children. The Team believes that outcome measures should be developed across all of the public and private services for children. In addition, the Team felt strongly that several data items currently collected could be eliminated.

## **Conclusion**

The State and Community Consensus Team supports continued expansion of community-based services for youth in the Commonwealth. The Team believes services at CCCA and SWVMHI adolescent unit must continue until significant additional acute inpatient

mental health services are provided in every region of Virginia either through additional publicly-operated institutions or public purchase of inpatient beds. Other services must also be developed to assure continuity of care and reduce admissions or readmissions, these services include additional crisis stabilization service, private acute psychiatric care, preventive services, and other intensive mental health services.

**Appendix A: State and Community Consensus Team Members**

<b>Name</b>	<b>Organization</b>
Margaret Nimmo Crowe	Voices for Virginia's Children
Mira Signer	NAMI Virginia
Vicky Hardy-Murrell	Virginia Federation for Families/Mental Health America
Robert Gunther, MD	Virginia--AAP
Betsy Strawderman	Prince William CSB
Diana Barnes	District 19 CSB/VACSB Council
Lisa Moore	Mt. Rogers CSB
Robert Tucker	Valley CSB
Sandy Bryant	Central Valley CSB
Barbara Shue	CCCA
Cynthia McClaskey	SWVMHI
Joe Tuell	CCCA
Renee Musser Hummell	Former patient
Dean Lynch	VACO
Macy Fox	Parent
Naomi Verdugo	Parent
Allison Marcus	UMFS (Leland House)
Bill Semones	Centra Health
Debbie Tanner	Riverside
Jim Krag	Psychiatric Society of Virginia
Rick Bridges	UHS--Marion
Betty Dixon	National Counseling Group
Catherine Hancock	DMAS
Merilee Fox	DOE
Heidi Dix	DBHDS
James Reinhard, MD	DBHDS
James Stewart	OIG
Pam Fisher	DBHDS
Janet Lung	DBHDS
Steve Peed, MD	DJJ
Mark Derbyshire	Carillion Clinic