



The Campaign for Children's Mental Health

Virginians Speak Out: A Report from the Campaign for Children's Mental Health July 2010

The purpose of this report, the first in a series from the Campaign, is to summarize citizen opinion on the current state of children's mental health services. Future reports will focus on policy recommendations for improving access to care. In Virginia, the child mental health "system" is really a complex patchwork of public and private services that are regulated and funded by multiple state agencies across three secretariats: Health and Human Resources, Public Safety, and Education. The feedback below includes comments on all aspects of this system: services funded through any means – including Medicaid, private insurance, and the Comprehensive Services Act – and provided by both public community services boards and private providers.

Four hundred parents and professionals across the Commonwealth attended public forums to voice their opinions about the children's mental health system during a listening tour held by the Campaign for Children's Mental Health. The clear message from participants at every forum was that Virginia's child mental health system is in crisis. The array of mental health services needed by children and families is not available, and access to the care that exists is complicated by the fragmented service delivery system. The result is that many children with mental health problems and their families are left largely on their own, unable to access services until problems have become crises.

The Campaign, sponsored by Voices for Virginia's Children and launched in December 2009, hosted the forums in April and May 2010 to learn more about the specific challenges faced by families and providers and to highlight these issues for the McDonnell administration, General Assembly members and other policy makers. Ray Ratke, Special Advisor for Children's Services to the Secretary of Health and Human Resources (now retired), served as the administration's official "listener" on the tour.

The Campaign reached out to citizens at eight forums across the Commonwealth: Lynchburg, Roanoke, Richmond (two forums), Loudoun, Fairfax, Williamsburg and Norfolk. Providers and parents from other localities in the state, including far southwest Virginia, southside Virginia, and Charlottesville, attended these forums as well. Participants were largely service providers, both public and private, and those working in related child-serving fields (e.g. schools). Parents or other

family members of children with mental health challenges were present at all but one of the forums.

In conjunction with the forums, the Campaign surveyed Virginians about the children's mental health system. All individuals (approximately 500) on the Campaign's email listserv, including forum participants, were invited to complete a brief electronic survey. Surveys were completed by 147 people, a 29% response rate.

This report provides information about the feedback received from both the forums and the surveys.



Forum Feedback

Identification of Needed System Reforms

Participants were asked to identify issues that need to be addressed in their region, as well as to recommend state and local policy changes that

would increase the quality of or access to children's mental health services in their region.

Create Comprehensive Array of Quality Services

Recommendations about the **array and quality of services** available were extensive. With the recent growth in the number of in-home and other community-based providers, participants expressed grave concern over the lack of quality oversight and monitoring of these services. Also, participants in all forums identified significant gaps in the array of services; long waiting lists for services or having to travel to access psychiatric care were frequently mentioned. Participants in all areas called for an increase in prevention and early intervention services. They expressed frustration that the system is geared toward children in crisis, who must be served with high-intensity and expensive services, leaving no way to pay for less intensive services that could prevent crises. Participants also cited a need for non-medical services, such as after-school activities, mentoring, and parent education and support, to help children with mental health challenges and their families. Both parents and providers called for more school-based prevention and intervention efforts. Participants also noted that despite improvements in some localities in involving parents in decision-making, much work remains to be done to make families true partners in the child mental health system.



Achieve Consistency Across Virginia

The **need for greater consistency in the services available statewide** was cited at every forum. The disparity among localities in services offered and policies for accessing them is particularly frustrating for parents. It is also difficult for private providers who are trying to develop new services in a multi-jurisdictional area. Participants called for greater leadership from the state and greater collaboration within regions to increase the consistency of services available.

Increase System Coordination

Extensive discussion occurred at each forum about the **fragmentation of the overall system** at both the state and local levels. At the state level, responsibility for funding, licensing and regulation of child mental health services is divided among multiple agencies within three secretariats. Several participants cited the state's demand for local collaboration as part of the Children's Services System Transformation but noted that it was not demonstrated amongst the various agencies and secretariats at the state level. As examples, they cited contradictory regulations being sent to localities from various state child-serving agencies. This lack of cohesiveness leaves local child-serving agencies at odds with one another and causes children to go without services. Parents report being overwhelmed and confused about how and where to access services, and many participants cited the need for a centralized resource to help parents navigate the system.

Strengthen Workforce

Comments about the child mental health **workforce** largely centered on how the training of the workforce affects the quality of services. Across the board, participants called for quality assurance. Participants also wanted the qualifications of providers to be transparent to parents. Many comments were made about the shortage of child psychiatrists, and thus the related need for increased training of pediatricians and other primary care providers. Increased training in children's mental health was also suggested for school personnel. Participants in several areas cited the need for greater cultural competence of providers to help them work with diverse populations of families.

Address Insurance Barriers

Finally, participants raised a number of issues related to both **public and private insurance**. Overwhelmingly, parents attending the forums expressed frustration that private insurance covers very few mental health services for children and that paying out of pocket for services is cost-prohibitive. This leaves a significant number of children without needed treatment. Providers and parents expressed challenges with Medicaid's medical model of reimbursement, meaning that only the child with the diagnosis can be treated rather than addressing underlying problems in the family or addressing the effect of a child's mental health problem on other family members. Providers expressed significant concerns about the new

Medicaid managed care vendor and the perceived inconsistency of pre-authorization decisions. Again, they expressed frustration that the reimbursement system is geared toward serving children in crisis. Providers were also concerned about the possible implementation of Medicaid managed care in behavioral health. They fear that limiting the duration and availability of services will actually lead to greater use of high-end placements, such as residential care, costing more money and reversing the progress made as a result of the Transformation.

Recent Improvements

Participants were asked to comment on any improvements to the children's mental health system made in their region during the last two years. Attendees at all forums were able to identify some positive changes, which were largely attributable to the Children's Services System Transformation. These included:

- An increase in certain types of community-based services
- Increased collaboration among local child-serving agencies
- Increased family involvement in service delivery in some areas
- Additional workforce training around the Transformation's practice model

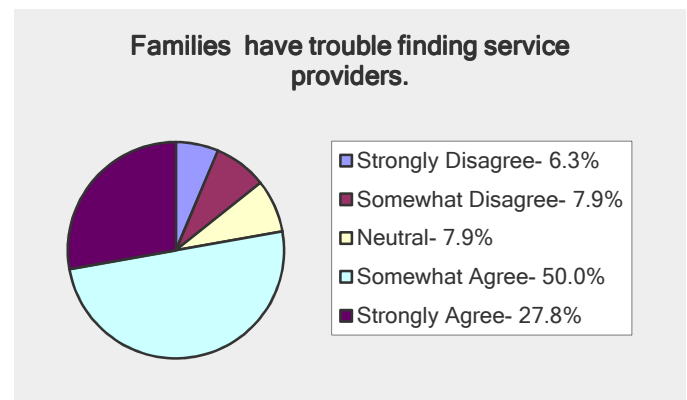
Service growth was most prevalent in intensive in-home services, therapeutic day treatment in schools, and intensive care coordination by community services boards. The combination of more community-based options and increased collaboration among child-serving agencies with the goal of maintaining children in the community led to fewer children in residential placement. Positive comments about the increased number of services, however, were tempered by serious concerns about the quality of some new services.

Increased family involvement in the delivery of children's services was primarily due to training of the workforce on the new practice model of Transformation. Child-serving agencies, particularly departments of social services, are reported to be involving families as partners in determining the best services for their children using national models of family engagement.

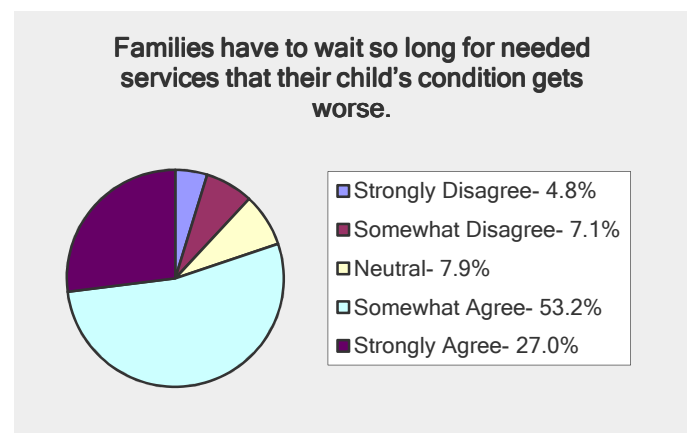
Statewide Survey Results from Professionals

The Campaign conducted brief online surveys of providers and parents in May and June 2010. Survey respondents were asked a series of five questions about access to children's mental health services in their region. As only twenty responses were submitted by families, the Campaign will conduct additional outreach to families to increase the number of respondents. The following results are from the 127 surveys completed by professionals.

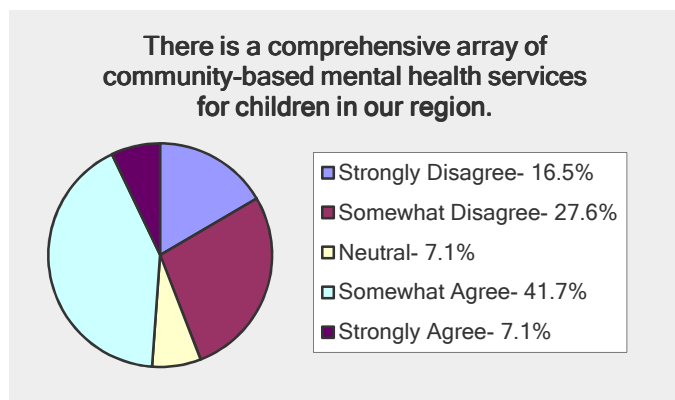
78% of professionals from around the state agreed that "families have trouble finding service providers." These responses are consistent with the qualitative feedback from the forums that the system is fragmented and confusing for families and that the availability of services is inadequate.



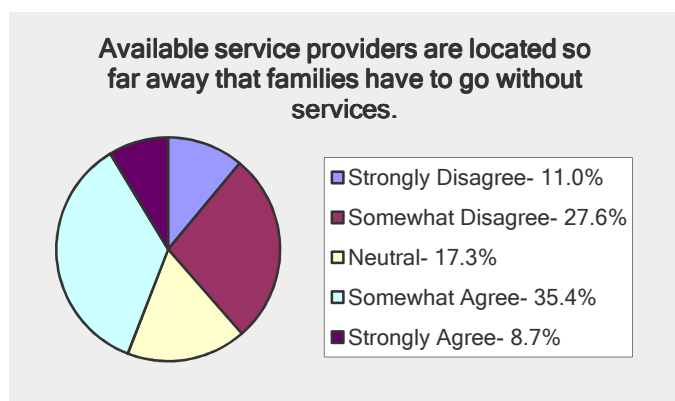
80% of respondents agreed that "families have to wait so long for needed services that their child's condition gets worse." These data confirm that a shortage of providers has dire consequences for the children who are seeking treatment and unable to find it.



49% of respondents agreed that “there is a comprehensive array of community-based mental health services for children in our region.” The responses to this question are mixed, possibly indicating the geographic difference in the array of services offered. A report by the Office of the Inspector General in 2008 confirmed that the availability of children's services at community services boards varies widely from one area to the next. In addition, it should be noted that this question merely asks about the array of services, not the capacity of the system. Thus, a region could have a wide array of mental health services but still have long waiting times to access some or all of those services.

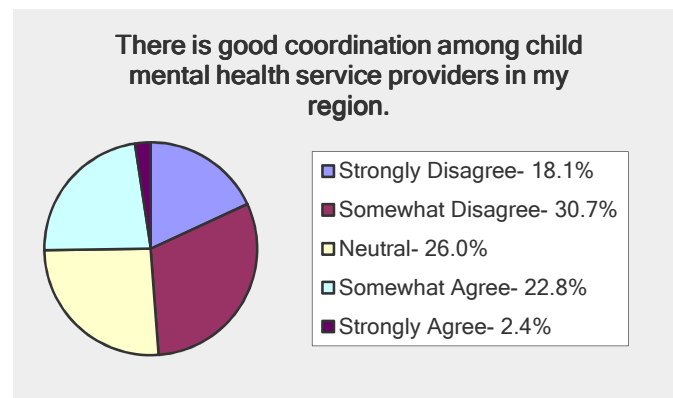


44% of respondents agreed that “available service providers are located so far away that families have to go without services.” The responses to this question were mixed, possibly indicating a geographic difference in the availability of service providers. Forum participants from rural areas indicated that travel to access services was a barrier.



25% of respondents agreed that “there is good coordination among child mental health service providers in my region.” These data indicate that despite recent progress toward greater collaboration in some areas of the state, much

work remains to be done to create a more cohesive system.



Conclusion

The forums and survey results provide important opportunities for the Campaign and policy makers to learn about the most current concerns across the Commonwealth. The overwhelming message was that the fragmented and inadequate system that exists now creates significant problems for children and families. In addition to the unnecessary human suffering caused by the troubled system is the financial cost of delivering services in this manner. The inescapable conclusion of this community feedback is that the children's mental health system must be reformed not only to provide the children of Virginia with the mental health treatment they need, but also to make the most effective and efficient use of the system's current and future resources.

The Campaign for Children's Mental Health is a three-year advocacy initiative sponsored by Voices for Virginia's Children. The Campaign is led by a Steering Committee comprised of Mental Health America- Virginia, National Alliance on Mental Illness (NAMI) Virginia, and the Virginia Association of Community Services Boards. Funding for the Campaign is generously provided by Consumer Health Foundation, Bon Secours Virginia Health System, HCA Virginia Health System, Carilion Foundation, and Inova Health System.

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Children's Mental Health in Virginia: System Deficiencies and Unknown Outcomes

National estimates of children's mental health disorders indicate that one in five children ages 9 to 17 experiences a diagnosable mental health disorder in the course of a year, and roughly one in ten experiences a serious disturbance.¹ In Virginia, this means that between 85,129 and 104,046 children and adolescents in struggle with a serious emotional disturbance.² Mental health disorders are not limited to this age range, however; infants and young children also experience mental health issues.³

Finding meaningful state-level data about children's mental health services is challenging in part because the service delivery system is so fragmented. National data indicate that many children who have mental health treatment needs do not receive services.⁴ In Virginia, those children who do receive services may find them within the school system, social services system, juvenile justice system, Comprehensive Services Act, or from public or private mental health providers. There is no uniform data collection process across these different systems, and very little outcome data are available regarding the services provided.

This report describes services available largely through the various agencies within Virginia's Secretariat of Health and Human Resources, although it also touches on services provided in schools and in the juvenile justice system. The state agencies that largely hold the keys to accessing public mental health services for children are found within Health and Human Resources: the Department of Behavioral Health and Developmental Services, the Office of Comprehensive Services, and the Department of Medical Assistance Services.

Department of Behavioral Health and Developmental Services

Community Services Boards

The Department of Behavioral Health and Developmental Services (DBHDS) contracts with forty regional community services boards (CSBs) to provide community-based children's mental health services, as well as adult mental health services and services for those with intellectual disabilities and substance use disorders. The CSBs are required by the Code of Virginia to provide emergency services and case management as funding permits.⁵ Other types of children's services are not mandated and are largely dependent on the availability of funding to support them.

Detailed data about children served at CSBs are not available on a regular basis; however, there are current systems-based data available because of a General Assembly-directed planning process currently underway at the Virginia Department of Behavioral Health and Developmental Services (DBHDS; formerly the Department of Mental Health, Mental Retardation and Substance Abuse Services). In October 2010, DBHDS released its interim report which identified major deficiencies in the array and capacity of current services statewide (Table 1). The report identified 39 distinct services within nine categories that comprise a comprehensive system of care, as well as the four types of base services (crisis response services, case management and intensive care coordination, psychiatric services, and in-home services) that are critical to have available to children statewide.⁶ In January 2011, DBHDS released the first set of data from a survey of the forty CSBs about the number and types of children's mental health services provided by CSBs (Table 1).

Table 1. Service Categories in Comprehensive System of Care

Assessment and Evaluation
Outpatient or Office Based Services (including Child Psychiatry*)
Case Management*
Home and Community Based Services (including intensive in-home services*)
Intensive Community Supports
Community Crisis Response Services*
Residential
Inpatient

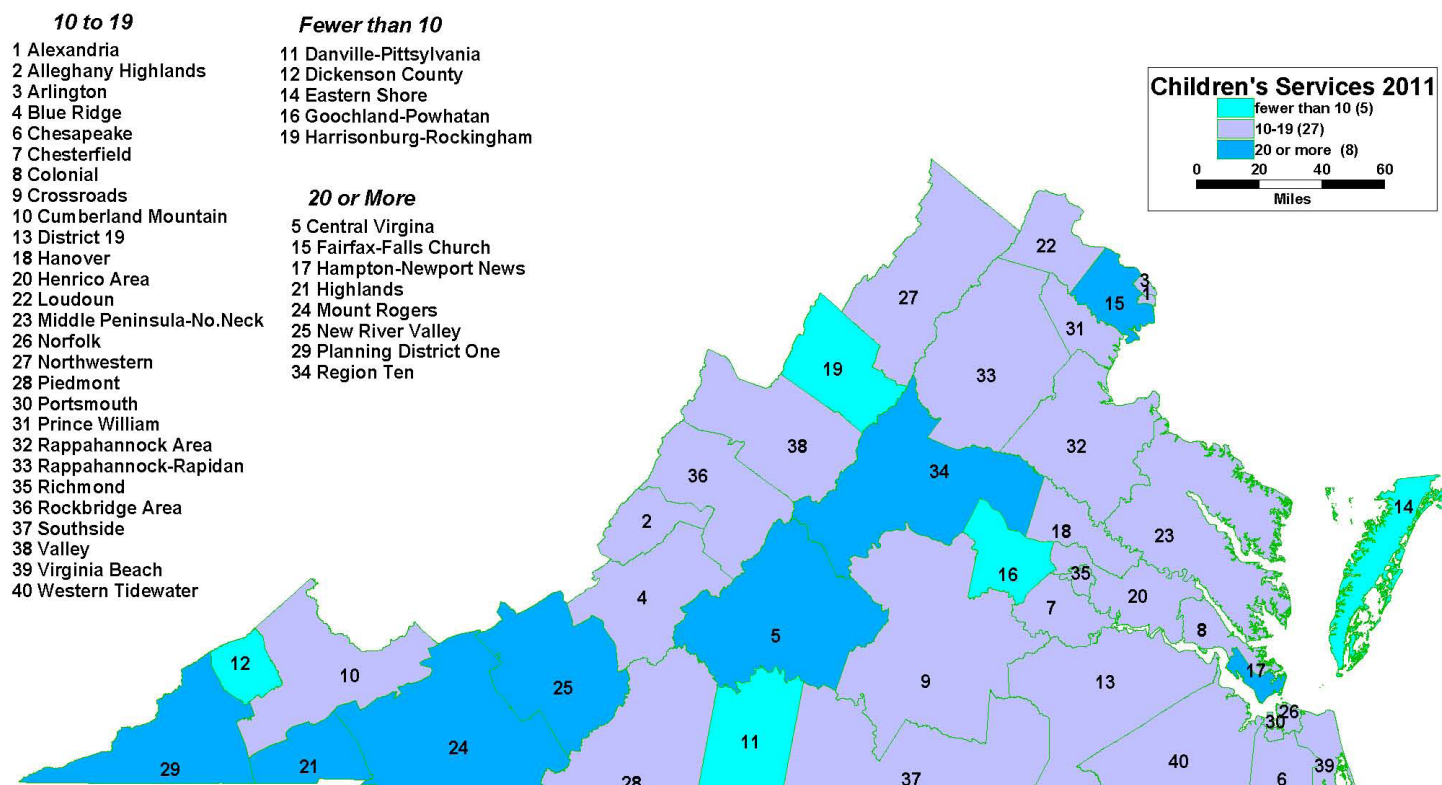
*The four services identified in the report as base services that should be available to children statewide.

Source: Virginia Department of Behavioral Health and Developmental Services

DBHDS is continuing to analyze the survey results and will release more detailed data related to capacity of the CSBs in each service area later this year. These data will be critical in determining the ability of children to access a particular service in any given area of the state. While having the entire array of services is ideal, an adequate capacity of early intervention and intermediate level services could mitigate the need for higher capacity in more intensive and restrictive services. For this reason, the Department has prioritized making the four base service categories available statewide.⁷

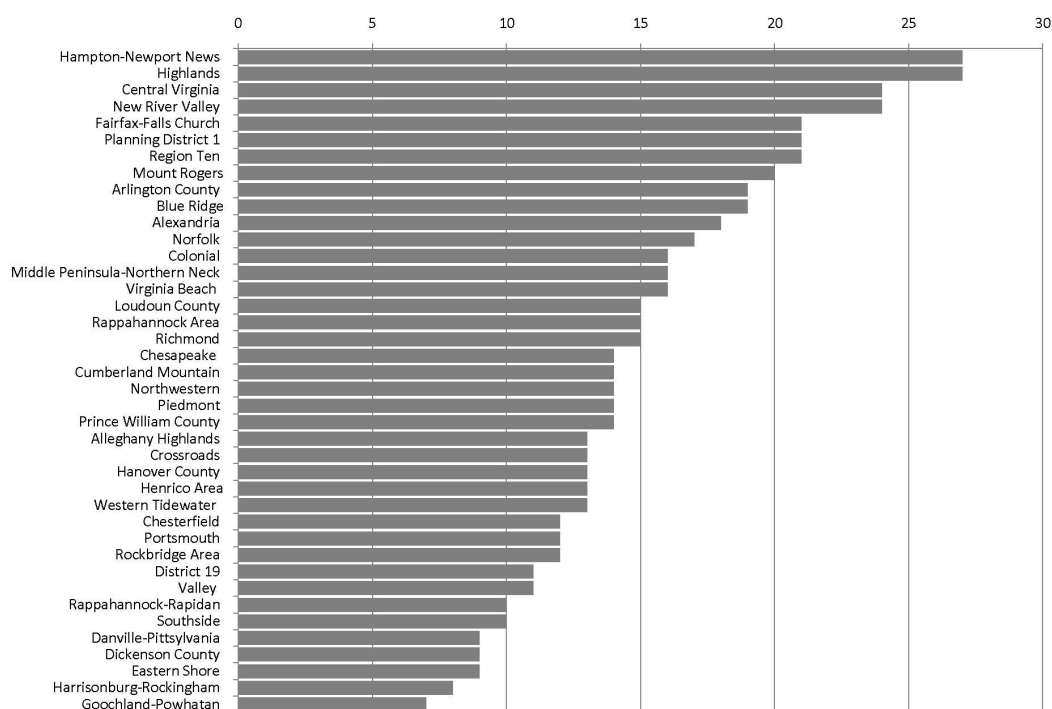
The report found that CSBs in every area of the state lack the full array of 39 services and that there is a great deal of variability in the amount and types of services available from one region to the next. Eight of the 40 CSBs (20%) provide 20 or more services. Five of the CSBs (13%) provide fewer than 10 services. The remaining 27 CSBs provide between 10 and 19 of the services (Figure 1 and Figure 2).

Figure 1. Number of Services Available in CSBs by Geographic Area, 2011



Department of Behavioral Health and Developmental Services; map created by Virginia Association of Community Services Boards

Figure 2. Number of Service Types Provided by CSBs, 2011



Department of Behavioral Health and Developmental Services

Many of the services in the array are provided outside of the physical facilities of CSBs in other community locations. CSB staff provide a range of services in schools, from therapy (14 CSBs) to behavioral specialists (4 CSBs) to therapeutic day treatment (18 CSBs provide mainstream day treatment and 12 provide self-contained day treatment).⁸ CSB staff also provide mental health services in locally-operated juvenile detention centers. In FY10, CSBs served 4,450 youth in detention statewide with services such as emergency, consumer monitoring, assessment and evaluation. CSBs also provided more intensive services, such as outpatient counseling or case management, to 730 youth residing in detention centers.^{9,10}

Only 25% of the CSBs provide services within all four categories of base services. The most critical gap in the four base services is in the category of community crisis response services, defined as “24/7 on-call specialized children’s emergency service access.” The mostly widely provided crisis response service by CSBs, in-home crisis stabilization, is only provided by 10 CSBs (25%). The least available service is emergency respite care, which is only provided by 2 CSBs (5%).¹¹ Though these survey data represent a critical first step in learning about Virginia’s array of services, it is unknown how many children actually receive these crisis services from the CSBs that offer them because data on capacity are not yet published.

We do know broadly, however, that the capacity of the system to meet the need is insufficient. CSBs reported average statewide waiting lists in weeks for a variety of services from January to April of 2009. Wait times ranged from three weeks for case management, intensive substance abuse outpatient services, and substance abuse case management to twelve weeks for medication management.¹²

Mental health professionals surveyed by Voices’ Campaign for Children’s Mental Health in 2010 indicated that having to wait for services has a negative impact on the children and families; 80% of those surveyed agreed with the statement “Families have to wait so long for needed services that their child’s condition gets worse.”¹³ The child’s deteriorating mental condition often leads to the necessity of more intensive and expensive interventions.¹⁴

The system-level data from DBHDS are a more detailed update of data collected about children’s services provided by CSBs in a 2008 report by the Office of the Inspector General.¹⁵ Findings are consistent between the two reports regarding the incomplete array of services and the variability of the array statewide.

In FY10, the 40 CSBs provided mental health services to 30,324 children, 72% of whom had or were at risk of serious emotional disturbance.¹⁶ A total of 53,043 children were served by the CSBs in FY10 across all program areas (excluding the 13,241 children served through early intervention- see below).¹⁷ The number of children served by CSB mental health services has remained fairly constant over the last five years, while the overall number of children served by CSBs has increased substantially (Table 2). A change in record-keeping beginning in FY08 placed some children previously counted in the mental health category in the new category of “services available outside of a program area.”

Table 2. Number of Children Receiving CSB Mental Health Services, FY06-FY10

FY06	43,982
FY07	47,016
FY08	55,671
FY09	59,618
FY10	66,284

Girls are more likely to receive mental health services from CSBs than boys: Of the 30,324 children served in mental health services in FY10, 61% were female. Just over half of children served, 51%, fell between the ages of 3 and 12. Forty-six percent were teenagers, ages 13 to 17, while children from birth to age 2 comprised 3% of those served. Black children were overrepresented in the CSB mental health system compared to the population as a whole; 31% of children who received services were Black, compared to 22% of the overall child population in Virginia.¹⁸ White children comprised 56% of those served, and 7.4% of children reported Hispanic ethnicity.¹⁹

There is no system-wide effort across CSBs to collect outcome data about children served in its mental health programs. Many individual CSBs collect outcome data about particular programs (e.g., therapeutic day treatment provided in schools). Some CSB day treatment programs measure pre- and post-scores for grades, citizenship, absences and suspensions for children receiving the services.²⁰ Collecting and reporting outcome data is not required of any providers by the state, but it could be immensely helpful to policy makers in analyzing and supporting effective mental health interventions.

DBHDS annually surveys parents and family members of children who have received outpatient mental health services at the CSBs to determine their satisfaction with services and their perception of child outcomes.²¹ In FY09, 73.1% of caregivers expressed general satisfaction with the services their child received. Only 50.7%, however, agreed that services had resulted in a positive outcome for their child. The reason for this discrepancy is unclear. Responses may be a true reflection of the efficacy of services, or perhaps some children may not have participated in services long enough for functioning to improve (65% of the survey respondents’ children were still receiving services at the time of the survey, and the length of time the children had been receiving services is unknown.)²²

Acute Inpatient Psychiatric Hospitalization

During the last twenty years, Virginia has significantly reduced the number of state-run psychiatric hospital beds for children from a high of 172 beds in 1992.²³ Currently, Virginia has only one public acute psychiatric hospital remaining: the Commonwealth Center for Children and Adolescents (CCCA) in Staunton, operated by DBHDS. CCCA, a secure facility with 48 beds, serves as the public safety net for children in acute psychiatric crisis from around the state. It serves children without insurance, children whose insurance benefits have been exhausted, children incarcerated by the juvenile justice system, children sent for court-ordered psychological evaluations, and children whose behaviors are severe enough that private hospitals will not accept them.

The other remaining state facility prior to its closure in May 2010 due to budget constraints was the adolescent unit at Southwestern Virginia Mental Health Institute in Marion, a 16-bed unit for teens in that part of the state.

In FY09, CCCA admitted 793 children and adolescents for a total of 13,271 bed days, with an average daily census of 36.4 children. In FY10, 749 children were admitted for a total of 11,312 bed days, with an average daily census of 31.0. The reduction in the number of children and bed days was largely due to the fact that CCCA had to relocate to Western State Hospital, also in Staunton, for five months of the year. During that time CCCA only had 24 beds available instead of the full 40.

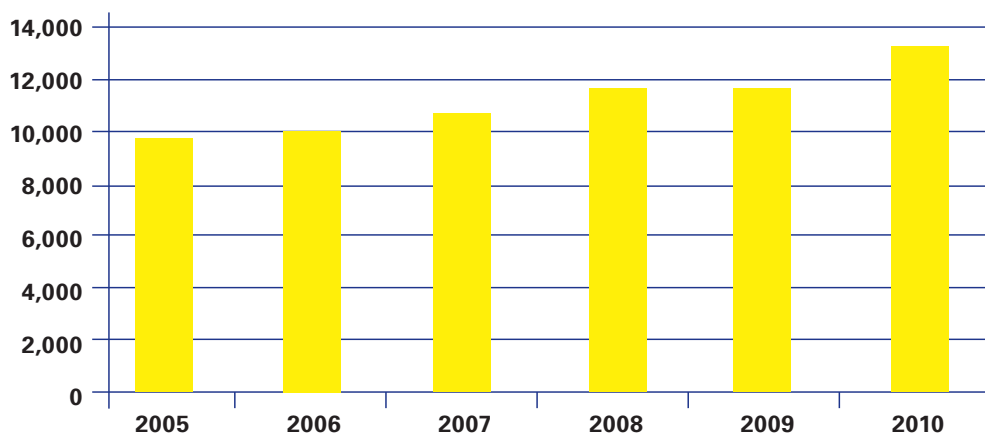
In the first eight months of FY11, CCCA admitted 469 children and youth for a total of 8,091 bed days. The average daily census for this eight-month period of time was 33.3 children, although February represented a peak month with an average daily census of 39.6. Of the total number of children admitted, 83 were readmissions, meaning that the child had previously been in CCCA this fiscal year. The main reason children are readmitted is because they are being released to community services that are inadequate to maintain them successfully.²⁴

Early Intervention

Infant and Toddler Connection is Virginia's early intervention system for identifying and providing services for children from birth to three "who are not developing as expected or who have a medical condition that can delay normal development."²⁵ The early intervention system is also referred to as "Part C," referencing the portion of the federal Individuals with Disabilities Education Act (IDEA) that requires all states to have an early intervention system. In Virginia, the state Department of Behavioral Health and Developmental Services administers Part C. Children and their families are eligible for early intervention services based on the child's need, regardless of the family's ability to pay.

DBHDS estimates that 3% of Virginia's infants and toddlers, or about 18,495 children, are potentially eligible for Part C services based on data estimates such as poverty rates, prevalence of low birth weight babies, children placed on the hearing registry, the number of children assessed and needing services in one year, and the rates of states with similar eligibility.²⁶ The number of children served by Part C has increased over time to a high of 13,241 in 2010 (Figure 3).

Figure 3. Number of Children Served via Part C in Virginia, 2005-2010 ²⁷



Note: Data for each year represent the time frame from December 2 of the previous year to December 1 of the year reported.

Data on the race/ethnicity of children receiving Part C services in FFY09, the latest year for which data are available, indicate that 56% were White, 21% were Black, 12% were Hispanic, and 4% were Asian, which corresponds roughly to the racial and ethnic population of children in Virginia.^{28, 29}

Federal law requires the state agency that administers Part C to report data on its performance; as a result, DBHDS surveys families about the services they receive. A 2008 report on the Part C program indicated that 77.5% of families believed "early intervention services helped them help their child develop and learn."³⁰ The 2010 report indicated that 80.3% of families believed this.³¹

Office of Comprehensive Services

Contributing to the complexity of the public mental health system for children is the Comprehensive Services Act (CSA), a law enacted in 1993 in Virginia that pooled treatment funding from a number of state agencies to create a designated funding stream for children with intensive treatment needs who are involved in multiple service systems. The state funds are combined with local matching funds (match rates vary by locality) and administered locally. A total of 14,505 children received funding for services through CSA in FY04; in FY10 that number had risen to 17,568.³² The Office of Comprehensive Services, led by the State Executive Council, is the state entity responsible for management of CSA funds.

The CSA system is mandated to fund services for children involved in the foster care system (or at risk of becoming involved in it), who made up 68% of the total children served in FY10 and for students with special education needs too severe to be served effectively in public schools (or at risk of a private day or residential placement), who made up 23% of the total population in FY10. CSA also gives localities the option of funding services for “non-mandated” children, those who have similar needs but technically fall outside the definitions of the mandated populations. Sixty percent of localities chose to fund services for these children, although “non-mandated” children make up only a small fraction of the total CSA population. In FY10, 1,375 children (8% of the total) received non-mandated services through CSA.³³ The limited number of non-mandated children served through CSA means that many children with intensive mental health needs are left with no designated funding source to access needed services, significantly narrowing the potential impact of CSA funds.

Close to one half of all children served in CSA have a diagnosed mental health disorder; in FY04, 46% had a mental health diagnosis. The figure was 44% in FY10, with 9% of the total children diagnosed with an autism spectrum disorder (a new data point in FY09).³⁴ There is wide variation by locality in the number of children in CSA who have a diagnosed mental health disorder, ranging from no children in some localities to 100% of the CSA population in other localities.³⁵ Such wide variation in rates of diagnoses raises questions about accuracy of the data and variability in data collection processes statewide. Without accurate data, it difficult to draw conclusions about the extent of mental health needs in children involved in CSA.

Of the total of 17,568 children served via CSA in FY10, the average age was 12 years and 9 months. Boys were more likely to be served in CSA than girls: 61% were male. Fifty-six percent of those served via CSA were White.³⁶ Black youth are overrepresented in the population of youth served by CSA: 22% of the child population in Virginia is Black,³⁷ compared to 37% of the children in CSA. This is correlated with the fact that 68% of the CSA population is in foster care,³⁸ and Black youth are overrepresented in the foster care system, comprising 38% of Virginia’s foster care population.³⁹

A significant effort has been made in the last several years through the Children’s Services System Transformation initiative to increase the number of children in foster care served closer to home and in the least restrictive environment possible. One strategy to achieve the goal of decreased use of congregate care for children (including group homes and psychiatric residential treatment facilities) was to increase the local CSA match rate for congregate care and decrease the local match rate for community-based alternatives. In each of the last two years, 14% fewer children have been served in residential care through CSA and total expenditures on residential care have decreased significantly as well.

In FY10, 3,156 children, or 18% of the total number of children served in CSA, were placed in residential care. In FY09, 3,697 children, or 21% of the total, were served in residential care.

Over the last six, years, the total gross expenditures in CSA have risen from \$283.6 million in FY05 to \$356.8 million in FY10. However, the percentage of total CSA funds used for residential care has decreased considerably, from a high of 47% of total gross expenditures in FY05 to 27% of total gross expenditures in FY10. For the first time in the history of CSA, total expenditures decreased in both FY09 and FY10 as a result of the decreased use of residential care (Table 3).⁴⁰

Table 3. CSA Residential Costs as Percentage of Total Expenditures

Fiscal Year	Residential Cost	Total Gross Cost	Percent
2010	\$ 94.9M	\$356.8M	26.6%
2009	\$120.8M	\$376.4M	32.1 %
2008	\$155.2M	\$388.7M	39.9%
2007	\$149.7M	\$352.8M	42.4%
2006	\$138.1M	\$307.2M	44.9%
2005	\$132.9M	\$283.6M	46.9%

Virginia Office of Comprehensive Services for At-Risk Youth and Families

Curbing the excessive or inappropriate use of residential care has been a positive trend, but one Virginia will have difficulty continuing without a greater availability of effective community-based treatment options. With savings being generated for the first time in CSA, an opportunity exists to reinvest these funds into developing a more robust system of community-based care that will allow children to receive intensive treatment without leaving their homes and communities.

Department of Medical Assistance Services

The Department of Medical Assistance Services is Virginia's Medicaid agency, and Medicaid is a significant funder of mental health services provided to children in Virginia. There are three broad categories of children's mental health services funded by Medicaid in Virginia: psychiatric services, mental health clinic services and community mental health rehabilitation option services. Psychiatric services include inpatient acute hospitalization, psychiatric residential treatment, and treatment foster care case management for children.⁴¹ Clinic services include outpatient psychiatric and substance abuse services. Both are managed by the Medicaid managed care organizations. Rehabilitation services are carved out of managed care and managed directly by the Department of Medical Assistance Services (DMAS). These services include the following services used for children: intensive in-home services, therapeutic day treatment, crisis intervention, crisis stabilization services, mental health support services, and case management.⁴²

Enrollment of low-income children in Medicaid has grown: 429,081 children were enrolled in Medicaid (excluding Family Access to Medical Insurance Security, or FAMIS, Virginia's public health insurance program for low-income working families) in FY04 and 563,379 children were enrolled in FY10, an increase of 31%. Total claims expenditures (for all types of medical services, not just mental health services) for low-income children during this same time period have increased 109%, from roughly \$637 million to \$1.3 billion state and federal funds.

Expenditures for psychiatric residential treatment facilities increased 69% from \$45 million in FY04, to a high of \$76 million in FY08. The last two fiscal years have seen a 14% decrease in residential facility expenditures due to efforts to serve more children in the community (see discussion under CSA above). In FY10 Medicaid spent \$65.6 million on residential treatment.⁴³

Expenditures for community-based mental health services have grown significantly in recent years, partly due to the decreased use of residential care. In FY10 these services for adults and children cost \$466.4 million, with services to children comprising 60% of the total. The two services with the most explosive growth have been the children's services of intensive in-home and therapeutic day treatment, which account for almost 70% of the total spending for community-based mental health services in Virginia. Intensive in-home expenditures have increased by 250% since FY06, and day treatment expenditures have increased by 418% since FY06. These services are provided by both CSBs and private providers, though private providers bill by far the greatest share for these two services (98% for in-home and 76% for day treatment).

While such explosive growth could signal better access to mental health services for children with diagnoses, this has unfortunately not been the case. DMAS did not have typical management controls in place for these services until the last two years, leading to exponential growth in the number of private providers and provision of services to children who did not need them. Weak provider qualifications, lack of prior authorization, lack of standards for child assessments, and lack of marketing restrictions led to inappropriate use of the services. DMAS has reacted by implementing prior authorization and marketing regulations, conducting more audits, and strengthening provider qualifications, as well as by reducing rates for these services.⁴⁴ While many of these steps are welcome efforts to control the inappropriate use of these services, the reduction in rates has a detrimental effect on the highly qualified providers, limiting access to high quality treatment for the children who genuinely need the services.

In the 2011 General Assembly session, significant steps toward curbing inappropriate use of Medicaid community mental health services were passed. The budget included language instructing DMAS to develop a plan of care coordination for behavioral health services in Medicaid by July 2012. In addition, the budget called for five pilot projects to begin July 2011 to focus specifically on access to children's services.

In addition to the above-mentioned Medicaid services, Virginia Medicaid also has a waiver for children's mental health. In March 2008, Virginia began implementing the Children's Mental Health Program as a result of receiving a demonstration grant from the federal Centers for Medicare and Medicaid Services. The purpose is to provide a wide range of community-based services to children with serious emotional disturbance who would otherwise be in psychiatric residential treatment facilities. Children who qualify for the waiver are those under the age of 21 who have been in a psychiatric residential facility for at least 90 days, have a psychiatric diagnosis, and remain eligible for Medicaid after they leave the residential facility (the family's income is no longer counted towards eligibility, only the child's).

Since its inception, fewer than 60 children have received community-based services through the waiver.⁴⁵ While a number of services are available to children enrolled in the waiver, the mostly widely used waiver service is respite care. Once on the waiver, children have access not only to the unique waiver services, but also to all other Medicaid-funded mental health services.⁴⁶ Anecdotally, the low number of children served through the waiver is due to a variety of issues,

foremost of which seems to be a lack of waiver service providers due to low reimbursement rates. Alexandria, one locality that has successfully used the waiver for children returning to the community, has paired the CSB case manager who has become an expert in using the waiver with the intensive care coordinator, charged with helping the community bring children back from residential treatment.⁴⁷

Given that there are waiting lists for CSB services and that communities are continuing to try to serve more children outside of residential care settings, increased efforts should be made by localities and the state to determine and attempt to overcome the barriers to maximizing the use of this waiver.

Juvenile Justice System

The prevalence of children with mental health diagnoses in the juvenile justice system indicates that many children are not receiving appropriate mental health treatment in the community. Children with untreated mental health disorders are more likely to end up committing acts that land them in court, among other negative outcomes.⁴⁸

Data indicate that a majority of youth committed to the state juvenile correctional centers have mental health disorders beyond those disorders related to their delinquency. In FY10, the average daily population in all state-run juvenile justice facilities was 859 youth, and the total number of youth committed to the Department was 608. In FY10, 56% of males and 58% of females had a history of prescription psychotropic medication use upon intake. In the same year, 56% of females and 54% of males had a mental health disorder upon intake.⁴⁹ These percentages exclude attention deficit hyperactivity disorder because such a large percentage of the population has this diagnosis (32% in FY08). They also exclude conduct disorder, oppositional defiant disorder, and substance abuse/dependence disorder because these disorders likely contributed directly to the behavior for which the youth was committed.^{50, 51}

All youth receive a psychological screening and evaluation upon intake at the Reception and Diagnostic Center (RDC). The Behavioral Services Unit provides treatment services to all youth in the RDC and in individual juvenile correctional facilities. Categories of treatment include mental health treatment, substance abuse treatment, sex offender treatment, and aggression management.

Although demographic data are not available about the subpopulation of youth diagnosed with a mental health disorder, demographic data are available for the entire population of youth committed to DJJ. In FY10, 65% of the youth committed to DJJ were Black, and 95% were male.⁵² This overrepresentation of Black youth in the juvenile justice system is consistent with national data which show that at every stage of the juvenile justice process, racial and ethnic minority youth are disproportionately represented. In particular, Black youth nationally are arrested at 2.1 times the rate of White youth, held in detention centers pre-adjudication at over 5 times the rate of White youth, and sent to residential placement (i.e. committed to the state's juvenile correctional centers) at 4.5 times the rate of White youth. In Virginia, the rate of overrepresentation is higher than the national average for commitments to juvenile correctional centers: Black youth are committed at 5.8 times the rate of White youth.⁵³ The overrepresentation of Black youth in the juvenile justice system combined with the high rate of mental health diagnoses among the committed population at large triggers the question: Are Black children and youth with mental health problems being treated differently by the mental health system than those of other races?

Conclusions and Implications

The data available describing children with mental health needs in Virginia is extremely fragmented, with very little focus on the outcomes for children. Data collection happens in multiple agencies and departments but with little uniformity across departments and with no entity assigned the responsibility to consolidate, report and interpret the disparate data. There also appears to be variability in the accuracy of data reported at the locality level for CSA, which perhaps points to a need for improved training and/or accountability. In addition, most of the data available are not easily accessible to the public. There is also no systematic effort currently in place to determine whether children receiving mental health treatment across the various systems are achieving positive outcomes.

Available data present a picture of a system characterized by major local and regional gaps in critical community-based services. The map depicting availability of children's services shows the variability of service availability across the state. Combined with waiting list data, this indicates a clear shortage of services available to children with mental health problems in Virginia, unacceptably long waits for services, and inconsistent use of research-based best practices. It is noteworthy that in the midst of such complexity and fragmentation, a few localities have nevertheless developed state-of-the-art systems of care for children with mental health disorders.

Given the amount of public funding expended on children's mental health services and the many children with mental health disorders still not able to access these services, improved data collection is a key element to analyzing system gaps and inefficiencies and working toward improved outcomes for children.

Voices' Impact on Child Mental Health in Virginia

The most urgent concern about children's mental health in Virginia is access to services, and Voices for Virginia's Children has advocated for better access to children's mental health services since 2000. As the only child advocacy organization tackling this complex issue, Voices began by conducting research about the state of the system, publishing a *Special Report: Issues in Children's Mental Health* in 2000.

Early on, Voices advocated successfully with other partners to have FAMIS, the state's children's health insurance program, cover similar community-based mental health services as Medicaid (Medicaid covers children under 133% of the federal poverty level, and FAMIS covers children from 133%-200% of the federal poverty level). Voices has also advocated with partner Virginia Association for Community Services Boards (VACSB) for additional resources for community services boards, specifically for funds that CSBs use to serve children non-mandated for services in CSA and for funds to place CSB clinicians in every juvenile detention center.

A central issue brought to light and advocated for by Voices was the problem of parents having to relinquish custody of their children to social services solely for the purpose of accessing mental health treatment. This practice had typically occurred in Virginia when children needed intensive services that were not covered by their private insurance and that their families could not afford. The children did not qualify in the existing CSA mandated categories; thus, there was no funding source for their treatment unless their parents relinquished custody so that they became mandated. Voices first brought this issue to the attention of the State Executive Council, the leadership team responsible for policy development and implementation of the CSA, with the help of parent Trudy Ellis in 2004. A combination of media attention to the issue and a study by the SEC resulted in an Attorney General's opinion and legislation that clarified that children at-risk of entering foster care solely to receive mental health services are a CSA mandated population.

In December 2009, Voices launched a new initiative, the Campaign for Children's Mental Health, to gain greater visibility and support for its mental health advocacy efforts. The Campaign – a three-year project led by a steering committee including National Alliance on Mental Illness (NAMI) Virginia, Mental Health America- Virginia, and the Virginia Association of Community Services Boards – has recruited more than 60 organizational partners. The Campaign seeks to build the political will and public support to pass legislation and budget reform that will increase access to mental health services for children in Virginia.

Early achievements for the Campaign include successfully opposing the proposed closure of the Commonwealth Center for Children and Adolescents in the 2010 General Assembly session and successfully opposing proposed cuts to the CSA budget and the Medicaid children's mental health budget in the 2011 General Assembly session. The Campaign is working toward having significant legislative and budget reforms introduced in the 2012 session as Voices continues to lead advocacy efforts on children's mental health issues in Virginia.

Voices for Virginia's Children is a statewide, privately funded, nonpartisan research and advocacy organization that builds support for practical public policies to improve the lives of children. We are the independent voice advocating for children, especially those who are disadvantaged or otherwise vulnerable and who often go unheard in the public policy arena. Using our KIDS COUNT system, we track multiple indicators of the well-being of Virginia's children and use that information to identify unmet needs and guide policy recommendations. A recognized leader in child advocacy, Voices mobilizes support for initiatives by conducting research, developing sound, data driven policy solutions, building coalitions, and helping people articulate their support for children.

This report was written by Margaret Nimmo Crowe, Senior Policy Analyst at Voices for Virginia's Children. Margaret is the Coordinator of the Campaign for Children's Mental Health, a collaborative advocacy initiative sponsored by Voices to build the public support and political will to transform the children's mental health system in Virginia. She can be reached at margaret@vakids.org. Further information about the Campaign can be found at www.vakids.org.

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The Campaign for Children's Mental Health

Action Agenda 2011-2012

Children with mental health disorders and their families need to have a full array of high quality treatment and support services in their own communities, no matter where in Virginia they reside.

Policies:

- Invest approximately \$20 million to expand the array and capacity of community-based services to assure a consistent base level of services for children and families statewide. Services can be provided by community services boards (CSBs) or through public-private partnerships and include:
 - Array of crisis response services (DBHDS* estimates \$6.326 million to fund 5 regional demonstration crisis stabilization units and \$10 million to fund 5 regional demonstration mobile crisis teams.)
 - Case management and intensive care coordination (DBHDS estimates \$1.6 million to add 1 case manager per CSB to 20 CSBs with inadequate capacity.)
 - Psychiatric services (DBHDS estimates \$1.4 million to fund 5 demonstration programs with a child psychiatrist in each region to provide direct services and extensive training; alternatively, VACSB** estimates \$2.2 million to provide psychiatry to additional 4,000 children through a variety of means.)
 - High quality in-home services: Monitor new efforts to control quality through independent clinical assessments of Medicaid services by CSBs, which begin July 2011.
- Equip a highly trained and qualified workforce by establishing a children's behavioral health workforce development initiative, led by DBHDS. (DBHDS estimates initial cost of \$500,000 to contract with a university, hire coordinator, and provide 2 child psychiatry fellowships @ \$100,000 each.)
- Ensure high quality of services through increased licensing, quality assurance, and data collection and analysis capabilities at DBHDS, in coordination with quality assurance initiatives in Medicaid. (DBHDS estimates \$160,000 for 2 staff to develop data reports and conduct quality monitoring for children's CSB services.)

Children with serious mental health disorders who require public sector services need to have access to the same array of services regardless of payment source or custody status in order to maximize the impact of and curb inappropriate use of public dollars in the treatment system.

Policies:

- In creating its blueprint for care coordination for Medicaid behavioral health services (to be implemented by July 1, 2012), Virginia must develop a specialized system of care coordination for children with serious emotional disturbance (SED). This system should be managed by a qualified nonprofit entity and operate in a manner consistent with system of care principles. It must also assure the use of best practices and high-quality services – including coordinating with primary care – and ensure sound management of public funds to avoid unnecessary or inappropriate expenditures and produce desired outcomes as cost-effectively as possible.

- In addition to this specialized care coordination system for children with SED within Medicaid, Virginia must develop a plan for a comprehensive child behavioral health system of care for all children with SED who need public sector services. This system of care must reduce fragmentation in services to children with SED, which are currently delivered or financed by Medicaid, the Comprehensive Services Act and/or the CSB system. The system of care should combine/consolidate all available funds to ensure that children with SED, regardless of their funding source or custody status, have access to timely, appropriate, high-quality services. The Governor should name a commission to lead and implement the planning process and also ensure the full participation of all relevant secretaries and department heads. The planning process must include an array of stakeholders and especially engage the participation of parents/family members of children with SED. The plan should be completed by July 1, 2012.

Children with mental health disorders and their families should be recognized and included as experts on their own and their children's treatment needs.

Policies:

- The Secretary of Health and Human Resources should launch a major statewide initiative, utilizing regional pilot programs, across publicly-funded or –regulated child-serving systems to promote genuine family and youth engagement in the treatment of children's mental health disorders through extensive use of family engagement practices.
 - Require in all child-serving systems the use of family engagement strategies that are endorsed by the state and coordinated across systems to include the voice of the children needing treatment, their families, and natural supports identified by them and their families in treatment and service planning.
 - Provide comprehensive, ongoing training to all stakeholders involved in these systems at the state and local levels, including families and family organizations.
 - Ensure that family engagement strategies help families coordinate mental health care with their children's primary medical care.

*DBHDS stands for the Department of Behavioral Health and Developmental Services

**VACSB stands for the Virginia Association of Community Services Boards

The Campaign for Children's Mental Health is an advocacy initiative sponsored by Voices for Virginia's Children and led by a steering committee including National Alliance on Mental Illness (NAMI) Virginia, Mental Health America- Virginia, and the Virginia Association of Community Services Boards. For more information, visit www.1in5kids.org or contact Margaret Nimmo Crowe, campaign coordinator, at margaret@vakids.org or 804-649-0184 ext 23.

Richmond Times-Dispatch

Initiative could better use children's mental health funds

By: MARGARET NIMMO CROWE, MIRA SIGNER

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National data show that one in five kids has a mental health disorder, and only one in five of those is getting treatment. Based on those statistics, we could fill the Richmond Coliseum three times with the number of Metro Richmond-area children suffering with untreated mental health conditions.

Given that staggering unmet need, mental health and child advocates are wary of any new policy that could further restrict access to care. So we went on high alert in July when Virginia launched a new initiative designed to better screen kids seeking mental health services under Medicaid, the state's insurance for low-income children, pregnant women and the disabled.

The General Assembly designed this new initiative to help ensure the most effective use of the limited, precious dollars that are put into children's mental health. Under the new approach, children seeking Medicaid-funded intensive in-home services, therapeutic day treatment or mental health supports must first be evaluated by a community services board (CSB), the local public agencies that provide treatment and case management to citizens with mental illness.

Now three months into effect, it has sparked debate among children's mental health advocates and providers.

Some have already concluded the program, which is still in its infancy, is unfairly denying care to those who need it. Critics include some of the providers who receive Medicaid reimbursements for treating children.

However, those of us at the National Alliance on Mental Illness (NAMI) Virginia and Voices for Virginia's Children, a nonprofit, nonpartisan advocacy group, say it is too early to draw conclusions about this initiative, which is designed to address serious problems.

For example, expenditures for certain Medicaid-funded children's mental health services were increasing exponentially. In just four years, expenditures for intensive in-home services rose 250 percent, and expenditures for therapeutic day treatment rose 418 percent.

In many cases, the increase in services meant more children were remaining in their communities and homes rather than unnecessarily moving to a residential treatment facility, which is positive.

However, there was a systemic problem: There was no requirement that children receive independent assessments. The only people assessing many children for their mental health treatment needs were the providers who stood to profit from giving the services.

That is, in part, why government data show a significant percentage — in some localities as many as 20 percent — of children were getting more expensive services than their condition required. Many could have benefited from a less intensive, less expensive and more appropriate intervention, such as outpatient therapy.

We all have a responsibility to ensure good stewardship of scarce funds in treating children when four-fifths of the children with mental health conditions are not getting the help they need.

As with all new processes, government, advocates, parents and others must monitor the new approach and give feedback to help improve it.

As advocates, we are asking many questions, including:

- Are the community service boards, which conduct the assessments, offering convenient appointment times? While many already offer Saturday and evening appointments, they all should.
- Is transportation to appointments a barrier? LogistiCare, the state's Medicaid transportation contractor, is supposed to provide this transportation within specified time frames. If this is not happening consistently, Medicaid should investigate.
- Do families understand the nature of the services that are being recommended by the assessor? Independent assessors can play a critical role in educating families about the appropriate type of treatment for meeting their children's needs.
- Do families have the information necessary to make an informed choice about who provides the service to their children? For families who have not selected a provider before the assessment, the state requires that the assessor give them a list of all possible providers without making any recommendations. While this ensures fairness to all providers, it does not help families make an informed choice. We can improve this process by giving these families a fact-based report card that summarizes publicly available information such as credentials, services provided and child outcomes.

We call on all concerned to evaluate objectively the new process and provide constructive suggestions for improvement. While we may not agree on the process that led Virginia to implement this new approach, we can all agree on one thing: Virginia children with mental health disorders deserve the highest-quality, most appropriate treatment when they need it, wherever they live in the state.

Our children's mental health system has a long way to go, but we believe that policies ensuring that children are properly assessed are a step in the right direction.

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