

Comprehensive State Plan

2010-2016

**Virginia Department of Behavioral Health and
Developmental Services**

December 8, 2009

Comprehensive State Plan 2010-2016

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Comprehensive State Plan 2010-2016

Executive Summary

Section 37.2-315 of the *Code of Virginia* requires the Department of Behavioral Health and Developmental Services (Department) to develop and update biennially a six-year Comprehensive State Plan. The plan must identify the services and supports needs of persons with mental health or substance use disorders or intellectual disability across Virginia; define resource requirements for behavioral health and developmental services (formerly referred to as mental health and substance abuse services and mental retardation services); and propose strategies to address these needs. This section also requires that the plan be used in the preparation of the Department's biennium budget submission to the Governor.

Services System Overview: Title 37.2 of the *Code of Virginia* establishes the Department as the state authority for the behavioral health and developmental services system. The mission of the Department's central office is to provide leadership and service to improve Virginia's system of quality treatment and prevention services and supports for individuals and their families whose lives are affected by mental health or substance use disorders or an intellectual disability.

The Department seeks to promote dignity, choice, recovery, and the highest possible level of participation in work, relationships, and all aspects of community life for these individuals and is committed to implementing the vision "of a consumer-driven system of services and supports that promotes self-determination, empowerment, recovery, resilience, health, and the highest possible level of individual participation in all aspects of community life, including work, school, family and other meaningful relationships" (*State Board Policy 1036 (SYS) 05-3*).

Virginia's public services system includes 16 state facilities and 39 community services boards and one behavioral health authority (referred to as CSBs).

- CSBs are established by local governments and are responsible for delivering community behavioral health and developmental services, either directly or through contracts with private providers. They are single points of entry into publicly funded behavioral health and developmental services system, with responsibility and authority for assessing individual needs, providing an array of services and supports, and managing state-controlled funds for community-based services. In FY 2008, CSBs provided mental health services to 101,796 individuals, developmental services to 25,053 individuals, substance abuse services to 43,857 individuals, and services available outside a program area (e.g., emergency services) to 85,896 individuals, for an unduplicated total of 243,629 individuals who received some type of behavioral health or developmental service. Although the total number of individuals served by CSBs continues to increase, the CSBs continue to confront waiting lists for services. Between January and April 2009, 14,579 individuals were waiting to receive at least one CSB service.
- The 16 state facilities provide highly structured intensive inpatient treatment and habilitation services. Current operating bed capacities are 1,600 for state hospitals (excluding the Hiram Davis Medical Center, with an operating capacity of 87 beds and the Virginia Center for Behavioral Rehabilitation with an operating capacity of 312 beds) and 1,549 for training centers. In FY 2009, state facilities served a total of 6,866 individuals, a 3.3 percent decrease from FY 2008.

Funding for Virginia's public behavioral health and developmental services system comes from a variety of sources, including state general funds, local matching dollars, federal grants, and fees, including Medicaid. Medicaid reimbursement has grown steadily over the last four biennia. As a result, the percentage of the services system's total budget represented by Medicaid revenues has grown from 39 percent in FY 2000 to 52 percent in FY 2008.

In FY 2008, total services system expenses were almost \$2.004 billion, of which:

- \$1,372.0 million (68 percent) was expended by CSBs,
- \$ 595.0 million (30 percent) was expended by state facilities, and
- \$ 37.3 million (2 percent) was expended by the Department’s central office.

In FY 2008, the distribution of state-controlled resources was \$290.9 million (32 percent) for CSBs, \$594.7 million (64 percent) for state facilities, and \$37.3 million (4 percent) for the central office. With the current budget shortfall, state revenues have been and are likely to continue to be cut in the near future. The Department experienced budget reductions of \$16.9 million in FY 2008, \$24.2 in FY 2009, and \$39.7 million in FY 2010. The following table breaks out these reductions across state facilities, CSBs, and the central office/Office of the Inspector General.

Reductions in Department of Behavioral Health and Developmental Services State General Fund Appropriations in FY 2008, FY 2009, and FY 2010

Reductions:	FY 2008	FY 2009	FY 2010
State Facilities	\$11,081,229	\$ 7,001,056	\$18,346,004
Community Services Boards	\$ 5,000,000	\$12,400,000	\$16,703,180*
Central Office/Inspector General	\$ 781,018	\$ 4,826,124	\$4,632,188
Total Reduction	\$16,862,247	\$24,227,180	\$39,681,372

*Note: The FY 2010 CSB reduction was offset using \$4.5 million in one-time special fund revenues, for a new FY 2010 reduction of \$12.1 million.

The FY 2009 reduction includes a \$15,067,179 cash transfer reduction of Special Revenue Funds from state training center collections, which is not included in the above table because it did not change the Department's appropriation. These reductions do not include local budget cuts incurred by CSBs.

Estimated Prevalence: By applying prevalence rates from national epidemiological studies and the 2007 National Household Survey on Drug Use and Health to *2008 Population by Age and Sex* estimates from the Weldon Cooper Center for Public Services at the University of Virginia, the Department estimates that:

- Approximately 316,552 adults have had a serious mental illness during the past year.
- Between 85,129 and 104,046 children and adolescents have a serious emotional disturbance, with between 47,294 and 66,211 exhibiting extreme impairment.
- Approximately 139,844 individuals are conservatively estimated to have a developmental disability, of which 71,526 (ages 6 and older) have an intellectual disability and 1 in 91 children have an autism spectrum disorder.
- Approximately 18,495 infants, toddlers, and young children (birth through age 5) have developmental delays requiring early intervention services.
- Approximately 180,453 adults and adolescents (ages 12 and older) abuse or are dependent on any illicit drug, with 128,337 meeting the criterion for dependence, and 476,215 adults and adolescents abuse or are dependent on alcohol, with 168,050 meeting the criterion for dependence.

Only a portion of persons with diagnosable disorders will need services at any given time, and an even smaller portion will require or seek services from the public sector.

Critical Issues and Strategic Directions: The Plan details seven critical issues facing Virginia and identifies 14 goals and supporting objectives and action steps to achieve the Department’s mission and vision. Strategic directions and goals for each critical issue follow.

Transforming Virginia's System of Care:

- Implement a recovery and resilience-oriented and person-centered system of behavioral health and developmental services and supports.

Peer-Provided and Peer-Directed Services and Related Initiatives That Promote Recovery and Person-Centered Principles and Practices:

- Involve individuals who are receiving services and family members in planning, evaluating, and delivering behavioral health and developmental services.

Access to Services and Supports That Meet Individual Needs:

- Promote the concepts of treatment in the most integrated settings appropriate and encourage individual and family choice as central to the U.S. Supreme Court Olmstead Decision.
- Promote and support the implementation of evidence-based and best practices.
- Assure that communities provide quality recovery and resilience-oriented and person-centered assessments, services, and supports that are appropriate to the needs of individuals receiving services.
- Reduce the incidence of alcohol, tobacco, and other drug use and abuse and suicide among Virginia youth and adults.
- Assure that state facilities provide quality assessment, treatment, rehabilitation, training, and habilitation services that are appropriate to the needs of individuals receiving services.
- Enable Virginia's behavioral health and developmental services system to prepare for and respond to terrorism-related and other major disasters.

Partnerships for Services System Transformation:

- Increase the ability of Virginia agencies and services systems to partner in addressing the needs of and challenges experienced by individuals with mental health, substance abuse, or co-occurring disorders or intellectual disability.
- Encourage and facilitate greater private provider participation in the public behavioral health and developmental services system.

Infrastructure and Technology:

- Provide state facility infrastructure and community housing that efficiently and appropriately meets the needs of individuals receiving behavioral health or developmental services.
- Manage information efficiently in an environment that is responsive to the needs of users and protects identifiable health information about individuals receiving services.

Human Resources Management and Development:

- Recruit and retain a highly-skilled and appropriately sized behavioral health and developmental services workforce.

Service Quality and Accountability:

- Enhance the capacity of the behavioral health and developmental services system to improve quality of care.

Summary of Resource Requirements: The following capacity development priorities respond to critical issues facing Virginia’s behavioral health and developmental services system. Given the current budget constraints facing the Commonwealth, the Department recognizes that these requirements will require a multi-biennia investment, when resources are available.

Mental Health Services

Local inpatient purchase of service (LIPOS) and crisis stabilization services for individuals whose acute care needs can be met with community services rather than in a state hospital.

Crisis intervention training for law enforcement, jail diversion, mobile crisis teams, and restoration to competency services for individuals involved in the criminal justice system.

Community services capacity development to assist individuals in their recovery and address unmet service needs of individuals with mental health disorders on CSB waiting lists.

Suicide Prevention Across the Lifespan Plan for the Commonwealth of Virginia implementation.

Substance Abuse and Prevention Services

Community services capacity development to reduce the average wait time for services from 25 days to 10 days and address unmet service needs of individuals with substance use disorders on CSB wait lists.

Services and supports for individuals to decrease their involvement with the criminal justice system and disease relapse.

Evidenced-based prevention services.

Child and Family Services

Community services capacity development to divert children and adolescents from inappropriate care in congregate residential settings including juvenile detention centers, residential treatment centers, and state hospitals.

Part C infant and toddler intervention services capacity development to accommodate an eight percent increase in referrals of infants and toddlers and address Part C operational needs.

Developmental Services

Waiver capacity development of 400 additional slots each year to enable individuals with intellectual disability to live productive lives in community settings.

Enhanced waiver services plans for individuals who have significant behavioral and medical challenges to allow them to live in small group home or family home settings rather than in a training center or community ICF/MR. Services and policy changes include:

- A 25 percent increase in waiver rates for in-home support and small (4 or fewer beds) congregate residential services;
- Day support and employment services;
- Behavioral consultation assessment and monitoring and staff training in behavioral strategy implementation;
- Nurse monitoring of skilled nursing activities and overseeing individual stability/progress; and;
- Removal of penalties for providers who keep a residential bed vacant for consumers who may require hospital stays or for other valid situations.

Community services capacity development for individuals with intellectual disability who are not eligible for the ID waiver but need services that will allow them to remain in community settings.

Community services capacity development to ensure that individuals with developmental disabilities who have severe functional disabilities receive targeted case management services.

Conclusion: The directions established in the *Comprehensive State Plan 2010-2016* would enable the Commonwealth to accelerate the transformation of the public services system to a more completely community-based system of care while preserving the important roles and service responsibilities of state hospitals and training centers in Virginia's publicly funded behavioral health and developmental services system.

The policy agenda for the publicly funded behavioral health and developmental services system for the next biennium will focus on sustaining progress in implementing the vision of recovery and person-centered delivery of behavioral health and developmental services and investing in the services capacity and infrastructure needed to address issues facing the services system. Department priorities for the next biennium follow:

- Initiatives to increase access to transitional and permanent community housing for individuals with mental health or substance use disorders or intellectual or developmental disabilities. Affordable community housing is the area most lacking in the Commonwealth's array of services and supports and is the primary barrier to individuals who are transitioning from state facilities to the community.
- Initiatives to enhance the existing Medicaid waiver for individuals with intellectual disability to assure that they can receive "comparable services and supports" to those provided in an ICF/MR facility. This lack of comparability has increased family reliance on ICF/MR settings, which are more costly for the state and more restrictive and removed from individuals' family, friends, and their home communities.
- Initiatives to build a Virginia behavioral health – medical health partnership that promotes a "one person, one team, one plan" approach to serving individuals. The need for such an integrated system of services and supports is well documented, yet there is little interface between these two systems, except at the crisis or emergency level of each system.
- Initiatives to expand behavioral health and criminal justice partnerships and service delivery for individuals with mental health or substance use disorders who are at risk of involvement or are currently involved in the criminal justice system. Diversion and intervention efforts will result in reduced reliance on jail beds and state facility beds devoted to forensic treatment needs.
- Initiatives that advance a comprehensive system for health information exchange (HIE) across the behavioral health and developmental services system; with other providers that serve individuals with mental health or substance use disorders or intellectual disability; and with other state agencies that fund behavioral health or developmental services. A comprehensive HIE approach would produce improved efficiencies in service delivery, better service coordination, and enhanced capacity for performance measurement.

Comprehensive State Plan

2010 - 2016

I. INTRODUCTION

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

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

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

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

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

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

The *Comprehensive State Plan 2010-2016* has been expanded to include developmental services. This plan continues to build on the recommendations of the Department's Integrated Strategic Plan (ISP). The ISP was the product of a two-year strategic planning process that has involved hundreds of interested Virginians and provided a framework for transforming Virginia's publicly funded behavioral health and developmental services system. In 2009, the Department reviewed and affirmed the ISP critical success factors and updated priority implementation actions required to achieve these success factors.

Key initiatives in the *Comprehensive State Plan 2010-2016* have been incorporated in the Agency Strategic Plan (ASP) and associated Service Area Plans prepared as part of the 2010-2012 biennium budget submission to the Department of Planning and Budget. Using a uniform structure and cross-agency taxonomy of state programs and activities provided by the Department of Planning and Budget, the Department's ASP is intended to align the Department's vision, goals, services, objectives, and resource plans with the guiding principles, long-term vision, and statewide objectives established by the Council for Virginia's Future. The Council was established by §2.2-2684 of the *Code of Virginia* to advise the Governor and the General Assembly on implementation of the Roadmap for Virginia's Future process.

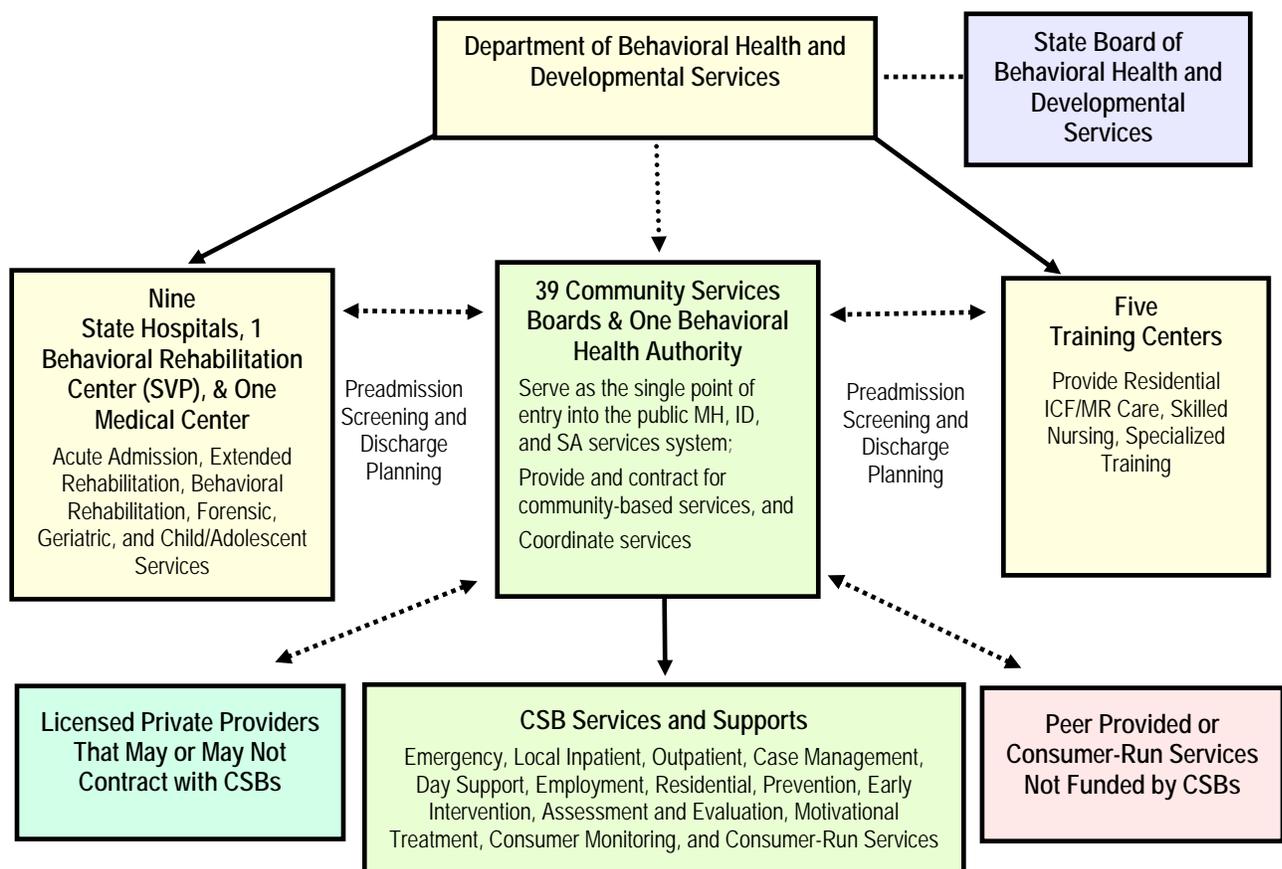
The draft *Comprehensive State Plan 2010-2016* was placed on the Department's website for public review and comment on October 19, 2009. Copies also were provided to individuals upon request. On November 17, 2009, the State Board of Behavioral Health and Developmental Services (State Board) and Department staff conducted a video conference public hearing at four sites to receive public comment on the draft Plan. Three individuals provided comments at the hearing. These individuals also submitted written or e-mail comments. In addition, the Department received ten other comments by phone, mail, fax, or email. At its December 8, 2009 meeting, the State Board reviewed public hearing testimony and other comments received on the draft Plan and considered changes proposed by the Department in response to this public comment.

II. SERVICES SYSTEM OVERVIEW

Services System Structure and Statutory Authority

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

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



Title 37.2 of the *Code of Virginia* establishes the Department as the state authority for the Commonwealth’s publicly-funded behavioral health and developmental services system. By statute, the State Board offers policy direction for Virginia’s services system.

The mission of the Department’s central office is to provide leadership and service to improve Virginia’s system of quality treatment and prevention services and supports for individuals and families whose lives are affected by mental health or substance use disorders or intellectual disability. The central office seeks to promote dignity, choice, recovery, and the highest possible level of participation in work, relationships, and all aspects of community life for these individuals.

Responsibilities of the Department include:

- Providing leadership that promotes strategic partnerships among and between CSBs, state facilities, and the central office and effective relationships with other agencies and providers;
- Providing services and supports in state hospitals (civil and forensic) and training centers;
- Supporting the provision of accessible and effective behavioral health and developmental services and supports provided by CSBs and other providers;
- Assuring that public and private providers of behavioral health or developmental services and supports adhere to licensing standards; and
- Protecting the human rights of individuals receiving behavioral health or developmental services.

Characteristics of Community Services Boards and Trends

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

Community services boards:

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

The private sector is a vital partner with CSBs in serving individuals who need behavioral health or developmental services. In addition to serving many individuals through contracts with CSBs, private providers also serve other individuals directly, for example through various Medicaid waiver programs with plans of care case managed by CSBs and mental health clinic and inpatient psychiatric treatment services.

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

Combined Classification of Community Services Boards

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

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

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

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

CSB Mental Health Services

In FY 2008, 101,796 individuals received CSB mental health services. This represents an unduplicated count of all individuals receiving any mental health services.

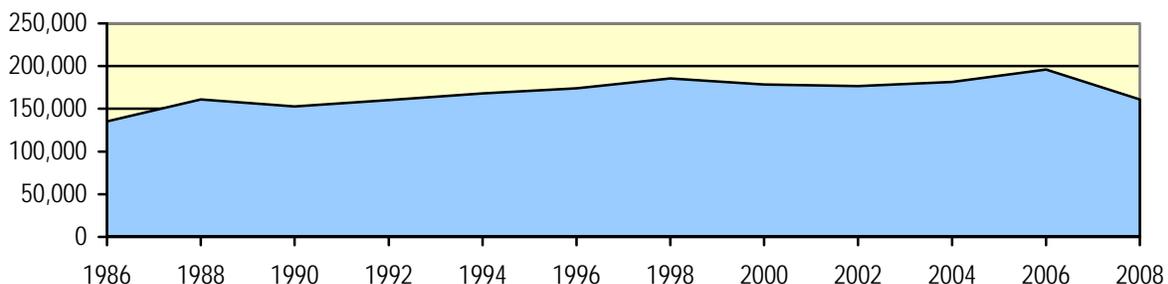
Number of Individuals Receiving Mental Health Core Services in FY 2008

Core Service	# Served	Core Service	# Served
Local Inpatient Services	2,765	Individual Supported Employment	1,206
Outpatient Services	85,424	TOTAL Employment Services	1,306
Assertive Community Treatment	1,708	Highly Intensive Residential	237
TOTAL Outpatient Services	87,132	Residential Crisis Stabilization	2,313
Case Management Services	50,151	Intensive Residential	224
Day Treatment/Partial Hospitalization	3,789	Supervised Residential	1,448
Ambulatory Crisis Stabilization Services	312	Supportive Residential	5,714
Rehabilitation Services	5,655	TOTAL Residential Services	9,936
TOTAL Day Support Services	9,756	TOTAL Individuals Served	161,046
Sheltered Employment Services	61	TOTAL Unduplicated Individuals	101,796
Group Supported Employment	39		

Source: FY 2008 Community Services Performance Contract Annual Reports, Department.

Between FY 1986 (the first year that annual performance contract data was submitted by CSBs) and FY 2008, the numbers of individuals receiving various CSB mental health services grew from 135,182 to 161,046, an increase of 19 percent. In FY 2008, the Department added a new program area, Services Available Outside of a Program Area. The number of individuals receiving mental health services between FY 2006 and FY 2008 decreased because some services that had been counted in previous years (i.e., Emergency, Consumer Monitoring, Assessment and Evaluation, Consumer-Run, and Early Intervention Services) were moved to this fourth area for FY 2008.

**Trends in Numbers of Individuals Receiving CSB Mental Health Services
FY 1986 - FY 2008**



These numbers are duplicated counts of individuals because they display numbers of people receiving mental health services by core service categories.

A significant number of individuals served by CSBs have severe disabilities. In FY 2008, of the individuals receiving mental health services, 42,529 adults (57 percent) had a serious mental illness and 19,448 youth (70 percent) had or were at risk of having a serious emotional disturbance. This does not include 6,700 adults with serious mental illness and 2,000 youth with or at risk of serious emotional disturbance who received only emergency services.

CSB Developmental Services

In FY 2008, 25,053 individuals received CSB developmental services. This represents an unduplicated count of all individuals receiving any intellectual disability services.

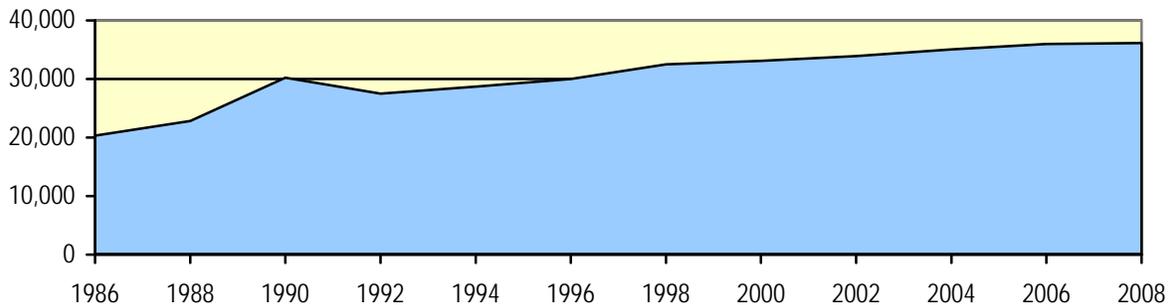
Number of Individuals Receiving Developmental Core Services in FY 2008

Core Service	# Served	Core Service	# Served
Outpatient Services	81	Highly Intensive Residential	119
Case Management Services	17,590	Intensive Residential	864
Rehabilitation or Habilitation	2,675	Supervised Residential	496
TOTAL Day Support Services	2,675	Supportive Residential	1,368
Sheltered Employment Services	892	TOTAL Residential Services	2,847
Group Supported Employment	739	Infant and Toddler Intervention Services	10,185
Individual Supported Employment	1,132	TOTAL Individuals Served	36,141
TOTAL Employment Services	2,763	TOTAL Unduplicated Individuals	25,053

Source: 2008 Community Services Performance Contract Annual Reports, Department.

Between FY 1986 (the first year that annual performance contract data was submitted by CSBs) and FY 2008, the numbers of individuals receiving various CSB developmental services grew from 20,329 to 36,141, or by 77 percent.

**Trends in Numbers of Individuals Receiving CSB Developmental Services
FY 1986 - FY 2008**



These numbers are duplicated counts of individuals because they display numbers of people receiving developmental services by core service categories.

CSB Substance Abuse Services

In FY 2008, 43,657 individuals received substance abuse services from CSBs. This represents an unduplicated count of all individuals receiving any substance abuse services.

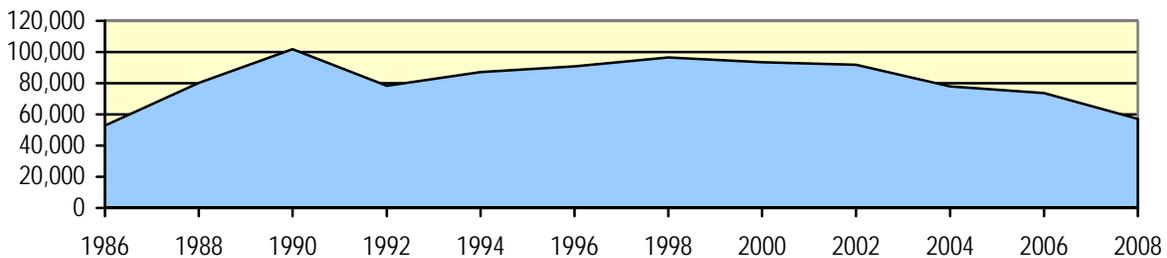
Number of Individuals Receiving Substance Abuse Core Services in FY 2008

Core Service	# Served	Core Service	# Served
Local Inpatient	222	Highly Intensive Residential	4,391
Community Hospital-Based Detox	271	Residential Crisis Stabilization Services	18
TOTAL Local Inpatient Services	493	Intensive Residential	2,809
Outpatient Services	33,521	Jail-Based Habilitation	1,831
Opioid Detoxification	243	Supervised Residential	267
Opioid Treatment Services	2,032	Supportive Residential	129
TOTAL Outpatient Services	35,796	TOTAL Residential Services	9,445
Case Management Services	10,023	TOTAL Individuals Served	57,219
Day Treatment/Partial Hospitalization	1,462	TOTAL Unduplicated Individuals	43,657
TOTAL Day Support Services	1,462		

Source: 2008 Community Services Performance Contract Annual Reports, Department.

Between FY 1986 (the first year that annual performance contract data was submitted by CSBs) and FY 2008, the numbers of individuals receiving various CSB substance abuse services grew from 52,942 to 57,226, an increase of eight percent. In FY 2008, the Department added a new program area, Services Available Outside of a Program Area. The number of individuals receiving substance abuse services between FY 2006 and FY 2008 decreased because some services that had been counted in previous years (i.e., Emergency, Motivational Treatment, Consumer Monitoring, Assessment and Evaluation, and Early Intervention Services) were moved to this fourth area for FY 2008.

**Trends in Numbers of Individuals Receiving CSB Substance Abuse Services
FY 1986 - FY 2008**



These numbers are duplicated counts of individuals because they display numbers of people receiving substance abuse services by core service categories.

CSB Services Available Outside a Program Area

In FY 2008, 85,896 individuals received CSB services available outside a program area.

Number of Individuals Receiving Services Available Outside a Program Area in FY 2008

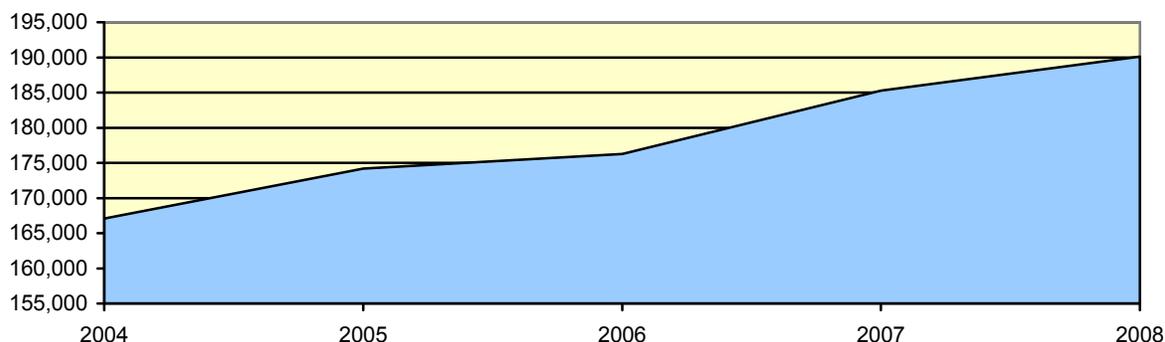
Core Service	# Served	Core Service	# Served	Core Service	# Served
Emergency Services	55,718	Motivational Treatment	2,324	Assessment and Evaluation	17,347
Consumer Monitoring Svcs.	7,039	Early Intervention Services	2,411	Consumer-Run Services	1,057
TOTAL Individuals (Not Unduplicated)					85,896

Source: 2008 Community Services Performance Contract Annual Reports, Department.

Unduplicated Count of Individuals Receiving CSB Services

With the implementation in FY 2004 of the Community Consumer Submission (software that extracts and transmits encrypted data from CSB information systems to the Department), a totally unduplicated count of individuals receiving CSB services across all program areas became available for the first time. In FY 2008, the unduplicated count of individuals served across each program area and in Services Available Outside a Program Area was 190,125.

**Trends in Unduplicated Numbers of Individuals Receiving CSB Services
FY 2004 - FY 2008**



Appendix B contains detailed information on CSB service utilization trends for individuals served and services provided by CSBs in FY 2008, and condensed core services definitions.

Characteristics of State Hospitals and Training Centers and Trends

State Hospitals

State hospitals provide highly structured intensive inpatient services, including a range of psychiatric, psychological, psychosocial rehabilitation, nursing, support, and ancillary services. Specialized programs are provided to older adults, children and adolescents, and individuals with a forensic status. Operating (staffed) bed capacities on July 9, 2009 and FY 2009 average daily census for the state hospitals follow.

State Hospital Operating Capacities and FY 2009 Average Daily Census

MH Facility	Beds	ADC	MH Facility	Beds	ADC
Catawba Hospital	120	92	Piedmont Geriatric	135	112
Central State Hospital	277	249	Southern VA MHI	74	70
CCCA	48	30	Southwestern VA MHI	174	152
Eastern State Hospital	385	369	Western State Hospital	260	227
Northern VA. MHI	129	119	Total Operating Capacity (Beds) and ADC	1,600	1,419

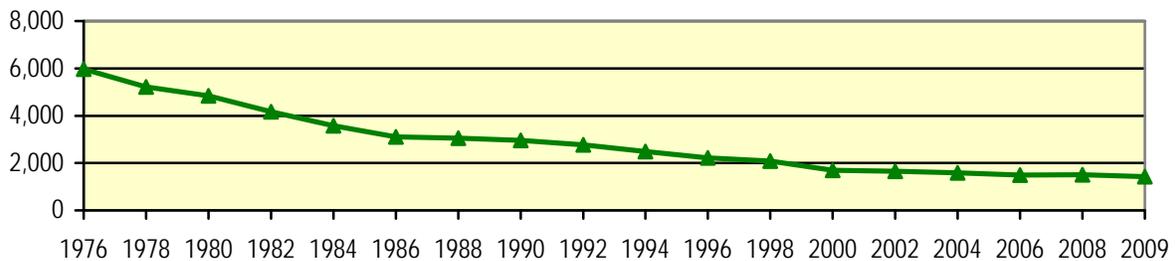
Note: HDMC, with an operating capacity of 87 beds and an ADC of 46 and VCBR, with an operating capacity of 312 beds and an ADC of 114 are not included in this table.

All state hospitals and the Hiram Davis Medical Center (HDMC), which provides medical and skilled nursing services to individuals receiving state facility services, are accredited by the Joint Commission (formerly the Joint Commission for Accreditation of Healthcare Organizations). Child and adolescent services provided by the Southwestern Virginia Mental Health Institute (SVMHI) and the Commonwealth Center for Children and Adolescents (CCCA) are licensed under the CORE regulations for residential children's services. The Virginia Center for

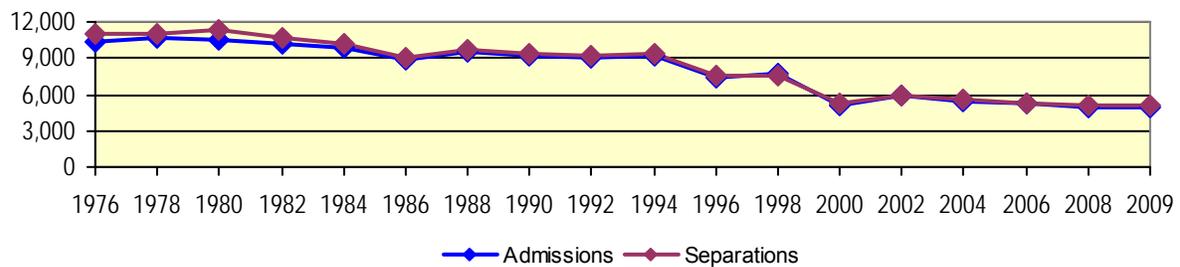
Rehabilitative Services (VCBR) provides individualized rehabilitation services in a secure facility to individuals who are civilly committed to the Department as sexually violent predators.

Between FY 1976 and FY 1996, the average daily census at state hospitals, excluding the Hiram Davis Medical Center, declined by 3,745, or 63 percent (from 5,967 to 2,222). Between FY 1996 and FY 2009, the average daily census declined by 36 percent (from 2,222 to 1,419). Between FY 1996 and FY 2009, excluding the HDMC and VCBR, admissions declined by 35 percent (from 7,468 to 4,884) and separations (discharges) declined by 33 percent (from 7,529 to 5,042). In FY 2009, VCBR experienced 61 admissions and 3 separations.

Trends in State Hospital Average Daily Census (ADC) FY 1976 - FY 2009



Trends in State Hospital Admissions and Separations FY 1976 - FY 2009



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

Training Centers

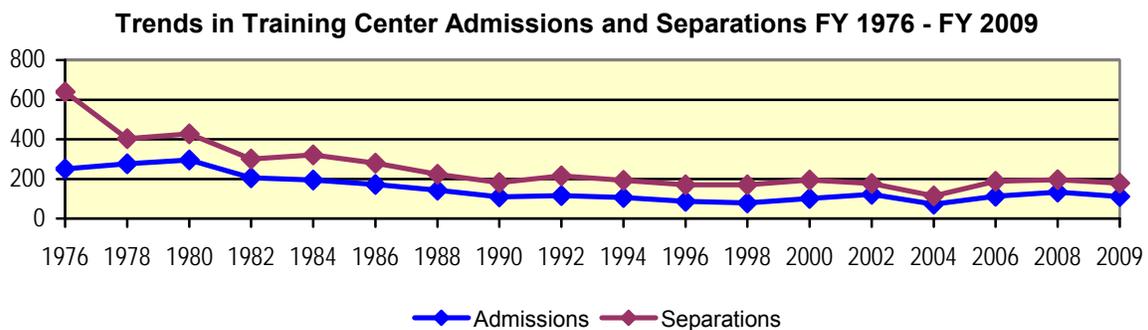
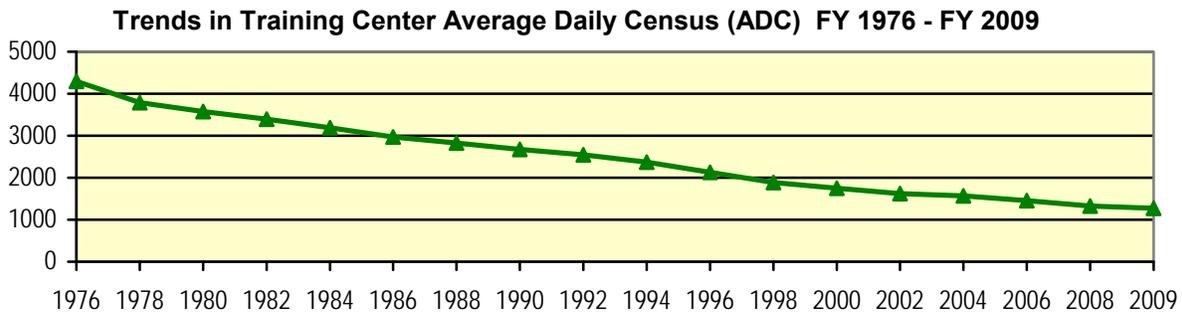
Training centers provide highly structured habilitation services, including residential care and training in areas such as language, self-care, independent living, socialization, academic skills, and motor development for individuals with an intellectual disability. All training centers are certified by the U.S. Centers for Medicare and Medicaid (CMS) as meeting Medicaid Intermediate Care Facility for the Mentally Retarded (ICF/MR) standards of quality. In addition, Central Virginia Training Center provides skilled nursing services. Operating (staffed) bed capacities on July 9, 2009 and FY 2009 average daily census for each training center follow.

Training Center Operating Capacities and Average Daily Census

Training Center	Beds	ADC	Training Center	Beds	ADC
Central Virginia Training Center	558	450	Southside Virginia Training Center	361	293
Northern Virginia Training Center	220	171	Southwestern Virginia Training Center	210	199
Southeastern Virginia Training Center	200	164	Total Operating Capacity (Beds) and ADC	1,549	1,276

Between FY 1976 and FY 1996, the average daily census at training centers declined by 2,161, or 51 percent (from 4,293 to 2,132). Between FY 1996 and FY 2009, the average daily census declined by 40 percent (from 2,132 to 1,276). Between FY 1996 and FY 2009, training center admissions increased by 28 percent (from 87 to 111). Between FY 1996 and FY 2009, training center separations (discharges) decreased by 20 percent (from 223 to 179).

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



Profile of Individuals Receiving Services and Supports in State Facilities

In FY 2009, 6,866 individuals were served in state facilities. Of these, 5,306 unduplicated individuals received 6,360 episodes of care in state hospitals; 1,386 unduplicated individuals received 1,436 episodes of care in training centers, and 152 unduplicated individuals were served at VCBR. In general, the individuals served in state facilities are Caucasian (64 percent), male (60 percent), between 18 and 64 years of age (79 percent), and receiving mental health support services (78 percent).

The average age of individuals served in training centers was 48 years of age and their average length of stay was 28.6 years, with 2.6 percent of the episodes of care (38) being less than seven days and 10.1 percent (145) being more than 50 years.

During FY 2009, 61 individuals were admitted to VCBR and three individuals were discharged. All of the individuals were male and 95 percent were between 21 to 64 years of age.

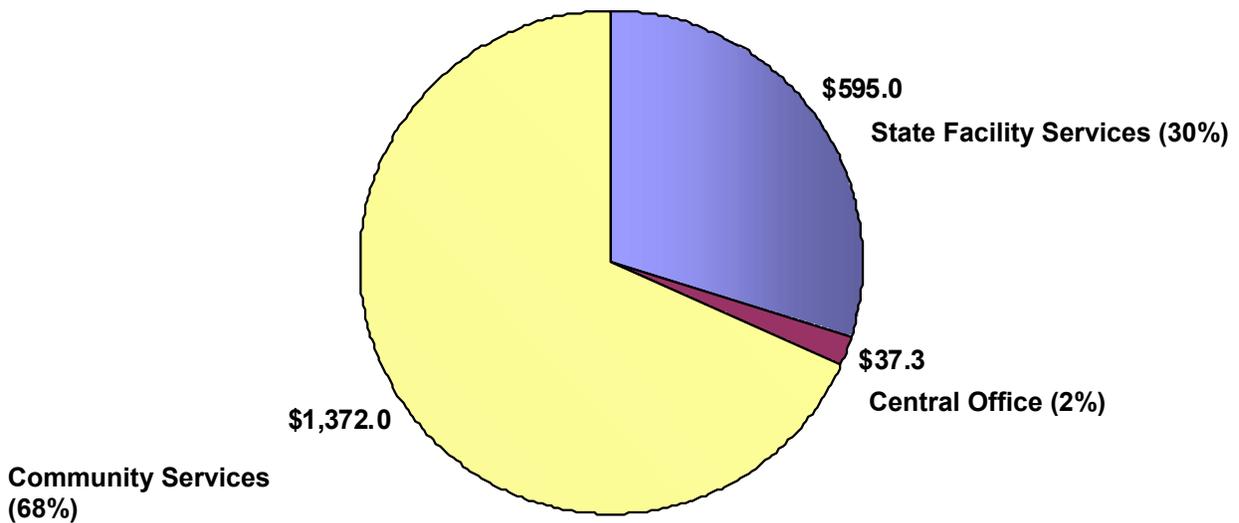
Appendix C contains detailed information on state facility utilization, including the numbers served, average daily census, admissions, separations, and utilization, by CSB.

Services System Funding and Trends

Charts depicting the services system's total resources for **FY 2008** from **ALL SOURCES** (rounded and in millions), including the Department's final adjusted appropriation, local matching funds, all fees, and Medicaid ID waiver payments to private vendors, follow.

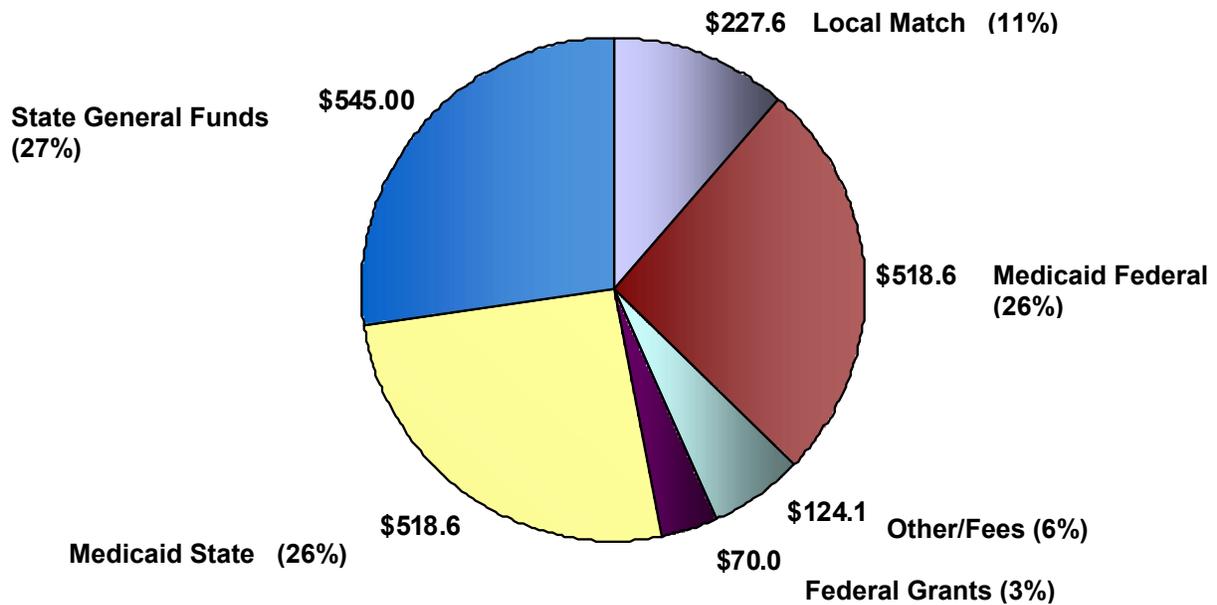
FY 2008 Total Services System Funding

\$2.004 Billion

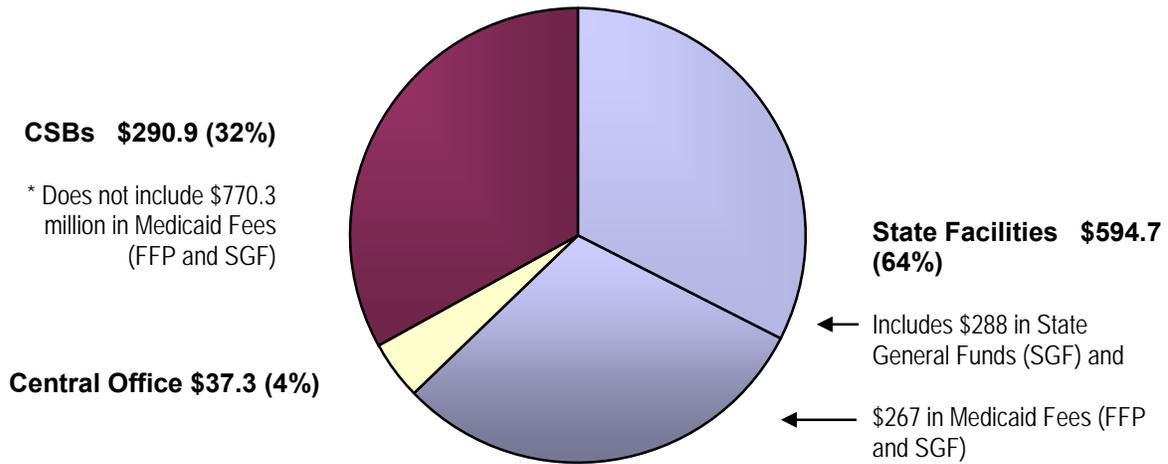


FY 2008 Total Services System Funding by Funding Source

\$2.004 Billion



FY 2008 Total State-Controlled Expenditures
\$ 922.9 Million

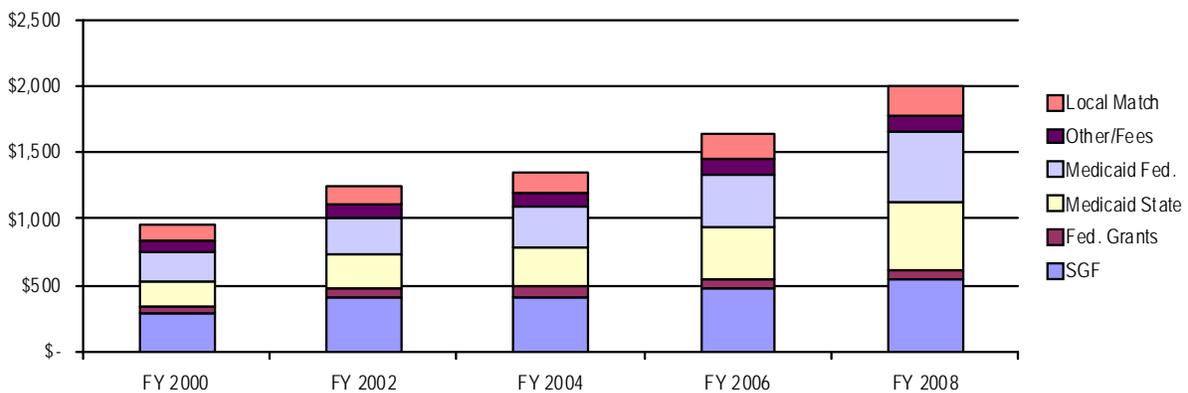


Total Services System Funding Trends by Funding Source

Between FY 2000 and FY 2008, total services system funding grew by 22 percent from \$1,644.8 million to \$2,004.0 million. The following table depicts funding by source (in millions) for this time period.

Total Services System Funds by Source
FY 2000 – FY 2008

	FY 2000	FY 2002	FY 2004	FY 2006	FY 2008
State General Funds	399.9	408.2	408.7	482.4	544.9
Federal Grants	56.2	72.2	78.7	68.5	70.0
Medicaid - State	209.0	256.9	302.1	390.9	518.6
Medicaid - Federal	223.2	273.3	303.7	390.9	518.6
Other/Fees	102.0	92.8	99.0	115.8	124.1
Local Match	115.9	149.3	166.2	196.2	227.6
Total	\$1,106.3	\$1,252.7	\$1,358.4	\$1,644.8	\$2,004.0



Dollars in charts and table above are in millions

III. DESCRIPTIONS OF POPULATIONS SERVED AND PREVALENCE ESTIMATES

Individuals Who Have a Serious Mental Illness or Serious Emotional Disturbance

A mental disorder is broadly defined in the *DSM-IV-TR (Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision)* as a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g., a painful symptom) or disability (i.e., impairment of one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom.

Mental disorders are common. The annual prevalence of these disorders is nearly 20 percent, and the lifetime prevalence of all mental disorders in the general population is 20-25 percent. Only a portion of individuals with diagnosable disorders will need services at any given time and an even smaller portion will require or seek services from the public sector.

There have been many significant advances in the treatment of mental illness, to the extent that today there are many effective treatments for most mental disorders. In addition to emergency services that are available to any individual in crisis, Virginia's public services system provides services to adults who have serious mental illnesses and children who have or are at risk of experiencing serious emotional disturbance.

Serious Mental Illness means a severe and persistent mental or emotional disorder that seriously impairs the functioning of adults, 18 years of age or older, in such primary aspects of daily living as personal relationships, self-care skills, living arrangements, or employment. Individuals with serious mental illness who also have been diagnosed as having a substance use disorder or intellectual disability are included in this definition. Serious mental illness is defined along three dimensions: diagnosis, level of disability, and duration of illness. All three dimensions must be met to meet the criteria for serious mental illness.

- **Diagnosis:** an individual must have a major mental disorder diagnosed under the *DSM-IV-TR*. These disorders are: schizophrenia, major affective disorders, paranoia, organic or other psychotic disorders, personality disorders, or other disorders that may lead to chronic disability.
- **Level of Disability:** There must be evidence of severe and recurrent disability resulting from mental illness that must result in functional limitations in major life activities. Individuals should meet at least two of the following criteria on a continuing or intermittent basis.
 - a. Is unemployed or employed in a sheltered setting or a supportive work situation, has markedly limited or reduced employment skills, or has a poor employment history.
 - b. Requires public financial assistance to remain in the community and may be unable to procure such assistance without help.
 - c. Has difficulty establishing or maintaining a personal social support system.
 - d. Requires assistance in basic living skills such as personal hygiene, food preparation, or money management.
 - e. Exhibits inappropriate behavior that often results in intervention by the mental health or judicial system.
- **Duration of Illness:** The individual is expected to require services of an extended duration, or his treatment history meets at least one of the following criteria.
 - a. The individual has undergone psychiatric treatment more intensive than outpatient care, such as crisis response services, alternative home care, partial hospitalization, or inpatient hospitalization, more than once in his or her lifetime.

- b. The individual has experienced an episode of continuous, supportive residential care, other than hospitalization, for a period long enough to have significantly disrupted the normal living situation.

Substance use disorders frequently occur in conjunction with serious mental illness.

Serious Emotional Disturbance means a serious mental health problem that affects a child, from birth through age 17, and can be diagnosed under *DSM-IV-TR* or meets specific functional criteria.

- Problems in personality development and social functioning that have been exhibited over at least one year's time,
- Problems that are significantly disabling based on social functioning of most children of the child's age,
- Problems that have become more disabling over time, and
- Service needs that require significant intervention by more than one agency.

Substance use disorders frequently occur in conjunction with serious emotional disturbance.

Children "At-Risk" of Serious Emotional Disturbance means a condition experienced by a child, from birth through age 7, which meets at least one of the following criteria:

- The child exhibits behavior or maturity is significantly different from most children of the child's age, and is not due to developmental or intellectual disability, or
- Parents or persons responsible for the child's care have predisposing factors themselves, such as inadequate parenting skills, substance use disorder, mental illness, or other emotional difficulties, that could result in the child developing serious emotional or behavior problems, or
- The child has experienced physical or psychological stressors, such as living in poverty, parental neglect, or physical or emotional abuse, which put him at risk for serious emotional or behavior problems.

Individuals Who Have Intellectual Disability or Another Developmental Disability

Intellectual disability, which is identified as "mental retardation" in the *Code of Virginia*, means a disability originating before the age of 18 years that is characterized concurrently by (i) significantly sub-average intellectual functioning as demonstrated by performance on a standardized measure of intellectual functioning, administered in conformity with accepted professional practice, that is at least two standard deviations below the mean and (ii) significant limitations in adaptive behavior as expressed in conceptual, social, and practical adaptive skills. With each individual, limitations often co-exist with strengths. With appropriate personalized supports over a sustained period, the life functioning of individuals with mental retardation generally will improve; however, mental retardation is a life-long disability. The American Association on Intellectual and Developmental Disabilities (AAIDD) has adopted the term "intellectual disability" in place of "mental retardation."

Developmental disabilities are a diverse group of severe chronic conditions that are due to mental or physical impairments, or both, are manifested before a person reaches age 22, and usually last throughout a person's lifetime. People with developmental disabilities have problems with major life activities such as language, mobility, learning, self-help, and independent living. Among the array of developmental disability conditions, the Department and CSBs may serve individuals who have an autism spectrum disorder or a severe chronic disability that is attributable to cerebral palsy, epilepsy, or any other condition, other than mental illness, that is found to be closely related to intellectual disability when the condition results in substantial functional limitations in three or more areas of major life activities and impairment of general intellectual functioning or adaptive behavior that is similar to that of persons with intellectual disability and requires comparable treatment, services, or supports.

Individuals Who Have a Substance Use Disorder

Substance use disorders (SUDs) are types of mental disorders that are "related to the taking of a drug of abuse (including alcohol), to the side effects of a medication, and to toxin exposure" (DSM IV, Fourth Edition). There are two levels of substance use disorders: substance addiction (dependence) or substance abuse.

- Substance addiction (dependence), as defined by the International Classification of Diseases, Clinical Modification (ICD-9-CM), means uncontrollable substance-seeking behavior involving compulsive use of high doses of one or more substances resulting in substantial impairment of functioning and health. Tolerance and withdrawal are characteristics associated with dependence. Dependence is a maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following occurring at any time in the same 12-month period.
 1. Needing markedly increased amounts of the substance to achieve intoxication or a desired effect or having a markedly diminished effect with continued use of the same substance
 2. Having the characteristic withdrawal syndrome for the substance or the same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms;
 3. Taking larger amounts of the substance or over a longer period than was intended;
 4. Having a persistent desire or unsuccessful efforts to cut down or control substance use;
 5. Spending a great deal of time on activities necessary to obtain the substance, use the substance, or recover from its effects;
 6. Giving up or reducing important social, occupational, or recreational activities because of substance use; and
 7. Continuing substance use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.
- Substance abuse, as defined by ICD-9-CM, means a maladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to the repeated use of substances. It leads to clinically significant impairment or distress, as manifested by one (or more) of the following occurring within a 12-month period:
 1. Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions, or expulsions from school; neglect of children or household);
 2. Recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use);
 3. Recurrent substance-related legal problems (e.g., arrests for substance-related disorderly conduct); and
 4. Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with spouse about consequences of intoxication, physical fights).

Prevalence Estimates

When planning for Virginia's future public behavioral health and developmental services system, it is important to have a sense of how many individuals might seek care from the services system. This section uses national epidemiological studies as the basis for extrapolating Virginia prevalence rates for adults with serious mental illnesses, children and adolescents with serious emotional disturbances, individuals with an intellectual or developmental disability, and individuals with substance use disorders. Prevalence is the total number of cases within a year.

This differs from incidence, which is the number of new cases within a year. The source for the following prevalence estimates is *2008 Population by Age and Sex, July 1, 2008*, Weldon Cooper Center for Public Service at the University of Virginia.

Estimated Prevalence for Adults with Serious Mental Illnesses: An estimate of the number of adults ages 18 and over with serious mental illnesses was developed using the methodology published by the U.S. Center for Mental Health Services of the Substance Abuse and Mental Health Services Administration in the Federal Register, Volume 64, No. 121, Thursday, June 24, 1999. This methodology estimates that 5.4 percent or 316,552 adults in Virginia have a serious mental illness.

Estimated Prevalence for Children and Adolescents With Serious Emotional Disturbance: An estimate of the number of children and adolescents ages 9 through 17 with serious emotional disturbances was developed using the methodology published by the U.S. Center for Mental Health Services of the Substance Abuse and Mental Health Services Administration in the Federal Register, Volume 63, No. 137, Friday, July 17, 1998. This methodology estimates that between 85,129 and 104,046 children and adolescents in Virginia have a serious emotional disturbance (level of functioning score of 60) and between 47,294 and 66,211 have serious emotional disturbance with extreme impairment (level of functioning score of 50).

Estimated Prevalence for Individuals with an Intellectual Disability: National research on the prevalence of intellectual disability range from 1 and 3 percent of the population over age 6 (Arc of the United States, October 2004). A conservative approximation (using the 1 percent rate) estimates that 71,526 individuals age 6 and over in Virginia have an intellectual disability.

Estimated Prevalence for Individuals with Developmental Disabilities: The U.S. Centers for Disease Control and Prevention (CDC) and the U.S. Administration on Developmental Disabilities (ADD) and its parent organization, the U.S. Administration on Children and Families (ACF), conservatively estimate the prevalence of developmental disabilities is from 1.2 percent to 1.8 percent of the general population. Using the 1.8 percent rate recommended by the ADD to state DD Councils, 139,844 Virginians may have a developmental disability. Recent estimates by the CDC's National Center for Health Statistics are that one in 91 children has an autism spectrum disorder.

Estimated Prevalence for Infants and Toddlers in Need of Early Intervention Services: The prevalence rate nationally for children born with birth defects is between 3 and 5 percent of children born annually. Using national and Virginia studies of children with specific diagnoses selected by Virginia, estimates of children with delay influenced by Virginia poverty rates, prevalence of low birth weight children, children identified on the hearing registry; children assessed and requiring services in one year, and rates of states with comparable eligibility, the Department estimates that 3 percent of Virginia's infants and toddlers or 18,495 are potentially eligible for Part C services.

Estimated Prevalence for Individuals with Substance Use Disorders: Prevalence estimates of substance abuse and dependence in the past year for individuals who are age 12 and over were obtained from the 2007 National Household Surveys on Drug Use and Health (NSDUH). Estimated prevalence of adults and adolescents reporting past year dependence or abuse of alcohol or other drugs follows:

- Dependence on or abuse of any illicit drug – 2.77 percent or 180,453 Virginians are dependent on or abuse illicit drugs. An estimated 128,337 Virginians, or 1.97 percent of the total population, met the criterion for dependence.
- Dependence on or abuse of alcohol – 7.31 percent or 476,215 Virginians are dependent on or abuse alcohol. An estimated 168,050 Virginians, or 3.17 percent of the total population, met the criterion for dependence.

Appendix D contains prevalence estimates for serious mental illness, serious emotional disturbance, intellectual and development disability, and drug and alcohol dependence by CSB.

IV. CURRENT AND FUTURE SERVICE NEEDS

CSB Waiting Lists

The following table displays the number of individuals who were on CSB waiting lists for community mental health, developmental, or substance abuse services during the first four months of 2009.

Numbers of Individuals on CSB Waiting Lists for Mental Health, Developmental, or Substance Abuse Services: January - April 2009

Populations of CSB Waiting Lists	Numbers Who ARE Receiving Some CSB Services	Numbers Who Are NOT Receiving Any CSB Services	Total Numbers on CSB Waiting Lists
CSB Mental Health Waiting List Count			
Adults	3,407	739	4,146
Children and Adolescents (C & A)	1,369	557	1,926
Total Waiting for Mental Health Services	4,776	1,296	6,072
CSB Developmental Waiting List Count			
Adults	3,520	678	4,198
Children and Adolescents (C & A)	1,596	664	2,260
Total Waiting for Developmental Services	5,116	1,342	6,458
CSB Substance Abuse Waiting List Count			
Adults	1,181	693	1,874
Adolescents (Adol.)	84	91	175
Total Waiting for Substance Abuse Services	1,265	784	2,049
Grand Total on All CSB Waiting Lists	11,157	3,422	14,579

This count includes 154 individuals who were on mental health and substance abuse services waiting lists, 11 who were on mental health and developmental services waiting lists, and two who were on substance abuse and developmental services waiting lists.

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

On August 4, 2009, there were 4,834 individuals on the Statewide Waiting List for ID Waiver Services (2,518 were on the waiver urgent waiting list and 2,316 on the waiver non-urgent list). CSB developmental wait lists included 2,096 individuals who were also on the ID waiver urgent waiting list, 1,919 who were on the ID waiver non-urgent list, and 391 who were on CSB ID waiver planning lists. Of the individuals on CSB wait lists for developmental services, 508 had an allocated ID waiver slot but were waiting for waiver services that were not yet available and 88 had an ID waiver slot but were waiting for services that were not covered by the ID waiver.

**Numbers of Individuals on CSB Mental Health Services Waiting Lists
Diagnostic Information: January – April 2009**

Diagnosis	Adult	C & A	Diagnosis	Adult	C & A
Serious Mental Illness (SMI)	2,618		Co-occurring MI/ID	90	26
Serious Emotional Disturbance (SED)		994	Co-occurring MI/IS/SUD	21	1
Any Other MI Diagnosis	719		Developmental Disability (Not ID)	26	25
Any Other ED or MI Diagnosis		464	Not Known at This Time	513	383
Co-occurring MI/SUD	888	70			

**Numbers of Individuals on CSB Developmental Services Waiting Lists
Diagnostic Information: January – April 2009**

Diagnosis	Adult	C & A	Diagnosis	Adult	C & A
Intellectual Disability	3,467	1,564	Co-occurring ID/MI/SUD	21	1
Cognitive Developmental Delay	44	425	Autism	178	247
At Risk for Cognitive Developmental Delay	6	64	Developmental Disability (Not ID/ or Autism)	36	117
Co-occurring ID/MI	655	99			
Co-occurring ID/SUD	11	1	Not Known at This Time	46	90

**Numbers of Individuals on CSB Substance Abuse Services Waiting Lists
Diagnostic Information: January – April 2009**

Diagnosis	Adult	Adol.	Diagnosis	Adult	Adol.
Substance Dependence	943	26	Co-occurring SUD/MR	12	1
Substance Abuse	280	27	Co-occurring SUD/MI/MR	7	1
Any Other SA Diagnosis	85	1	Developmental Disability (Not MR)	2	0
Co-occurring SUD/MI	686	44	Not Known at This Time	340	87

The following table depicts the length of time that individuals were reported to be on CSB mental health, developmental, or substance abuse services waiting lists.

Length of Time on CSB Waiting Lists for All Services: January – April 2009

	Mental Health Services		Developmental Services		Substance Abuse Services		Total
	Adult	C & A	Adult	C & A	Adult	Adol.	
Under 1 Month	174	30	48	9	103	3	367
1 to 3 Months	2,689	1,583	476	290	1,126	146	6,310
4 to 12 Months	908	274	540	508	458	22	2,710
13 to 24 Months	224	30	578	534	100	3	1,469
25 to 36 Months	56	4	443	266	39	0	808
37 to 48 Months	25	0	421	187	15	1	649
49 to 60 Months	19	1	358	142	6	0	526
61 to 72 Months	9	1	282	105	3	0	400
73+ Months	36	1	999	210	24	0	1,270
Not Reported	6	2	53	9	0	0	70
Total	4,146	1,926	4,198	2,260	1,874	175	14,579

For individuals reported to be on CSB waiting lists for longer than 48 months, the most frequently listed services for which the individuals were waiting follow.

- Adults on mental health services wait lists: psychiatric and medication management services;
- Adults and children and adolescents on developmental services wait lists:
 - Adults: supportive services (supportive living, in-home, personal assistance, companion services), case management, supervised residential services, intensive residential (congregate) services, and rehabilitation/habilitation services (center and non-center-based)
 - Children and adolescents: supportive services (supportive living, in-home, personal assistance, companion services), case management, rehabilitation/habilitation services (center and non-center-based), and assistive technology; and
- Adults on substance abuse services wait lists: outpatient and case management services.

Other Indicators of Community-Based Services Needs

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

- Virginia Department of Education counts made on December 1, 2008, identified 10,629 students ages six to 22+ with a primary disability (as defined by special education law) of emotional disturbance and 10,863 students with an intellectual disability who are receiving special education services. Counts for children age three to five identified 7,605 children who had a developmental disability and 881 children with autism spectrum disorder.
- In January 2008, Virginia communities participated in a statewide one-day point-in-time count and found 8,610 homeless persons. The count found 1,635 individuals (19 percent of all persons who were homeless) had been homeless for a year or longer or had been homeless at least three times in the previous four years and also had a disabling condition (i.e., meeting the HUD definition of chronic homelessness). As a one-day point-in-time survey, this significantly under reports the total number of individuals who are homeless.
- Among pregnant women aged 15 to 44 years, an average of 5.2 percent had used illicit drugs in the past month based on combined 2006 and 2007 National Survey on Drug Use and Health data. This rate was significantly lower than the rate among women in that age group who were not pregnant (9.7 percent). The rate of current illicit drug use in the combined 2006-2007 data was lower for pregnant women than for non-pregnant women among those aged 18 to 25 (7.2 vs. 16.0 percent, respectively) and among those aged 26 to 44 (3.0 vs. 6.5 percent). Among women aged 15 to 17, however, those who were pregnant had a higher rate of use (22.6 percent) than those who were not pregnant (13.3 percent).
- According to the 2007 National Survey on Drug Use and Health, among youth aged 12 to 17, the types of drugs used in the past month varied by age group.
 - Among 12 or 13 year olds, 1.4 percent used prescription-type drugs nonmedically, 1.1 percent used inhalants, and 0.9 percent used marijuana.
 - Among 14 or 15 year olds, marijuana was the most commonly used drug (5.7 percent), followed by non-medical use of prescription-type drugs (3.4 percent), and inhalants (1.4 percent).
 - Among 16 or 17 year olds, marijuana also was the most commonly used drug (13.1 percent), followed by non-medical use of prescription-type drugs (4.9 percent), hallucinogens (1.2 percent), inhalants (1.0 percent), and cocaine (0.9 percent).

V. CRITICAL ISSUES AND STRATEGIC RESPONSES

A. Transforming Virginia's System of Care

Integrated Strategic Plan for Virginia's Services System

In 2009, the Department revisited its Integrated Strategic Plan (ISP), *Envision the Possibilities: An Integrated Strategic Plan for Virginia's Mental Health, Mental Retardation, and Substance Abuse Services System* and affirmed the following priorities for transforming Virginia's behavioral health and developmental services system.

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

Vision for the Future Services System in Virginia

The Department is committed to implementing the vision “of a consumer-driven system of services and supports that promotes self-determination, empowerment, recovery, resilience, health, and the highest possible level of individual participation in all aspects of community life, including work, school, family and other meaningful relationships” (State Board Policy 1036 (SYS) 05-3).

Services and Supports Principles and Practices

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

- Attain their highest achievable level of health and wellness;

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

Participation of Individuals Receiving Services and Family Members: Individuals and family members must be actively involved in and be afforded multiple opportunities to participate in all aspects of services planning, policy development, and implementation at the state and community levels. Their perceptions and life experiences are important drivers for system transformation activities, particularly in areas such as:

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

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

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

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

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

- Services and supports are person-centered. Individuals receiving services and family members have access to information, are involved in service planning, and have decision-making power over the types of services and supports they need and use. The specific needs of each individual are at the center of service planning and care coordination.
- The services system is designed to intervene early to minimize crises through early screening and assessment, appropriate interventions that keep individuals receiving services connected to their families and natural supports, and seamless access to services.
- Services and supports are available and delivered as close as possible to an individual's home community and in the least restrictive setting possible, are culturally and age sensitive and appropriate, and are fully integrated and coordinated with other community services.
- Adults and children requiring services and supports from multiple agencies are provided care that is coordinated across agencies.
- Services and supports are flexible, allow for the greatest amount of individual choice possible, and provide an array of acceptable options to meet a range of individual needs.

- A consistent minimum level of types and amounts of services and supports is available across the system, with timely access to needed services.
- Prevention, early intervention, and family support services are critical components of the services system.
- Services are universally and equally accessible regardless of the individual's payment source.
- Services are of the highest possible quality and are based upon best and promising practices, where such practices exist.
- Services are provided in an efficient and cost-effective manner to enhance quality and continuity of care and take advantage of technologies that provide appropriate access to properly protected information.
- Emphasis is placed on continuous quality improvement at the provider and system levels, with performance and outcome measures focused on self-determination, empowerment, recovery, resilience, and community integration.
- Integrated and flexible public funding of services and supports promotes person-centered and recovery-oriented services and supports.
- Public funding is adequate to meet individual needs and includes cost inflators to sustain capacity and address the total costs of service delivery.
- The services system is committed to state facility and community workforce training, retraining, development, retention, and expansion to needed staffing levels.

Wide Front Door: The ISP envisions Virginia's services system as having a wide "front door" for screening and assessing the needs of individuals who seek publicly funded services or supports. Initial screening and state-of-the-art assessments should be provided by well-qualified and highly trained staff. Assessment results should be based on the complexity of the individual's condition or his level of functioning and determine the types, levels, and amounts of needed services and supports. Following assessment and regardless of where an individual lives in Virginia, individuals and their families should have access to a broad array of services and supports, including safety net services, that promote independence and enable individuals to live in their own homes or natural environments wherever possible, and when not possible, with other family members.

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

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

The policy affirms the responsibility of CSBs to serve as the single points of entry into the safety net of public services, to screen and assess individuals, and to manage and review access to and utilization of public safety net services. It defines the public safety net to include services delivered by private inpatient and community service providers under contract to CSBs or state facilities and identifies the following safety net services: local emergency services, in-home assistance and support or out-of-home respite care, non-hospital based crisis stabilization or

detoxification services, acute stabilization in local psychiatric or substance abuse inpatient or medical detoxification services, and specialty services provided in state facilities on a regional or statewide basis. The policy directs that public safety net services shall be available to the greatest extent possible on a 24 hours per day and seven days a week basis within clinically reasonable time periods to anyone who needs them.

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

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

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

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

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

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

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

- Prevention and early intervention services,
- Infant and toddler intervention,
- Respite care,
- In-home services, including intensive in-home therapy by licensed clinicians,
- Care coordination and case management,
- Medication and medication education services,
- Outpatient treatment provided by trained clinicians using best and promising practices,
- Integrated treatment for persons with co-occurring diagnoses,

- Supported employment and vocational training,
- Rehabilitation and day support services,
- Day treatment provided in schools or clinics,
- Supervised and supportive residential services, and
- Intensive community treatment, training, and transitional services.

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

Although provision of services and supports in an individual's home community is preferable, there may be situations where needed services are beyond the capacity of localities to provide. Services and supports, such as those listed below, would be provided regionally through regional programs or specialized teams or through teletherapy or teleconsultation technologies:

- Regional behavioral consultation teams serving individuals with co-occurring diagnoses;
- Expert consultation teams for nursing homes and assisted living facilities; and
- Specialty clinical services (e.g., extensive assessments for medical and psychiatric needs, child and family therapy, and medical and dental supports).

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

- Intermediate treatment and rehabilitation and intensive treatment for individuals with severe or complex conditions, or both, requiring care in state hospitals;
- Intensive short-term acute inpatient crisis intervention, stabilization, and treatment for children and adolescents with high acuity or high complexity behavioral health conditions, or both;
- Intensive medical (to include skilled nursing), behavioral, or other specialized supervision and therapeutic interventions for individuals with an intellectual disability;
- Secure forensic and not guilty by reason of insanity (NGRI) services; and
- Behavioral rehabilitation services for sexually violent predators.

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

- Minimum safety net services, as described in State Board Policy 1038;
- Outpatient treatment services, including intensive in-home services, medication and medication education services, and assertive community treatment;
- Case management and care coordination;
- Day treatment provided in schools or other sites and rehabilitation services;
- Supported employment services;
- Supervised residential services, including in-home respite care, and supportive residential services, including respite care;
- Prevention and early intervention, including infant and toddler services; and

- Services managed and provided by consumers, including peer-to-peer drop-in centers, individual wellness recovery planning, peer-run programs, family resource centers, and consumer and family member education and support.

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

Critical Success Factors

Seven critical success factors listed below are required to realize the vision of a recovery and resilience-oriented and person-centered system of services and supports. Achievement of these critical success factors requires the support and collective ownership of all system stakeholders.

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

Goals, Objectives, and Action Steps

Goal 1: Implement a recovery and resilience-oriented and person-centered system of behavioral health and developmental services and supports.

Objective:

1. ***Incorporate the vision and values of recovery and person-centeredness into policies, practices, and the organizational culture at the state and local levels.***

Action Steps:

- a. Continue public awareness efforts with policymakers, state and local government officials, individuals and family members, public and private providers, and the general public.
- b. Support peer-to-provider training and other learning opportunities for staff of the Department's central office, state facilities, and licensed public and private providers on how they might align their organizational cultures with the vision and services values.
- c. Revise Department policies and regulations to reflect recovery and resilience-oriented and person-centered principles.

- d. Support the statewide use of instruments that assess implementation of recovery and person-centered values and use assessment results to track organizational culture change.
- e. Implement a variety of training opportunities designed to increase the knowledge and skills of staff at all levels of state facilities and community provider organizations in implementing recovery, resilience, and person-centered principles and practices.

B. Peer-Provided and Peer-Directed Services and Related Initiatives That Promote Recovery and Person-Centered Principles and Practices

Behavioral Health Services

Virginia is committed to involving consumers and families in policy-making, service delivery, training, service development and quality improvement. Numerous initiatives are underway to accomplish this objective, through various direct service programs and initiatives that promote self-determination and empowerment, mutual support, leadership, health and wellness, and recovery for people with or affected by mental health and substance use disorders.

Peer-Provided Direct Services: One aspect of Virginia’s commitment to involvement of individuals receiving services is the financial support for direct services provided to individuals by individuals who have themselves experienced mental health, substance use, or co-occurring disorders, i.e., by peers. Peer support is known to be an important factor in the recovery process for many individuals with mental health and substance use disorders. Federal, state, and local funding in Virginia continues to be used for peer-provided and peer-run services and supports delivered through CSBs, state hospitals, and peer-operated programs. This includes CSBs and state hospitals hiring their own peer staff and providing support for independent programs managed by peers through contracts or other partnership arrangements. The Department also contracts with several peer-run service programs throughout Virginia.

In FY 2008 and FY 2009, significant expansion of peer-provided services occurred through the state-funded System Transformation Initiative and through targeted allocations of federal Mental Health and Substance Abuse Block Grant funds. Transformation Initiative funds were used by CSBs in part to hire many new peer specialists, and federal block grant funds were used to expand existing contracts with peer-run service providers and initiate new peer-run services. To support this effort, the Department provided four two-week peers specialist training programs which allowed 80 peers to be trained for these roles. Particularly significant expansion occurred during this period with the advent of five new recovery support programs targeted to persons with substance use disorders and co-occurring mental health and substance use disorders. These initiatives establish an important ongoing partnership between the addictions peer community and traditional treatment providers.

The following table describes peer-provided behavioral health services that are offered through peer-run organizations in Virginia.

Organization	Description
On Our Own Roanoke	This program provides co-occurring support, veteran’s outreach, psycho-social programs, WRAP, and wellness groups.
On Our Own Charlottesville	This program provides co-occurring support, psycho-social programs, WRAP, and wellness groups.
Laurie Mitchell Employment Center	The center provides employment training, computer classes, resume writing and interview training as well as social activities.

Organization	Description
WeCare, Inc	This program is a consumer owned and operated co-occurring recovery program providing. It provides recovery oriented training to consumers suffering with a serious mental illness and substance abuse issues.
Depression and Bi-Polar Support Group	This consumer owned and operated program provides support meetings during the week and on weekends. This program provides recovery oriented training based on the Pathways to Recovery Program.
Central Virginia Co-Op	This consumer run program is supported through Central Virginia Community Services Board. It provides recovery oriented training, socialization, computer training and support to consumers in the Central Virginia region.
Friends4 Recovery	This consumer owned and operated bi-lingual program is based on a wellness model. It provides recovery oriented and wellness training in English and Spanish in the Richmond area.
The Coalfields Coalition	The Coalfields Coalition is building a strong peer community across a geographically large region by providing locally-based peer support services, using Recovery Action Plans (RAP), and working closely with the regional substance abuse services coalition. (Cumberland Mountain, PD 1 and Dickenson County CSBs)
Colonial CSB/SpiritWorks	In addition to working with consumers to develop Recovery Action Plans (RAP), this program has established local peer support services and is providing technical assistance to peer-run programs.
Region Ten CSB	This program has hired Recovery Coaches and is helping consumers develop Recovery Action Plans.
PD 19/House of Job/Voices Against Crack	This program is using Recovery Coaches and is working in the community to establish Recovery Housing.

Related Initiatives to Provide Education and Other Supports to Promote Self-Determination, Empowerment, and Recovery: In addition to direct services, the Department supports numerous behavioral health organizations and initiatives that provide training, public information, education, assistance and support to persons with mental health disorders, their families and communities across Virginia. Among other outcomes, these initiatives help educate Virginians about behavioral health issues, mental health and substance use disorders, treatment and supports, and recovery.

These initiatives are intended to reduce stigma and foster a more welcoming and responsive system of care for individuals and families receiving services. They create empowering experiences for peers that can help them take charge of their wellness and recovery. Regardless of the nature of their interaction with Virginia’s system of care, these activities create a better experience for Virginia’s consumers and families. The following table summarizes these initiatives.

Organization	Description
Virginia Organization of Consumers Asserting Leadership (VOCAL)	VOCAL is the statewide organization of persons with mental illness. VOCAL initiatives include: <ul style="list-style-type: none"> o VOCAL CO-OP: Provides technical assistance to peer-run programs statewide. o REACH – Recovery Education and Creative Healing: Training of workshop leaders for Wellness Recovery Action Plan (WRAP) approach to wellness management. o VOCAL Network: Support for statewide peer network through membership services, networking and communication, conferences, and related activities.

Organization	Description
SAARA of Virginia	<p>SAARA is the statewide voice advocating for treatment and recovery to prevent the harmful effects of substance abuse upon individuals, families, businesses, and the community. SAARA offers the following:</p> <ul style="list-style-type: none"> ○ Public information about impact of addictions and resources and services available for treatment and prevention ○ Family support and advocacy for youth (with VAFOF) ○ Publication of semiannual newsletter, <i>The Recovery Advocate</i> ○ Operation of peer recovery community center serving the greater metropolitan area of Richmond
National Alliance on Mental Illness of Virginia (NAMI-VA)	NAMI-Virginia provides support, information, and statewide educational programs to consumers, families, and communities.
Mental Health America – Virginia (MHAV)	MHAV provides Consumer Empowerment Leadership Training (CELT) to enable persons with mental illness to be effective and influential participants in various planning and oversight roles, on committees and councils, etc.
Virginia Federation of Families for Children's Mental Health (VAFOF)	VAFOF educates and supports parents and caregivers of children with behavioral health problems through a variety of activities, including workshops and annual conferences that provide information about the services system and teach skills to effectively access services.
Virginia Human Services Training Program	The VHST program is a collaborative effort of the Department, Region Ten CSB, the Department of Rehabilitation Services, and Piedmont Virginia Community College. VHST offers graduates a career studies certificate in human services. Graduates are employed by CSBs.
Southwest Virginia Consumer and Family Involvement Project	This peer-driven project prepares individuals with mental illness to become meaningfully involved in the mental health system by providing education, advocacy, and support. Project activities focus on increasing individual and family participation in decision-making and policy formation, in service planning, and in the delivery and evaluation of publicly funded mental health services.
Family Support Services Project in Southwest Virginia	The project is directed to family members of persons with serious mental illness and involves close collaboration with CSBs in the southwest region and the Southwestern Virginia Mental Health Institute. The project develops and assists family support groups with education, support, and advocacy.

Developmental Services

Involvement by individuals receiving services and their families is a critical component of all developmental services supported through the Department. This includes individual and family involvement in the development of their case management and Medicaid waiver plans, agreement to these plans, and participation in the annual planning process for services. Individuals receiving intellectual disability services and their families are involved in a number of policy and planning processes, including the Advisory Consortium on Intellectual and Developmental Disabilities (TACIDD), which is comprised of self-advocates and family members of individuals receiving community and state facility services and supports.

The Department continues to be actively involved in developing ways to expand person-centered practices through training, resources, and systems changes to make person-centered practices the norm in Virginia. Two Centers for Medicare and Medicaid Services (CMS) funded multi-agency, multi-year projects, the Real Choices Systems Transformation grant and the Money Follows the Person demonstration grant, have leadership teams composed of up to 51

percent self advocates and family members. These teams provide direction and offer input on the future direction of services for persons with intellectual disability in Virginia.

The goals of the five-year Money Follows the Person demonstration grant are to rebalance Virginia's long-term support system, giving individuals more informed choices and options about where they live and receive services, and to support the transition of individuals from institutions to community-based alternatives. This project also promotes quality supports through person-centered practices.

Each year, all CSBs give family satisfaction surveys to families of people with an intellectual disability receiving case management services. Families return the surveys directly to the Department and results are analyzed to determine individual or family member perceptions of services. Results are shared with each CSB.

Goals, Objectives, and Action Steps

Goal 2: Involve individuals who are receiving services and family members in planning, evaluating, and delivering behavioral health and developmental services.

Objectives:

1. *Increase opportunities for individual and family involvement, education, and training.*

Action Steps:

- a. Increase the number and diversity of individuals receiving services and family members who advise the Department through focus groups and participation on councils, committees, and workgroups.
- b. Continue to fund a statewide recovery and peer-to-peer education program run by and for individuals receiving services and supports.
- c. Promote and expand training to prepare individuals receiving services and family members for meaningful roles in planning and policy making activities.
- d. Promote opportunities for CSBs and state facilities to support peer and family education and training.
- e. Keep peer-run programs, family organizations, and advocacy organizations fully informed about opportunities to be involved in system initiatives and activities.

2. *Increase opportunities at the system and individual levels for individuals and family members to determine the developmental services and supports they receive.*

Action Steps:

- a. Provide training for providers on developing person-centered environments for individuals with intellectual disability and their families.
- b. Develop, in collaboration with potential users, materials and training modules for families that better enable individuals with intellectual disability to guide their own services.
- c. Determine the satisfaction of families and individuals who receive services through a survey method.

3. *Promote the establishment and expansion of peer-run programs across Virginia.*

Action Steps:

- a. Continue to fund and support Virginia's statewide network of peer organizations and family alliances that increase the voice and representation of individuals receiving services and supports.
- b. Partner with DMAS to develop Medicaid coverage for peer-run programs.

- c. Support the establishment of new peer-run programs, including programs that address recovery issues of older adolescents and persons with co-occurring mental health and substance use disorders.

C. Access to Services and Supports That Meet Individual Needs

Olmstead Decision Implementation Update

In 1999, the United States Supreme Court issued a decision in the case of Olmstead v. L.C., 119 S. Ct. 2176 (1999). This case involved a challenge under Title II of the Americans With Disabilities Act (ADA), 42 U.S.C. § 12132, by two women with mental disabilities who lived in mental health facilities operated by the state of Georgia but wished to live in the community. The ADA prohibits discrimination in public services furnished by governmental entities (Title II, 42 U.S.C. § 12131-12165).

Title II regulations issued by the U. S. Attorney General include an integration regulation stating: “A public entity shall administer services, programs and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities.” The most integrated setting is that which enables individuals with disabilities to interact with non-disabled persons to the fullest extent possible. The U.S. Supreme Court held that Georgia had violated the ADA by forcing these women to remain in a state mental hospital after their treating professionals had determined that they were ready for discharge.

In the decision, the Court held that a state is required under Title II of the ADA to provide community-based treatment for persons with mental disabilities when:

- The state’s treatment professionals determine that such placement is appropriate;
- The affected persons do not oppose such placement; and
- The placement can be reasonably accommodated, taking into account the resources available to the state and the needs of others with disabilities.

Although the Olmstead case involved two individuals with a mental disability, the decision is broad in its scope and applies to all qualified persons with disabilities covered by the ADA. It applies to all qualified individuals with mental, physical, or sensory disabilities. It applies to individuals who are institutionalized or who are at risk of institutionalization. The Olmstead decision does not prohibit institutional placement, but, in fact, recognizes it as the least restrictive setting for some individuals who cannot handle or benefit from community settings. Additionally, the decision affirms that there is no federal requirement that imposes community-based treatment of patients who do not desire it.

States must make reasonable accommodations in programs in order to provide community-based services to qualified individuals, unless doing so would fundamentally alter the services provided. This “fundamental alteration” standard is met if the state can demonstrate that it has:

- A comprehensive, effectively working plan for placing qualified persons with mental disabilities in less restrictive settings, and
- A waiting list that moves at a reasonable pace not controlled by the state’s efforts to keep its institutions fully populated.

The importance of the Virginia Olmstead initiative to the Executive Branch was underscored by Executive Order 2 (2006), issued by Governor Kaine on his first day in office. The Department continues to take an active leadership role in the Commonwealth’s Olmstead implementation efforts through participation on the State Implementation Team, now composed of 21 executive branch entities, four Secretariats, two Councils, and six local government and agency representatives. The Team has lead responsibility for developing an integrated plan for Virginia

that advances community integration opportunities. The Team works collaboratively with agency staff and the 21-member Community Integration Advisory Commission to implement Virginia's *Cross-Governmental Strategic Plan to Assure Continued Community Integration of Virginians with Disabilities*.

The *2008 Update and Progress Report to Virginia's Comprehensive Cross-Governmental Strategic Plan* was adopted by the Community Integration Implementation Team and the Community Integration Advisory Commission on August 28, 2008. The update and progress report specifies the following goals, developed from the Vision statement within the Olmstead Task Force Report.

1. Virginians with disabilities who currently reside in a state mental health, mental retardation (now intellectual disability), nursing, or assisted living facility will have the opportunity to choose to move from these facilities to an appropriate, more integrated setting and stay there.
2. Virginians with disabilities who are at risk of unwanted admission to a state mental health, mental retardation (now intellectual disability), nursing, or assisted living facility, will have the opportunity to receive services and supports that prevent admission.

The vision of community integration will be realized only when people with disabilities can achieve the following goals:

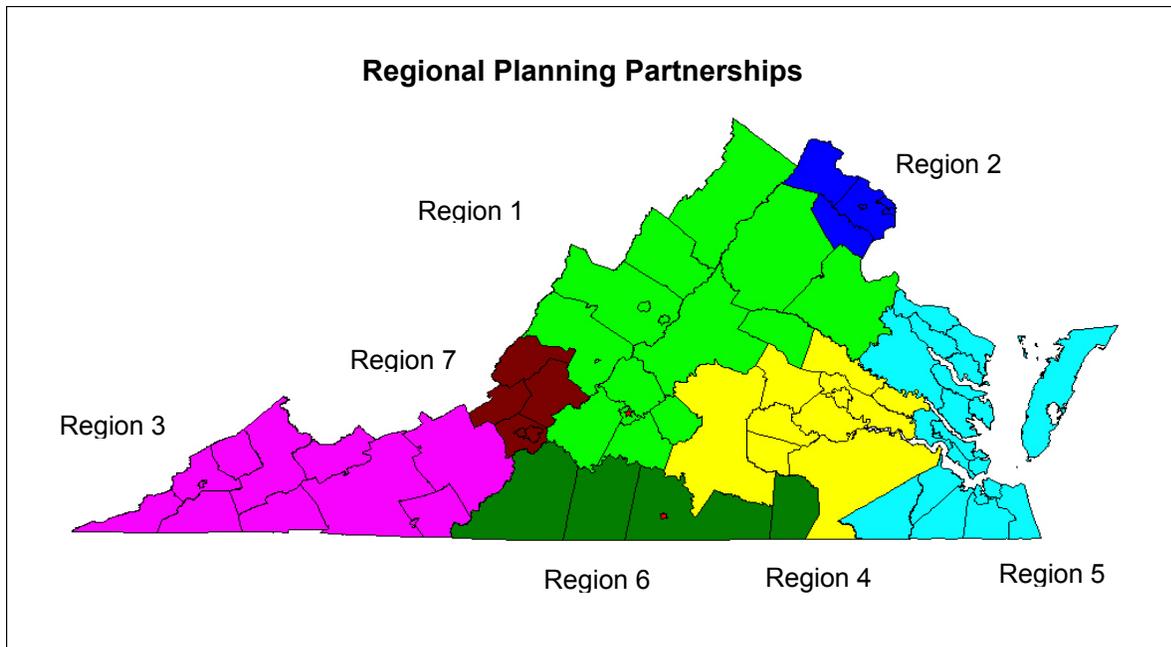
- Plan, fully understand, and choose among services and supports they need, self-directing them to the extent possible;
- Choose among individuals and agencies qualified to provide the services and supports they select;
- Locate and obtain housing appropriate to their needs and preferences;
- Locate and obtain a job, if appropriate;
- Access transportation appropriate to their needs;
- If they lack capacity to make decisions, have the same choices, options, and benefits as other Virginians with disabilities through a surrogate decision-maker qualified to act on their behalf; and
- Access ongoing supports in order to stay in the most integrated setting of choice, self-directing them to the extent possible.

The Implementation Team will continue to work with the Community Integration Advisory Commission in coming years to realize the goals and action steps outlined in the Cross-Governmental Strategic Plan.

Implementation of the System Transformation Initiative

During the 2006-2008 biennium, the Department implemented the first phase of what was envisioned to be a multi-year System Transformation Initiative (STI) to invest in community services and supports and reduce Virginia's historic reliance on state facilities. This initiative represented an historic opportunity to make a positive difference in the lives of individuals with mental health or substance use disorders, intellectual disability, or co-occurring disorders.

For the biennium, just over \$187.5 million in state general and Medicaid funds were used to support a wide array of community investments. Each regional partnership established services and supports priorities that were tailored to its needs and, with guidance provided by the Department, coordinated implementation of these services and supports. .



Behavioral Health Services Community Capacity Investments: STI funds supported provision of emergency, acute psychiatric inpatient, ambulatory and residential crisis stabilization, residential, case management, day treatment, rehabilitation, discharge assistance plan, and peer-provided services to 13,074 adults with mental health or co-occurring mental health and substance use disorders in FY 2007 and 19,034 persons in FY 2008. These funds significantly enhanced Virginia's array of crisis services, particularly residential and ambulatory crisis stabilization, mobile crisis stabilization and outreach crisis teams, psychiatric crisis stabilization, and 24-hour availability of face-to-face crisis counseling.

Jail-Based and Juvenile Detention Services: STI funds expanded the array of behavioral health services for individuals involved in local criminal justice systems. In FY 2007, 439 inmates received mental health treatment services and 60 were diverted prior to trial. In FY 2008, 308 inmates received services, 108 were diverted prior to trial, and 115 early had releases linked to mental health treatment. The diversion of 108 inmates prior to trial reduced demand for state psychiatric hospital beds by an estimated 9,720 bed days.

Initiative funds supported CSB clinical and case management staff in all 23 juvenile detention centers. In FY 2007, of the 2,209 youth admitted to juvenile detention centers where mental health services were provided, 2,060 received mental health screening and assessment at intake, 808 youth received case management services, 814 received individual face-to-face therapy, 16 were admitted to state hospitals, and 394 were released to the community with an aftercare plan for individual face-to-face therapy. In FY 2008, of the 13,383 youth admitted to juvenile detention centers, 12,468 received mental health screening and assessment at detention intake, 2,737 received case management, 1,227 were released to the community with an aftercare plan, and 121 were admitted to a residential facility.

Child and Adolescent System of Care Services: STI funds supported four systems of care projects that provide an array of evidence-based services including multi-systemic therapy, functional family therapy, dialectical behavioral therapy, and other services and supports to children and adolescents served by the Richmond Behavioral Health Authority, Planning District 1 CSB, Alexandria CSB, and Cumberland Mountain CSB. In FY 2007, 53 of 84 youth enrolled in STI supported evidence-based services achieved desired clinical outcomes. In FY 2008, 111 of 168 enrolled youth completed services. In addition, 1,361 youth received an array of services, including foster care prevention, intensive in-home services, therapeutic day treatment, alternative day support services, case management, crisis, and psychiatry services.

Early Intervention Services: STI enabled local early intervention systems (local lead agencies) for Virginia's Part C Early Intervention System for infants and toddlers with disabilities to serve 5,559 additional children in FY 2007 and 5,969 children in FY 2008. A total of 10,408 children received Part C services in FY 2007 and 11,336 received services in FY 2008.

Developmental Services: STI funds supported an additional 654 community ID waiver slots, including 110 slots for children, and 117 ID waiver slots for training center residents. In FY 2007, all 255 community slots and all 48 training center slots were allocated. In FY 2008, all 399 new community slots and 44 of the 69 new training center slots were allocated. Training centers are working to assign the remaining 25 training center slots. Also, waiver reimbursement rates for congregate residential services were increased by 10 percent and other selected services by 5 percent. These increases supported direct care salaries and benefits, which contributed to service expansion and sustainability of existing services.

Guardianship Services: STI funds provided guardianship services through a partnership with the Department for the Aging to 83 individuals living in training centers and 122 individuals living in the community in FY 2007 and an additional 101 individuals in FY 2008.

Implementation of Evidence-Based and Best Practices

Evidence-based practices (EBPs) are those interventions that integrate the best research evidence with the best clinical expertise and values focused on individuals receiving services (Institute of Medicine Report Crossing the Quality Chasm, 2005). Evidence-based practices emphasizing individual participation, choice, recovery, and self-determined outcomes have the potential to significantly improve the quality of life for individuals receiving services. The 1999 *Surgeon General's Report on Mental Health* underscored that, for the most part, the effective interventions that exist for many mental disorders are simply not available to the majority individuals who could benefit from them. Some EBPs for the treatment behavioral health problems in adults and children are listed below. There should be many other evidence-based practices in the future and some "promising practices" being researched currently include peer supports, supported housing, trauma-informed and trauma-specific services, and specialized treatments for people diagnosed with borderline personality disorder.

Evidence-based practices for adults with serious mental illness or co-occurring substance use and mental health disorders follow.

- Co-Occurring Disorders: Integrated Dual Disorders Treatment
- Illness Management and Recovery
- Standardized Pharmacological Treatment
- Family Psychoeducation
- Supported Employment
- Assertive Community Treatment (ACT)
- Motivational Enhancement Therapy (MET)
- Cognitive Behavioral Therapy (CBT).

Virginia continues to support the implementation of selected EBPs. Most individuals have access to "new generation" medications, whether in CSB or state facility programs. There are 20 Assertive Community Treatment (ACT) programs in 19 CSB service areas. Sixteen of these are licensed Programs of Assertive Community Treatment (PACT) teams and four are licensed Intensive Community Treatment (ICT) teams. Together, these programs served over 1,700 individuals in FY 2008. Outcome data from the ACT initiatives have shown dramatic reductions in state hospital usage, increased stability in housing, and reduced involvement with the criminal justice system. The Department promotes Supported Employment and has underwritten the development of the resource guide, "*Successful Competitive Employment for Consumers in Recovery from Serious Mental Illness*" and distributed it to all CSBs. This manual, developed

through a partnership with the Department of Rehabilitative Services (DRS) and Department of Medical Assistance Services (DMAS), provides guidance on how to implement this EBP and blend the necessary funding through the agencies' respective reimbursement streams.

The Department supports and promotes peer support services. In partnership with DRS, the Department continues to fund the Virginia Human Services Training (VHST) Program, through which 63 trained graduates have become employed at their local CSB in part-time and full-time jobs. They work as PACT team peer support specialists, case manager assistants, residential services assistants, mental health support services workers, and partial hospital program aides, etc. In addition, through July 2008, The Department has provided other peer support specialist training to approximately 80 individuals receiving mental health services and held two 2-day conferences providing training on integrating peer specialists in the agency for over 200 providers, consumers, and agency supervisors. The Virginia Supreme Court's Commission on Mental Health Law Reform established a committee in 2008 on Workforce Development, through which a subcommittee on the Peer Support Workforce was also formed to develop a six-year plan to expand peer supports in the Virginia's behavioral health system.

The Department has begun the promotion of trauma-informed emergency services through its web based certification training program for preadmission screening evaluators and independent examiners. The American Psychiatric Association's Diagnostic and Statistical Manual (DSM-IV) defines a "traumatic event" as one in which a person experiences, witnesses, or is confronted with actual or threatened death or serious injury, or threat to the physical integrity of oneself or others. A person's response to trauma often includes intense fear, helplessness, or horror. Trauma can result from experiences that are "private" (e.g. sexual assault, domestic violence, child abuse/neglect) or more "public" (e.g. war, terrorism, natural disasters). Trauma has been linked to hallucinations and delusions, depression, suicidal tendencies, chronic anxiety, hostility, and dissociation. In fact, between 51 percent and 98 percent of public mental health clients diagnosed with severe mental illness have been found to have trauma histories, and prevalence rates within substance abuse treatment programs and other social services are similar. Trauma-informed services are based on an understanding that traditional behavioral health service delivery approaches may exacerbate the vulnerabilities of trauma survivors, and services are redesigned to be more supportive and to avoid re-traumatization (see "*The Science of Trauma; A research-based overview of the nature and impact of trauma*" found at <http://mentalhealth.samhsa.gov/nctic/trauma.asp>).

Several initiatives are helping to increase the use of substance abuse evidence-based practices in CSBs and their contract agencies. Guidance bulletins have been distributed to CSBs that identify "best practices" in specific areas of clinical practice. Regularly scheduled technical support visits to CSBs provide assistance in clinical issues, including identifying clinical practice models and assisting with evaluation design. Additional training and technical is available through departmental and grant-funded initiatives to support the adoption and implementation of evidence-based programs for youth.

Evidence-based practices for children and adolescents with emotional disturbance or co-occurring substance use and mental health disorders follow.

- Multi-systemic Therapy (MST)
- Functional Family Therapy (FFT)
- Motivational Enhancement Therapy (MET)
- Cognitive Behavioral Therapy (CBT)
- Cannabis Youth Treatment Services (MET/CBT)
- Dialectical Behavioral Therapy (DBT)
- Seeking Safety
- Seven Challenges

- Motivational Interviewing
- Therapeutic Foster Care
- Many prevention interventions.

Members of the Virginia General Assembly have placed strong emphasis on the use of evidence-based practices in working with children. The Virginia Commission on Youth has developed the *Collection of Effective Treatment Modalities for Children with Mental Health Treatment Needs* that has been updated annually and posted on both the Commission's and the Department's websites. The Department has been an active collaborator with the Commission in the development, review, and updating of the Collection and the implementation of evidence-based practices. To support this work, the Commission, the Department, and the Virginia Office of Comprehensive Services co-sponsored a statewide conference in 2007, "*Systems of Care and Evidence-Based Practices: Tools that Work for Youth and Families*". Over 600 individuals representing all sectors of the field of children's services attended. Additionally, through the Adolescent Infrastructure Grant, the Department has provided funding and technical assistance to CSBs to assist them in implementing an evidence-based program for adolescents who have substance use or co-occurring substance use and mental health disorders.

For individuals with intellectual disability, challenging behaviors can adversely affect their abilities and opportunities to participate fully in any aspect of community life. Positive Behavior Support (PBS) offers a comprehensive, science-based approach to behavior change that teaches people with challenging behaviors and the people who support them new skills for successful living in the community. PBS integrates behavioral technology with person-centered values and has been successful with children and adults who have an intellectual or other developmental disability. An endorsement in PBS has been an accepted credential for the provision of ID waiver behavioral consultation services since July 2006. The number of PBS-endorsed behavior consultants has steadily risen across the state. Applied Behavior Analysis (ABA) is often cited as the most effective behavioral approach for individuals with autism, especially while they are young, to help them learn effective tools for getting their needs met through socially acceptable means rather than through challenging behaviors.

Experts in the field of prevention have developed rigorous approaches to evaluate and identify prevention programs that are effective. These programs are recognized by state and federal mental health, substance abuse, education, and juvenile justice systems as evidence- or science-based programs. The Department currently funds 12 science-based prevention programs for families, including services for new parents, Head Start children and their parents, and families with children and adolescents. Program directors are working closely with program developers and university faculty to evaluate the programs. Thus far, program evaluation data indicate that children gained in their awareness of drug harm and increased their levels of cooperation and social skills. Evaluation results for parents show fewer inappropriate parental expectations and increased overall parenting and monitoring skills. Evaluation of the families showed an increase in communication skills and family interaction.

The Department must increase its focus on adopting evidence-based practices to effectively achieve its mission. This includes raising awareness of evidence-based practices, enhancing provider competency, and developing and sustaining evidence-based programs and services. Advances in communication technology can greatly enhance the dissemination and transfer of information to practitioners and can make the most current research and practice information readily accessible to most practitioners, allowing them to integrate this information into their daily practice. To strengthen Virginia's services system through this technology, several ingredients must be in place, including

- Commitment of leadership at the state, local, and program levels,
- Education and skill building for practitioners,

- Supportive administrative practices,
- Incentives and rewards tied to the use of EBPs,
- Feedback mechanisms (e.g., measurement of outcomes), and
- Stable long-term financial support for EBPs.

Provider Training and Skill Development

Technology transfer and skill development of the existing workforce is a critical issue for the behavioral health and developmental services system. The Department's commitment to implementation of evidence-based and best practices requires affirmative actions to enhance the skills of behavioral health and developmental services providers.

Behavioral Health Services:

Preadmission Screening Evaluators Training – Virginia Code §37.2-808 and §37.2-809 specify that designees or employees of local CSBs who complete evaluations to assess the need for psychiatric hospitalization, emergency custody, or involuntary temporary detention must complete a certification program approved by the Department. The certification process and qualifications for preadmission screening evaluators have been updated and a core training curriculum was implemented in July 2009.

Peer Specialist Training - Through July 2008, the Department provided peer support specialist training to approximately 80 individuals receiving mental health services. Additionally, two 2-day conferences, sponsored in part by the federal mental health block grant, provided training on peer support, recovery, and peer specialists to over 200 providers, consumers and agency supervisors. The Virginia Supreme Court's Commission on Mental Health Law Reform, through its Peer Support Workforce subcommittee, is developing a six-year plan to expand peer supports in Virginia's behavioral health services system.

Co-Occurring Disorders – The Virginia Service Integration Program supported ongoing training provided by Dr. Kenneth Minkoff and Dr. Christie Cline, leading experts in the field. Training was offered to regions to build provider skills in the areas of co-occurring disorders and several statewide conferences were provided on system transformation, evidence informed practices, and screening and assessment with adults and adolescents. Over 550 individuals attended these conferences. Regional trainings also focused on strengthening supervision skills and implementing system change and quality improvement are planned. In 2008, the Department conducted a survey of mental health and substance abuse professionals in CSBs and state hospitals to identify where gaps in knowledge and skills exist. Using data from the survey, the Department and the VASIP workgroup developed a comprehensive training plan targeting the development of core competencies for serving individuals with co-occurring disorders.

Virginia Summer Institute for Addiction Studies - Every summer, the Department joins with a number of other state agencies and organizations, including the College of William and Mary, Mid-ATTC, the Virginia Association of Alcoholism and Drug Abuse Counselors, the Virginia Association of Drug and Alcohol Programs, the Substance Abuse Certification Alliance of Virginia, the Substance Abuse and Addiction Recovery Alliance, the Department of Corrections, the Department of Criminal Justice Services, and the VACSB Substance Abuse Council to host a summer institute training event at the College of William and Mary. This training provides presentations and workshops delivered by nationally known experts in the treatment and prevention of substance use disorders. Topics range from basic knowledge to advanced training, including a three-credit graduate level course. Although up to 750 individuals have attended previous summer institutes, the 2009 session was scaled back to three days for fewer than 350 attendees to accommodate current budget constraints.

Graduate Student Scholarship Program – Since 2007, the Department has participated with the Consortium for Substance Addiction Organizations in a scholarship incentive program for the

recruitment of master's level substance use disorder counselors. The scholarships are targeted to students being trained to be mental health professionals and are awarded to students who agree to pursue an addictions concentration in their graduate program, followed by a commitment to provide co-occurring or addiction services in the public sector for two years following graduation.

Prevention Training– Prevention has evolved into a science-based service and specific training in prevention theory and practice for CSB prevention management and staff is necessary for the implementation of effective prevention services in communities. Prevention training is provided through a specialized prevention track at the Virginia Summer Institute of Addiction Studies, the Communities Builders Network Conference, the Virginia Tobacco Settlement Foundation, and specialized training events. The Department also provides prevention-specific training and technical assistance to CSBs and conducts annual regional summits to update CSB prevention directors on changes and new developments in the field. Since 2004, 18 of the 40 CSB prevention directors are new and have minimal or no experience or training in prevention. To address this issue, the Department sponsors a formal mentorship program for new CSB prevention directors in which more experienced prevention directors, through contract, provide monthly prevention practice supervision for one year to assigned novice directors. The Department also provided scholarships for CSB prevention directors to apply and test for the Certified Prevention Professional certification exam provided by the Substance Abuse Certification Alliance of Virginia.

Developmental Services:

Behavioral Support Training: Many direct care workers do not have experience or training in how to work with individuals with intellectual disability, particularly those with behavioral challenges resulting from co-occurring mental illness or autism. On July 1, 2006, the Department implemented a system-wide, web-based training program, College of Direct Support (CDS), to enhance the general training for direct care staff and providers. The CDS has proven to be a very promising on-line approach for increasing the competencies of direct care workers in training centers and private programs. The CDS allows individuals to earn college credit, thereby promoting an effective career ladder for otherwise difficult to retain staff.

Community Services and Supports Capacity Issues

Recent transformation and system reform initiatives, while significant by Virginia standards, represent an initial commitment of resources needed to realize the goals established by the President's New Freedom Commission and Virginia's *Cross-Governmental Strategic Plan to Assure Continued Integration of Virginians with Disabilities into the Community*. Although the Governor and General Assembly have recognized the importance of continued investment in community services capacity to meet existing needs, the current downturn in the economy has thwarted Virginia's ability to sustain a multi-year commitment to capacity development.

In December 2008, the National Bureau of Economic Research announced that the U.S. economy had been in recession since December 2007. Research indicates that factors such as higher unemployment that accompany economic recession are associated with increased prevalence and severity of some mental illnesses. (Murphy GC and Athanaso JA, 1999) There appears to be general consensus in the literature that involuntary job loss increases the risk of psychiatric disorder, including clinical and subclinical depression, anxiety, substance abuse, and antisocial behavior. Longitudinal studies suggest that job loss tends to precede the onset of such disorders. The effect of recession on persons who have not lost employment is more difficult to estimate. Recent research on demand for mental health services during a recession predicts that there may be an initial decrease in demand for "maintenance" mental health services because people are trying to save on out-of-pocket expenses but that this decrease in preventive services is likely to result in a later surge in demand for acute care services,

including hospitalization. The research also suggests that "coerced" treatment may increase as societal tolerance for people with behavior problems drops. (Catalano R, 2009)

In a national telephone survey conducted for the American Psychological Association, released on April 30, 2009, more than 66 percent of American women polled said that the economic recession had negatively affected their lives or the lives of their loved ones. Respondents reported sharp increases in their levels of stress, anxiety, frustration, and other negative mental health indicators since the fall of 2008. These increases were even greater in communities experiencing significant job losses and wage cuts. Survey results suggested that, while women were focusing more on the needs of their families than on themselves, they tended to be resilient and resourceful. Just over three-quarters reported that they had increased positive activities during the past six months and 85 percent said that they could see the benefit in receiving support from a mental health professional for emotional or mental health concerns.

Before the economic downturn, communities lacked basic behavioral health and developmental services capacity to address existing demand and anticipated population growth. The lack of health insurance coverage and parity for the treatment of mental illnesses and substance use disorders forced many persons who would have otherwise sought private sector care to rely on the public system for treatment. New demands by individuals who have lost their jobs and may be seeking help for the first time and by the growing numbers of people who lack access to services because they can no longer afford insurance or they have inadequate coverage will place even greater pressure on public behavioral health services providers.

Health economists with the Office of the Actuary at the U.S. Centers for Medicare and Medicaid Services predict a large sustained shift away from private providers and health plans and toward public providers and plans. They predict that factors related to the recession will contribute to the expansion of demand for public services including:

- Increasing unemployment and associated loss of employer-provided health benefits;
- Decreasing ability of employers to subsidize health benefits due to tighter margins;
- Decreasing ability of individuals with private insurance to afford increasing out-of-pocket expenses; and
- Decreasing availability of private providers to offer sliding scale or charity care due to smaller margins, investment losses, and decreased donor support. (Sisko, A, Truffler C, Smith C, et.al., 2009)

These factors will place an additional strain on the public behavioral health care system at a time when state and local government revenues have been and are likely to continue to be cut in the near future. The Department experienced budget reductions of \$16.9 million in FY 2008, \$24.2 in FY 2009, and \$39.7 million in FY 2010. The following table breaks out these reductions across state facilities, CSBs, and the central office/Office of the Inspector General.

Reductions in Department of Behavioral Health and Developmental Services State General Fund Appropriations in FY 2008, FY 2009, and FY 2010

Reductions:	FY 2008	FY 2009	FY 2010
State Facilities	\$11,081,229	\$ 7,001,056	\$18,346,004
Community Services Boards	\$ 5,000,000	\$12,400,000	\$16,703,180*
Central Office/Inspector General	\$ 781,018	\$ 4,826,124	\$4,632,188
Total Reduction	\$16,862,247	\$24,227,180	\$39,681,372

*Note: The FY 2010 CSB reduction was offset using \$4.5 million in one-time special fund revenues, for a new FY 2010 reduction of \$12.1 million.

The FY 2009 reduction includes a \$15,067,179 cash transfer reduction of Special Revenue Funds from state training center collections, which is not included in the above table because it

did not change the Department's appropriation. These reductions do not include local budget cuts incurred by CSBs.

Services Needed by Individuals on CSB Waiting Lists: To document existing service demands, the Department asked CSBs to complete a point-in-time survey of each person identified by the CSB as being in need of specific services during the first quarter of calendar year 2009. This waiting list information includes individuals who sought service and were assessed by that CSB as needing the service. It does not capture the number of people who requested service from a CSB, but did not follow through with the assessment process when they learned there was a waiting list for that service. Needed services and average service wait times by program area are depicted for adults (ages 18 and over) and children and adolescents (ages 17 and below) on the following tables. Services are defined in Appendix B.

**Numbers of Individuals on CSB Mental Health Services Waiting Lists by Service:
January – April 2009**

Service	Adult	C & A	Service	Adult	C&A
Outpatient Services					
Psychiatric Services	1,530	836	Intensive In-Home	12	523
Medication Management	1,354	681	Assertive Community Treatment	307	20
Counseling and Psychotherapy	1,449	1,082			
Case Management					
Case Management	786	752			
Day Support Services					
Day Treatment/Partial Hospitalization	149		Therapeutic Day Treatment		249
Rehabilitation	499	69			
Employment Services					
Sheltered Employment	102	4	Individual Supported Employment	308	73
Group Supported Employment	84	6			
Residential Services					
Highly Intensive	130	10	Supervised	306	18
Intensive	162	22	Supportive	644	133
Early/Infant-Toddler Intervention					
Infant and Toddler Intervention	6	9			

In June 2009, 187 individuals in state hospitals were identified as having their discharges delayed due to extraordinary barriers. By December 2009, this number had decreased to 150.

**Numbers of Individuals on CSB Developmental Services Waiting Lists by Service:
January – April 2009**

Service	Adult	C & A	Service	Adult	C&A
Outpatient Services					
Psychiatric Services	480	185	Behavior Management	443	357
Medication Management	484	225			
Case Management					
Case Management	1,694	1,119			

Service	Adult	C & A	Service	Adult	C&A
Day Support Services					
Habilitation (Center Non-Center)	989	657			
Employment Services					
Sheltered Employment/Prevocational	694	179	Individual Supported Employment	612	123
Group Supported Employment	557	112			
Residential Services					
Highly Intensive (ICF/MR)	246	61	Supportive(Supported Living, In-Home, Personal Assistance, Companion Services, Respite)	2,105	1,651
Intensive (Congregate)	812	241			
Supervised (Congregate)	867	152			
Infant-Toddler Intervention					
Infant and Toddler Intervention	0	50			
Other Supports					
Nursing Services	158	118	Environmental Modifications	330	381
Assistive Technology	468	652	Personal Response System (PERS)	50	25
Therapeutic Consultation	263	212			

In September 2009, training centers reported 94 individuals for whom appropriate community supports were being actively sought.

**Numbers of Individuals on CSB Substance Abuse Services Waiting Lists by Service:
January - April, 2009**

Service	Adult	Adol.	Service	Adult	Adol.
Outpatient Services					
Intensive SA Outpatient	607	27	Opiod Detoxification	83	4
Outpatient	1,065	118	Opioid Treatment	132	2
Case Management					
Case Management	418	27			
Day Support Services					
Day Treatment/Partial Hospitalization	64	9	Rehabilitation	60	3
Employment Services					
Sheltered Employment	12	0	Individual Supported Employment	88	13
Group Supported Employment	23	0			
Residential Services					
Highly Intensive	66	7	Supervised	68	3
Jail-Based Habilitation	213	4	Supportive	65	4
Intensive	122	13			
Early Intervention					
Early Intervention	3	4			

Average Wait Times for CSB Behavioral Health and Developmental Services: As part of the waiting list survey, CSBs were asked to estimate the number of weeks individuals waited

prior to their receipt of specific services. Average wait times across the CSBs for specific services follow.

Average Wait Times in Weeks to Access Services Reported by CSBs: April 2009

Service	Mental Health Services		Developmental Services		Substance Abuse Services	
	Adults	C & A	Adults	C & A	Adults	Adolescents
Initial Assessment	5.16	4.76	8.09	8.94	4.36	3.20
Outpatient Services						
Medication Services	7.07	11.58	6.53	6.72	6.35	6.47
Psychiatric Services	7.60	6.91	6.52	6.81	6.61	6.17
Counseling & Psychotherapy	6.25	5.09			6.56	5.44
Behavior Management			28.22	7.37		
Intensive SA Outpatient					3.30	2.71
Intensive In-Home		4.44				
Methadone Detox					2.40	1.00
Opioid Replacement					9.88	0
Assertive Community Treatment	9.75					
Case Management Services						
Case Management Services	3.93	3.41	19.97	9.69	3.38	2.93
Day Support Services						
Day Treatment/Partial Hospitalization	2.00				2.00	
Therapeutic Day Treatment (C&A)		8.67				
Rehabilitation/Habilitation	4.78	2.00	54.06	19.30	6.00	0
Employment Services						
Sheltered Employment	1.00		37.18	17.10	1.00	0
Group Supported Employment	11.00		50.97	28.60	5.00	0
Individual Supported Employment	9.00	2.00	51.48	12.80	7.30	0
Residential Services						
Highly Intensive Residential Services	15.20		79.58	29.20	5.00	0
Jail-Based Habilitation					8.00	
Intensive Residential Services	40.50		90.80	28.60	5.00	7.00
Supervised Residential Services	22.22	6.50	79.73	28.60	13.67	0
Supportive Residential Services	20.67	18.00	72.19	41.52	28.83	4.00
Early Intervention/Infant and Toddler Intervention Services						
Early Intervention						3.60
Infant and Toddler Intervention				2.83		
ID Waiver Services						
Nursing Services			28.47	10.27		
Environmental Modifications			73.95	32.9		
Assistive Technology			79.86	34.66		
Personal Response System (PERS)			91.00	27.00		
Therapeutic Consultation			55.43	7.52		

Service	Mental Health Services		Developmental Services		Substance Abuse Services	
	Adults	C & A	Adults	C & A	Adults	Adolescents
Limited Services						
SA Social Detoxification					2.00	2.00
Motivational Treatment	4.00				3.50	4.71
Consumer Monitoring	5.00	7.00	4.88	4.73	5.00	2.00
Assessment and Evaluation Services	5.77	3.50	4.84	5.44	2.58	2.87

In CSBs that provide targeted services for older adults, service wait times for those individuals may be significantly higher than the general adult population. For example, one CSB reported that older adults waited six week on average from initial contact to first scheduled appointment, 16 weeks for medication services, ten weeks for counseling and psychotherapy and four weeks for day treatment.

Anticipated Changes Influencing Future Demand for Behavioral Health and

Developmental Services: The Department anticipates a variety of factors will converge to increase demand for services provided by the public behavioral health and developmental services system. These include:

- Increasing services demand resulting from Virginia demographic trends, particularly the:
 - continued significant growth in Northern Virginia, Central Virginia, and Eastern Virginia;
 - growing numbers of older adults who will require behavioral health services to enable them to reside in their homes or other community placements; and
 - increasing cultural diversity of Virginia’s population;
- Increasing numbers of veterans who are returning to Virginia from Iraq and Afghanistan and are experiencing behavioral health service needs;
- Increasing demand for specialized interventions and care by individuals with co-occurring combinations of mental illnesses, substance use disorders, intellectual disability, or other cognitive deficits, chronic medical conditions, or behavioral challenges;
- Evolving needs of individuals receiving behavioral health and development services who require ongoing preventive care, who have more complex medication regimes, or who are experiencing serious medical conditions requiring specialized health services;
- Additional demands for specialized services resulting from the aging of current caregivers;
- Increasing numbers of adults and juveniles in the criminal justice system with identified behavioral health service needs; and
- Emerging responsibilities of the behavioral health and developmental services system for serving individuals with developmental disabilities, including autism spectrum disorder.

Initiatives to Improve Service Availability and Accessibility

Mental Health Law Reform Initiative: The Department has worked closely with the Virginia Supreme Court’s Commission on Mental Health Law Reform to study and recommend changes to Virginia’s mental health statutes and behavioral health services system. The goals of this effort, which began in 2006, include reducing the need for involuntary commitment by improving access to behavioral health services, reducing criminalization of people with mental health disorders, making the process of involuntary commitment fairer and more effective, enabling individuals receiving behavioral health services to have more choice over the services they receive, and helping young people with mental health problems and their families before these problems spiral out of control.

Less than a year after the Commission's study began, the deadliest mass shooting on a university campus in the United States took place on April 16, 2007 at Virginia Polytechnic Institute and State University (Virginia Tech) in Blacksburg. Twenty-seven students and five teachers were killed and 29 persons were injured. The accused shooter, a fourth year student at Virginia Tech, committed suicide. Approximately 18 months earlier, in December 2005, this individual had been briefly hospitalized under a temporary detention order (TDO) and was subsequently committed to involuntary outpatient psychiatric treatment. Following his release to outpatient care, he had received minimal treatment. In its report, the Virginia Tech Review Panel, appointed by Governor Kaine to conduct an independent investigation of the shooting, highlighted many weaknesses in the involuntary treatment process as well as inadequacies in the associated mental health services, particularly short-term crisis stabilization and comprehensive outpatient services. Based on the Commission's work and the findings of the Panel, the Governor and General Assembly initiated far-reaching statutory reforms as well as expansion of crisis stabilization and other "safety net" services.

In 2008, the General Assembly enacted a package of reforms that made major changes to Virginia's involuntary treatment laws and enhanced access to services to ensure individuals with mental health disorders get the treatment they need. These measures were to address the most significant and immediate problems identified by the Commission and the Virginia Tech Review Panel that had contributed to the mass shooting on April 16, 2007. The most significant of these reforms involved changing the existing "imminent danger" and "inability to care for self" criteria (widely believed to be too restrictive and vague) to broader and clearer standards based on "substantial likelihood" of causing or suffering harm. Other major areas of reform included new mandatory outpatient treatment procedures, clarification of permitted disclosures, new responsibilities for CSBs for participation in the involuntary process and coordination of care, more specific responsibilities for CSB preadmission screeners and independent examiners, clarification of court procedures, new evidentiary provisions, and other reforms.

In 2009, the major areas of statutory reform focused on making the involuntary process more consumer-focused. New statutes were enacted to fine-tune the 2008 legislation, to allow transportation by persons other than law officers, to allow instructional advance directives to be executed in circumstances other than end-of-life situations, and to allow short-term psychiatric admission of incapacitated persons without judicial order. In addition, new laws were enacted to create a comprehensive mandatory outpatient treatment procedure for minors.

Accompanying these statutory reforms was an infusion of \$28.3 million in the 2008-2010 biennium budget to build additional service capacity, including expanded emergency services; crisis stabilization services; and case management, inpatient, and outpatient services for individuals in need of emergency mental health services. These funds also were provided to address the administrative impact of civil commitment reforms, such as new responsibilities for attending involuntary admission hearings, coordinating services, and collecting data.

The Department has collaborated extensively with services system stakeholders to support implementation of new laws and services. In addition the Department (with the Office of the Attorney General) has provided statewide and regional training events in June of 2008 and June of 2009. The Department has also established a "Mental Health Reform" web-page to create a resource for stakeholders. The web-page has training materials, guidance documents, FAQ's and other resources for users. The Department has supported the collection of new data about the commitment process in Virginia, through direct support of the CMHLR research and also through new reporting structures in the CSB Performance Contract. Lastly, the Department has established an on-line certification program for CSB preadmission screeners and independent examiners, which allows CSB and other practitioners to access mandated training through Virginia's *Learning Management System* technology.

For the future, the Department continues its active participation in the ongoing work of the Commission on Mental Health Law Reform. FY 2010 will focus primarily on issues related to access to services, but also on some related areas of law that remain on the Commission's study agenda (e.g., length of Virginia's temporary detention period).

Autism Spectrum Disorder and Developmental Disability Services: Two new Department positions, a specialist in autism services and a specialist in general developmental disabilities, were funded by the 2009 General Assembly. These positions will concentrate on promotion of employment and housing initiatives and non-waiver funded service development.

The autism spectrum disorder specialist is reaching out to all organized parent groups and other stakeholder organizations whose efforts are concentrated on autism spectrum disorder initiatives to seek opportunities for communication, collaboration, and mutual support. The Department has established a formal linkage to Commonwealth Autism Services and is developing a memorandum of agreement that outlines the support to be offered by the Department and efforts that will be pursued jointly to develop ongoing education, training, and understanding of issues related to autism and furthering state development of autism policy initiatives. The Department also will coordinate training to CSBs and private providers on services for persons with autism. A priority audience for this training will be CSB case managers who interact with families of individuals with autism spectrum disorder who seek services. This training will focus on the wide variety of service options that are available currently to ensure that families are not left without information on possible options due to lack of knowledge on the part of the case manager.

The developmental disabilities specialist is working to strengthen relationships with the broader housing community and is pursuing initiatives to develop alternative housing for adults with developmental disabilities. The 2009 Appropriation Act directed the Department to study investment models and best-practices for the development of affordable and accessible community-based housing for persons with intellectual and related developmental disabilities. This study, presented to the General Assembly in late 2009, identified housing and support alternatives to increase the availability of community housing, leverage state dollars, and promote individualized, person-centered options for individuals with developmental disabilities.

The Department has joined the National Association of State Directors of Developmental Disabilities Services, which sponsors the Supported Employment Leadership Network (SELN) project. Through this association, the Department will be able to pursue training opportunities designed to develop and promote supported employment initiatives across Virginia. The Department also plans to become an active participant in the SELN project and to promote the use of the supported employment model in Virginia's Medicaid waivers. The Department also will explore alternatives to Medicaid-funded services for this population.

The Department is continuing an ongoing dialogue with DMAS concerning the waivers and opportunities to move forward together in the development of a more comprehensive developmental disabilities system. As an initial step, the Department participated with DMAS and stakeholder representatives on the development of a framework for an autism waiver.

Services System Transformation for Children with Mental Health Disorders: *Mental Health: A Report of the Surgeon General* cites concerns about inappropriate diagnoses of children's mental health problems. The Report identified the following mental disorders with their onset in childhood and adolescence: anxiety disorders, learning and communication disorders, attention-deficit and disruptive behavior disorders, mood disorders (e.g. depressive disorders), autism and other pervasive developmental disorders, eating disorders, tic disorders, and elimination disorders. (*Surgeon General's Report*, 1999) A growing body of empirical evidence estimates a prevalence rate as high as 50 percent for the co-occurrence of alcohol and other drug use among adolescents with mental health disorders. (Petrla, Foster-Johnson, and Greenbaum, 1996)

Too often, children with behavioral health problems do not receive services until they are in crisis and require services in a secure setting such as a hospital, detention center, or state juvenile correctional facility. While progress has been made with system initiatives to develop community service capacity, most notably the passage of the Comprehensive Services Act (CSA) in 1992 and more recent funding initiatives that support four System of Care projects and behavioral health services in juvenile detention centers, services for children with behavioral health issues continue to be fragmented and disparate across the Commonwealth. While the CSA encourages flexible funding and provides a structure for cross-agency collaboration at the state and local levels for serving children in their own families and communities, Virginia continues to rely too heavily on residential care. With inadequate community services that help keep their children at home, parents are forced to move from agency to agency seeking the coordinated package of services their children need.

The Commonwealth initiated a Children's Services System Transformation Initiative in late 2007 to improve outcomes for children and their families who are involved with Virginia's child-serving systems. This initiative, which is being implemented with support of the Governor and First Lady, the Secretary of Health and Human Resources, and state agencies with child serving responsibilities in partnership with national experts such as the Annie E. Casey Foundation, is intended to strengthen permanent family connections for children and youth by transforming how children's services are delivered. The Department and CSBs, along with other Virginia state and local child serving agencies, private providers, family members, and advocates, are active participants in this transformation process.

The goal of the Children's Services System Transformation Initiative is for every child who is involved with Virginia's child-serving agencies to achieve his or her greatest potential and for every family to be empowered to provide support for its children. Short-term objectives follow:

- Increasing the number and rate at which youth in foster care move into permanent family arrangements;
- Increasing the number of placements of at-risk children and youth with kin and foster parents;
- Devoting more resources to community based care;
- Reducing the number of group care placements; and
- Embracing data and outcomes-based performance management.

Six interconnected building blocks provide the foundation for transformation workgroup actions to change Virginia's culture and approach to delivering services.

- *Practice model* - This set of shared principles provides a clear structure that guides policy, practice, and behavior and drives accountability;
- *Training* - This involves retooling the state's training system by adopting a model of competency-based in-service training;
- *Resource Family Development* - This is the process of recruiting, developing, and supporting resource families, which include foster, adoptive, and kinship parents;
- *Managing by Data* - This involves developing a consistent process for capturing and using data to support decision-making, improve practice quality, track child and family progress over time, and promote accountability;
- *Family Engagement Model* - This leverages family resources and gives a stronger voice to children and families through active engagement with staff and other important stakeholders in decisions that affect a child's life; and
- *Community Based Continuum* - This family-based practice model renews commitment to expanding community-based approaches, providing incentives and building local service

capacity to meet growing demand, restructuring existing services, assuring intensive care coordination, and supporting community-based alternatives to detention.

In 2009, the Children's Services System Transformation Initiative published an action plan with the following components to spread transformation statewide.

- Providing opportunities for localities to learn about the initiative and resources and best practices that can help them launch transformation;
- Helping child-serving staff accomplish the six transformation building blocks through in-depth training that allows for greater support and more precise technical assistance;
- Building capacity through regional collaboratives that focus on information-sharing and practical guidance for implementing transformation at the local level; and
- Fully implementing the transformation in the 13 CORE localities selected in 2007 to improve family engagement, reduce their congregate care placement rates, and develop community capacity and using their experience and expertise as a resource for neighboring communities.

Appropriation Act language, which had been in place since 2004, directs the Department to develop an integrated policy and plan for children's behavioral health services. The 2009 plan, developed in collaboration with the System of Care Advisory Team (SOCAT) comprised of CSBs, state agencies, parents, advocates, private providers, and others, included recommendations to improve and assure uniform availability of a core set of child and adolescent services across Virginia, particularly emergency and crisis stabilization, care coordination (case management), intensive in-home and home-based services, and intensive care coordination. The report recommended community capacity development in the following areas when state budget conditions improve:

- Intermediate level community services, System of Care projects, and school-based mental health services;
- Monitoring and oversight positions in child-serving agencies;
- Workforce capacity enhancements provided by teaching centers of excellence;
- Family resource, support, and service coordination; and
- Psychiatry and psychology fellowships.

The report also supported continuation of the Children's Services System Transformation activities, including coordination provided by the Special Advisor on Children's Services.

Older Adult Initiatives: Nationally, the older adult population accounts for about 12.4 percent of the total population. The anticipated impact of aging "baby boomers" will increase this proportion to 20 percent by 2030. (Federal Interagency Forum on Aging, Korper and Council, 2002) This is likely to place increased pressure on health care services and the demand for social services. Virginia's behavioral health and developmental services system must plan for the accelerated growth of the older adult population and its proportionately greater and more expensive healthcare needs.

According to *Mental Health: A Report of the Surgeon General* (1999), almost 20 percent of the population 55 and older, or an estimated 348,214 of the 1,758,655 older Virginians (2008 Population Estimates), will experience specific mental disorders that are not part of the "normal" aging process. Best estimate one-year prevalence rates for specific mental disorders, based upon epidemiological catchment area information described in the *Surgeon General's Report*, follow.

**Estimated One Year Prevalence Rates in Virginia of
Mental Disorders Not Associated with Aging**

Disorder	Percent	Number	Disorder	Percent	Number
Any Anxiety Disorder	11.4	200,487	Somatization	0.3	5,276
Any Mood Disorder	4.4	77,381	Severe Cognitive Impairment	6.6	116,071
Schizophrenia	0.6	10,552	Any Other Mental Disorder	19.8	348,214

Mental Health: A Report of the Surgeon General, Chapter 5 Older Adults and Mental Health (page 336),
Source of prevalence estimates: D. Regier and W. Narrow, personal communication, 1999.

The *Surgeon General's Report* estimates that an *unmet* need for mental health services may exist for up to 63 percent of adults aged 65 years and older with a mental disorder (p. 341). Also, many older adults need treatment for alcohol and drug abuse disorders and do not receive it; they may be more likely to hide their substance abuse and may be less likely to seek professional help. (CSAT, 1998) Alcohol and prescription drug misuse and abuse occur among older adults for a variety of reasons, including unintended interactions between alcohol and other drugs, use of multiple drugs, confusion, lack of judgment, or miscommunication. Because of insufficient knowledge, limited research data, and hurried office visits, health care providers tend to overlook substance abuse and prescription drug misuse among older adults, mistaking the symptoms for those of dementia, depression, adverse drug reactions, or other problems common to this population. (Gambert and Katsyoannis, 1995)

The growing need to better serve older adults, including those with mental health or substance use disorders or intellectual disability, represents a shift in cultural perspectives on aging. Society once assumed that older adults required no more than custodial or end-of-life care. Now, with increased longevity; a renewed respect for the social, political, and economic contributions of this population; and the demand for more appropriate treatment choices by individuals who receive services, there are strong pressures on service delivery systems to develop new treatment models. For example, a challenge for older adults with intellectual disability who are living in group settings is to be allowed to "retire" from work or other day activities, since it is the policy of many such homes that residents remain off-site during the day.

Treatment models for older adults with mental health or substance use disorders or an intellectual disability must be well coordinated, respond to the unique needs of a population with growing health issues, and provide services that promote new roles for individuals who seek to continue as productive members of their communities. Inpatient geriatric treatment services will not be the answer to the burgeoning geriatric population. The baby boom cohort will be demanding "aging in place" community and home-based services; available resources will need to be planned and developed to meet this demand. Services include informed and educated primary care providers equipped to manage and treat minor psychiatric conditions in older adults, short-term respite care that includes psychiatric treatment, assisted living and nursing facilities with integrated psychiatric treatment options, payment systems where the money follows the person, and enhanced availability of programs such as the PACE Model that allows for Medicaid coverage of psychiatric care in the individual's own residence.

Integrating behavioral healthcare into primary care and other generalist settings will benefit older adults with substance use disorders or milder cases of substance dependence. Clearly, many of these individuals could be identified through substance use screening procedures in primary care or other generalist settings and could benefit from brief interventions delivered by physicians, nurses, pharmacists, and social workers who interact with them on a regular basis, sometimes in their own homes.

Virginia lacks adequate behavioral health and developmental services infrastructure to meet the current needs of older adults. The provision of services to older adults is complicated by the

limited number of specialized community-based programs in Virginia and lack of providers trained to serve older individuals with mental health or substance use disorders or intellectual disability. Although some older adults living in nursing facilities are receiving case management and other specialized services through OBRA-87 funding, long-term care facilities report problems managing behavior of their residents with behavioral health and developmental disorders. This is particularly salient because behavioral disturbance is the single largest predictor of long-term care admissions. (Hamel, Gold and Andres, 1990) An inability to manage behavior problems can translate into injuries to the person, other residents, and caregivers. At times, long term care facilities respond to behavior problems with an over reliance on medications due to the lack of access to psychiatric care.

As Medicare, Medicaid, and other insurers decrease reimbursement for services, increased responsibility is being placed on the Department and CSBs to serve older adults in community settings. The Department and CSBs have worked together and with other stakeholders to develop regional model programs in Northern Virginia and Eastern Virginia to provide innovative direct care services for older adults in their home communities with the goal of reducing the need for psychiatric hospitalization. These initiatives are collaborating with local service area providers to create programs that meet the needs of their communities, including:

- regional specialized gero-psychiatric behavioral health mobile teams and specialized assisted living and nursing home teams;
- discharge assistance funding,
- regional private bed purchase funds;
- specialized services and supports that incorporate evidence-based and best practices, including on-site geriatric psychiatric services provided through a PACE program, partial hospitalization, intensive outpatient services and adult day care extensive outreach services, education/support and participation in advocacy; and
- strategic planning activities.

Despite these new initiatives, the number of older adults receiving CSB mental health services declined between FY 2005 and FY 2008 (from 12,592 to 11,626 served) even though the number of Virginia adults over age 60 grew by around 3 percent annually. During the same period, the number of adults ages 50-60 receiving CSB mental health services increased. Given the lack of current capacity, coupled with increased pressures resulting from demographic trends and expected declines in available resources, older adults are likely to have great difficulty accessing needed behavioral health and developmental services.

The Department has established a Geriatric Services Leadership Team that is working to develop and implement a Master Plan for Geriatric Services. This effort envisions an integrated model for the delivery of specialized clinical behavioral health services for older adults. It promotes continuity of care through a continuum of providers and shared commitment to ensure the proper level of care and recognizes the importance of ongoing collaboration with CSBs, community providers of aging services, and other community organizations to increase capacity for aging in place, when appropriate, for older adults. Among the outcomes that could be achieved with adequate staffing and supporting infrastructure are:

- Implementation of program initiatives that monitor outcomes in several supportive living situations;
- Development and dissemination of a directory of older adult service models organized by regions;
- Provision of technical assistance and training and education on best practices for serving older adults; and
- Improved monitoring and accountability of specialized services.

Implementation of the master plan will require energized collaborative partnerships with public and private providers and the academic community and sustained commitment to improving access to services and supports to the extent possible given available resources, ensuring service quality and effectiveness, and monitoring for older adult service outcomes.

Diversion and Treatment Services for Individuals Involved with the Criminal Justice System: According to a June 2009 study published by the Council on State Governments Research Center, nearly 17 percent of all individuals booked into jails have a serious mental illness. When post-traumatic stress disorder is added to the calculation, the average rises to 19 percent (Steadman, et. al. 2009). Significantly, many individuals with mental health disorders who are involved in the criminal justice system are poor, uninsured, disproportionately representative of minority populations, homeless, or living with co-occurring mental health and substance use disorders. These individuals, when incarcerated, frequently do not receive adequate behavioral health services and, upon release, have difficulty re-entering and reintegrating into the community. They are highly likely to recycle through the behavioral health and criminal justice systems and to require more intensive levels of care in both systems. Many lose their income supports and health insurance benefits are not provided with adequate linkages to behavioral health services and supports. A similar situation exists for youth with serious emotional disturbances who are in the juvenile justice system.

State Board Policy 1041 (SYS) 06-4 Services for Individuals with Mental Illnesses, Mental Retardation, or Substance Use Disorders Who Are or Are at Imminent Risk of Becoming Involved with the Criminal Justice System, adopted in 2006, encourages and supports the identification, development, and implementation of an array of services to prevent the involvement of individuals with mental health or substance use disorders or intellectual or developmental disabilities in the criminal justice system and reduce demand on and prevent readmission of individuals involved with the criminal justice system to state hospitals.

Behavioral health and developmental services for individuals who are involved in Virginia's criminal justice system should be a community-focused endeavor whenever possible. Many individuals with mental health or substance use disorders or intellectual or developmental disabilities can be served through a variety of approaches:

- For those who are at risk for incarceration or charged with crimes that do not represent a significant public safety risk, provide pre- and post-booking, pre-trial alternatives, and community treatment services such as crisis intervention teams and crisis stabilization programs to prevent behavioral health situations from requiring criminal justice response, divert individuals from incarceration or detention whenever legally possible, and link individuals to community-based services and supports.
- For those who, for public safety reasons, cannot be treated in the community, provide improved methods for delivering an array of behavioral health treatment in Department of Corrections (DOC) facilities, Department of Juvenile Justice (DJJ) correctional centers and half-way houses, juvenile detention facilities, and local and regional jails.
- For those requiring traditional forensic services due to their legal status, provide court-ordered evaluation and treatment services in the least restrictive setting possible, including services in the community or in local jails and hospitals where appropriate.
- For those being released from incarceration or detention, provide post-incarceration and re-entry services that include appropriate clinical services and supports at the time of release.

In January 2008, the Governor issued Executive Order No. 62, establishing the Commonwealth Consortium for Mental Health and Criminal Justice Transformation. The Consortium is led by the Secretaries of Public Safety and Health and Human Resources and partners with the Office of the Supreme Court, the Office of the Attorney General, and representatives from each agency having a significant impact on the population of individuals with mental health or

substance use disorders or intellectual or developmental disabilities and criminal justice involvement. The Consortium has two goals: transformation planning to identify, evaluate, and support the development of jail diversion models and establishment of a Criminal Justice and Mental Health Training Academy for the Commonwealth. The Department is working with the Consortium to achieve these goals and is providing leadership through the following initiatives to develop a comprehensive approach to addressing the needs of individuals with mental health or substance use disorders or intellectual or developmental disabilities who are at risk for involvement or involved in Virginia's criminal justice system.

- Strengthening criminal justice and behavioral health partnerships:
 - A statewide position has been established to support and enhance collaboration, education, and interoperability of criminal justice and behavioral health initiatives at the state, regional, and local levels;
 - The Department and the Department of Criminal Justice Services (DCJS) are pursuing grant opportunities and collaborating on cross-agency training on behavioral health and criminal justice initiatives.
- Developing the competence of localities to identify the most effective points of intersection and appropriate intervention for individuals with mental health or substance use disorders or intellectual or developmental disabilities in order to prevent or reduce their involvement in the criminal justice system and promote access services and supports and community integration:
 - The Sequential Intercept Model and Cross Systems Mapping for Communities initiatives were introduced at the Governor's Conference in May 2007.
 - The Department has supported training of 22 criminal justice and mental health experts as Cross Systems Mapping facilitators.
 - Cross-Systems Mapping workshops for criminal justice and behavioral health providers and consumer and community representatives have been implemented in 11 localities. These workshops use the Sequential Intercept Model to review local resources, identify and prioritize gaps, and develop tailored action plans to improve systems interoperability and outcomes for individuals with mental health and substance use disorders who are involved in the criminal justice system. Twelve sessions are scheduled in FY 2010.
- Enhancing and expanding an array of jail diversion, jail-based forensic, treatment, and criminal justice/behavioral health collaborative programs across Virginia:
 - CSBs provide emergency services, including evaluations and preadmission screening for hospitalization, to individuals in local and regional jails and juvenile detention centers and conduct non-emergency evaluations, including evaluations of competency to stand trial, criminal responsibility, and waivers of juvenile court jurisdiction. Many CSBs provide individual and group behavioral health counseling; psychiatric and medication services; and restoration to competency services to the offender population through local initiatives developed jointly with local and regional jails and juvenile detention centers. The Department supports a number of programs providing behavioral health services to adults in local and regional jails and children and adolescents in juvenile detention centers. Three CSBs receive funds to provide intensive substance abuse treatment patterned after offender-based therapeutic communities in separate jail living areas.
 - CSBs also provide services through 16 adult and eight juvenile drug courts to non-violent felons who are offered this as an alternative to incarceration and treatment in jail. In addition, four localities operate family drug courts and one operates a court specifically for DUI offenders. Drug courts combine long-term (12-18 months), strict, frequent supervision by probation staff, intensive drug treatment by clinicians, and close judicial monitoring by the court.

- Jail diversion and reentry programs are being implemented in ten localities with high numbers of persons with mental illness in local or regional jails. Courts in these localities also refer a high percentage of their defendants to state hospitals for restoration of competency to stand trial. From the almost \$6 million provided in the 2008-2010 biennium budget, ten localities are expanding their jail-based services; six are developing or enhancing Crisis Intervention Team (CIT) programs, three have established post-booking diversion programs, six are providing enhanced assessment and linkage to services at the post-booking/pre-trial stage, three are enhancing limited re-entry and linkage to services, and one is funding a full time probation position to serve the needs of individuals with behavioral health service needs on state probation. These programs have helped to prevent long waits for admission to state hospitals for emergency treatment or competency restoration.
- State hospitals provide evaluation, emergency inpatient treatment, and treatment to restore competency to adult and juvenile offenders. The Department is taking steps to reduce the time that jail inmates wait for admission to state hospitals for acute treatment. These steps have included allocation of resources for community-based diversion strategies, which enabled 439 jail inmates to receive diversion-related services in FY 2007. In addition, state hospital forensic programs have made meaningful changes in their operations to reduce wait list times by restructuring their programs, improving their screening and triage practices, and providing consultation and assistance to jail staff on how to effectively manage inmates in jail settings.
- Promoting the adoption of law enforcement CIT programs to ensure the safety of individuals with mental health or substance use disorders or intellectual or developmental disabilities who are in crisis and law enforcement officers, while preventing unnecessary involvement of these individuals in the criminal justice system:
 - The Department is collaborating with the DCJS to develop and implement minimal standards for Virginia CIT programs, as required by the 2009 General Assembly.
 - The Virginia CIT Coalition, a consortium comprised of localities that are developing, implementing, or providing CIT programs, has been established. The Coalition provides continuing education and training to CIT providers and shares information through a web site and quarterly meetings. It also is assisting with the CIT program standards.
 - Virginia CIT programs have created mentoring and shared training opportunities, including 40-hour start-up training and 20-hour train-the-trainer programs to help localities establish consistently effective programs and local training capabilities.
- Expanding knowledge about criminal justice and behavioral health initiatives:
 - The Department has partnered with the Institute of Law, Psychiatry, and Public Policy at the University of Virginia, DCJS, and the National GAINS Center to produce demonstrable evidence on the economic and clinical efficacy of the jail diversion programs supported by 2008-2010 biennium funding.
 - In addition to the Cross-Systems Mapping, four regional trainings on criminal justice and mental health collaboration and mental health issues were held. These initiatives have provided nearly 500 individuals across the Virginia criminal justice and behavioral health services systems with valuable information, tools, and resources to improve outcomes for individuals with mental health or substance use disorders and enhance systems interoperability.

Services for Veterans and Their Families: Virginia has recognized that its responsibilities to the state's veterans go beyond an enduring gratitude. In Executive Order 19 (2006) Governor Kaine stated that "it is only right that our Commonwealth do all that it can to ensure that our veterans and their families receive the benefits, support, quality care, and recognition they have earned through service and sacrifice." The Governor has established an aggressive agenda for

supporting Virginia's veterans, including those with mental health or substance use challenges. Executive Order 19 (2006) calls on each agency to identify opportunities for improving services and addressing the continuum of care needs of disabled veterans. In pursuit of this objective, the Department and CSBs have formed a strong partnership with the Virginia Department of Veterans Services (DVS) across many areas of veterans care.

Policymakers anticipate that surging demands for behavioral health services among veterans of post-9/11 deployments will require a substantial increase in long-term behavioral health service capacity in Virginia. While the actual scope of behavioral health service needs from combat exposure is still under examination, initial returns indicate that it is significant. Initial studies, surveys and numbers of those seeking treatment through the federal Department of Veterans Affairs (VA) indicate that at least one-third of the men and women who have served in Iraq and Afghanistan are in need of some behavioral health services. Other assessment efforts and trends indicate that these levels could be dramatically understated. Analysis on the long-term behavioral health effects of operational deployments on family members is also incomplete and inconclusive, though indicators point to growing needs for services by these individuals as well.

A recent US Department of Defense (DOD) study of the mental health needs of service members returning from Iraq and Afghanistan asserts that "combat imposes a psychological burden that affects all combatants, not only those vulnerable to emotional disorders or those who sustain physical wounds." (DOD, Defense Health Board, 2007) This report further states that the behavioral health challenges on the military health system come from two emerging "signature injuries" - post-traumatic stress disorder and traumatic brain injury - which are increasing due to a range of causes. Fortunately, more veterans appear to be seeking assistance and treatment voluntarily because of proactive programs, growing media coverage and declining stigma associated with behavioral health.

A growing body of evidence demonstrates that as many as half of military veterans and their families will face significant mental health challenges in the coming years. The behavioral health impact of these veterans on the jurisdictions where they choose to live following discharge from active service will be dramatic. Based on current rates of diagnosis reported by the VA for recently discharged veterans seeking care at VA facilities, if historic trends in the veteran portion of Virginia's population continue, Virginia could face a 15-20 percent surge in the numbers seeking behavioral health services over current levels.

The Department, DVS, and DRS are implementing a state level strategy, the Virginia Wounded Warrior Program (WWP), to respond to the behavioral health needs of Virginia veterans. The WWP was created in 2008 to ensure that services to veterans and their families are readily available in all areas of the state. Under the WWP, \$1.7 million dollars has been awarded to five regional coalitions in Northwestern Virginia (\$300,000), Northern Virginia (\$400,000), Southwest Virginia (\$190,000), Central and Southside Virginia (\$190,000), and Tidewater Virginia (\$620,000). Services provided by the VWWP grant recipients range from increased outpatient counseling and crisis intervention for veterans and their spouses and children to day programs and other supports for veterans with traumatic brain injuries. The initial grant period is through June 2010. DVS has also established Regional Directors in the Southern, Western, Northern, and Richmond areas to facilitate partnership-building and service delivery.

Services for Individuals Who Have Co-Occurring Disorders

Intellectual Disability and Mental Health or Substance Use Disorders: The National Association for the Dually Diagnosed (NADD) has broadly defined dual diagnosis as the co-existence of manifestations of both intellectual disability and a mental health disorder. These individuals may have any level of intellectual disability and the full range of psychopathology that exists in the general population. Many professionals estimate that between 20 and 35 percent of all persons with an intellectual disability also has a psychiatric disorder. Families and individuals receiving developmental supports may not be aware that it is possible to have a

concurrent mental health or substance use disorder, resulting in the failure to recognize the signs and symptoms of this disorder. This lack of awareness increases the likelihood that these individuals will face multiple barriers to accessing the services and supports they need.

Individuals with a serious mental illness and intellectual disability may reside in the community and enter the service system because of challenging, difficult-to-manage behaviors that may pose a threat of serious harm to themselves or others. They may be at increased risk for psychiatric hospitalization because they require specialized supports in a secure environment. Other individuals may be supported in a state training center or community ICF/MR.

Providing appropriate treatment for individuals with intellectual disability and a concurrent mental health or substance use disorder has been recognized as problematic in all states. Behavioral health and developmental services providers must be skilled in diagnosis of intellectual disability and mental health or substance use disorders and knowledgeable about appropriate services and supports needed by individuals who have both diagnoses. Although progress has been made in establishing regional protocols and teams to coordinate services for individuals in crisis, Virginia does not have a systematic or comprehensive approach for meeting the needs of these individuals. There also is a lack of community-based expertise in diagnosing, treating, and supporting individuals who require behavioral health services.

The Department has sponsored statewide Positive Behavioral Supports training to enable professionals to increase their knowledge of and to expand the number of professionals providing behavior consultation services through the ID waiver to individuals with behavioral challenges that result from mental health or substance use issues. These multi-session training events, including subsequent mentoring by an experienced facilitator, are endorsed by DMAS.

Substance Use and Mental Health Disorders: Co-occurring substance use and mental health disorders are characterized by the simultaneous presence of two independent medical disorders – psychiatric disorders and alcohol and other drug use disorders. Co-occurring substance use and mental health disorders can occur at any age. Of those Virginians with an addictive disorder, 42.7 percent or 238,098 individuals also had a least one mental disorder during the 12-month period, according to the *Report to Congress on the Prevention and Treatment of Co-occurring Substance Abuse Disorders and Mental Disorders*.

Individuals with co-occurring substance use and mental health disorders challenge Virginia's behavioral health services system. Three systemic barriers restrict services to these individuals – restricted services funding, lack of specifically designed programming, and lack of trained professionals. The Department is in the final year of a five-year federal State Incentive Grant for the Treatment of Persons with Co-occurring Substance Related and Mental Disorders (COSIG) grant to improve Virginia's ability to address the complex treatment needs of individuals with co-occurring mental health and substance use disorders and has applied for a one year no cost extension through September 2010. This initiative, now called the Virginia Service Integration Program (VASIP), has promoted the use of validated instruments for screening co-occurring disorders, built existing infrastructure capacity; provided training and technical assistance by nationally recognized experts on evidence-based and culturally competent treatment practices for individuals with co-occurring disorders; conducted workforce surveys of CSB and state facility staff; developed a workforce training and development plan to improve core competencies of staff providing services; trained consumers in a co-occurring self help model and provided support in establishing groups in their communities; trained a statewide network of trainers; and obtained training and consultation in the use of validated fidelity instruments to assist programs with evaluation and quality improvement.

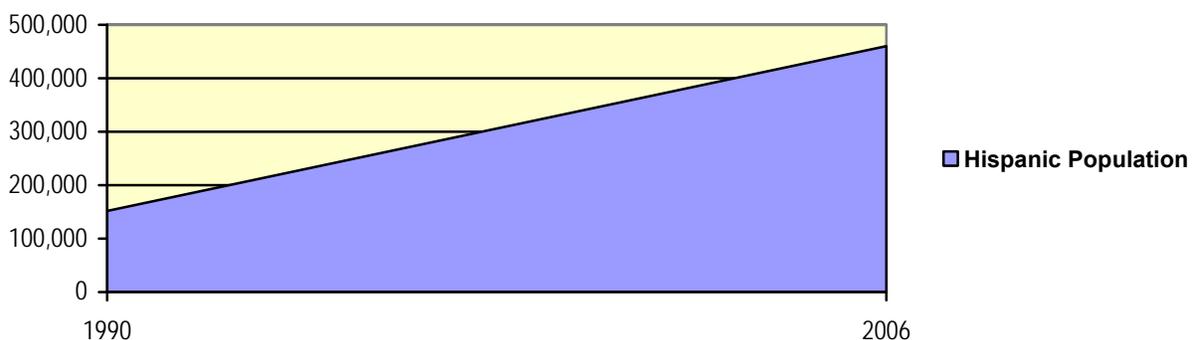
Integrated treatment, as opposed to sequential or parallel forms of treatment, offers the most positive outcomes for individuals experiencing co-occurring disorders. (RachBeisel, Scott, and Dixon 1999; Drake et al., 2001, Schneider 2000, Drake and Wallach 2000) Through the VASIP, the Department is promoting the adoption of the *Comprehensive, Continuous, Integrated*

System of Care (CCISC) model at all levels of the services system. CCISC is designed to be an accepting umbrella for all best practices in the treatment of individuals with co-occurring disorders. It incorporates the principles of integrated system planning, a welcoming environment, uniform program capability in dual diagnosis, universal practice guidelines, dual competence, concurrent treatment for simultaneous primary disorders, ease of access, treatment matching to subtypes of individuals with dual diagnoses, utilization of parallel phases for treatment planning, readiness stages are not a barrier, treatment over time, and maintaining continuity of relationships with clinicians. (Minkoff, 1989, 1991, 2000, 2001)

In 2005, the Department was awarded a federal State Adolescent Treatment Coordination (SAC) grant to develop necessary infrastructure to support the development and provision of substance abuse treatment services for youth who have a substance use or co-occurring disorder. Virginia applied for and received a one year no cost extension to the grant and the fourth year will conclude in July 2009. The three-year SAC (known in Virginia as Project TREAT) grant focused on funding and promotion of evidence-based practices, collaboration across state systems, workforce development, and development of family support and advocacy efforts. Grant activities included the establishment of an interagency workgroup to identify and address infrastructure needs across systems and this group will continue meeting to provide guidance and advocacy after the grant concludes. An adolescent services provider network was also created. The grant supported provision of technical assistance and skill-based training to implement evidence-based programs to 17 CSBs as well as statewide training across systems in adolescent best practices, supervision, and use of ASAM criteria with adolescents. The CSBs who received training and technical assistance for implementation continue to provide services utilizing those models (Seven Challenges, MET/CBT 5 and 7, Motivational Interviewing, and DBT for Adolescents).

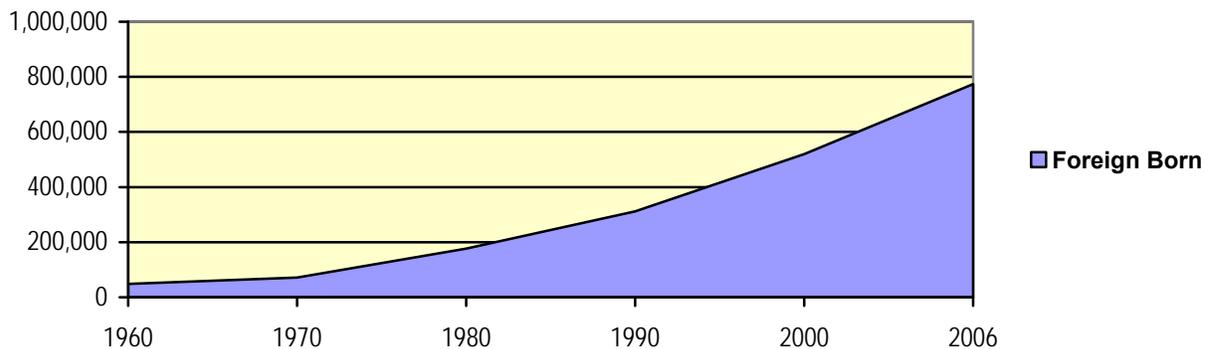
Through the VASIP and SAC initiatives, the Department is working to establish a more comprehensive approach for technology transfer for both central office and CSB staff that will promote consensus and evidence-based approaches in treatment delivered to individuals with both mental health and substance use disorders. Despite these considerable efforts, Virginia does not yet have a distinctive, planned, comprehensive and coordinated approach to delivering services to individuals with co-occurring disorders.

Individuals Who Experience Cultural or Linguistic Barriers to Services: According to U.S. Census Bureau's 2007 estimates, Virginia's population is 73 percent Caucasian, 20 percent African-American, five percent Asian, two percent Two or More Races, and less than one percent Other. Virginia's population is becoming more diverse. According to the Weldon Cooper Center for Public Service, between 1980 and 2005, Virginia minority population (race and Hispanic origin other than white/non-Hispanic) increased from 22 percent to 33 percent. Virginia's Hispanic population tripled from 152,000 in 1990 to more than 460,000 in 2006, or six percent of the total population (as compared to 15 percent in the U.S. as a whole).



This increase is attributed to immigration and to births. Of all Hispanic immigrants to Virginia, nearly 90 percent arrived in the U.S. in the last five years, 66 percent in the last 10 years, and 44 percent in the last 15 years. The distribution of Virginia's Hispanic population is concentrated in the three major metropolitan areas and selected rural areas. Fairfax County is home to more than one-quarter of all of Virginia's Hispanic residents.

The Weldon Cooper Center for Public Service reports that one in ten Virginians is foreign-born. Between 1960 and 2006, Virginia's foreign-born population increased significantly, from 48,000 to 774,000:



The Center estimates that of the 773,785 individuals residing in Virginia in 2006 who were identified as foreign born, 331,954 (43 percent) were naturalized citizens and 441,831 (57 percent) were immigrants. For Virginia's foreign born population, 40 percent were from Asia, 36 percent were from Latin America, 13 percent were from Africa, and the 2 percent were from North America or Oceania. Virginia's naturalized population is more likely to be from Asia. This population generally arrived earlier (the majority before 1990), is older and better educated, is employed in higher status occupations, and has lower poverty rates. Virginia's immigrant population is more likely to be Hispanic. The population generally arrived later (the majority between 2000 and 2006), is younger and not as well educated, is employed in low status occupations, and has higher poverty rates. Over half speak English less than "very well."

Although Virginia's foreign born population comes from over 100 countries, El Salvador, Korea, Philippines, Mexico, Vietnam, India, China, Bolivia, Guatemala, Peru, United Kingdom, and Germany sent the highest numbers in 2006. Between 2000 and 2006, foreign born individuals from El Salvador, China, Mexico, Bolivia, Peru, and India increased by over 50 percent. The Washington metropolitan area leads the Commonwealth, with one in every five residents being foreign born, followed by Harrisonburg (nine percent), and Charlottesville, Richmond, Virginia Beach, and Winchester (six percent).

The Surgeon General's Supplemental Report: Culture, Race and Ethnicity in Mental Health (2001) documented disparities for individuals of color, including:

- Limited availability of services;
- Lower likelihood of receiving services even where services are available;
- Greater likelihood of receiving poorer quality of care and disproportionate negative treatment outcomes;
- Over-represented in hospitalizations (more restrictive settings); and
- Under-represented in research.

The National Academy of Sciences (2002) found that some non-white population groups may experience a range of barriers to services, even when insured at the same level as whites, including barriers of language, geography, and cultural familiarity.

As Virginia's population becomes more diverse, providers must increase the cultural and linguistic competence of workforce members and organizations. In July 2001, the US Department of Health and Human Services Office of Minority Health released national standards on *Culturally and Linguistically Appropriate Services* (CLAS) in health care. These standards address culturally competent care, language access services, and organizational supports. CLAS standards mandate that service providers receiving Federal funds must address the language needs of individuals receiving services who have limited English proficiency. Organizations where language assistance is likely to be needed must:

- Establish a point of contact for language assistance for the organization,
- Determine the availability of resources and ways to access these resources to provide timely language assistance, and
- Arrange and pay for language assistance.

The Hogg Foundation for Mental Health at the University of Texas (2001) has described cultural competency as the integration and transformation of knowledge, information, and data about individuals and groups of people into specific clinical standards, skills, service approaches, techniques and marketing programs that match an individual's culture and increase the quality and appropriateness of health care outcomes. Culture is critical in determining what people bring to the clinical setting. It affects language, how concerns are expressed, how help is sought, the development of coping styles and social supports, and the degree to which stigma is attached to mental health problems. Addressing service disparities experienced by cultural communities require that providers assess the following:

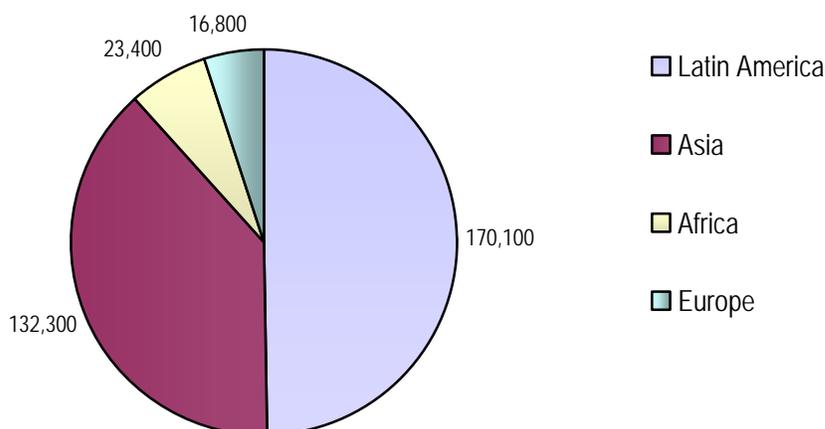
- *Availability* - Does the service exist?
- *Accessibility* - Is the service exists, is it easily usable by applicable cultural communities?
- *Affordability* - Can potential users in applicable cultural communities afford the service and can the provider afford to provide the service?
- *Appropriateness* - Does the service produce the desired clinical and functional outcomes for potential users in applicable cultural communities?
- *Acceptability* - Do individuals in applicable cultural communities perceive the service to be in keeping with the norms, values, and practices of their communities?

The cultural appropriateness of behavioral health and developmental services may be the most important factor in the accessibility of services by certain population groups. Developing culturally sensitive practices can help reduce barriers to effective treatment and service utilization. Cultural competence requires that organizations do three things:

1. Have a defined set of values and principals and demonstrate behaviors, attitudes, policies, and structures that enable them to work effectively cross-culturally;
2. Have the capacity to value diversity, conduct self-assessment, manage the dynamics of difference, acquire and institutionalize cultural knowledge, and adapt to diversity and the cultural contexts of the communities they serve;
3. Incorporate all of the above into all aspects of policy-making, administration, practice, and service delivery and systematically involve individuals receiving services, key stakeholders, and representatives of communities that experience cultural and linguistic barriers to services in these activities.

Linguistic competence is the capacity of an organization and its personnel to communicate effectively and convey information in a manner that is easily understood by diverse audiences. Of the 7,140,000 people in Virginia who were age 5 and older, 342,500 were identified as speaking English "less than very well." The following chart depicts their regions of birth.

Numbers of Foreign-Born Individuals in Virginia Who Speak English "Less Than Well" by Region of Birth



Source: 2006 American Community Survey

In 2006, 26 percent of Virginia households were linguistically isolated, where no household member over age 13 spoke English "very well." Of these households, 41 percent were originally from Latin America, 23 percent from Asia, 10 percent from Africa, and nine percent from Europe.

In 2007 and 2008, the Department sponsored statewide Workforce and Cultural Competency Conferences. These conferences educated service providers, policy-makers, and administrators about cultural competence and highlighted evidence-based practices and strategies for integrating cultural competence into ongoing service delivery and creating multicultural work environments. Additionally, in 2008, the Department established a position in the central office and a statewide steering committee to promote and improve access to behavioral health and developmental services for multicultural populations across Virginia.

The initial focus of the Department's new Office of Cultural and Linguistic Services is to develop infrastructure supports, including a mission statement, vision, and policy; provide outreach to and link providers with individuals who could serve as cultural brokers; and establish state and local advisory councils. A comprehensive systemwide cultural and linguistic organizational assessment of practices, structures, programs, and policies of CSBs, state facilities, and other providers also is underway. Results of this assessment will enable the Department to:

- Evaluate the degree to which providers are effectively addressing the preferences and needs of culturally and linguistically diverse groups;
- Identify areas where the Department can provide support and assistance to:
 - improve the responsiveness of services to the needs of culturally and linguistically diverse groups;
 - develop culturally and linguistically competent policies, structures, and practices; and
 - promote access to and utilization of behavioral health and developmental services by individuals in need of services and supports; and
- Develop a state cultural and linguistic competence strategic plan, with clearly defined short and long term goals, measurable objectives, fiscal and personnel resource requirements, and identified consumer and community partnerships.

Future plans include developing templates and guidelines for provider cultural and linguistic competency plan development, establishing on-line and classroom training opportunities, developing a baseline cultural and linguistic data system to include individual and general population demographic data and language needs, establishing performance indicators related

to the delivery of culturally and linguistically competent services, and recommending culturally and linguistically appropriate evidence-based treatments and practices.

Individuals Who Are Deaf, Hard of Hearing, Late Deafened, or Deafblind: The Department has worked closely with the Advisory Council for Services for People Who Are Deaf, Hard-of-Hearing, Late Deafened, or Deafblind (Advisory Council) to identify and evaluate the critical behavioral health service needs of this population and to recommend service improvements. The Advisory Council, composed of service providers, state agency representatives, and advocates, has noted that hearing loss affects 8.6 percent of the general population. Between five and 10 percent of these individuals also experience a loss of vision. Research generally suggests that the prevalence rates for serious mental illness within the deaf, hard of hearing, late deafened, and deafblind populations are consistent with those found in the general population. Some studies suggest a higher prevalence rate for adjustment and personality disorder, emotional or behavioral dysfunction, and substance use disorders. Contributing factors to this may include isolation due to communication barriers, lack of family support, underemployment, late onset of hearing loss, and lack of social identification.

However, communication barriers associated with hearing loss can seriously impede access to CSB programs, resulting in the need for specialized services and accommodations for these individuals. The Department currently supports specialized consultation and direct services to this population on a regional basis throughout Virginia. However, current funding is limited, and as a result, some regions have experienced chronic difficulties in recruiting and retaining qualified staff to provide these specialized services. The Department remains committed to improving the capacity of the service system to ensure available and accessible specialized resources, professionals, support services, and technical assistance for this population. The Department and Advisory Council have identified the following focus areas for action:

- Providing additional assistance and resources for state facilities and CSBs to address the communication and cultural needs of this population;
- Allocating additional resources for regional programs to meet the service needs of this population; and
- Increasing inter-regional collaboration to ensure continuity of care and the effective provision of behavioral health and developmental services to this population.

Prevention Service Priorities:

Substance Abuse Prevention Services: Prevention is aimed at substantially reducing the incidence of alcohol, tobacco, and other drug use and abuse, with a focus on the enhancement of protective factors and the reduction of risk factors. Prevention services include activities that involve people, families, communities, and systems working together to promote their strengths and potentials. Effective prevention services reduce the number of new cases of substance use disorders. Risk factors may be biological, psychological, social, or environmental and can be present in individuals, families, schools, and the community. When a child experiences a higher number of risk factors, such as poor school achievement, parents with poor family management skills, and neighborhoods where drug use is tolerated, the child is more likely to experiment and use alcohol, tobacco, or other drugs. Protective factors, such as social and resistance skills, good family and school bonds, and the capacity to succeed in school and in social activities, can reduce the impact of risk factors. Human service providers, schools, law enforcement organizations, faith and business communities, and parents and youth work together in prevention planning coalitions to plan and implement prevention programs and strategies that strengthen protective factors while reducing risk factors.

The Department oversees and supports substance abuse prevention services delivered through CSBs. Currently, community-based prevention services are funded with the SAPT Performance Partnership Grant and meet federal regulations that direct its use. Other funds for prevention

services are available through competitive grant processes from several state and federal agencies. Through collaborative efforts in the Governor's Office on Substance Abuse Prevention and federal agencies, most requirements for prevention programs and processes are the same or similar.

The Department adopted a community-based prevention planning process in 1995. Through this process, CSBs work with human service, education, and local government representatives to conduct needs and resource assessments; identify service gaps and at-risk populations; and plan, implement, and evaluate prevention programs and environmental strategies that address identified risk factors. In a survey conducted for the 2010-2016 Comprehensive State Plan, CSBs reported that prevention coalitions identified availability of tobacco, alcohol, drugs, and other substances; family management problems; early initiation of problem behaviors; and friends who engage in problem behaviors as the most significant risk factors. CSBs identified services for middle and elementary school students and their families as priority areas. The Prevention and Promotion Advisory Council to the State Board also has identified the need to focus on prevention services for the family.

A FY 2005 statewide youth survey found that 35 percent of the surveyed youth said alcohol, cigarettes, and drugs were easy to obtain, which is down from 44 percent in the 2000 survey. The mean age of first use of tobacco products by respondents increased to 12.29 from 12.25 in 2000. The mean age of first use of alcohol increased from 12.29 in 2000 to 13.23 in 2005, with 14.43 percent of the youth reporting that they were drinking regularly in 2005, compared to 14.51 percent in 2000. These positive trends may reflect increased use of evidence-based prevention programs by CSBs. Continuation of these programs should help continue this downward trend of youth substance use in Virginia. On a less positive note, inhalant abuse, evidenced in past 30-day use, increased from 4 percent in 2000 to 6 percent in 2005, with 8 percent of Virginia's 8th graders reporting use of inhalants in the last 30 days. This was twice the national average for the same time period. As a result of the increase in inhalant use, the Virginia Inhalant Prevention Coalition was formed and conducted two annual conferences for prevention and education personnel. The Department of Education sponsored the development of a K-12 curriculum guide on inhalant use prevention that is now used across the Commonwealth. Local surveys conducted by prevention coalitions indicate inhalant use has decreased significantly.

Suicide Prevention: In 2007, 903 persons in Virginia committed suicide. Based on an assessment of these suicides, the Virginia Violent Death Reporting System (VVDRS) compiled a portrait of risk factors or warnings for suicide:

- The individual had a history of suicide attempts;
- The individual had disclosed his intent to commit suicide;
- The individual had expressed suicidal thoughts;
- The individual's family or friends expected the suicide;
- The individual had exhibited unusual behavior in the two weeks prior to suicide;
- The individual's mood at the time of his suicide was depressed;
- The individual had been sleeping too little.

For those individuals who disclosed their intent to commit suicide, 28 percent of the family or friends took action to prevent suicide and 15 percent did not take the disclosure seriously. Among the family or friends who took action, 24 percent encouraged or sought mental health treatment for the individual, 20 percent limited access to firearms, 19 percent either checked on or tried to persuade the individual not to commit suicide, 15 percent called 911 or law enforcement, and five percent intensely monitored the individual. According to the VVDRS, of the suicide victims who had a mental health problem, 24 percent had seen a psychiatrist and

seven percent had seen a primary care physician in the previous two months. Of the suicide victims who had physical health problems, 21 percent had limited independence, 14 percent had a terminal illness, 10 percent were either hopeless about resolving or dealing with the problem or their problem affected their ability to work, five percent had refused or were not compliant with medical treatment, and four percent had experienced a worsening of the problem in the preceding two weeks.

The Department is an active partner with the Virginia Department of Health (VDH), VDA, DJJ, and DOC to promote awareness throughout Virginia aimed at reducing suicide across the life span. Following the completion of *Suicide Prevention Across the Lifespan Plan for the Commonwealth of Virginia* (SD 17, 2004), the Department was designated by the General Assembly as the Commonwealth's lead agency for suicide prevention across the life span in 2005. Broad goals of the plan include: prevention of death from suicide, reduction of the occurrence of other self-harmful acts, increased risk recognition and access to care, promotion of the awareness of suicide, reduction of the stigma associated with suicide; and leadership and infrastructure development. Implementation of this plan has been hampered by the lack of funds to support dedicated resources at the Department.

In October 2008, the VDH Division of Injury Prevention was awarded a three year grant from SAMHSA aimed at preventing youth suicide. This grant is supporting implementation of the Virginia Youth Suicide Prevention Initiative, a comprehensive array of state and community level approaches to prevent suicide, including:

- Raising public and provider awareness through:
 - Public awareness campaigns;
 - Targeted gatekeeper trainings;
 - Middle and high school resource kits;
 - School mini-grants to support staff training and student awareness; and
 - Prevention stakeholders meetings.
- Providing evidence-based and best practice suicide risk recognition and early intervention training and encouraging help-seeking behavior, including:
 - Suicide Alertness for Everyone (SafeTALK);
 - Applied Suicide Intervention Skills Training (ASSIST);
 - Assessing and Managing Suicide Risk (AMSR); and
 - Response: A Comprehensive High School-Based Suicide Awareness Program.
- Funding comprehensive evidence-based suicide prevention approaches in the following communities and on college campuses:
 - Rappahannock-Rapidan CSB;
 - Crisis Line of Central Virginia;
 - Crisis Center of Southwest Virginia; and
 - James Madison University's Institute for Innovation in Health and Human Services in the Central Shenandoah Valley (in late 2009, this site will transition from local community work to the creation and promotion of a statewide campus mental health suicide prevention program).

These community initiatives are educating schools on establishing systemic processes for screening and referring youth and providing suicide prevention training to staff in middle and high schools, conducting needs assessments of local crisis intervention and post-intervention services, coordinating localized public information campaigns, developing local coalitions, and providing suicide prevention resources and training to community youth services providers and to youth and families.

Prevention of Youth Access to Tobacco Products: An Amendment to the federal Alcohol, Drug Abuse, and Mental Health Administration Reorganization Act requires that states conduct annual inspections of randomly selected tobacco retail outlets to determine how likely it is that underage youth are able to purchase tobacco products. The states must conduct compliance inspections of tobacco vendors as a condition for receipt of Substance Abuse Prevention and Treatment Block Grant funds, which support community substance abuse treatment and prevention services and total \$43 million. The rate of noncompliance must not exceed a previously agreed upon target rate. The current rate of 13.9 percent is below the required target of 20 percent noncompliance target. Media activities conducted by the Virginia Tobacco Settlement Foundation and community strategies focusing on policies and norms conducted by CSBs helped to reduce cigarette smoking rates of high school students from 28.6 percent in 2001 to 5.5 percent in 2007.

Responsibilities of State Hospitals, Training Centers, and the Virginia Center for Behavioral Rehabilitation

State facilities continue to be critical components of the Virginia behavioral health and developmental services system.

State Hospitals: Virginia's state hospitals exist today as key regional participants in the evolution of Virginia's behavioral health services system. State hospitals provide a variety of clinical services that are not available in all communities and are structured to best meet each individual's needs. These include psychiatric assessment and stabilization; medication management; nutritional management; psycho-social rehabilitation programming; psychiatric and rehabilitative therapies; and collaboration with the CSBs to help the CSBs fulfill their discharge planning responsibilities. State hospital services are further specialized by the age groups served at some facilities.

State hospitals provide services and supports to adults with serious mental illnesses and youth with serious emotional disturbances who are in crisis, who present with acute or complex conditions, or both, and who require the highly intensive and structured environments of care in an inpatient setting. Services provided by state hospitals focus on psychiatric stabilization and development of skills needed for successful community living. They enable individuals to develop skills and supports needed for success and satisfaction in specific environments and enhance other fundamental life skills, such as developing trusting relationships, increasing hope, motivation, and confidence, and making informed choices.

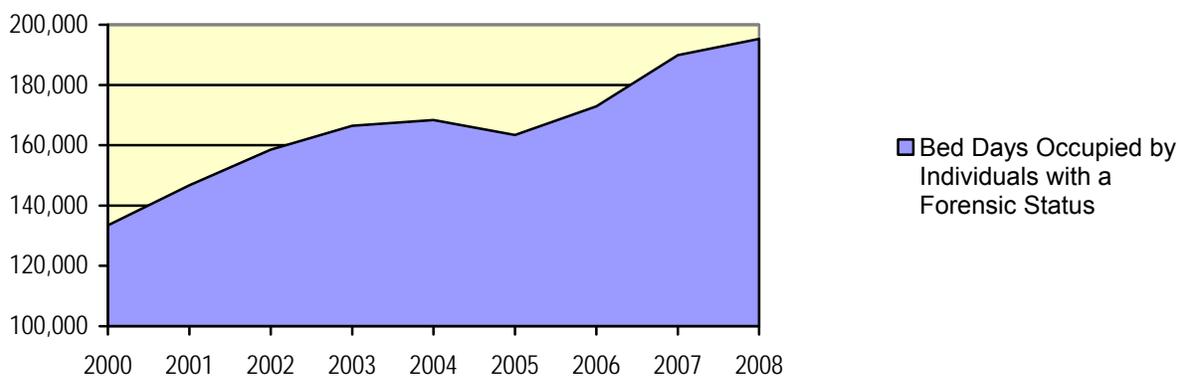
Because their services are generally provided in very structured and secure treatment environments, state hospitals face the challenge of creating a recovery-oriented, person-centered, and hopeful setting within which an individual's most critical needs and goals are incorporated into a plan for recovery that will serve as a guiding document in aiding the individual's return to his community, family, and life. Since 2007, the Office of the Inspector General (OIG) has conducted systemic reviews of the recovery experience of persons served at the eight state hospitals, specifically the extent to which their experience has reflected the principles of recovery, self-determination, and participation. These annual reviews included announced visits to each hospital, unannounced observations of treatment teams, and a follow-up survey. Findings and recommendations focused on treatment planning partnerships, choice, involvement in valued roles, relationships that support recovery, and provision of a supportive environment for recovery. Over the past three years, state hospitals have made significant progress in changing their culture to one that supports recovery, self-determination, empowerment, and person-centered planning.

State hospitals are advancing the concept of a recovery-oriented system to include the provision of integrated care for those with co-occurring mental health and substance use disorders. They are working to improve the cultural and linguistic competence of staff so they can better address

the recovery and communication needs of individuals and families in a culturally relevant manner. State hospitals also are improving their ability to provide services that demonstrate competence in trauma-informed care. The cultivation and maintenance of a well educated state hospital workforce is vital to the success of these efforts.

Through the Services System Transformation Initiative, the Department funded an array of services that are intended to enable more individuals to receive emergency and crisis services in their home communities and to use community rather than state hospital beds so they can return to their homes quickly. The services system also needs much improved methods of coordinating and integrating care with all relevant providers, including primary health care, vocational and life skills agencies, funding agencies, and community provider, and systemic approaches that effectively remove barriers to successful discharge from state hospitals and promote continuity of care within which communication and transitions are seamless for the individuals receiving state hospital services. As community services continue to be developed and services coordination, integration, and continuity improves, state hospitals can increasingly focus on providing longer-term care and specialized treatment when other community-based alternatives are not possible.

Even as the services system works to provide more services in the community, leaving only the most critically ill or challenging individuals to be cared for in state hospitals, the Department projects that state hospital adult bed capacities will continue at current levels in order to address increasing demands by individuals with a forensic status and from general population growth. In FY 2008, 1,620 unique individuals with a forensic legal status were served in state hospitals. These individuals occupied the equivalent of 535 beds and had an average length of stay of 120.5 days compared to 73.6 days for individuals without a forensic status. Between FY 2000 and FY 2008, state hospital bed days occupied by individuals with a forensic status increased from 133,440 to 195,273 bed days or from 22.6 to 35.2 percent of total state hospital bed days.



By removing significant barriers to community-based care, the state geriatric centers have been able to treat almost a third more individuals over the last year with no additional resources. The centers have developed strong partnerships with private nursing homes around the state to support and encourage the transition of individuals residing in state geriatric centers to the community. Selected geriatric center patients have been integrated into community settings by using trial visits prior to discharge and teams of center clinical staff to provide telephone consultation, site visits, and other support to community caregivers following discharge of these patients. State geriatric center psychiatrists were available to provide psychiatric services, including medication reviews, through direct communication with receiving nursing home psychiatrists and medical directors. To facilitate successful discharges, the geriatric centers included extensive documentation of each individual's psychiatric history and rationale for their current medications in their discharge documentation, which enabled the receiving nursing homes to justify psychiatric medication practices during Medicare/Medicaid (CMS) surveys. Without this documentation, nursing homes are required by CMS to complete mandatory drug

reductions (a new federal standard). This cooperative arrangement has been recognized as a best practice by the Virginia Healthcare Association, a professional organization for privately owned nursing homes and assisted living facilities.

The state geriatric centers also have developed partnerships with private and university-affiliated psychiatric facilities to create a system where acute care can be provided in community hospitals and longer-term treatment provided in state geriatric centers. Over the years, the percentage of individuals admitted to state geriatric centers under temporary detention orders (TDOs) had increased dramatically even though community hospitals could be reimbursed for TDO admissions and Medicare could pay for the first seven of 14 days of hospitalization if the patient was over 65 years of age. Community hospitals often experienced placement issues that resulted in stays beyond 14 days because there were no placements for these individuals. Community hospitals and the state geriatric centers now work closely with the Regional Utilization Management Committees to coordinate and manage transfers from private and university-affiliated hospitals to the centers. On an individual basis, this has enabled community hospitals to accept TDOs and provide acute treatment to individuals who otherwise would have been admitted to state geriatric centers for much longer average lengths of stay. On a systemic basis, the centers have freed resources they previously spent on acute care patients to develop relationships with nursing homes to discharge individuals who no longer require geriatric center services.

The proposed budget for FY 2010 included a recommendation to close all state inpatient beds for children and adolescents. This proposal was not approved by the General Assembly, which expressed concern about the availability of safety net services for children and adolescents who require intensive psychiatric services. The Appropriation Act directed the Department to convene a planning group comprised of families, community providers, advocates, and others, to examine the current and future role of the Commonwealth and private providers in providing acute psychiatric services for children and adolescents and to develop strategies for promoting high-quality community-based care while maintaining a safety net of services for children and adolescents who need acute psychiatric services. The planning group has been established and is examining the Commonwealth's future role in providing acute psychiatric services to children and adolescents. The need for state hospitals will continue until adequate high quality community-based crisis stabilization services and other supports are available in all regions of the Commonwealth. These services and supports should provide alternatives that reduce inpatient admissions; however, it remains to be determined if state hospitals must continue to operate in some capacity to address a small sub-population of children and adolescents with extreme needs or those who have interaction with criminal justice system. The planning group will submit its report to the General Assembly in late 2009.

State Training Centers: The five state training centers provide medical and psychiatric assessment, preventive and general healthcare, medical stabilization, and supports focused on developing skills needed for successful community living to persons with intellectual disability who require highly intensive and structured environments of care. Although their traditional function has focused on long-term care, training centers also provide short-term respite and emergency care. All training centers have Regional Community Support Centers, which offer an array of dental, behavioral, and other therapeutic services and supports to individuals receiving community-based supports.

The majority of individuals receiving training center services (90 percent) are between 22 and 65 years of age, with only two percent below the age of 22 and eight percent over age 65. Most have either a hearing or vision deficit, or both, or one or more neurological conditions in addition to their intellectual disability. Many are non-ambulatory (requiring specialized wheelchairs) or need significant staff assistance to walk. A significant portion (34 percent) has at least one psychiatric diagnosis. Increasingly, training centers are serving two very distinct populations:

- Individuals with co-occurring severe intellectual disability and pervasive physical disabilities or medical conditions such as seizures, scoliosis, or gastrointestinal problems; and
- Individuals with mild to moderate levels of intellectual disability and co-occurring mental illness and challenging behaviors.

In response to a legislative request, HJR 76 (2005), Virginia conducted a study on the future of training centers. This study recommended that smaller, more narrowly focused training centers serve individuals with higher needs while community services capacity is developed to serve individuals with behavioral and medical needs. It supported the development of a seamless system of supports that would be provided based on each individual's level of need. No person would receive a higher level of supports than he or she actually required to be successful, thereby leveraging resources to expand services capacity. Individuals and their families would be the guiding force in directing the types of needed supports and person-centered rather than provider-centered funding mechanisms would provide resources necessary to develop and sustain these individualized supports.

The emergence of person-centered thinking and the continued development of enhanced community-based supports envisioned in the HJR 76 (2005) study have helped to change the provision of services and supports in Virginia. Over the past two years, training centers have been implementing person-centered planning processes and have expanded their missions to make short-term and transitional facility-based services more readily available. Most admissions to training centers today are due to one of two factors:

- There are changes in the behavioral patterns presented by the individual that are risking the health and safety of the individual or others in his or her community environment; or
- The individual has no place to go to receive supports needed to maintain his or her health and safety and funding does not exist for these supports to be provided in the community.

Long-term admissions are less common than they have been in the past. All training centers have developed strong ties with the communities they serve and each provides a variety of specialized services that support community systems. These supports draw on staff expertise and experience available at the training center and have the goals of diverting potential admissions by stabilizing individuals in their community placements or utilizing the centers' residential capacities to provide time-limited therapeutic services to individuals for whom the community has reserved funding for community supports upon his or her discharge.

Training center roles and responsibilities will continue to evolve over the next six years, as:

- Plans for the elimination of current waiver waiting lists are implemented;
- State-funded housing and other supports infrastructure is implemented in communities served by Southeastern Virginia Training Center and Central Virginia Training Center; and
- The Department and the DMAS jointly:
 - Develop community-based residential support models of four or fewer beds, including sponsored residential placements with specialized expertise in crisis and behavioral supports or skilled nursing and medical oversight;
 - Implement a tiered system of day support rates;
 - Enhance the ability of the waiver to support people who have challenging behaviors; and
 - Develop incentives for the provision of community-based skilled nursing services required for medical oversight.

Future training centers roles and responsibilities follow.

- Provide services and supports for individuals who present complex medical needs that cannot currently be met in community residences until an appropriate community residence is available;
- Provide services and supports for individuals who present behavioral challenges that require short-term, intensive intervention to return to the community;
- Provide services and supports for individuals that require short-term respite or stabilization;
- Provide services and supports for individuals that require short-term medication stabilization; and
- Provide services and supports for training center and community residents through the Regional Community Support Centers.

Training centers would continue to provide supports to long-term training center residents until appropriate community placements are available. With expanded and enriched capacity necessary to implement person-centered services, training center and CSB staff would closely monitor progress of all new admissions to assure that these individuals are achieving goals in their individual plans of care. As the individual's discharge plan is implemented, regular assessments would occur and determinations would be made regarding the individual's continued need for training center services and supports.

Virginia Center for Behavioral Rehabilitation (VCBR): Virginia legislation creating a civil commitment program for sexually violent predators (SVP) mandates the Department to open and operate a civil commitment program for persons found to be sexually violent predators, as defined in §37.2-900. VCBR, a 300 bed facility located in Burkeville, provides individualized treatment in a secure environment. Sexually violent predators are convicted sex offenders who are civilly committed to the Department at the end of their confinement in the Department of Corrections because of their histories of habitual sexually violent behavior and because their ability to control their violent tendencies is compromised by the presence of a “mental abnormality” or “personality disorder”. These individuals are predominantly male and are on average about 40 years old. They have long histories of sexually abusing children and adults and have shown very limited ability or willingness to abstain from committing sexual offenses.

International experience with the SVP population supports the use of a rehabilitation approach based on cognitive-behavioral principles and focused on relapse prevention. Treatment involves multiple, daily group sessions, individual behavioral therapy, vocational training, and work therapy and programs, as appropriate. Security and direct care staff work with clinicians to create an environment that challenges deviant and criminal thinking and behavior while reinforcing appropriate behavior.

VCBR was designed to reflect a system based on four SVP predicate crimes and a projected commitment rate of about 2 individuals per month. However, changes to the Code of Virginia enacted in 2006 increased the number of predicate crimes from four to 23 and the SVP commitment rate from less than one (actual rate) to nearly 5 per month. At this accelerated rate, VCBR will reach capacity in 2012.

The projected growth of VCBR could be slowed by expanding the availability of conditional release services, allowing more individuals to be safely placed in the community on SVP conditional release. This program of intensive supervision, monitoring, and treatment currently supervises 25 individuals, some who have been in the community on conditional release for five years. Each SVP conditional release postpones the need for designing and constructing an additional secure SVP facility. Moving one-fourth of commitments to SVP conditional release would save the Commonwealth \$1.4 million per year (based on a projection of 5 commitments per month). Releasing two individuals per month from secure confinement to SVP conditional release would push back reaching full capacity at the VCBR by a full year.

Housing is the primary impediment to placing more individuals in the community on SVP conditional release. About one-third of SVP cases are at least considered for conditional release. About half of all individuals reviewed for SVP conditional release are rejected and confined at the VCBR because no suitable housing is available. In order to move as many individuals as safely possible from the VCBR to SVP conditional release in the community, suitable and cost effective transitional housing would need to be developed for these individuals to facilitate successful community placement. This would enable the Commonwealth to provide a transitional program at VCBR to support eventual SVP conditional release and to construct a less costly institution when it becomes necessary to expand the number of secure beds for SVP civil commitment.

State Facility Operations: The Department monitors quality of care and performance improvement efforts in all state facilities on a routine basis. In addition, each state facility is responsible for meeting or exceeding the safety and operational parameters defined by a multitude of oversight agencies, including the Joint Commission, and the Centers for Medicare and Medicaid Services (CMS), and the Office of the Inspector General for Behavioral Health and Developmental Services (OIG).

Financial challenges have strained state facility resources and affected staff priorities, but these challenges have pushed state facilities to function more efficiently and to focus efforts to achieve their goals. Implementation of best and promising practices and advances in program design will enable state facilities to better meet the needs of aging and specialized populations of individuals, including those involved in the legal system, children and adolescents, and individuals who are civilly committed to the Department as sexually violent predators. Additional tools will be required to continue this progress. These include the creation of a system of standardized, relevant acuity measures that are based on specific criteria to aid state facilities in allocating key resources to meet the needs of individuals and to function more efficiently in the future. Also required will be the continued development of well designed and centralized facility-based data systems.

Disaster and Terrorism Preparedness and Recovery

Services System Preparedness: Virginia is the fifth most likely place for a disaster to occur in the United States. The Commonwealth has experienced as many disasters in the last ten years as Texas and California, the two most frequently declared states for major disasters. The continuing threat of terrorism, such as that which occurred September 11, 2001, the serial sniper attacks, natural disasters such as Hurricane Isabel, and, more recently, the Virginia Tech shootings, make it clear that the Virginia behavioral health system must be ready to respond. Virginia's first-hand experiences with disaster response have unequivocally confirmed that a rapid, efficient behavioral health response does assist individuals and communities in the recovery process. Following the attack on the Pentagon, Virginia initiated a crisis-counseling program, the Community Resilience Project, which was administered by the Department and delivered by the Northern Virginia CSBs. The project remained in full operation for 30 months and resulted in 683,000 crisis contacts and the distribution of more than 1.4 million pieces of educational literature to assist in coping and recovery. Similar crisis programs following Hurricane Isabel and other major events have supported countless Virginians. In the aftermath of these highly effective and successful behavioral health response initiatives, the services system is increasingly recognizing the importance of behavioral health as a critical and vital component in all aspects of emergency mitigation, preparedness, response, and recovery in state and local plans.

The Department is responsible for disaster and terrorism planning, preparedness, and response activities for the behavioral health services system. During a disaster situation, the Department performs immediate response and coordination activities with other state agencies, state facilities, and CSBs. This includes coordinating and preparing federal grants to secure federal

emergency response funding and assuring the provision of accurate, timely, and instructive information to the public and services system stakeholders.

The Department convened a Facility Preparedness Workgroup, consisting of state facility staff, to plan, prepare, and coordinate use of the Department's state facility assets. The Department has worked to strengthen vital public-private partnerships needed to assure an appropriate emergency response. It has developed and implemented training curricula for state facility, CSB, and public sector staff on emergency mental health response interventions and has established protocols for the development of mutual aid agreements among and between state facilities, community hospitals, and other health care organizations in Virginia. In June 2007, the Department entered into an agreement with SAMHSA under the Intergovernmental Personnel Act of 1970 to assign a SAMHSA employee with extensive experience in disaster behavioral health response at the federal level and state levels to the Department on a full time basis for three - four years.

State Facility Preparedness: The Joint Commission emergency management standards require hospitals and long term care facilities to engage in cooperative planning with other health care organizations (e.g. other hospitals providing services to a contiguous geographic area) to facilitate the timely sharing of information, resources, and assets in an emergency response. State facilities have engaged in local and statewide planning processes that have resulted in identification and pooling of assets and regional evacuation planning. While state facilities are poised to assist in any community emergency response, Department policy requires that facility resources and assets first be made available to respond to the needs of individuals who are receiving state facility services and staff. Several state facilities have partnered with regional emergency planning efforts to increase regional hospital surge and response capability. An analysis of state facility assets conducted by the Facility Preparedness Work Group determined that significant additional funding is needed to increase emergency generator capacity at those facilities.

Community Services Board Preparedness: CSBs have continued to progress in the development of All-Hazards Disaster Response Plans that include attention to each stage of an emergency event. These plans will be used to assure CSBs are prepared to respond to all types of disasters that may occur in their service areas. Additionally, CSBs have undertaken efforts to develop collaborative relationships with their local public health departments and emergency management agencies, and are focusing current efforts on improving their Pandemic Flu planning efforts. Through the availability of Virginia Department of Health (VDH) funds, CSBs have participated in regional training forums on disaster response and behavioral health interventions. A major project was undertaken in 2008 and 2009 with the establishment of seven CSB workgroups on seven key areas in emergency planning and preparedness, resulting in a CSB Report with recommendations. Emphasis for the upcoming year will include implementation of those recommendations and additional disaster response training, specifically geared to disaster behavioral health Medical Reserve Corps (MRC) volunteers and development of memoranda of understanding with local response partners. From 2007 through 2009, regional training was conducted to enable CSBs to provide training to their local response partners. This training was provided in conjunction with VDH.

Goals, Objectives, and Action Steps

Goal 3: Promote the concepts of treatment in the most integrated settings appropriate and encourage individual and family choice as central to the U.S. Supreme Court Olmstead decision.

Objective:

- 1. Work with the Community Integration Oversight Advisory Committee and Community Integration Implementation Team to monitor implementation of the Olmstead Task Force Report recommendations.**

Action Step:

- a. Participate with the Community Integration Oversight Advisory Committee and the Community Integration Implementation Team in the preparation of information, analyses, and reports, as requested.

Goal 4: Promote and support the implementation of evidence-based and best practices.

Objectives:

1. ***Develop shared commitment to the adoption of evidence-based and best practices across the Department, CSBs, and state facilities.***

Action Steps:

- a. Obtain state-level technical assistance from SAMHSA's Co-Occurring Center for Excellence on implementation of evidence-based practices, including building consensus on the need for implementing these practices among service providers.
 - b. Revise existing service definitions to incorporate evidence-based and best practices, where appropriate.
 - c. Implement methods to recognize and reward exemplary evidence-based programs that demonstrate positive individual outcomes.
2. ***Increase the basic knowledge and competency of public and private behavioral health and developmental services providers in the use of evidence-based and best practices.***

Action Steps:

- a. Explore the potential for public-academic partnerships to develop centers of excellence or training institutes that support statewide implementation of evidence-based practices.
- b. Sponsor regional or onsite training programs and symposia for community and state facility providers that feature national experts on evidence-based practices.
- c. Provide onsite technical assistance to CSBs to develop, implement, and evaluate evidence-based practices.
- d. Support Mid-Atlantic Technology Transfer Center efforts to disseminate knowledge of evidence-based practices and explore opportunities for additional collaboration.
- e. Disseminate the *Evidence-Based Practices Supported Employment Implementation Resource Kit* and provide training and consultation to public and private community behavioral health services providers, DRS, and other entities.
- f. Continue to sponsor the Virginia Summer Institute for Addiction Studies and support participation by CSBs and their contract agencies.
- g. Increase the number of training, support, and skill-building opportunities available to CSB prevention directors and staff on evidence-based prevention services.
- h. Periodically evaluate the utilization of evidence-based practices in community and state facility programs.

Goal 5: Assure that communities provide quality recovery and resilience-oriented and person-centered assessments, services, and supports that are appropriate to the needs of individuals receiving services.

Objectives:

1. ***Establish community services and supports that that minimize crises, reduce reliance on the most intensive levels of care, and promote independent living and individual and family choice.***

Action Steps:

- a. Expand the capacity of communities to provide services that promote community integration and provide alternatives to state hospital or training center admissions.
- b. Work with DMAS to implement the ID and DD waivers in a manner that is flexible and responsive to the needs of individuals with intellectual or developmental disabilities.
- c. Implement the Service Intensity Scale (SIS) and person-centered planning practices for individuals receiving developmental services.
- d. Assess opportunities to leverage resources, including grants, new funding mechanisms, and private investment opportunities.
- e. Expand family supports and other initiatives that allow individuals to have control over how their service dollars are spent.
- f. Enhance central office administrative infrastructure to enhance its presence in the field, monitor existing programs' performance and services recipients' outcomes, and maintain compliance with CMS expectations.

2. *Increase services and supports capacity throughout Virginia's behavioral health and developmental services delivery system.*

Action Steps:

- a. Address critical community service deficits, including the needs of individuals on CSB behavioral health and developmental services waiting lists and the inflationary pressures on services sustainability.
- b. Expand access to crisis stabilization and other safety net services.
- c. Work with DMAS to secure additional ID waiver slots to address current waiting lists.
- d. Implement additional systems of care projects to serve children and adolescents.
- e. Expand Part C early intervention services for infants and toddlers (ages 0-3) and their families to prevent or alleviate later developmental or learning problems.
- f. Work with DRS and the Department of Education to facilitate access to post-secondary transition services.

3. *Support implementation of statutory reforms to the involuntary commitment process.*

Action Steps:

- a. Continue to participate in the ongoing work of the Commission on Mental Health Law Reform.
- b. Provide statewide and regional training events on changes in the Virginia involuntary commitment process.

4. *Incorporate services and supports for individuals with autism spectrum disorder or developmental disabilities in Virginia's behavioral health and developmental services delivery system.*

Action Steps:

- a. Reach out to all organized parent groups and other stakeholder organizations whose efforts are concentrated on autism spectrum disorder or developmental disabilities initiatives to increase communication, collaboration, and mutual support.
- b. Coordinate training for CSBs and private providers on services and supports for persons with autism.
- c. Promote autism spectrum disorder and developmental disability employment and housing initiatives.
- d. Support efforts of the Commonwealth Autism Service to develop autism policy initiatives and provide ongoing education, training, and understanding of issues related to autism.
- e. Continue an ongoing dialogue with DMAS concerning opportunities to move forward in the development of a more comprehensive developmental disabilities services system.
- f. Explore opportunities for non-waiver funded service development.

5. *Promote the establishment of an integrated system of service delivery that responds to the behavioral health and developmental services needs of children and adolescents and their families.*

Action Steps:

- a. Support efforts to implement the continuum of behavioral health and developmental services for children and adolescents.
- b. Support efforts of the Children's Services System Transformation Initiative.
- c. Enhance linkages with local schools to fill gaps and build community capacity for youth who are transitioning from children's to adult services.
- d. Increase the number of fellowships and expand training and education opportunities to increase the numbers of child psychiatrists, child psychologists, and other difficult-to-recruit clinicians practicing in Virginia.
- e. Provide ongoing behavioral health care training to child and adolescent behavioral health services providers and health care professionals such as pediatricians, family practitioners and primary care physicians.
- f. Support training efforts across systems to increase providers' knowledge regarding best practices and support necessary skill development.

6. *Develop a comprehensive, community-based continuum of specialized behavioral health and developmental services for older adults in Virginia.*

Action Steps:

- a. Work with CSBs, community providers of aging services, and community organizations to raise their awareness of the behavioral health service needs of older adults.
- b. Support efforts of CSBs to establish specialized capacity for responding to the behavioral health services and support needs of older adults.
- c. Explore the feasibility of expanding the PACE and other "money follows the person" initiatives with DMAS.
- d. Continue to allocate OBRA funding on an annual basis for specialized services needs of individuals in nursing homes with intellectual disability.
- e. Explore potential financial resources for the development of individual-centered, family-focused, community-based services for older adults that reflect best practices.
- f. Provide assistance, training, and clinical support to nursing homes and assisted living facilities on the effective management of behaviors such as wandering and aggression that may result in referrals to state geriatric centers.
- g. Work with the DMAS to establish a support model for older adults who are receiving ID waiver services.
- h. Participate with the VDA in the implementation of nine "no wrong door" Decentralized Resource Centers funded through an Aging and Disability Resource Center grant.

7. *Provide jail diversion and jail and community-based treatment services that enhance Virginia's capacity to effectively intervene and prevent or reduce the involvement of individuals with mental health and substance use disorders or intellectual or developmental disabilities in the criminal justice system.*

Action Steps:

- a. Strengthen state and local behavioral health and criminal justice partnerships and criminal justice and behavioral health collaborative programs.
- b. Work with the Consortium for Mental Health and Criminal Justice Transformation to support and enhance collaboration, education, and criminal justice-behavioral health partnerships at the state, regional, and local levels.

- c. Conduct Cross-Systems Mapping workshops that enable communities to review local resources, identify gaps, and develop action plans to improve criminal justice and behavioral health systems interoperability.
- d. Promote the adoption of law enforcement CIT programs to prevent individuals who are in crisis from involvement in the criminal justice system.
- e. Expand the array and capacity of jail diversion services, including pre-and post-booking, pre-trial alternatives, and community treatment services that prevent or divert individuals from incarceration.
- f. Continue to work with CSBs and private providers to expand the provision of forensic evaluation services in the community.
- g. Enhance the capacity of CSBs to provide competency restoration services in jails and community settings.
- h. Support CSB efforts to develop community alternatives that provide a higher level of support and services for individuals receiving forensic services in state hospitals, thereby decreasing their need for prolonged and more restrictive hospitalization.
- i. Continue to provide training and technical assistance to CSBs to enhance their management of insanity acquittees who have been conditionally released.
- j. Encourage CSB participation on local drug court planning and implementation committees.
- k. Expand jail-based behavioral health services that reduce demand for secure forensic treatment and prevent re-hospitalization of inmates.
- l. Produce data-based evidence on the economic and clinical efficacy of the 10 jail diversion programs funded by the General Assembly.
- m. Continue to work with the DCJS in pursuing grant opportunities and collaborating on cross-agency training on behavioral health and criminal justice initiatives

8. *Assure that CSBs are aware of and are prepared to address growing service needs among veterans of post-9/11 deployment and Virginia National Guard members.*

Action Steps:

- a. Partner with DVS to assess existing and emerging service needs and prepare for long term care requirements of veterans experiencing progressively adverse effects from traumatic injuries.
- b. Participate with DVS in the implementation of the Virginia Wounded Warrior Program.
- c. Provide specialized training to CSB clinicians on challenges confronting veterans and their families, including PTSD and the behavioral health effects of traumatic injuries.
- d. Assist the CSBs to leverage the resources necessary to provide needed behavioral health services to veterans.

9. *Promote and reinforce collaboration and joint responsibility for the provision, coordination, and oversight of services and supports for individuals with co-occurring intellectual disability and mental health or substance use disorders.*

Action Steps:

- a. Continue to work with the CSBs and state facilities to implement regional protocols for serving individuals with co-occurring intellectual disability and mental health or substance use disorders.
- b. Provide cross training for state facility and community clinicians and direct care workers aimed at identifying and appropriately responding to the needs of individuals with co-occurring intellectual disability and mental health or substance use disorders, clarifying service responsibilities and reconciling differences in language, philosophy, and expected outcomes among services providers.

- c. Provide opportunities for individuals receiving services and their families to receive education about co-occurring intellectual disability and mental health or substance use disorders and to actively participate in treatment planning and service delivery.
- d. Provide technical assistance and training to state facilities and public and private community providers on steps necessary to implement best practices for serving individuals with co-occurring intellectual disability and mental health or substance use disorders.
- e. Increase the number of staff trained and endorsed in positive behavioral supports.

10. Strengthen the ability of CSBs and state hospitals to provide specifically designed services for individuals with co-occurring mental health and substance use disorders.

Action Steps:

- a. Develop a VASIP Sustainability Plan focused on continued implementation of person-centered engagement and integrated and recovery-oriented systems of care.
- b. Support statewide implementation of instruments that enable the Department, CSBs, and state hospitals to assess the degree to which their organizations support the Comprehensive, Continuous, Integrated System of Care model.
- c. Identify core competencies required of professionals to meet the needs of individuals with co-occurring mental health and substance use disorders.
- d. Provide training, technical assistance, and consultation to CSB and state hospital clinicians to increase their knowledge of and competencies in providing assessments, interventions, and integrated services to individuals with co-occurring mental health and substance use disorders.
- f. Establish expectations and benchmarks for measuring the services system's attainment of integrated treatment capability at the program and system levels.

11. Increase the capacity of the behavioral and developmental services system to provide culturally and linguistically appropriate services and supports to diverse populations across Virginia.

Action Steps:

- a. Increase the ability of behavioral and developmental services providers to adapt to and work effectively with the diverse cultures of the communities they serve.
- b. Provide training and assistance to services providers on implementation of the National Standards on Culturally and Linguistically Appropriate Services (CLAS).
- c. Develop a statewide Cultural and Linguistic Competency Plan in collaboration with community stakeholders and services providers.
- d. Identify, disseminate, and promote the adoption of culturally and linguistically appropriate services and practices.
- e. Develop tools that are available to assist system stakeholders evaluate their capacity to provide culturally and linguistically appropriate services
- f. Work with CSBs, state facilities, and other public and private providers to incorporate cultural and linguistic competency into their strategic planning, policies, and service protocols.
- g. Identify and link services providers to individuals and organizations who are representative of diverse communities and are willing to mentor and train staff in addressing the cultural and linguistic needs of their communities.
- h. Coordinate regional, local, and statewide cultural and linguistic training opportunities.

12. Provide accessible behavioral health or developmental services resources to individuals who are deaf, hard of hearing, late deafened, or deafblind.

Action Steps:

- a. Continue to support services provided by the regional coordinators.
- b. Work with the Advisory Council to identify needed program enhancements and ways that the service system can appropriately refer individuals to culturally competent community and state facility providers.
- c. Provide technical assistance and guidance to providers regarding services and supports that are available to individuals who are deaf, hard or hearing, late deafened, or deafblind.

Goal 6: Reduce the incidence of alcohol, tobacco, and other drug use and abuse and suicide among Virginia youth and adults.

Objectives:

1. Increase opportunities to plan and implement prevention services at the state and local levels.

Action Steps:

- a. Continue and strengthen the ability of community-based prevention planning coalitions to engage in an on-going prevention planning process and address identified risk and protective factors and service needs.
- b. Share training, technical assistance, and planning resources with a variety of agencies and organizations invested in reducing substance abuse and dependence.
- c. Continue to build collaborative relationships at the state level and encourage and support collaboration at the local level to enhance environmental change and implement strategies that reduce exposure to risk and enhance protective factors.
- d. Administer a statewide youth survey with the Virginia Tobacco Settlement Foundation.
- e. Review CSB prevention services plans, Performance-Based Prevention Services data, and written reports annually to ensure that prevention services address prioritized risk factors, are evidence-based, and are supported by collaborative and complementary services of other systems and groups.

2. Expand suicide prevention training and awareness activities targeted to youth and adults.

Action Steps:

- a. Initiate implementation of the *Suicide Prevention Across the Lifespan Plan for the Commonwealth of Virginia*.
- b. Participate as an active partner in the implementation of the Virginia Youth Suicide Prevention Initiative.

3. Continue to emphasize reduction of youth access to tobacco products.

Action Steps:

- a. Continue to educate youth about the harmful effects of tobacco use and support tobacco specific prevention strategies and activities.
- b. Develop a strategic prevention focus on regions reporting highest noncompliance.
- c. Continue to measure noncompliance in accord with the Synar Amendment.

Goal 7: Assure that state facilities provide quality assessment, treatment, rehabilitation, training, and habilitation services that are appropriate to the needs of individuals receiving services.

Objective:

1. Offer a comprehensive array of person-centered treatment, rehabilitation, habilitation, and training services that promote self-determination, recovery and resilience, and community participation.

Action Steps:

- a. Maintain sufficient numbers of trained staff in each state facility to ensure services are appropriate to the populations served, to provide quality services, and to assure the safety of individuals receiving services.
- b. Encourage state hospitals to incorporate and implement strategies such as peer-to-peer supports; computer and Internet access; and educational, career development, and job training opportunities in their comprehensive recovery plans.
- c. Develop and implement strategies in each training center that facilitate person-centered planning and promote self-determination and community participation.
- d. Encourage all state facilities to implement wellness programs with activities designed to lower obesity, hypertension, diabetes, and heart disease and to facilitate exercise and other healthy lifestyle choices.
- e. Reduce bed utilization in state hospitals and training centers through aggressive monitoring of service plans and discharge efforts that reduce lengths of stay and enable individuals to be integrated more quickly into the community.
- f. Support the efforts of the OIG to monitor the progress of state facilities in improving quality of care.

Goal 8: Enable Virginia's behavioral health and developmental services system to prepare for and respond to terrorism-related and other major disasters.**Objectives:****1. Provide training to all CSBs and state facilities on all hazards disaster response.****Action Steps:**

- a. Support CSB efforts to develop, refine, and exercise their all-hazards emergency response plans and secure additional disaster training.
- b. Implement the emergency planning and preparedness recommendations developed by CSB workgroups.
- c. Promote the involvement of state facilities in the Virginia Hospital and Healthcare Association's regional hospital emergency preparedness councils.
- d. Provide training specifically geared to disaster behavioral health Medical Reserve Corps volunteers.

2. Establish structures and relationships that will assure an immediate, effective, and coordinated response to terrorism-related and other major disasters by the behavioral health and developmental services system.**Action Steps:**

- a. Link CSBs, state and private facilities, school systems, public health departments, faith communities, professional organizations, academic institutions, and others into planning and response to disasters and terrorism-related events.
- b. Encourage development of formal memoranda of understanding between contiguous CSBs to provide mutual support and response to disasters.
- c. Encourage and assist CSBs to develop strong supportive working relationships and memoranda of understanding with their local response partners.
- d. Continue to support training that enables CSBs to train their local response partners.
- e. Work with CSBs and state facilities to improve their services system disaster response infrastructure and communication capabilities.
- f. Assure that all state hospital disaster plans meet Joint Commission standards.

D. Partnerships for Services System Transformation

State-Level Partnerships

The Department continues to strengthen its partnerships with many state agencies that provide services and supports to or interact with individuals who have mental health or substance use disorders, intellectual disability, or co-occurring disorders. These partnerships help to raise awareness of the needs and challenges of individuals receiving behavioral health and developmental services, provide opportunities for coordinating state-level policy direction and guidance to local services systems, and support statewide and community-based initiatives that promote access to and continuity of needed services and supports.

Medicaid: States rely heavily on financial support from the federal government for their behavioral health and developmental services systems. As a result, Medicaid is now the largest single source of funds for community services across Virginia. The increasing prominence of Medicaid funding in CSB budgets has emphasized the importance of interagency collaboration in policy development, provider expansion, education and training of providers, development of quality assurance measures, and provider oversight. Virginia needs to take advantage of opportunities used by many other states to expand critically needed services that could be covered under Medicaid and to align existing services to recovery, resilience, and person-centered principles and practices. Virginia is implementing a Money Follows the Person Demonstration grant, which provides enhanced federal Medicaid matching funds for a 12 month period to individuals with disabilities and older adults transitioning from institutions to community residences. The Department is working closely with DMAS and other state agencies and private organizations to implement this important effort.

The Department also plays an important policy input role with DMAS in exploring and implementing other Medicaid initiatives in Virginia, including the recent expansion of Medicaid coverage for substance abuse services, enacted by the 2007 General Assembly. The Department worked with DMAS to develop an ID waiver renewal package that incorporates person-centered principles. The Department also has been involved with DMAS in implementing the expansion of community rehabilitative services to include co-occurring mental health and substance abuse treatment, completing the successful application for a child and adolescent Alternatives to Psychiatric Residential Treatment demonstration waiver, clarifying policies related to mental health services in Supported Employment programs, and developing Peer Specialist training curricula to meet paraprofessional qualification requirements. This interagency collaboration is also apparent in the improved Department and DMAS data sharing agreement to support services development and oversight efforts.

Social Services: The Department works closely with DSS in a variety of programs and services that help individuals cope with and recover from the effects of poverty, abuse, and neglect and achieve self-sufficiency. Several areas of collaboration include services to families who are TANF recipients, services to families confronting child custody issues, and services to substance-exposed infants and their families. DSS and DMAS have also worked with the Department to develop a portable auxiliary grant to demonstrate how individuals with mental health disorders residing in assisted living facilities may prefer individualized services and supports provided to them in more independent living situations.

Housing: The Department has collaborative linkages and partnerships with VHDA, DHCD, the Disability Commission's Housing Workgroup, CSBs, and public and private housing providers to promote, enhance, and develop housing opportunities for individuals receiving behavioral health services. Department staff work with the Virginia Coalition to End Homelessness and support PATH outreach and engagement activities for individuals who are homeless and recovery-focused housing alternatives, such as Oxford Houses, for individuals with substance use disorders.

For individuals with behavioral health disorders, poverty is one of the most pervasive, significant, and devastating barriers to recovery and achieving maximum participation in the community. The monthly Supplemental Security Income (SSI) payment for an individual in Virginia in 2008 was \$637 and, if SSI represents an individual's sole source of income, \$190 in monthly housing costs would be considered affordable. However, that year, the average fair-market rent for a one-bedroom apartment was \$818, or 127 percent of the individual's entire monthly SSI check. The fundamentals of this equation often lead people with mental health disorders to live in substandard housing, to lack opportunities for meaningful activity and daily structure, to have limited social and recreational resources, to have difficulty gaining access to quality health care, and to experience alienation and loneliness. A portable auxiliary grant for individuals with mental health disorders that could be transferred from assisted living facilities to help pay the costs for housing in more independent living situations would help demonstrate how to meet their preferences for individualized services and supports, while bridging the income gap between SSI and standard housing costs.

Primary Health Care: There are a number of published studies showing that individuals with serious mental health disorders have higher rates of physical disability, significantly poorer health, and higher mortality rates than the general population. Physical health care is considered a core component of basic services for individuals with behavioral health disorders although this care is often fragmented for these individuals. There is an increasing professional recognition of the essential interconnection between physical and behavioral health and keen interest in finding ways to link physical and behavioral health systems of care (NASMHPD, 2005). It is critical that individuals receiving public behavioral health and developmental services are screened, assessed, and receive needed treatment for physical health issues.

The Department and the CSBs maintain partnerships with appropriate agencies and entities, including the VDH, DHP, Virginia Community Healthcare Association, Virginia Rural Health Resource Center, Virginia Hospital and Healthcare Association, Virginia College of Emergency Physicians, and Virginia Association of Free Clinics. Through these collaborative efforts, guidance materials and protocols have been developed to assist clinicians and direct service workers to recognize signs of physical health problems in individuals with behavioral health issues and improve coordination between behavioral health and developmental services and primary health care agencies. In addition, increasing emphasis is being placed on working closely with primary care professionals to have them conduct screening for substance use disorders, refer for psychosocial treatment, and, in some cases, provide office-based pharmacology treatment to address substance use disorders, especially opiate dependence.

Employment Services and Supports: Individuals with mental health or substance use disorders, intellectual disability, or co-occurring disorders face challenging obstacles to obtaining and maintaining competitive employment. Pervasive stigma, the limited availability of the evidence based practice of supported employment, fear of losing health insurance coverage, complicated funding streams, and poorly coordinated vocational assistance programs are some of the many factors that overwhelm individuals attempting to secure employment or employment services. Mental health and substance abuse employment initiatives between the Department and DRS provide specialized vocational assistance services in CSBs, including the creation and distribution of a guidance manual for CSBs and DRS counselors entitled, "*Successful Competitive Employment for Consumers in Recovery from Serious Mental Illness*". A multi-agency initiative involving the Department, DMAS, DRS, and the academic community has further developed Virginia-specific WorkWORLD™ decision support software to support people with disabilities who are making decisions about gainful work activity and the use of work incentives. The Department supports use of this software to expand training on Social Security work incentives and other benefits counseling.

Criminal Justice and Juvenile Justice Services: In too many cases, the criminal justice system has become the primary source for behavioral health care. In ongoing efforts to improve

screening, ensure appropriate treatment and supports, and enhance interagency planning and coordination to better meet the needs of individuals involved with the criminal justice system, the Department maintains strong working relationships with DOC, DJJ, and DCJS. The Department received funds from the 2008 General Assembly to expand jail diversion programs and has granted funds to CSBs for 10 local or regional projects that include stakeholders from the criminal justice system, such as police or sheriffs and courts. These funds also support state and local training initiatives such as CIT and related efforts such as cross-system mapping activities. The Department and DJJ have collaborated on an initiative, originally supported with federal funds but now supported by state funds, to provide CSB short-term behavioral health services in 23 of 25 juvenile detention centers. DOC works closely with the Department to improve access to hospital and community treatment resources for inmates who have been released from DOC facilities and screen inmates who are potentially eligible for civil commitment to the Department as sexually violent predators. DCJS has partnered with the Department to develop and implement cross training in behavioral health evaluation and treatment methods for law enforcement personnel, including jail security staff. In an effort sponsored by the Substance Abuse Services Council, the Department is working closely with DOC and DJJ to identify common measures of treatment outcomes.

Education: The Department has partnered with the Department of Education (DOE) to support collaborative activities between schools and the behavioral health and developmental services system. Beginning with children birth to three, the Department is the lead agency for the services under Part C of the Individuals with Disabilities Education Act. DOE is involved with all state initiatives focused on Part C services, including the state Virginia Interagency Coordinating Council for Part C. Local lead agencies for Part C also work collaboratively with their local school divisions to assure continuity for young children when they transition from Part C services to their community school. For the school age population, the Department works closely with DOE on a variety of interagency initiatives to improve in-school support for school-age children with behavioral health problems and enhance state and local collaboration to improve outcomes for Virginia's children. This includes intensive efforts to keep children in their homes and community schools.

To support the transition from school age through young adulthood, the Department participates on the Virginia Intercommunity Transition Council (VITC). VITC brings together all of the partners to facilitate coordinated services for this age group, including DOE and technical assistance centers located in several major Virginia public universities.

Advocacy: Department central office and state facility staff work cooperatively with the Virginia Office for Protection and Advocacy (VOPA) to protect and advocate for the human and legal rights of individuals with mental health or substance use disorders, intellectual disability, or co-occurring disorders. Section 51.5-37.1 of the *Code of Virginia* requires the Department to report all deaths and critical incidents to the VOPA within 48 hours of occurrence or discovery and provide follow-up reports of the known facts.

Local Interagency Partnerships

At the local level, these critical partnerships include school systems, social services, local health departments, and area agencies on aging. Services provided by these local agencies are critical to the success of individuals with mental health or substance use disorders, intellectual disabilities, or co-occurring disorders, including Medicaid rehabilitation services, waiver services, auxiliary grants for assisted living facilities, Medicaid eligibility determinations, various social services, guardianship programs, health care, vocational training, housing assistance, and services for TANF recipients. Some local agencies also participate on Part C local interagency coordinating councils and provide Part C services to infants and toddlers.

Partnerships with Private Providers

The private sector is a vital partner with CSBs in serving people with mental health or substance use disorders, intellectual disabilities, or co-occurring disorders. In addition to serving many individuals through contracts with CSBs, private providers also serve other individuals directly, for example, through various Medicaid programs such as the ID waiver (with plans of care managed by CSBs) and inpatient psychiatric treatment services. Private provider participation in the services system is another major strength of the public behavioral health and developmental services system. This participation has grown dramatically over the last six years. The continued expansion of waiver services and some Medicaid rehabilitation services have been major factors influencing this growth.

Despite this significant expansion, two limiting phenomena have been apparent in this process: the absence of private providers in certain parts of the state and the need for private providers to offer more of particular types of services. Consequently, the development of private providers needs to be fostered and supported in various parts of the state. This includes encouraging existing private providers to expand their operations to other parts of the state, to begin offering other services, and to increase their current capacities. This also includes identifying and, where possible, offering incentives to promote the development of new private providers. These initiatives should be joint efforts by the Department and CSBs, working closely with the private provider community and DMAS.

A number of conditions have limited, reduced, or jeopardized private provider participation in the publicly funded behavioral health and developmental services system.

- While Medicaid rehabilitation services and home and community-based waiver reimbursement rates have been increased slightly in past years, many rates still need to be increased. In some areas of the state, Medicaid fees reportedly do not cover the cost of providing services; consequently, private providers are not able to offer those services on an economically sustainable basis. Additionally, some waiver residential providers have converted to community ICF/MR facilities due to low waiver reimbursement rates.
- A growing proportion of individuals have inadequate or no health insurance coverage. Managed care plans continue to limit services covered, amounts of services allowed, and amounts paid for services. In the current business climate, employers facing ever-increasing costs of their traditional health plans have found it necessary to reduce coverage and increase employee premiums, deductibles, and co-payments.
- Information about potential private providers may not be readily available to CSBs when their staffs are developing individualized services plans.
- Some private residential or inpatient providers may resist serving some individuals receiving CSB services because of the severity of their disabilities or lack of information about effective treatment approaches for them.
- Market forces have led to shifts in private sector service provision despite the obvious and significant public sector needs for particular services. A clear example of this condition is the continuing reduction in local private psychiatric inpatient hospital beds in some parts of the state that are available to CSBs and the Department. Some providers no longer offer this service due to inadequate reimbursement rates; others have converted their inpatient beds to other uses. In response, the Department has promoted regional utilization management efforts to carefully manage access to these beds and has funded expanded crisis stabilization programs as an alternative to hospitalization.
- Like public providers, the private sector is experiencing increasing difficulties in recruiting and retaining qualified staff, including professionals, such as nurses and other clinical staff, and para-professionals, such as residential aides and personal care staff.

- The large capital cost sometimes associated with the implementation of new services, particularly residential services, may inhibit private sector participation.
- The lack of state and federal subsidies or initiatives to expand affordable housing. For individuals receiving SSI or SSDI, the affordability gap for apartments is significant.
- Inadequate or lack of funding for non-waiver services and supports.
- Finally, the significant start up costs, such as staff recruitment and training, equipment purchases, acquisition of space, and operating at less than full capacity during implementation, that are often required to initiate a new service may make it difficult for smaller providers to do so, limiting their participation in the publicly-funded services system.

Partnerships with Local Governments and Community Services Boards

The 134 cities or counties in Virginia continue to be vital members of the state-local partnership that enables the provision of community behavioral health and developmental services to more than 190,000 Virginians annually. Local governments partner with the Commonwealth through the CSBs that they established and maintain and through their financial and other support of services offered by those CSBs. The Department will continue to communicate through CSBs with local governments about their concerns and ideas, such as ways to enhance service quality, effectiveness, and efficiency.

In 2004, the Department took a new approach in developing its community services performance contract with CSBs. In collaboration with CSBs, the Department developed the new contract from a blank slate and produced a greatly shortened and more focused contract, which included the *Community Services Contract General Requirements Document* and a new document, the *Central Office, State Facility, and Community Services Board Partnership Agreement*. The Department and CSBs have continued and strengthened this very effective and productive approach in the intervening fiscal years.

The Partnership Agreement describes the values, roles, and responsibilities of the three operational partners in the public behavioral health and developmental services system: CSBs, state facilities, and the Department's central office. It reflects the fundamental, positive evolution in the relationship between CSBs and the Department to a more collegial partnership. It recognizes the unique and complementary roles and responsibilities of the Department and CSBs as the state and local authorities for the public behavioral health and developmental services system. The goal of the agreement is to establish a fully collaborative partnership process through which CSBs, the central office, and state facilities can reach agreements on operational and policy matters and issues. Through this agreement, the partners implement the vision statement articulated in State Board Policy 1036 to improve the quality of care provided to individuals receiving services and to enhance the quality of their lives. While they are interdependent, each partner works independently with both shared and distinct points of accountability, such as state, local, or federal government, other funding sources, and individuals receiving services and their families; and all partners embrace common core values.

System Leadership Council

The Department established the System Leadership Council in August 2000 in response to a desire to include a mechanism in the community services performance contract for providing continuity, enhancing communication, and addressing systemic issues and concerns. The Council includes representatives of CSBs, state facilities, local governments, local hospitals, private providers, individuals receiving services and their families, advocacy organizations, regional jails, the State Board, and the Department's central office. The Council continues to serve as a coordinating mechanism to discuss issues and problems from a systemic point of view, providing continuity, enhanced communication, and a consistent perspective over time. The Council's work and recommendations affect the organization and delivery of publicly funded

services in Virginia. The Council continues to meet at least quarterly to:

- Identify, discuss, and resolve a broad range of issues and problems;
- Examine current system functioning and identify ways to improve or enhance the operations of the public behavioral health and developmental services system; and
- Identify, propose, develop, and monitor the implementation of new service modalities, systemic innovations, and other approaches for improving the accessibility, responsiveness, and cost effectiveness of publicly funded behavioral health and developmental services.

Goals, Objectives, and Action Steps

Goal 9: Increase the ability of Virginia agencies and services systems to partner in addressing the needs of and challenges experienced by individuals with mental health, substance abuse or co-occurring disorders or intellectual disability.

Objectives:

1. *Realize cost savings to the Commonwealth by expanding Medicaid funding for community behavioral health and developmental services.*

Action Steps:

- a. Maximize opportunities within the State Medical Assistance Plan to incorporate recovery and person-centered practices into Medicaid service definitions and provider manuals.
- b. Partner with DMAS to align Medicaid waiver and rehabilitation services with recovery and person-centered principles and practices.
- c. Work with DMAS to establish Medicaid-coverage for peer providers and peer-run services and dental services for adults receiving waiver services.
- d. Continue the Department's participation in the development of Medicaid procedures and regulations that affect behavioral health and developmental services.

2. *Increase the stability of families affected by mental health and substance use disorders that are receiving TANF benefits or are involved with child or adult protective services.*

Action Steps:

- a. Provide behavioral health services to families involved in TANF, ASFA, or other social services programs.
- b. Continue to work with DSS to improve identification and assessment strategies and match individual needs to service type, intensity, and length of treatment.
- c. Utilize the interagency Safe Families in Recovery Strategic Plan and memorandum of understanding to facilitate planning and collaboration.

3. *Expand safe and affordable housing alternatives that meet the needs of individuals receiving behavioral health or developmental services.*

Action Steps:

- a. Work with VHDA, DHCD, the Disability Commission's Housing Workgroup, CSBs, the Virginia Coalition to End Homelessness, and public and private housing providers to maximize the use of all available housing resources.
- b. Collaborate with VHDA, DHCD, and other housing agencies in the design and implementation of affordable housing development plans for low-income and homeless individuals with mental health or substance use disorders or intellectual disability.
- c. Continue to meet with VHDA, DHCD, CSBs, centers for independent living, disability services boards, and area agencies on aging to understand local and regional housing needs, priorities, and strategies for state resources.

- d. Assist CSBs and publicly funded services providers in accessing federal resources for housing and community-based supports for individuals receiving services.
- e. Support the development and sustainability of Oxford Houses.
- f. Work with CSBs and private providers to develop community housing for individuals served through the Money Follows the Person demonstration grant.
- g. Continue to provide information to CSBs about grants and other funding opportunities that provide resources to meet housing needs.

4. *Improve the physical health and wellness of individuals receiving behavioral health or developmental services.*

Action Steps:

- a. Expand partnerships between providers of physical health and behavioral health and developmental services.
- b. Continue collaborative partnerships with primary health care providers to improve identification, screening and diagnosis, and treatment of individuals with substance use disorders.
- c. Support the development of formal agreements and cross-referral networks between CSBs and free clinics, federally funded health centers, and other providers of primary care services.
- d. Encourage state facilities and CSBs to include wellness strategies in individualized service plans for individuals they serve.

5. *Improve competitive employment opportunities and outcomes for individuals receiving behavioral health and developmental services.*

Action Steps:

- a. Continue to collaborate with the Disability Commission, DRS, DSS, DMAS, constituency groups, and other state agencies to address inter-agency financial and organizational barriers to implementing evidence-based practices of supported employment and identify funding streams for employment-related services and supports.
- b. Continue to participate in the implementation of the Medicaid Works initiative and WorkWORLD™ Software.
- c. Identify and, as appropriate, collaborate with DRS and other entities on federal and other grant opportunities for enhancing employment services, supports, and outcomes for individuals with mental health or substance use disorders.
- d. Partner with DRS to provide cross-training initiatives for respective staff and increase access to vocational services, job training, and rehabilitation for individuals with mental health or substance use disorders.
- e. Increase access of individuals, family members, case managers, and public and private vocational and employment-related services providers to accurate information on existing SSI and SSDI work incentives and SSA individualized benefits assistance planning.
- f. Continue to work with DSS, DRS, and DMAS to increase utilization of continual Medicaid coverage for individuals on 1619 (b) status with the Social Security Administration.

Goal 10: Encourage and facilitate greater private provider participation in the public behavioral health and developmental services system.

Objectives:

- 1. *Identify ways to increase the number of private providers participating in the publicly managed services system and to expand the array of services they offer.***

Action Steps:

- a. Increase service availability and encourage greater private sector participation in the publicly funded services system.
- b. Partner with CSBs, the Virginia Hospital and Healthcare Association, health planning agencies, individuals, families, and advocacy groups to identify and implement regional and statewide strategies for ensuring the availability of an adequate number of local acute psychiatric beds and appropriate alternatives that could serve individuals in need of acute inpatient psychiatric services in their communities.
- c. Partner with CSBs and private providers to address workforce issues affecting the availability of adequate numbers of quality staff in community services.
- d. Incorporate start-up expenses such as staff recruitment and training, equipment purchases, acquisition of space, and operating at less than full capacity during the implementation phase and sustainability costs in Department funding requests.

E. Infrastructure and Technology

State Facility Capital Issues and Priorities

The Department operates 16 facilities in 12 locations. These facilities include 412 buildings, containing about 6.5 million square feet of space, with an average age of 49 years and a median age of 55 years. Maintenance and renovation funding has not been adequate to prevent a gradual decline in the condition of these buildings or to allow renovations to meet current treatment and code requirements. The result is that many state facility buildings are inefficient to operate and require major renovations to comply with current life safety and code standards and certification requirements. Most state facility buildings also are in generally poor condition and replacements of major building systems are required. Required replacements include fire alarm systems and fire sprinkler systems, renovations for appropriate emergency egress, hurricane hardening, and increased numbers of bathrooms.

The Department's proposed Six Year Capital Improvement Plan has two essential components: The first are projects necessary to keep operational buildings in use for the next three biennia, including roof, utility, HVAC, and environmental hazard abatement. The second is a phased program of facility replacements to improve physical environments and appropriately address the program needs of individuals receiving services. Appendix F provides a listing of capital priorities proposed for the next three biennia (FY 2011 through FY 2016).

Status of State Facility Redesigns and Replacements

The Department must ensure that the facilities it operates are safe, efficient, well maintained, and appropriately designed to meet the needs of both the services providers and recipients. During the last biennium, the Department completed construction of two facilities:

- *Replacement of the Hancock Geriatric Treatment Center at Eastern State Hospital* - This new 150-bed replacement facility was completed and occupied in April 2008.
- *Virginia Behavioral Rehabilitation Center* - This 300-bed facility for the treatment of individuals committed to the Department as sexually violent predators is complete and in operation. Phase 1 was completed on schedule and Phase 2 was completed six months ahead of schedule.

A third facility replacement project is under construction:

- *Replacement of Eastern State Hospital's Adult Mental Health Treatment Center* - A new 150-bed facility is replacing the hospital's adult mental health programs. This project is currently in the construction phase, using the same team that constructed the Hancock Geriatric Treatment Center. It is scheduled for occupancy in July 2010.

The following facility replacement and renovation projects are in the design phase:

- *Replacement of Western State Hospital* - The developer for Western State Hospital replacement has been selected and design work has begun on this project. The Department has signed an Interim Agreement with Balfour Beatty Construction, Inc. for the design and construction of a new 246-bed replacement facility. The completion is estimated at 36 to 42 months, depending on the site selected.
- *Replacement of Southeastern Virginia Training Center* - The Department is supporting the efforts of the Department of General Services, Division of Engineering and Buildings, Bureau of Facility Management in the design and construction of a 75-bed replacement facility on the existing site of the facility. A PPEA proposal was received by the Department of General Services and has been advertised for competing proposals. A major component of this effort is the creation of additional community housing into which residents at the facility can move. The Appropriation Act calls for the development of 12 community ICF and six waiver group homes.
- *Renovation of Central Virginia Training Center* – The Department has been pursuing the path of renovating residences on campus to correct privacy and Life Safety Code issues. Building No. 11 has been fully renovated and is operation. Buildings No. 8 and No. 12 have been submitted for final code compliance review. Construction is expected to begin in the fall of 2009. In parallel with this effort is the creation of additional community housing into which residents of the facility can move. The Department has received a PPEA proposal to provide community housing.

Several years ago before Executive Orders 48 and 82 were issued, the Department recognized the continually escalating cost of energy and the environmental benefits of burning cleaner fuels. Department-operated energy plants were converted to burning a combination of fuels that allows flexibility in utilizing the least expensive fuel. The majority of the plants were converted to natural gas and low-sulfur fuel oil. The exception is Piedmont Geriatric Hospital where a biomass boiler burning wood-manufacturing, waste product (sawdust) was retained. It remains one of only three wood-burning boiler plants in the Commonwealth's system. The Department has pursued a number of initiatives to reduce its energy consumption.

- Energy Performance Contract - The Department recognized the need to modernize an aging, energy delivery system that was wasting energy and was costly to operate. It entered into five separate energy performance contracts at the Petersburg Complex (including Southside Virginia Training Center, Hiram Davis Medical Center and Central State Hospital), Southwestern Virginia Mental Health Institute, Central Virginia Training Center, Southwestern Virginia Training Center, and Catawba Hospital. All of these contracts have proved successful and have met their objectives in modernizing the energy delivery systems and reducing energy consumption. Subsequently, the Department signed a statewide agreement to re-assess its state facilities and look for additional energy savings projects that were not considered in the first efforts. As a result of this effort, capital funds have been melded with the energy performance contract to replace the entire HVAC system at Southside Virginia Training Center.
- Renewable Energy Sources - Two state facilities have implemented renewal energy sources. Southwestern Virginia Training Center combined a capital project with the energy performance contract to convert its residential buildings to ground-source heat pumps; a system that uses the earth as an energy storage mechanism and is far more efficient in extreme temperatures. Piedmont Geriatric Hospital continues to seek the best energy alternatives and has obtained permission from the Department of Environmental Quality to utilize native warm season grasses (NWSG) as a source of fuel for its biomass boiler. This boiler alone was able to avoid more than \$500,000 in fuel cost this past fiscal year by not burning fuel oil. With the addition of NWSG as a fuel source, the facility will have the flexibility of burning several, low-cost fuels while vastly mitigating its carbon footprint.

- Laundry Energy Improvements - One of the largest state facility energy consumers is the laundry operation. A comparison of laundry operations yielded opportunities at Piedmont Geriatric Hospital and Central Virginia Training Center for reducing energy consumption and cost of operation. Piedmont Geriatric Hospital and Southside Virginia Training Center have regionalized their laundry operations. Central processing at Southside Virginia Training Center is far more efficient and has saved both energy and cost at Piedmont Geriatric Hospital. Piedmont's energy plant was facing an increased demand due to the location of the new Virginia Center for Behavioral Rehabilitation at the Nottaway Complex with Piedmont Geriatric Hospital. At Central Virginia Training Center, most laundry is now processed through the Virginia Correctional Enterprise system. The central laundry facility has been eliminated, saving energy and operating costs.
- Building Area Reductions - At Eastern State Hospital, the construction of the new Hancock Geriatric Treatment Center has reduced the building area and provides a more energy efficient building to serve individuals. This has occurred while improving the environment of care at the facility. The construction of the hospital's new adult mental health treatment center will further reduce the energy consumption at this campus. When all phases of construction are complete, this will reduce the hospital's building area by nearly 50 percent. At Central Virginia Training Center, consolidation has allowed several buildings to be closed and taken off the energy system. This is reducing operating costs and energy consumption at this large facility. At Western State Hospital, the Department is in the design phase for a replacement facility. This new facility will have the same bed capacity but will vastly reduce the building area, operating costs, and energy costs. It is being designed to meet the U. S. Green Building Council's LEED® criteria for SILVER.

The Department continues to look for the most cost effective strategies for providing needed energy for efficient operation of the state facilities. This is being done to be good stewards of Department funds and to focus resources to improve the Department's ability to meet the needs of individuals receiving services in state facilities. In a report issued by the Department of Mines, Minerals and Energy, the Department accounted for nearly 30 percent of all reported energy cost savings statewide, making it a leader among state agencies. In FY2008, the Department has already exceeded its FY2010 energy cost reduction goal that was set out in Executive Order 48. According to the report, of the non-education related departments reporting, the Department accounted for more than 75 percent of all energy savings reported in the Commonwealth.

Information Technology Issues and Priorities

The Department's information technology (IT) program provides coordination, guidance, oversight, and support to central office and state facility IT programs, including IT infrastructure transformation activities, security, compliance, and web and application development. The central office technology team strives to comply with COV technology, application development, and project management standards for all IT activities. This has been challenging because the Department continues to face additional pressure from budgetary constraints that resulted in elimination of information technology staff positions in FY 2009 and FY 2010.

IT Transformation: The Department's IT program is working with the Virginia Information Technologies Agency (VITA) and Northrop Grumman (NG) partnership to implement the major goals of VITA transformation – desktop/laptop standardization, centralization of Help Desk functions, server consolidation, and messaging, network, security, data center, and voice and video investments. IT transformation, when complete, will improve constituent services and address many of the long-standing technology challenges and operational efficiency issues affecting the Department. The transformation process is approximately 70 percent complete. Messaging Transformation - email and active directory conversion -is scheduled for completion by December 2009.

IT Investment Management: Adopting COV standards and procedures has required significant changes for Department users of IT services and developers but is providing a considerably more stable and reliable technology environment. In December 2008, the Department implemented the COV Information Technology Investment Management (ITIM) process for central office technology initiatives. This process, which included the establishment of an Information Technology Investment Board, will enable the Department to identify potential business value in all proposed IT investments, select and prioritize IT investments that best meet Department business needs, monitor the progress and performance of technology initiatives, and determine if selected technology investments are continuing to deliver the expected business values of constituent service, operational and efficiency, and strategic alignment to Department and COV goals and performance measures.

IT Security: The Department's investment in IT security provides business value because it protects constituent information, assures appropriate access to information, and enables the Department to implement new and updated federal HIPAA requirements and COV security standards. The following standards and directives affect IT Security initiatives:

- VITA Security Standards 501-01
- VITA Data Protection Standard 507-00
- VITA IT Security Audit Standard SEC502-00
- Comptroller's Directive 1-07 (ARMICS).

This investment will support provision of safeguards and controls that are necessary to ensure effective operation of the Department's technology environment and data and, as such, remains a high priority for the Department.

Department Enterprise Applications: The major enterprise applications for the Department are AVATAR (facility billing), FMS (facility and central office financial management), and CCS (CSB accountability reporting). CCS is an agency-developed application; the other enterprise applications are third-party vendor solutions. The Department maintains 20 additional applications (developed in-house) to support CO, state facility, and community business functions, including human rights, licensing, facility operations, quality management, risk management, Medicaid Waiver, Part C services, SVP services, discharge planning, forensic services, community contracting, information technology, and public relations. The development team utilizes accepted industry standards.

The Department is implementing a pharmacy management system to replace an outdated pharmacy application. This project, awarded to General Electric (GE) Healthcare, will improve operational efficiency and constituent services by improving customer experience, providing better access to information, increasing ease of use, improving service quality and reducing errors, and adding new services. The GE Centricity Pharmacy application will be integrated with the existing state facility billing and AVATAR Admission Discharge Transfer application. This project will effectively set the stage for later integration with the proposed electronic health record and will support the agency's risk reduction efforts to mitigate errors and improve individual safety and pharmacy customer service. The scheduled completion date for the pharmacy application is June 2010.

The Department's IT environment and staff continue to support legacy applications using older technologies but utilize current technologies for all new development. As resources permit, the Department will replace outdated legacy systems and this will offer opportunities for cost savings and improved service.

IT Priorities: Department IT strategies for the next two years focus on:

- **Service** - Deliver efficient and effective technology services and shared solutions by leveraging infrastructure to enhance application reliability and reduce infrastructure and software costs;

- ***IT Management and Infrastructure*** - Improve operations, security, and reliability by completing COV infrastructure transformation activities; and
- ***Cross-Boundary Solutions*** - Create, strengthen, and expand technology partnerships within the Department, across state agencies, and beyond state government, particularly in the areas of health information technology and health information exchange programs.

Goals, Objectives, and Action Steps

Goal 11: Provide state facility infrastructure and community housing that efficiently and appropriately meets the needs of individuals receiving behavioral health or developmental services.

Objectives:

- 1. Improve the capital infrastructure of state hospitals and training centers to assure their compliance with life safety and applicable building codes and their appropriateness for active treatment services and supports.***

Action Steps:

- a. Accomplish critical state facility repairs that are necessary to maintain CMS certification or meet Joint Commission standards.
 - b. Complete the replacement of Eastern State Hospital's adult mental health treatment center.
 - c. Complete the design replacements of Western State Hospital and Southeastern Virginia Training Center and the renovation of Central Virginia Training Center.
 - d. Work with state facilities to identify and implement initiatives that generate energy efficiencies.
 - e. Continue to update individual state facility master plans to respond to the programming needs of individuals.
- 2. Build community housing capacity that will enable residents of Southeastern Virginia Training Center and Central Virginia Training Center to move to the community.***

Action Steps:

- a. Work with the CSBs, training centers, the Department of General Services, family members, advocates, and community stakeholders to design and construct community housing into which residents of the training centers can move.

Goal 12: Manage information efficiently in an environment that is responsive to the needs of users and protects identifiable health information about individuals receiving services.

Objectives:

- 1. Deliver efficient and effective technology services and shared solutions to central office, state facility, and community partners.***

Action Steps:

- a. Deploy the GE Centricity Pharmacy applications in all state facilities.
- b. Complete development and deploy the DELTA application to manage access to secure agency technology applications by CSBs and other providers.
- c. Develop and deploy the multi-agency critical incident management and reporting (CIMRS) application.
- d. Develop and implement a data warehouse application that uses standard reporting and business intelligence tools and consolidates data from multiple applications and provides a consolidated reporting environment for the Department.

- e. Architect a pilot technology solution to establish a data exchange process between Department software applications (e.g., ITOTS, human rights, Medicaid waiver) with one or more CSBs.
- f. Develop and deploy the ITOTS application.
- g. Determine if the use of Customer Relationship Management Software is a strategic development tool for the Department.
- h. Evaluate and move (if feasible) the AVATAR application from a UNIX hardware platform to Windows.
- i. Evaluate and implement (if feasible) a single laboratory technology application for state facilities.
- j. Use business intelligence reporting tools to publish CSB and state facility accountability measures on the Department's website.
- k. Deploy the following applications:
 - Core Measures application for the Joint Commission state hospital reporting;
 - Laboratory Data Systems Glucose Monitoring application in participating facilities;
 - Juvenile Competency application for central office and CSB use;
 - Part C Provider Credentialing application and associated interfaces with DMAS;
 - Updates to the CCS application for central office and CSB use.
- l. Upgrade existing state facility applications to current software versions and consolidate, where possible, these applications and databases on shared servers.
- m. Implement the IT Investment Management (ITIM) process agency-wide for oversight of new and ongoing Department technology investment.
- n. Work cooperatively with Department IT users and other agencies to identify and implement new shared services that can reduce technology costs and improve effectiveness across agencies.

2. *Improve the Department's information technology operations, security, and reliability.*

Action Steps:

- a. Complete implementation of all COV infrastructure transformation activities, including messaging and active directory transformation.
- b. Monitor VITA/NG Partnership performance.
- c. Follow established technology standards and best practices throughout the Department.
- d. Develop processes to implement investment management, project management, and change management processes in state facilities.
- e. Provide adequate training and orientation to Department IT development and security staff on COV technology standards, investment management, project management, application security, and enterprise architecture.
- f. Upgrade the Department's area wide network, as required.
- g. Complete state facility security risk assessments, including self- and on-site security audits, and security corrective action plans.
- h. Complete business impact analyses for all state facility applications.
- i. Update central office and state facility IT disaster recovery plans annually.
- j. Maintain, monitor, and manage a technology asset inventory of central office and state facility applications and utilize ProSight to manage the Department's application portfolio.
- k. Move identified servers from local data centers to the state data center.

3. *Create and expand technology partnerships within the Department, across state agencies, and beyond state government.*

Action Steps:

- a. Continue and expand collaborative activities around electronic health records and health information exchange with CSBs and non-government entities.
- b. Continue multi-agency technology collaborative activities within the agency and with services system partners and participate on the Governor's IT Healthcare Council, VITA/NG Partnership forums and committees, and other workgroups.
- c. Work with state facilities to maximize use of technology resources through server consolidation, web development, security program implementation, and asset management.
- d. Collaborate with the Virginia Enterprise Architecture Division in developing applications and utilizing business intelligence technology to meet Department IT needs.

F. Human Resources Management and Development

Recruitment and Retention of Critical Positions

Major human resources-related issues that affect the quality, effectiveness, and responsiveness of services and supports provided through Virginia's behavioral health and developmental services system follow:

- Shortages of and intense competition among services providers for health care professionals and direct care workers that limit pools of qualified applicants and increase difficulty in retaining well-qualified workers;
- Declining enrollments in key degree and specialty academic programs such as psychiatry, nursing, and masters level social work;
- Insufficient workforce development training and limited opportunities for professional growth;
- Lack of succession planning to address providers' aging workforce or initiatives to accommodate the increasing cultural diversity of the current workforce; and
- Increasing levels of competency expected of the workforce in the future.

Virginia's behavioral health and developmental services system cannot meet current demand for direct care staff that provides essential hands-on care to individuals who must depend upon others for the most basic activities of daily living. Demand for these positions, such as state facility direct services associates, is growing more than twice as fast as all other industries.

The continuing shortage of nurses, case managers, and professional staff has the potential to have significant service and financial impact on state facilities and community providers. The inability of providers to attract and retain qualified direct services support staff has been identified by all oversight entities. This problem affects state facilities, CSBs, and private providers, including Medicaid-funded services.

Current reimbursement rates for some services still do not cover service provision costs, making it all but impossible to offer incentives to match the competitive market. Providers also experience extra costs associated with overtime, contract employees, and continuous recruitment and training due to excessive turnover. Some providers are being financially burdened to the point of reducing capacity or going out of business.

The Department must ensure that each state facility has sufficient numbers of trained personnel across the entire spectrum of clinical and direct care positions to provide quality care and person-centered services. However, state facilities continue to experience staffing level issues, perhaps most notably at Southern Virginia Mental Health Institute. Additionally, Central Virginia Training Center, Southeastern Virginia Training Center, Southside Virginia Training Center, and Southwestern Virginia Training Center continue to experience difficulty recruiting and retaining nurses and direct care staff, psychiatrists, psychologists, primary care physicians, dieticians,

occupational and physical therapists, rehabilitation engineers (for specialized wheelchairs), speech pathologists, and audiologists.

These issues will place additional pressure on public and private providers to increase the productivity of their workforce members. Increased productivity can be accomplished by implementing technology improvements, better matching of workforce competencies with specific provider needs and the acuity levels of individuals receiving services and supports, and increasing the emphasis on education about new treatment modalities, and professionally accepted clinical practices. A variety of education and compensation incentives and workforce development initiatives are needed to enhance competency levels and retain workers in key health care occupations, including:

- Demonstration sites to encourage entry level and continued learning for nurses and case managers;
- Continued learning programs utilizing long-distance learning techniques and on-site formal education for nurses, health care aides, case managers, and other licensed providers,
- Nursing and case manager career ladders or pathways linked to educational awards, e.g., certificates, specialized diplomas, or associate degrees;
- System-wide public awareness and education campaigns and conferences to educate and recognize direct care services and career opportunities offered by the services system;
- Employee recognition programs; and
- Partnerships with academic institutions to explore loan repayment options, scholarships, tuition reimbursement; and grants for off-site educational programs.

The Department, state facilities, CSBs, and private providers have established an ongoing partnership through the Workforce Advisory Council to jointly address continuing services system workforce issues. The advisory council needs to continue to focus its efforts to strengthen the status of the direct support role and industry image; educate, train and develop frontline staff; develop career paths linked to education and training; secure systems change by improving income, linking wage enhancements to competency development; and revise public policy to provide the necessary tools for a transformation of the direct care worker into a direct care professional.

Implementation of High Performance Organization Principals and Practices

In March 2005, the Department initiated efforts to create a “high performance organization” in its central office and 16 state facilities. With assistance from the University of Virginia's Weldon Cooper Center for Public Services and the Commonwealth Center for High Performance Organizations, the Department has moved towards an organization that values and expects shared leadership, teamwork, and collaboration.

The high performance organization (HPO) model introduces a series of lenses through which an organization can view itself and decide what changes may be necessary to improve its performance. The process includes organizational assessment and change, relationship building, promotion of core competencies of leadership, and alignment between vision and values and structure and systems. The benefits of HPO are improved productivity, efficient use of resources, increased accountability and creativity, and a focus on the importance of every member of the organization.

For most organizations, implementing some of the principles of HPO can take seven to 10 years. Large scale organizations need a disciplined, well integrated, and well-resourced leadership team guiding the process. The Department's HPO work is guided by its Leadership Philosophy, which states:

We are a community of diverse, knowledgeable, creative, and dedicated individuals committed to service responsibility and partnership. We believe:

- *That people are motivated by shared leadership.*
- *That people are innovative and resourceful and when encouraged, trusted, empowered, and recognized, will play an integral leadership role.*
- *That teamwork is the way to fully use the different perspectives and experiences that each person brings to strengthen and support the decision-making process.*
- *That when each of us values and shares responsibility for creating a culture with clear goals, mutual support, respect, trust, and opportunity for continued learning, we can best achieve our mission.*

State facilities and the central office have implemented unique plans of action to promote the HPO philosophy, and a statewide team for information sharing and guidance is in place. The statewide team, ALOT (Advancing Leadership and Organizational Transformation), includes representatives from each state facility and the central office. Its mission is to:

- Guide the development and implementation of the HPO transformation and leadership shift within the Department.
- Promote capacity for achieving important, long-term policy goals and delivering the best possible behavioral health and developmental services to Virginians.
- Establish the Department as a consistently high performance organization at all levels.

ALOT team members educate, motivate, and communicate the work of leadership, finalize products, enhance leadership skill development and team collaboration, and support a consultative approach to work for more effective and shared organization performance.

The central office team, LEEP (Leading through Empowerment, Excellence, and Partnership), was established to continually improve the culture, operations, and environment of the central office by promoting empowerment, shared leadership, teamwork, collaboration, and quality. The expectations of the LEEP team are to:

- Create a culture where individuals share in leadership and are actively involved in teamwork and collaboration;
- Create a work environment where people feel valued and where their ideas may be freely expressed and acted upon as appropriate;
- Execute high performance ideas that are visible to employees and can be accomplished relatively soon (90-120 days) and to execute ideas that are visible to employees that have positive and long-lasting effects on employees (1-3 years); and
- Survey employees annually and measure results.

The LEEP team's accomplishments to date include:

- Assessed the central office work culture and identified improvements and issues to address over time;
- Conducted in-service training on topics such as communication, facilitation, performance management, and team building and convened Brown Bag or "mini-training" presentations on a variety of topics to help staff improve their skills;
- Provided regular feedback forums for staff input into policies and practices;
- Wrote the Central Office Code of Ethics and developed values to be added to all central office employee work profiles;
- Coordinated staff recognition and special events, including holiday parties;
- Presented HPO activities at weekly management meetings and quarterly staff meetings.

- Established workgroups to look at aligning work systems with central office values and identifying grant opportunities, and securing grants.

The Department continues to build its capacity to integrate its leadership philosophy into the manner in which the agency approaches business; supports program development and service delivery; and interacts with individuals receiving services and other stakeholders. The Department also is in the early stages of assessing its internal operating policies and procedures to determine the extent to which they align with the agency's leadership philosophy and facilitate higher performance in quality, client value, and costs.

Workforce Competency Development

The Department has initiated the following in-service training curricula for central office and state facility staff, which continue to be available as needed.

Performance Management Training -The Department agreed to be a pilot site for the state human resource agency's performance management training and trained most central office supervisors and managers in how to best utilize its most value resource, its people. The Performance Management course helps supervisors and managers appropriately supervise staff using state-specific policies and forms and proven management tools and theory. Topics included an Overview of the Performance Management Process, Development of an Employee Work Profile, Documentation and Feedback, Evaluating Performance, and the Probationary Period.

Communication Training - The Department, in collaboration with the LEEP team, designed and offered communication training to over 100 central office staff. The training topics include active listening, roadblocks to communication, feedback, and conflict resolution

Facilitation Training - The Department designed this training to enhance the ability of staff to interact, collaborate, and support one another through teamwork. Participants learned techniques to establish goals, secure resources, meet deadlines, and other facilitator tasks. The training also examined the development and progress of existing teams and made suggestions on how to enhance the work and outcomes of the team process. This training was made available to central office and facility staff and to the statewide ALOT team.

Team Building Training - The Department developed this training to promote the benefits of the team process and facilitate implementation of best practices for working together. The training, provided to central office and state facility staff as requested, examines the role of teams in improving the lives of the people with disabilities and teaches teamwork skills such as active listening, giving constructive feedback, and making the team person-centered.

Goals, Objectives, and Action Steps

Goal 13: Recruit and retain a highly-skilled and appropriately sized behavioral health and developmental services workforce.

Objectives:

- 1. Build partnerships for effective collaboration and consensus on workforce issues and initiatives and programs.**

Action Steps:

- a. Continue to partner with system stakeholders to address workforce issues and initiatives and, in collaboration with systemwide partners, include these initiatives in conferences and other educational forums.
- b. In collaboration with the Workforce Advisory Council, address system-wide workforce issues and prioritize initiatives for system-wide changes.
- c. Continue to plan and implement HPO initiatives in the central office and state facilities.

2. *Implement strategies to enhance recruitment and retention of critical positions.*

Action Steps:

- a. Work with secondary and technical schools and institutions of higher education to educate their students about the services system and potential career opportunities.
- b. Support scholarships and other incentives to increase the number of students entering training and academic programs for critical professional and direct care positions.
- c. Promote implementation of a career development path for state facility direct services associates.
- d. Partner with Virginia universities, colleges, community colleges, and other learning organizations to support on-site-training of graduate, undergraduate, and medical students at state facilities and CSBs.
- e. Maintain and enhance the Department's Workforce Development and Innovation Web Site as a resource for services system partners.
- f. Utilize a variety of communication techniques and strategies to recruit critical positions, including web promotion, brochures, posters, direct mail campaigns, employee referral cards, bumper stickers, newspaper articles and profiles, radio interviews, forums, exhibits, and outreach programs.

3. *Increase the competencies and productivity of professional, paraprofessional, and administrative support staff through distance learning, regional and statewide training programs, conferences, and other learning opportunities.*

Action Steps:

- a. Develop and implement on-site and distance learning educational programs for direct services associates and nursing staff that support career ladder progression for future and current nursing professionals and direct care professionals.
- b. Evaluate and obtain continuing education programs for critical positions by partnering with the community college system to offer continuing education credits or certificates.
- c. Implement training and cross-training programs designed to develop provider competencies necessary to meet the needs of the most challenging individuals, including individuals with co-occurring disorders and the gero-psychiatric population.
- d. Promote cross training of nursing home staff to address the needs of individuals who are at risk of placement in state facilities due to psychiatric or behavioral needs.
- e. Evaluate and implement incentives such as certificates, pay differentials, and other methods of recognition for direct care workers who obtain additional training.

G. Service Quality and Accountability

Quality Improvement

As Virginia's system of public behavioral health and developmental services is transformed, the Department must take proactive steps to create and sustain a culture of recovery, self-determination, and person centered planning. The Department's Integrated Strategic Plan envisions a services system in which public and private providers incorporate quality improvement structures and processes into their services delivery and administrative practices. To achieve this, the Department supports a number of strategies that promote continuous quality improvement across the behavioral health and developmental services system.

All state facilities have established self-monitoring processes and ensure that continuous quality improvement plans are developed and successfully implemented. Central office staff also works with state facilities to address and monitor facility-specific improvement plans that respond to findings of external consultants, Departmental internal audits, the Inspector General for Behavioral Health and Developmental Services (OIG), and VOPA. The OIG inspects,

monitors, and reviews the quality of services provided in state facilities and by licensed providers, including CSBs, private providers, and DOC mental health units. Key domains used to inspect and evaluate state facility performance include the facility's mission and values, individual access and admission, service provision and individual activities, facility operations related to individual and staff safety and environmental conditions, staffing patterns, system performance, and community relationships. OIG results and recommendations and implementation progress are reported to the Governor and General Assembly.

Critical components of any quality improvement effort involve the compilation and analysis of data about the services system and how it operates, making this data available in meaningful ways to decision makers, and demonstrating an ongoing commitment to using this data in decision-making at the system and individual program levels. The Department has submitted data for many years to the NASMHPD Research Institute for state hospitals that are accredited by the Joint Commission. These Core Measures provide quality management data that can be used to evaluate risk, quality, and outcomes at the individual and state facility levels.

Three priority quality improvement initiatives follow.

- ***Reducing Use of Seclusion and Restraint*** - Reducing and ultimately eliminating the use of seclusion and restraint in state facility and community-based settings is a priority at the federal level and in Virginia. In *Moving from Coercion to Collaboration in Mental Health Services*, an individual with a mental health disorder described the demoralizing effects of these practices, including:
 - Overwhelming physical, psychological, and spiritual trauma associated with seclusion and restraint;
 - Confusion and bitterness that derive from not being offered less severe interventions;
 - Loss of privacy and dignity;
 - Lack of attention to the individual's subjective experience;
 - Damage done to a individual's ability or willingness to be more open and trusting with service providers;
 - Effects of treatment produce trauma on the psyche; and
 - Dehumanization of the individual.

This individual stressed the importance of explaining what is going to happen to the patient in reassuring rather than threatening terms and the need to provide opportunities for individuals who are in crisis to have less restrictive options for resolution of the crisis. (Pollack, 2004)

Reduction in the use of seclusion and restraint requires a culture change within organizations at the overall administrative and individual staff levels. Numerous myths about the use of seclusion and restraint must be overcome, including unfounded beliefs that:

- Seclusion and restraint are used without bias and only in response to objective behaviors ;
- Seclusion and restraint are not used as punishment and only as a "last resort," when "absolutely necessary", or for "safety reasons;"
- Seclusion and restraint keep individuals receiving services and staff safe; and
- Staff knows how to recognize and deescalate violent situations or use alternatives.

Seclusion and restraint reduction efforts require:

- Demonstrated commitment by leadership to change the organizational culture;
- Use of recovery principles such as believing people with mental health disorders can recover, instilling hope, avoiding labeling, empowering people to be responsible, and sharing decision-making;

- Use trauma knowledge, including understanding the prevalence of trauma in individuals receiving services, impact of trauma on individuals, and how seclusion and restraint can exacerbate trauma effects and interfere with treatment;
- Organizational self-assessments that involve feedback from individuals receiving services and staff for quality improvement; and
- Staff education that includes elimination of myths and development of new skills.

The provision of non-coercive treatment and care in the state hospitals, including reduction in and elimination of the use of seclusion, restraint, and time-out, continues to be a priority of the Department and a focal point for the Office of the Inspector General. Therapeutic Options of Virginia (TOVA) is the Department's standard behavior interaction training program that was developed to meet the specific needs of staff that work with individuals with mental health disorders or intellectual disability. An Advisory Committee, which includes consumer and CSB representatives, oversees the structure, content, and operations of the TOVA program and ensures that the program is updated to meet the changing needs of consumers and staff. The Department's seclusion and restraint database serves as the basis for internal and external reporting of these restrictive procedures. The Department also collects data from licensed providers on their use of seclusion and restraint. Policies, procedures, and regulations are in place and are continuously updated to support reduction efforts.

- ***Improving Quality through Electronic Health Records (EHR)*** - Implementation of an EHR can provide significant improvements in service outcomes and the safety of individuals receiving services. However, increased service effectiveness is possible only when selection, design, and implementation EHR systems are guided by the needs of the staff that provide health services. Provider work processes must be reviewed and revised as necessary to take advantage of this new technology and information systems must support and enhance the work of providers through decision support systems, improved access to information, and a system of warnings and alerts. This requires the active participation of health care provider staff in developing the specifications, selection, training, migration planning, and on-site implementation of a system. The Department has established an e-records steering committee to provide policy-making and oversight body to guide the project. Ten teams are meeting regularly to plan for implementation of the Department's EHR. The teams include senior level clinicians from all disciplines, administrators, and a variety of direct care and support staff to serve as the subject matter experts in planning for this new system.
- ***Implementation of Community-Based Recovery and Person-Centered Services and Supports*** - The Department is establishing, in partnership with CSBs and other stakeholders, a system wide continuous quality improvement (CQI) process based on a consistent shared vision and with measurable and realizable implementation processes toward achieving a welcoming, recovery-oriented, integrated services system for individuals receiving services and their families. This emphasis is consistent with the Department's and the CSBs' interest in assuring that individuals receive the services and supports needed to support their recovery, empowerment, and self-determination. It also is consistent with the recognition that many of these individuals will have co-occurring mental health and substance use disorders or intellectual disability and will need services that are designed to welcome and engage them in co-occurring capable services.

The CQI process is intended to provide the capacity at local, regional, and state levels to measure progress in achieving performance expectations and goals, providing feedback, and planning and implementing improvement strategies. Its focus is on improving services and strengthening the engagement of CSBs in a multi-year, iterative, and collaborative CQI process. Initially, CSBs and the Department are engaging with stakeholders to perform meaningful self-assessments of current operations, determine relevant CQI performance

expectations and goals, and establish benchmarks for goals, determined by baseline performance, to convert those goals to expectations. The 2010 Performance Contract includes the following CSB expectations.

- CSBs that have not done so, shall conduct organizational self-assessments of service integration using the COMPASS tool and use the results of this self-assessment as part of their CQI plan and process.
- CSBs shall administer the Recovery Oriented Systems Indicators (ROSI) Consumer Survey with a statistically valid sample of individuals with serious mental illness receiving mental health services and the ROSI Provider Survey annually and report the results to the Department. In administering the ROSI, CSBs should involve individuals receiving services, for instance by training and hiring them to administer the ROSI and to compile and analyze the results.

Over time, CSBs will assess and report to the Department on their progress toward achieving these expectations and goals and will develop and implement a CQI plan to meet them. As benchmarks are attained and expectations and goals are achieved, CSBs and the Department will review and revise the performance expectations, goals, and benchmarks or establish new ones. As this joint CQI process evolves and expands, the Department and the VACSB will utilize data and reports submitted by CSBs to conduct a broader scale evaluation of service system performance and to identify opportunities for CQI activities across all program areas.

Oversight and Accountability

By statute and federal and state administrative requirements, the Department performs a number of oversight and accountability activities, including:

- ***Protecting Individual Human Rights*** - The Department operates a statewide human rights program established to protect the fundamental rights of individuals receiving services from state facilities and all services licensed or funded by the Department. Services providers must comply with regulations that recognize individuals receiving services have a right to full participation in decision-making and to services provided in accordance with sound therapeutic practice. The Department monitors compliance with state human rights regulations, investigates complaints and allegations of abuse and neglect, provides consultation and training to providers, and assists volunteer members who serve on state and local human rights committees.
- ***Licensing Services Providers*** - The Department licenses all behavioral health (mental health and substance abuse), developmental (intellectual disability), developmental disability waiver, and residential brain injury services. It ensures that providers meet and adhere to regulatory standards of health, safety, service provision, and individual rights; conducts annual unannounced inspections, investigates complaints and reports of serious injuries and deaths in licensed services; and initiates actions such as sanctions and revocations, where necessary. The licensing regulations are being revised to incorporate recovery and person-centered practices, reduce administrative burdens where possible, and promote the health and safety of individuals receiving services.
- ***Compliance with Agency Risk Management and Internal Controls (ARMICS) Standards*** - Each state agency must conduct an annual assessment of its agency-level risks and significant fiscal controls at the transaction level to assure compliance with laws and regulations and stewardship over the Commonwealth's assets. This assessment, which must be certified by the agency head to the Department of Accounts, documents internal control strengths, weaknesses, and risks. Annual updates assess improvements over the prior year's ARMICS implementation and organizational or procedural changes that require reevaluation of internal controls and retest controls that have not changed. In its FY 2009 ARMICS certification, the Department identified a significant weakness in its internal control

related to sub-recipient monitoring. This monitoring is intended to ensure CSB compliance with federal regulations and conditions of applicable grants. A corrective action plan, to be implemented by June 30, 2010, includes a risk assessment of CSBs to determine and prioritize future reviews; field site reviews of the highest risk CSBs; and follow-up on significant control problems identified by internal and external reviews and audits.

- **Risk and Liability** - Department and state facility leadership and staff must proactively address risks and liabilities inherent in ongoing programs and daily operations. This includes implementation of federal regulations governing the privacy and security of patient identifiable information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), compliance with Commonwealth of Virginia IT security requirements, and reporting state facility critical incidents, including deaths, to VOPA within 48 hours of occurrence or discovery.

Recognizing the significant growth in the numbers and types of community providers and the increasing complexity of populations served in state facilities and community settings, coupled with current budget realities that constrain staff resources, the Department is examining how it performs these oversight activities. For the human rights and licensing programs specifically, the Department is seeking opportunities to improve the ability of these programs to perform their mandated responsibilities within existing resources and in a manner that promotes the vision of recovery, self-determination, empowerment, and community integration for individuals receiving services. The goals of these examinations are to:

- Identify program efficiencies that would increase time that staff would have available to perform core responsibilities;
- Determine whether the programs' current organizational structures could be realigned to improve the programs' ability to meet their responsibilities with current staffing levels;
- Eliminate activities performed by staff that add minimal value to the achievement of program goals or detract from activities that would be more closely aligned to promoting the Department's vision; and
- Eliminate redundant or duplicative activities that are or should be performed by other Department offices or divisions.

The Department needs to leverage existing data that is generated through its oversight activities in more meaningful ways to inform decision making, analyze trends, and provide strategic interventions where needed. A key area of emphasis for the Department is enhancing the competency of public and private providers, especially new providers and those who operate small independent programs, to ensure that they have basic provider readiness skills and can integrate the principles and practices of recovery and person-centered planning into their operations. The Department is exploring the use of learning system technologies to facilitate the development of provider competencies and is examining approaches for providing focused technical consultation to providers to proactively enhance provider readiness and improve the quality of services and supports. This enhanced training and presence in the field, coupled with the increased use of data will enable the Department to focus its resources on oversight of high risk areas.

In addition to these required oversight activities, the Department has actively promoted the establishment of regional utilization review committees that manage the use of state hospital beds. These committees include state facility, CSB, and local hospital representatives. Currently, each region defines the populations for which it conducts utilization reviews and uses its own criteria in reviews. Over the next two years, the Department will be working with the regional utilization management committees to establish more uniformity in:

- Defining statewide expectations regarding utilization management practices;
- Collecting utilization review data in a consistent manner;

- Benchmarking these data with other state and federal datasets; and
- Evaluating the efficiency and effectiveness of regional utilization management activities.

CSB and State Facility Accountability Measures

Over the next three years, the Department will post performance and outcome data about CSBs and state facilities on its web site. The web site postings will include reference points (e.g., averages, ranges, or benchmarks), where possible or applicable, and definitions of the data and explanations of its significance to make the measures more useful and meaningful. Placing this data on the web site will provide useful information to individuals receiving services, family members, CSBs and state facilities, advocates, and the public about the services system. It also will respond to increased legislative interest in accountability and to requests from CSB executive directors for the Department to use the data that CSBs provide through the Community Consumer Submission (CCS). Using this data will improve data accuracy and enhance the quality of services provided by CSBs and state facilities. (See Appendix G)

Goals, Objectives, and Action Steps

Goal 14: Enhance the capacity of the behavioral health and developmental services system to improve quality of care.

Objectives:

1. *Promote the provision of services and supports without coercion in state facilities and community services.*

Action Steps:

- a. Provide ongoing training and consultation to state facility and community providers focused on building the skills necessary to implement the vision of a system that supports recovery in a non-coercive environment.
- b. Work with state facilities and inpatient and residential providers to reduce the frequency of seclusion, restraint, and forced medication.
- c. Continuously evaluate the utilization of restrictive procedures in state facilities and the effectiveness of reduction strategies and staff training.
- d. Evaluate community seclusion and restraint data to identify trends and training needs.
- e. Evaluate the ongoing effectiveness of the TOVA program and develop strategies to make TOVA more available to community programs.

2. *Implement an electronic health record in state facilities.*

Action Steps:

- a. Complete reviews of clinical work processes and develop requirements for an electronic health record.
- b. Seek funding for procurement of an electronic health record.
- c. Implement an electronic health record when funding is provided.

3. *Promote continuous quality improvement for the Department and behavioral health and developmental services system providers.*

Action Steps:

- a. Work with CSBs and stakeholders to design and implement a system wide continuous quality improvement process based on a consistent shared vision and with measurable and realizable implementation processes.
- b. Support CSB use of the COMPASS and ROSI instruments to perform meaningful self-assessments of current operations.

- c. Collaborate with CSBs to determine relevant CQI performance expectations and goals for inclusion in the community services performance contract and establish benchmarks for goals, determined by baseline performance, to convert those goals to expectations.
- d. Support state facility self-monitoring and continuous quality improvement plans and processes.

4. *Implement a comprehensive and consistent system-wide approach to public mental health utilization management.*

Action Steps:

- a. Work with the regional utilization management committees to establish more uniformity in utilization management protocols and practices for psychiatric inpatient services provided in state hospitals or purchased in local hospitals.

5. *Increase the effectiveness and efficiency of the Department's licensing program.*

Action Steps:

- a. Identify program efficiencies that would increase the time that the licensing specialists have available to perform inspections, issue licenses, and respond to complaints.
- b. Continue to make improvements in applicant training.

6. *Increase the effectiveness and efficiency of the human rights system.*

Action Steps:

- a. Identify program efficiencies that would increase the time that advocates have available for direct involvement with individuals receiving services.
- b. Determine whether the current human rights organizational structure could be changed to be more efficient and focused.
- c. Provide guidance and technical assistance on the regulations aimed at promoting treatment in the most integrated settings and enhancing consumer decision-making.

7. *Implement the Website CSB and State Facility Accountability Measures.*

Action Steps:

- a. Finalize specifications for each performance and outcome measure.
- b. Work with CSBs and state facilities to improve the quality of measurement data.
- c. Post measures on the Department's website.

VI. RESOURCE REQUIREMENTS

The following capacity development priorities respond to critical issues facing Virginia's behavioral health and developmental services system. Given the current budget constraints facing the Commonwealth, the Department recognizes that these requirements will require a multi-biennia investment, when resources are available.

Mental Health Services

Local inpatient purchase of service (LIPOS) and crisis stabilization services for individuals whose acute care needs can be met with community services rather than in a state hospital.

Crisis intervention training for law enforcement, jail diversion, mobile crisis teams, and restoration to competency services for individuals involved in the criminal justice system.

Community services capacity development to assist individuals in their recovery and address unmet service needs of individuals with mental health disorders on CSB waiting lists.

Suicide Prevention Across the Lifespan Plan for the Commonwealth of Virginia implementation.

Substance Abuse and Prevention Services

Community services capacity development to reduce the average wait time for services from 25 days to 10 days and address unmet service needs of individuals with substance use disorders on CSB wait lists.

Services and supports for individuals to decrease their involvement with the criminal justice system and disease relapse.

Evidenced-based prevention services.

Child and Family Services

Community services capacity development to divert children and adolescents from inappropriate care in congregate residential settings including juvenile detention centers, residential treatment centers, and state hospitals.

Part C infant and toddler intervention services capacity development to accommodate an eight percent increase in referrals of infants and toddlers and address Part C operational needs.

Developmental Services

Waiver capacity development of 400 additional slots each year to enable individuals with intellectual disability to live productive lives in community settings.

Enhanced waiver services plans for individuals who have significant behavioral and medical challenges to allow them to live in small group home or family home settings rather than in a training center or community ICF/MR. Services and policy changes include:

- A 25 percent increase in waiver rates for in-home support and small (4 or fewer beds) congregate residential services;
- Day support and employment services;
- Behavioral consultation assessment and monitoring and staff training in behavioral strategy implementation;
- Nurse monitoring of skilled nursing activities and overseeing individual stability/progress; and;
- Removal of penalties for providers who keep a residential bed vacant for consumers who may require hospital stays or for other valid situations.

Community services capacity development for individuals with intellectual disability who are not eligible for the ID waiver but need services that will allow them to remain in community settings.

Community services capacity development to ensure that individuals with developmental disabilities who have severe functional disabilities receive targeted case management services.

VII. CONCLUSION

This document responds to the requirement in §37.2-315 of the *Code of Virginia* for a six-year Comprehensive State Plan for mental health, mental retardation, and substance abuse services that identifies the services and supports needs of persons with mental health or substance use disorders or intellectual disability across the Commonwealth and proposes objectives and action steps to address these needs. The directions established in the *Comprehensive State Plan 2010-2016* would enable the Commonwealth to accelerate the transformation of the public services system to a more completely community-based system of care while preserving the important roles and service responsibilities of state hospitals and training centers in Virginia's publicly funded behavioral health and developmental services system.

The *Comprehensive State Plan 2010-2016* continues the direction set forth in previous *Comprehensive State Plans* to increase community options and individual choice; support opportunities for individual and family member education, training, and participation; promote collaborative activities with other agencies and services systems and private sector development; improve services oversight and accountability; advance quality improvement and care coordination; and address system administrative and infrastructure issues.

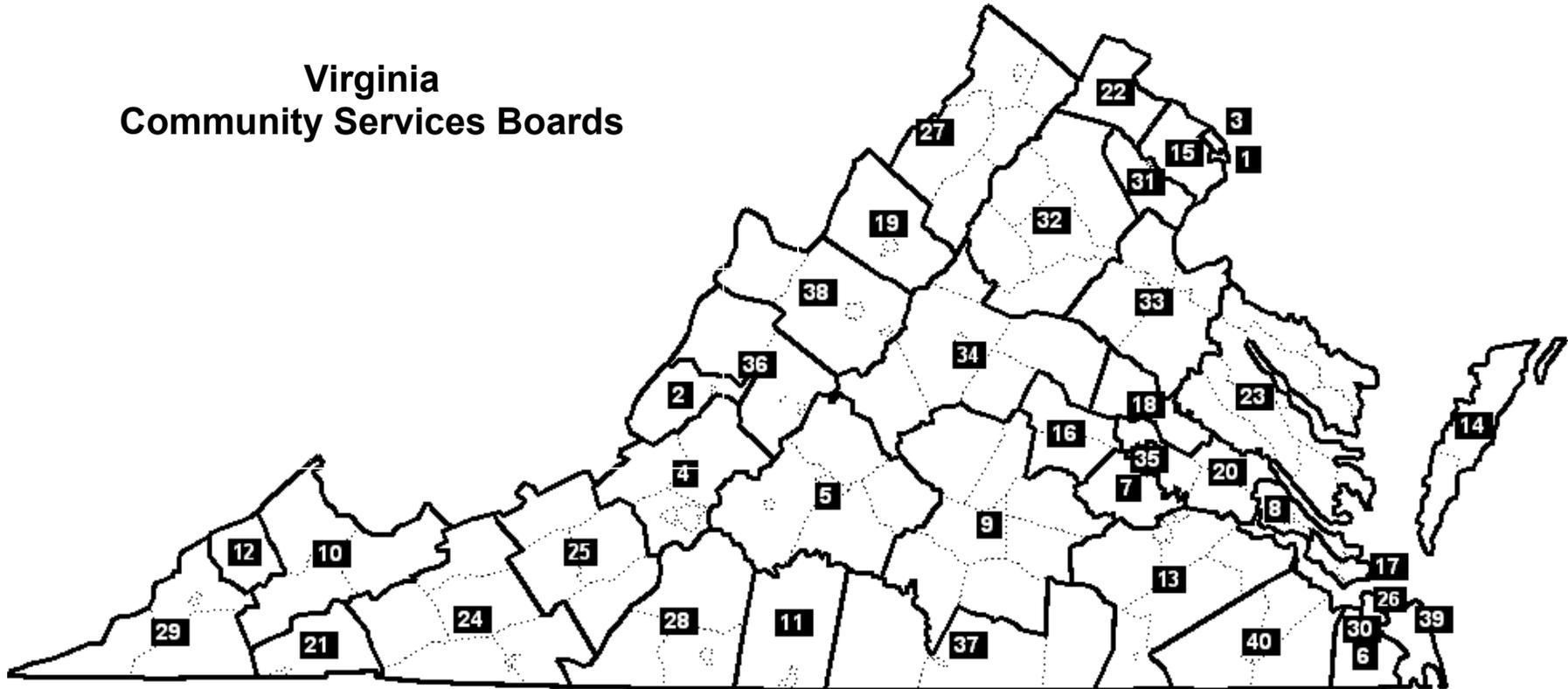
The policy agenda for the publicly funded behavioral health and developmental services system for the next biennium will focus on sustaining progress in implementing the vision of recovery and person-centered delivery of behavioral health and developmental services and investing in the services capacity and infrastructure needed to address issues facing the services system. Department priorities for the next biennium follow:

- Initiatives to increase access to transitional and permanent community housing for individuals with mental health or substance use disorders or intellectual or developmental disabilities. Affordable community housing is the area most lacking in the Commonwealth's array of services and supports and is the primary barrier to individuals who are transitioning from state facilities to the community.
- Initiatives to enhance the existing Medicaid waiver for individuals with intellectual disability to assure that they can receive "comparable services and supports" to those provided in an ICF/MR facility. This lack of comparability has increased family reliance on ICF/MR settings, which are more costly for the state and more restrictive and removed from individuals' family, friends, and their home communities.
- Initiatives to build a Virginia behavioral health – medical health partnership that promotes a "one person, one team, one plan" approach to serving individuals. The need for such an integrated system of services and supports is well documented, yet there is little interface between these two systems, except at the crisis or emergency level of each system.
- Initiatives to expand behavioral health and criminal justice partnerships and service delivery for individuals with mental health or substance use disorders who are at risk of involvement or are currently involved in the criminal justice system. Diversion and intervention efforts will result in reduced reliance on jail beds and state facility beds devoted to forensic treatment needs.
- Initiatives that advance a comprehensive system for health information exchange (HIE) across the behavioral health and developmental services system; with other providers that serve individuals with mental health or substance use disorders or intellectual disability; and with other state agencies that fund behavioral health or developmental services. A comprehensive HIE approach would produce improved efficiencies in service delivery, better service coordination, and enhanced capacity for performance measurement.

Appendix A

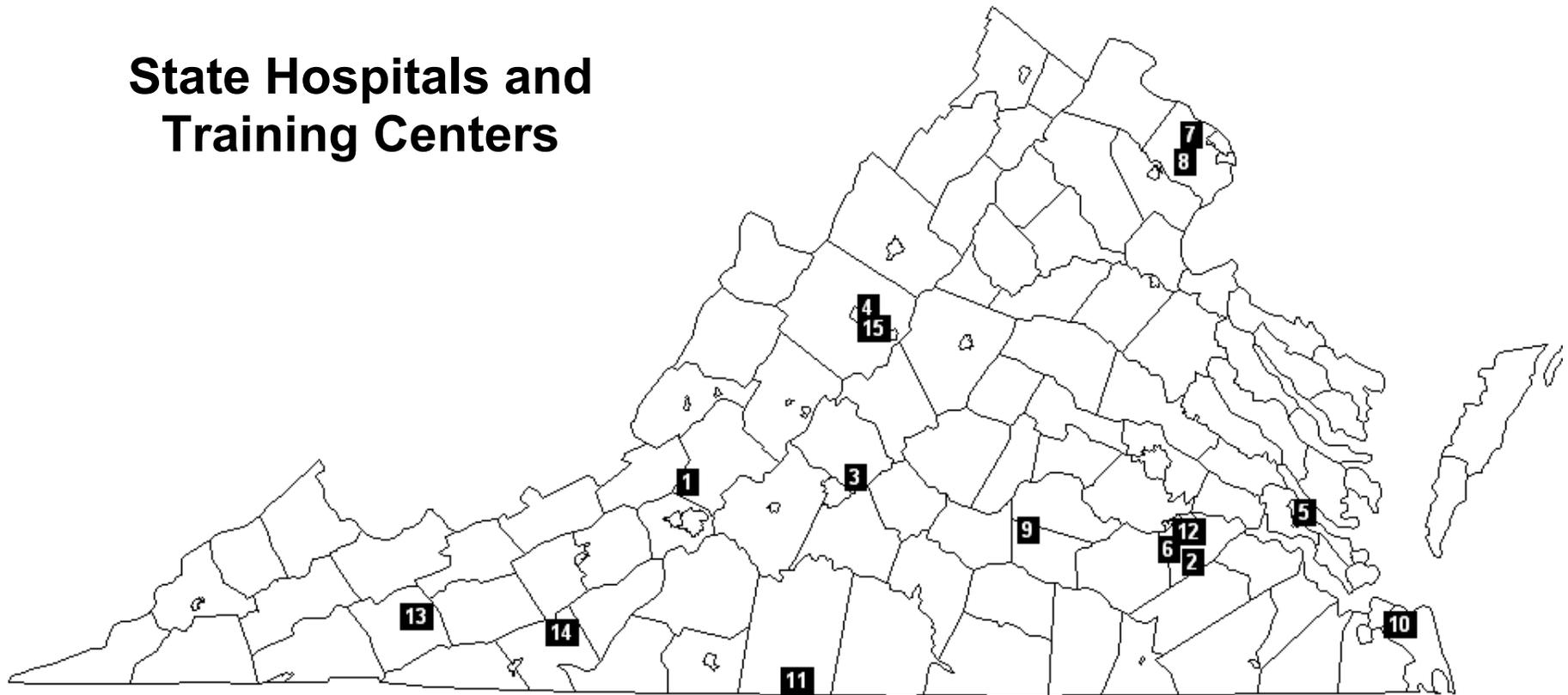
Maps of Community Services Board Service Areas and State Mental Health and Mental Retardation Facility Locations

Virginia Community Services Boards



- | | | | |
|------------------------|----------------------------|--------------------------------|-------------------------|
| 1 Alexandria | 11 Danville-Pittsylvania | 21 Highlands | 31 Prince William |
| 2 Alleghany Highlands | 12 Dickenson | 22 Loudoun | 32 Rappahannock-Rapidan |
| 3 Arlington | 13 District 19 | 23 Mid Peninsula-Northern Neck | 33 Rappahannock Area |
| 4 Blue Ridge | 14 Eastern Shore | 24 Mount Rogers | 34 Region Ten |
| 5 Central Virginia | 15 Fairfax-Falls Church | 25 New River Valley | 35 Richmond |
| 6 Chesapeake | 16 Goochland-Powhatan | 26 Norfolk | 36 Rockbridge Area |
| 7 Chesterfield | 17 Hampton-Newport News | 27 Northwestern | 37 Southside |
| 8 Colonial | 18 Hanover | 28 Piedmont | 38 Valley |
| 9 Crossroads | 19 Harrisonburg-Rockingham | 29 Planning District 1 | 39 Virginia Beach |
| 10 Cumberland Mountain | 20 Henrico Area | 30 Portsmouth | 40 Western Tidewater |

State Hospitals and Training Centers



	<u>Facility</u>	<u>Location</u>		<u>Facility</u>	<u>Location</u>
1	Catawba Hospital	Catawba	9	Piedmont Geriatric Hospital	Burkeville
2	Central State Hospital	Petersburg	9a	Behavioral Rehabilitation Center	Burkeville
3	Central VA Training Center	Madison Heights	10	Southeastern VA Training Center	Chesapeake
4	Commonwealth Ctr. for Children & Adolescents	Staunton	11	Southern VA Mental Health Institute	Danville
5	Eastern State Hospital	Williamsburg	12	Southside VA Training Center	Petersburg
6	Hiram W. Davis Medical Center	Petersburg	13	Southwestern VA MH Institute	Marion
7	Northern VA MH Institute	Falls Church	14	Southwestern VA Training Center	Hillsville
8	Northern VA Training Center	Fairfax	15	Western State Hospital	Staunton

Appendix B

Community Services Board Services Utilization and Condensed Core Services Taxonomy 7 Definitions

Community services boards (CSBs) offer varying combinations of core services, directly and through contracts with other organizations. All tables show actual data, derived from annual community services performance contract reports and community consumer submission extracts submitted by CSBs. Trends in numbers of consumers served between state FY 1988 and FY 2008, using the revised Taxonomy that created an additional category for services – Services Available Outside of a Program Area follow.

Table 1: Consumers Served by CSBs¹

FY	Mental Health Services		Developmental Services		Substance Abuse Services		Services Outside of a Program Area		Total	
	Und. ²	Dupl. ³	Und. ²	Dupl. ³	Und. ²	Dupl. ³	Und. ²	Dupl. ³	Und. ²	Dupl. ³
1988	110,082	161,033	14,354	22,828	57,363	80,138			181,799	263,999
1989	107,892	157,825	17,361	27,610	62,905	87,878			188,158	273,313
1990	NA	152,811	NA	30,198	NA	101,816			NA	284,825
1991	NA	161,536	NA	28,539	NA	103,288			NA	293,363
1992	NA	160,115	NA	27,525	NA	78,358			NA	265,998
1993	105,389	158,115	19,010	27,696	55,871	80,271			180,270	266,082
1994	107,131	168,208	19,742	28,680	59,471	87,166			186,344	284,054
1995	106,637	177,320	18,572	29,141	61,463	88,471			186,672	294,932
1996	116,344	174,126	19,169	30,006	64,309	90,750			199,822	294,882
1997	115,169	179,500	20,557	30,655	63,040	90,099			198,766	300,254
1998	119,438	185,647	20,983	32,509	68,559	96,556			208,980	314,712
1999	112,729	178,334	21,772	33,087	64,899	93,436			199,400	304,857
2000	118,210	180,783	22,036	26,086	61,361	88,358			201,607	295,227
2001	105,169	178,254	23,843	33,238	59,968	102,037			188,980	313,529
2002	107,351	176,735	24,903	33,933	59,895	91,904			192,149	302,572
2003	109,025	180,110	25,207	34,103	57,526	86,979			191,758	301,102
2004	109,175	181,396	23,925	35,038	53,854	78,008			186,954	294,442
2005	115,173	188,289	26,050	39,414	53,909	76,141			195,132	303,844
2006	118,732	195,794	26,893	36,004	52,416	73,633			198,041	305,431
2007	126,632	207,454	27,619	36,573	53,905	73,829			208,156	317,856
2008	101,796	161,046	25,053	36,141	43,657	57,219	73,123	85,896	243,629	340,302

NOTES:

- 1 Unduplicated counts of consumers were not collected by the Department every year. The NA notations show years in which this information was not collected.
- 2 Unduplicated (**Und.**) numbers of individuals are the total number of consumers receiving services in a program (mental health, mental retardation, or substance abuse services) area, regardless of how many services they received. If a person with a dual diagnosis (e.g., mental illness and substance use disorder) received services in both program areas, he or she would be counted twice.
- 3 Duplicated (**Dupl.**) numbers of individuals are the total numbers of consumers receiving each category or subcategory of core services. Thus, if a person received outpatient, rehabilitation, and supervised residential services, he would be counted three times, since he received three core services. These totals are added to calculate a total number of consumers served for each program area.

With the implementation in FY 2004 of the Community Consumer Submission (software that extracts individual consumer data from CSB information systems and transmits encrypted data to the Department) a totally unduplicated count of consumers at the CSB level across all program areas was available. The difference between the total unduplicated figure and the sum of the unduplicated number of consumers in each program area, shown in the preceding table, gives some indication of the numbers of individuals who may be receiving services in more than one program area. For example, in FY 2008, 53,304 individuals (243,629-190,125) received services in more than one program area.

Table 2: Unduplicated Count of Consumers Receiving CSB Services	
FY	Number of Individuals
2004	167,096
2005	174,183
2006	176,276
2007	185,287
2008	190,125

Table 3: FY 2008 Community Services Board Static Capacities by Core Service				
Services Available at Admission to a Program Area	Mental Health Services	Developmental Services	Substance Abuse Services	Grand TOTAL
Adult Psychiatric or Substance Abuse Inpatient	65.98		2.10	68.08
Community-Based SA Medical Detox Inpatient			9.75	9.75
Total Local Inpatient Services Beds	65.98		11.85	77.83
Day Treatment/Partial Hospitalization	1,746.15		203.70	1,949.85
Ambulatory Crisis Stabilization Services	21.25			21.25
Rehabilitation/Habilitation	2,393.00	2,095.04		4,488.04
Sheltered Employment	36.00	813.66		849.66
Group Supported Employment	21.00	682.00		703.00
Total Day Support Services Slots	4,217.40	3,590.70	203.70	8,011.80
Highly Intensive Residential Services	43.00	137.00	143.91	323.91
Residential Crisis Stabilization Services	111.52		5.00	116.52
Intensive Residential Services	187.56	792.50	491.90	1,471.96
Jail-Based Habilitation Services			439.00	439.00
Supervised Residential Services	851.50	466.71	97.28	1,415.49
Total Residential Services Beds	1,193.58	1,396.21	1,177.09	3,766.88

Note: Decimal fractions of beds and slots result from calculating these capacities for contracted services where a CSB purchases a number of bed days or days of service, which must be converted to numbers of beds or day support slots.

Table 4: FY 2008 Numbers of Individuals Receiving CSB Services by Core Service

Individuals Receiving Services Available Outside a Program Area					
1. Emergency Services	55,718	2.c. Assessment & Evaluation		17,347	
2. a. Motivational Treatment Services	2,324	2 d. Early Intervention Services		2,411	
2. b. Consumer Monitoring Services	7,039	3. Consumer Run Services		1,057	
Total Individuals Served				85,896 ¹	
Individuals Receiving Mental Health, Developmental, or Substance Abuse Services					
Services Available at Admission		MHS	DS	SA	TOTAL
4. Inpatient Services					
Local Inpatient Services	2,765		222	2,987	
Community Hospital-Based Detox			271	271	
TOTAL Local Inpatient Services	2,765		493	3,258	
5. Outpatient Services					
Outpatient Services	85,424	81	33,521	119,026	
Opioid Detoxification Services			243	243	
Opioid Treatment Services			2,032	2,032	
Assertive Community Treatment	1,708			1,708	
TOTAL Outpatient Services	87,132	81	35,796	123,009	
6. Case Management					
Case Management	50,151	17,590	10,023	77,764	
7. Day Support Services					
Day Treatment/Partial Hospitalization	3,789		1,462	5,251	
Ambulatory Crisis Stabilization	312			312	
Rehabilitation/Habilitation	5,655	2,675		8,330	
TOTAL Day Support Services	9,756	2,675	1,462	13,893	
8. Employment Services					
Sheltered Employment Services	61	892		953	
Supported Employment - Group Models	39	739		778	
Supported/Transitional Employment	1,206	1,132		2,338	
TOTAL Employment Services	1,306	2,763		4,069	
9. Residential Services					
Highly Intensive Residential Services	237	119	4,391	4,747	
Residential Crisis Stabilization Services	2,313		18	2,331	
Intensive Residential Services	224	864	2,809	3,897	
Jail-Based Habilitation Services			1,831	1,831	
Supervised Residential Services	1,448	496	267	2,211	
Supportive Residential Services	5,714	1,368	129	7,211	
TOTAL Residential Services	9,936	2,847	9,445	22,228	
11. Infant and Toddler Intervention Services					
11. Infant and Toddler Intervention Services		10,185		10,185	
TOTAL Individuals Receiving Services	161,046	36,141	57,226	254,413	
Unduplicated Individuals Receiving Services	101,796	25,053	43,657	243,629 ²	

¹ Total Individuals Receiving Services are not unduplicated numbers of individuals. Some individuals receive more than one type of service or services in more than one program area.

² Beginning in FY 2008, a fourth area, Services Available Outside of a Program Area was added, and 73,123 unduplicated individuals received only these services; this is included in the Totals column.

Table 5: FY 2008 Unduplicated Numbers of Individuals Receiving CSB Services by Age and Gender

Age	Mental Health Services			Developmental Services			Substance Abuse Services			Services Available Outside Program Area			Total
	Fem.	Male	Unk	Fem.	Male	Unk	Fem.	Male	Unk	Fem.	Male	Unk	
0-2	441	594	3	2,912	5,149	13	91	84	0	373	600	11	9,485
3-12	4,755	8,900	36	654	1,169	0	106	170	0	1,288	2,133	14	16,874
13-17	5,537	7,395	30	509	729	0	1,018	2,690	5	3,838	4,606	24	20,907
18-22	3,209	3,520	13	843	1,371	2	1,688	3,964	6	3,717	5,238	21	17,836
23-59	32,005	27,156	111	4,849	5,751	11	11,637	21,453	66	21,230	24,747	155	112,184
60-64	2,196	1,328	2	237	238	0	106	331	3	872	771	4	5,013
65-74	1,963	1,061	5	240	218	0	32	139	1	896	674	8	4,531
75+	1,035	434	5	66	69	0	5	26	1	922	573	10	2,808
Unknown	21	17	24	3	11	9	7	21	7	131	127	140	487
Total	51,162	50,405	229	10,313	14,705	35	14,690	28,878	89	33,267	39,469	387	190,125

Table 6: FY 2008 Numbers of Individuals Served Receiving Mental Health, Developmental, or Substance Abuse Services by Race and Gender

Race	Age									
	0-2	3-12	13-17	18-22	23-59	60-64	65-74	75+	Unknown	Total
Alaska Native	5	17	10	6	56	6	1	2	0	103
American Indian	14	37	51	37	336	11	4	1	0	491
American Indian or Alaska Native AND Black or African American	3	11	8	9	58	1	0	1	0	91
American Indian or Alaska Native AND White	3	16	26	14	125	3	3	0	0	190
Asian	284	116	246	266	1,300	59	45	18	5	2,339
Asian AND White	50	36	42	38	96	1	3	0	0	266
Black or African American AND White	228	417	266	138	508	8	14	10	0	1,589
Black or African American	1,978	4,276	5,810	4,476	29,430	1,138	1,085	574	40	48,807
Native Hawaiian or Other Pacific Islander	10	11	17	20	85	7	3	2	0	155
Other Multi-Race	249	191	176	99	295	1	4	5	2	1,022
Other	842	1,119	1,421	1,005	4,874	112	101	62	12	9,540
White	5,277	9,281	11,668	10,820	68,623	3,392	2,955	1,810	115	113,941
Unknown/ Not Collected	542	1,346	1,116	908	6,398	274	313	323	313	11,583
Total	9,485	16,874	20,907	17,836	112,184	5,013	4,531	2,808	487	190,125

CONDENSED CORE SERVICES TAXONOMY 7.2 SERVICE DEFINITIONS

SERVICES AVAILABLE OUTSIDE OF A PROGRAM AREA are provided to individuals without an admission to a program area (mental health, mental retardation, or substance abuse services); the CSB only opens a case on an individual and provides any of the following services.

EMERGENCY SERVICES are unscheduled and sometimes scheduled crisis intervention, stabilization, and referral assistance provided over the telephone or face-to-face, if indicated, 24 hours per day and seven days per week, to people seeking such services for themselves or others. Services also may include walk-ins, home visits, and jail interventions. Emergency Services include: preadmission screening associated with admission to a state hospital or training center or other activities associated with the judicial admission process; Critical Incident Stress Debriefing (CISD) services; and Medicaid Crisis Intervention and Short-Term Crisis Counseling and Mental Retardation Home and Community-Based (MRHCB) Waiver Crisis Stabilization and Personal Emergency Response System Services.

LIMITED SERVICES consist of the following activities that typically are short term, less than 30 days or four to eight sessions in duration, infrequent, or low-intensity services.

- **Motivational Treatment Services** are generally provided to individuals on an hourly basis, once per week, through individual or group counseling in a clinic. These services are structured to help consumers resolve their ambivalence about changing problematic behaviors by using a repertoire of data-gathering and feedback techniques. Motivational Treatment Services are not a part of another service; they stand alone. Their singular focus on increasing the consumer's motivation to change problematic behaviors, rather than on changing the behavior itself, distinguishes Motivational Treatment Services from Outpatient Services. A course of motivational treatment may involve a single session, but more typically four or eight sessions; and it may be repeated, if necessary, as long as repetition is clinically indicated. Prior to placement in motivational treatment, the individual's level of readiness for change is usually assessed, based on clinical judgment, typically supported by standardized instruments. An assessment may also follow a course of motivational treatment to ascertain any changes in the individual's readiness for change.
- **Consumer Monitoring Services** are provided to individuals who have not been admitted to a program area but have had cases opened by the CSB. For example, this includes individuals with opened cases whom the CSB places on waiting lists for other services. These individuals receive no interventions or face-to-face contact, but they receive Consumer Monitoring Services, which typically consist of service coordination or intermittent emergency contacts. Other examples of Consumer Monitoring Services include individuals who receive only outreach services, such as outreach contacts through Projects for Assistance in Transition from Homelessness (PATH), individuals in waiting list groups, and outreach by peers to individuals who are in need of services or have been referred for services.
- **Assessment and Evaluation Services** include court-ordered or psychological evaluations; initial assessments for screening, triage, and referral for individuals who probably will not continue in services; and initial evaluations or assessments that result in placement on waiting lists without receiving other services. An abbreviated individualized services plan and consumer record may be required.
- **Early Intervention Services** are intended to improve functioning or change behavior in those individuals identified as beginning to experience problems, symptoms, or behaviors that, without intervention, are likely to result in the need for treatment. Activities should not be included here that are really Outpatient Services to avoid record keeping or licensing requirements, since this exposes the CSB to increased liability and is not clinically appropriate. Services are generally targeted to identified individuals or groups. Early Intervention Services include: case consultation, groups for adolescents who have been suspended for use of alcohol or tobacco, and programs for children or adults exhibiting behavior changes following loss such as divorce, death of a loved one, and job loss. School-Based Interventions should be included in Prevention, Early Intervention, or Outpatient Services, as appropriate.

CONSUMER-RUN SERVICES are self-help programs designed, governed, and led by and for people in recovery. Consumer-Run Services employ peers as staff and volunteers and are often open on weekends and evenings beyond the usual hours that traditional services operate. Consumer-Run Services are usually open door or drop in, with no required applications, waiting times, or appointments. Services include networking, advocacy, and mutual support groups; drop-in centers; supported housing; hospital liaison; recreation and social activities; arts and crafts and exercise groups; peer counseling, mentorship, and one-on-one consultations; information and referrals; and knowledge and skill-building classes such as employment training, computer training, and other seminars and workshops. Consumer-run centers also may offer the use of washers and dryers, showers, telephones for business calls, mailboxes, and lending libraries.

SERVICES AVAILABLE AT ADMISSION TO A PROGRAM AREA are provided after an individual is admitted to a program area (mental health, mental retardation, or substance abuse services).

LOCAL INPATIENT SERVICES deliver services on a 24-hour-per-day basis in a hospital setting.

- **Acute Psychiatric or Substance Abuse Services** provide intensive short-term psychiatric treatment in state hospitals and intensive short-term psychiatric treatment, including services to persons with intellectual disability, or substance abuse treatment, except detoxification, in local hospitals. Services include intensive stabilization, evaluation, psychotropic medications, psychiatric and psychological services, and other supportive therapies provided in a highly structured and supervised setting.
- **Community-Based Substance Abuse Medical Detoxification Inpatient Services** use medication under the supervision of medical personnel in local hospitals to systematically eliminate or reduce the effects of alcohol or other drugs in the body.

OUTPATIENT SERVICES provide clinical treatment services, generally in sessions of less than three consecutive hours, to individuals and groups.

- **Outpatient Services** are generally provided to individuals on an hourly schedule, on an individual, group, or family basis, and usually in a clinic or similar facility or in another location. Outpatient Services may include diagnosis and evaluation, screening and intake, counseling, psychotherapy, behavior management, psychological testing and assessment, laboratory and other ancillary services, medical services, and medication services. Medical services include psychiatric, medical, psychiatric nursing, and medical nursing services by licensed psychiatrists, physicians, and nurses and the cost of medications purchased by the CSB and provided to individuals. Medication services include prescribing and dispensing medications, medication management, and pharmacy services. Medication-only visits are provided to individuals who receive only medication monitoring on a periodic (monthly or quarterly) basis from a psychiatrist, other MD, psychiatric nurse, or physician's assistant. Outpatient Services also include:
 - Intensive Substance Abuse Outpatient Services that are provided generally in a concentrated manner over a four to 12 week period for individuals who require intensive outpatient stabilization, such as people with severe psychoactive substance use disorders. Usually, these services include multiple group therapy sessions during the week plus individual and family therapy, consumer monitoring, and case management.
 - Intensive In-home Services that are time-limited, usually between two and six months, family preservation interventions for children and adolescents with or at risk of serious emotional disturbance, including individuals who have a co-occurring intellectual disability. In-home services are provided typically but not solely in the residence of an individual who is at risk of being moved into or who is being transitioned to home from an out-of-home placement. These services provide crisis treatment; individual and family counseling; life, parenting, and communication skills; case management activities and coordination with other required services; and 24 hour per day emergency response.
 - Medicaid MRHCB Waiver Skilled Nursing Services and Therapeutic Consultation Services.
- **Medication Assisted Treatment** combines outpatient treatment with administering or dispensing synthetic narcotics, such as methadone or buprenorphine (suboxone), approved by the federal Food and Drug Administration for the purpose of replacing the use of and reducing the craving for opioid substances, such as heroin or other narcotic drugs.
- **Assertive Community Treatment** consist of two modalities, Intensive Community Treatment (ICT) and Programs of Assertive Community Treatment (PACT).
 - Intensive Community Treatment is provided by a self-contained, interdisciplinary team of at least five full-time equivalent clinical staff, a program assistant, and a psychiatrist that (1) assumes responsibility for directly providing needed treatment, rehabilitation, and support services to identified individuals with severe and persistent mental illnesses; (2) minimally refers individuals to outside service providers; (3) provides services on a long-term care basis with continuity of caregivers over time; (4) delivers 75 percent or more of the services outside of the program's offices; and (5) emphasizes outreach, relationship building, and individualization of services.
 - Program of Assertive Community Treatment is provided by a self-contained, inter-disciplinary team of at least 10 full-time equivalent clinical staff, a program assistant, and a psychiatrist that meets the five criteria contained in the definition of *Intensive Community Treatment*.

Individuals served by either modality have severe symptoms and impairments that are not effectively remedied by available treatments or, because of reasons related to their mental illnesses, resist or avoid involvement with mental health services. This could include individuals with severe and persistent mental illnesses who have a co-occurring intellectual disability.

Assertive Community Treatment provides an array of services on a 24-hour per day basis to individuals in their natural environments to help them achieve and maintain effective levels of functioning and participation in their communities. Services may include case management; supportive counseling; symptom management; medication administration and compliance monitoring; crisis intervention; developing individualized community supports; psychiatric assessment and other services; and teaching daily living, life, social, and communication skills.

CASE MANAGEMENT SERVICES assist individuals and their family members to access needed services that are responsive to the person's individual needs. Services include: identifying and reaching out to individuals in need of services, assessing needs and planning services, linking the individual to services and supports, assisting the person directly to locate, develop, or obtain needed services and resources, coordinating services with other providers, enhancing community integration, making collateral contacts, monitoring service delivery, and advocating for people in response to their changing needs.

DAY SUPPORT SERVICES provide structured programs of treatment, activity, or training services, generally in clusters of two or more continuous hours per day, to groups or individuals in non-residential settings.

- **Day Treatment or Partial Hospitalization** is a treatment program that includes the major diagnostic, medical, psychiatric, psychosocial, and prevocational and educational treatment modalities designed for adults with serious mental health, substance use, or co-occurring disorders who require coordinated, intensive, comprehensive, and multidisciplinary treatment that is not provided in Outpatient Services. This subcategory also includes Therapeutic Day Treatment for Children and Adolescents, a treatment program that serves children and adolescents (birth through age 17) with serious emotional disturbances or substance use or co-occurring disorders or children (birth through age 7) at risk of serious emotional disturbance in order to combine psychotherapeutic interventions with education and mental health or substance abuse treatment. Services include: evaluation, medication education and management, opportunities to learn and use daily living skills and to enhance social and interpersonal skills, and individual, group, and family counseling.
- **Ambulatory Crisis Stabilization Services** provide direct care and treatment to non-hospitalized individuals experiencing an acute crisis related to mental health, substance use, or co-occurring disorders that may jeopardize their current community living situation. The goals are to avert hospitalization or re-hospitalization, provide normative environments with a high assurance of safety and security for crisis intervention, stabilize individuals in crisis, and mobilize the resources of the community support system, family members, and others for ongoing rehabilitation and recovery. Ambulatory crisis stabilization services may be provided in an individual's home or in a community-based program licensed by the Department. These services are planned for and provide services for up to 23 hours per day. Services that are integral to and provided in ambulatory crisis stabilization programs, such as Outpatient and Case Management Services, are included in the day support hours in ambulatory crisis stabilization programs.
- **Rehabilitation or Habilitation** consists of training services in the following modalities.
 - Psychosocial Rehabilitation provides assessment, medication education, opportunities to learn and use independent living skills and to enhance social and interpersonal skills, family support and education, vocational and educational opportunities, and advocacy in a supportive community environment focusing on normalization. It emphasizes strengthening the person's abilities to deal with everyday life rather than focusing on treating pathological conditions.
 - Habilitation provides planned combinations of individualized activities, supports, training, supervision, and transportation to individuals with an intellectual disability to improve their condition or maintain an optimal level of functioning. Specific components of this service develop or enhance the following skills: self-care and hygiene, eating, toileting, task learning, community resource utilization, environmental and behavioral skills, medication management, and transportation. Habilitation includes Medicaid MRHCB Waiver Day Support (Center-Based and Non-Center- Based) and Prevocational Services.

EMPLOYMENT SERVICES provide work and support services to groups or individuals in non-residential settings.

- **Sheltered Employment** programs provide work in a non-integrated setting that is compensated in accordance with the Fair Labor Standards Act for individuals with disabilities who are not ready, are unable, or choose not to enter into competitive employment in an integrated setting. This service includes the development of social, personal, and work-related skills based on an individualized consumer service plan.
- **Group Supported Employment** provides work to small groups of three to eight individuals at job sites in the community or at dispersed sites within an integrated setting. Integrated setting means opportunities exist for individuals receiving services in the immediate work setting to have regular contact with non-disabled persons who are not providing support services. The employer or the vendor of supported employment services employs the individuals. An employment specialist, who may be

employed by the employer or the vendor, provides ongoing support services. Support services are provided in accordance with the individual's written rehabilitation plan. Models include mobile and stationary crews, enclaves, and small businesses. Group Supported Employment includes Medicaid MRHCB Waiver Supported Employment - Group Model.

- **Individual Supported Employment** provides paid employment to an individual who is placed in an integrated work setting in the community. The employer employs the individual. On-going support services that may include transportation, job-site training, counseling, advocacy, and any other supports needed to achieve and to maintain the individual in the supported placement are provided by an employment specialist, co-workers of the supported employee, or other qualified individuals. Support services are provided in accordance with the consumer's individual written rehabilitation plan. Individual Supported Employment includes Medicaid MR HCB Waiver Supported Employment - Individual Model.

RESIDENTIAL SERVICES provide overnight care with an intensive treatment or training program in a setting other than a hospital or training center, overnight care with supervised living, or other supportive residential services.

- **Highly Intensive Residential Services** provide overnight care with intensive treatment or training services. These services include: mental health residential treatment centers such as short term intermediate care, residential alternatives to hospitalization, and residential services for individuals with dual diagnoses (e.g., mental health and substance use disorders, intellectual disability and mental health disorders) where intensive treatment rather than just supervision occurs; and Intermediate Care Facilities for persons with Mental Retardation (ICF/MR) that deliver active habilitative and training services in a community setting; and substance abuse detoxification services that provide specialized facilities with physician services available when required to systematically reduce or eliminate the effects of alcohol or other drugs in the body and return a person to a drug-free state and that normally last up to seven days. This subcategory also includes Community Geropsychiatric Residential Services that provide 24-hour non-acute care with treatment in a setting that offers less intensive services than a hospital, but more intensive mental health services than a nursing home or group home. Individuals with mental health disorders, behavioral problems, and concomitant health problems, usually age 65 and older, who are appropriately treated in a geriatric setting, receive intense supervision, psychiatric care, behavioral treatment, planning, nursing, and other health-related services.
- **Residential Crisis Stabilization Services** provide overnight direct care and treatment to non-hospitalized individuals experiencing an acute crisis related to mental health, substance use, or co-occurring disorders that may jeopardize their current community living situation. The goals are to avert hospitalization or re-hospitalization, provide normative environments with a high assurance of safety and security for crisis intervention; stabilize individuals in crisis, and mobilize the resources of the community support system, family members, and others for ongoing rehabilitation and recovery. Residential crisis stabilization services are provided in a community-based program licensed by the Department. These services are planned for and provide overnight care; the service unit is a bed day. Services that are integral to and provided in residential crisis stabilization programs, such as Outpatient and Case Management Services, are included in the bed day.
- **Intensive Residential Services** provide overnight care with treatment or training that is less intense than highly intensive residential services. It includes the following services and Medicaid MRHCB Waiver Congregate Residential Support Services.
 - Primary Care offers substance abuse rehabilitation services that normally last no more than 30 days. Services include intensive stabilization, daily group therapy and psycho-education, consumer monitoring, case management, individual and family therapy, and discharge planning.
 - Intermediate Rehabilitation is a substance abuse psychosocial therapeutic milieu with an expected length of stay up to 90 days. Services include supportive group therapy, psycho-education, consumer monitoring, case management, individual and family therapy, employment services, and community preparation services.
 - Long-Term Habilitation is a substance abuse psychosocial therapeutic milieu with an expected length of stay of 90 or more days that provides a highly structured environment where residents, under staff supervision, are responsible for daily operations of the facility. Services include intensive daily group and individual therapy, family counseling, and psycho-education. Daily living skills and employment opportunities are integral components of the treatment program. This also includes jail-based habilitation services, a substance abuse psychosocial therapeutic community, where residents, under staff and correctional supervision, are responsible for the daily operations of the program. Services include intensive daily group counseling, individual therapy, psycho-educational services, 12 step meetings, discharge planning, and pre-employment and community preparation services. Daily living skills in conjunction with the therapeutic milieu structure are an integral component of the treatment program. Normally, inmates served by this program are housed separately within the jail.

- Group Homes or Halfway Houses provide identified beds and 24 hour supervision for individuals who require training and assistance in basic daily living functions such as meal preparation, personal hygiene, transportation, recreation, laundry, and budgeting. The expected length of stay normally exceeds 30 days.
- **Supervised Residential Services** offer overnight care with supervision and services. This subcategory includes the following services and Medicaid MRHCB Waiver Congregate Residential Support Services.
 - Supervised Apartments are directly operated or contracted, licensed or unlicensed, residential programs that place and provide services to individuals in apartments or other residential settings. The expected length of stay normally exceeds 30 days.
 - Domiciliary Care provides food, shelter, and assistance in routine daily living but not treatment or training in facilities of five or more beds. This is primarily a long-term setting with an expected length of stay exceeding 30 days. Domiciliary care is less intensive than a group home or supervised apartment; an example would be a licensed assisted living facility (ALF) funded or contracted by a CSB.
 - Emergency Shelter or Residential Respite programs provide identified beds, supported or controlled by a CSB, in a variety of settings reserved for short term stays, usually several days to no more than 21 consecutive days.
 - Sponsored Placements place people in residential settings and provide substantial amounts of financial, programmatic, or service support. Examples include individualized therapeutic homes, specialized foster care, family sponsor homes, and residential services contracts for specified individuals. The focus is on individual consumer residential placements with expected lengths of stay exceeding 30 days rather than on organizations with structured staff support and set numbers of beds.
- **Supportive Residential Services** are unstructured services that support individuals in their own housing arrangements. These services normally do not involve overnight care delivered by a program. However, due to the flexible nature of these services, overnight care may be provided on an hourly basis. It includes the following services and Medicaid MRHCB Waiver Supported Living/In-Home Supports, Respite (Agency and Consumer-Directed) Services, Companion Services (Agency and Consumer-Directed), and Personal Assistance Services (Agency and Consumer-Directed).
 - In-Home Respite provides care in the homes of people with mental disabilities or in a setting other than that described in residential respite services above. This care may last from several hours to several days and allows the family member care giver to be absent from the home.
 - Supported Living Arrangements are residential alternatives that are not included in other types of residential services. These alternatives assist people to locate or maintain residential settings where access to beds is not controlled by a CSB and may provide program staff, follow along, or assistance to these individuals. The focus may be on assisting an individual to maintain an independent residential arrangement. Examples include homemaker services, public-private partnerships, and non-CSB subsidized apartments (e.g., HUD certificates).
 - Housing Subsidies provide cash payments only, with no services or staff support, to enable consumers to live in housing that would otherwise not be accessible to them. These cash subsidies may be used for rent, utility payments, deposits, furniture, and other similar payments required to initiate or maintain housing arrangements for consumers. This is used only for specific allocations of funds from the Department that are earmarked for housing subsidies. Numbers of consumers and expense information should be included in supportive residential services in the contract and reports. Information associated with other housing subsidies should be included in the services of which they are a part.

PREVENTION SERVICES are designed to prevent mental health or substance use disorders or intellectual disability. School-Based Interventions should be included in Prevention, Early Intervention, or Outpatient Services, as appropriate. Prevention Services involve people, families, communities, and systems working together to promote their strengths and potentials. Prevention is aimed at substantially reducing the incidence of mental health and substance use disorders and intellectual disability. Emphasis is on enhancement of protective factors and reduction of risk factors. The following six activities comprise prevention services. Information about these activities for substance abuse Prevention Services will be collected and reported separately from the performance contract or CCS through the KIT Prevention System.

- Information Dissemination provides awareness and knowledge of the nature and extent of mental health and substance use disorders and intellectual disability. It also provides awareness and knowledge of available prevention programs and services. Examples of information dissemination include media campaigns, public service announcements, informational brochures and materials, community awareness events, and participation on radio or TV talk shows. Information dissemination is characterized by one-way communication from the source to the audience.

- Prevention Education aims to affect critical life and social skills, including general competency building, specific coping skills training, support system interventions, strengthening caregivers, and decision-making skills training. Prevention education is characterized by two-way communication with close interaction between the facilitator or educator and the program participants. Examples of prevention education include children of alcoholics groups and parenting classes.
- Alternatives provide for the participation of specific populations in activities that are constructive, promote healthy choices, and provide opportunities for skill building. Examples of prevention alternatives include leadership development; community service projects; alcohol, tobacco, and other drug free activities; and youth centers.
- Problem Identification and Referral aims at the identification of those individuals who are most at risk of developing problematic behaviors in order to assess if their behaviors can be changed through prevention education. Examples include student and employee assistance programs.
- Community-based Process aims at enhancing the ability of the community to provide prevention and treatment services more effectively. Activities include organizing, planning, enhancing efficiency and effectiveness of service implementation, interagency collaboration, coalition building, and networking. Examples include community and volunteer training, multi-agency coordination and collaboration, accessing services and funding, and community team-building.
- Environmental prevention activities establish or change written and unwritten community standards, codes, and attitudes, thereby influencing the development of healthy living conditions. Examples include modifying advertising practices and promoting the establishment and review of alcohol, tobacco, and other drug use policies.

INFANT AND TODDLER INTERVENTION SERVICES provides family-centered, community-based early intervention services designed to meet the developmental needs of infants and toddlers and the needs of their families as these needs relate to enhancing the child's development. These services prevent or reduce the potential for developmental delays in infants and toddlers and increase the capacity of families to meet the needs of their at-risk infants and toddlers. Infant and toddler intervention is delivered through a comprehensive, coordinated, interagency, and multi-disciplinary services system. The identified individual receiving services is the infant or toddler. Infant and Toddler Intervention includes:

- | | |
|--|---------------------------------|
| a. assistive technology, | j. special instruction, |
| b. audiology, | j. psychological services, |
| c. family training, counseling, and home visits, | k. service coordination, |
| d. health services, | l. social work services, |
| e. nursing services, | m. speech-language pathology, |
| f. nutrition services, | n. transportation services, and |
| g. occupational therapy, | o. vision services. |
| h. physical therapy, | |
| i. medical services (for diagnostic or evaluation purposes only) | |

STATIC CAPACITIES

Number of Beds: the total number of beds for which the facility or program is licensed and staffed or the number of beds contracted for during the contract period.

Number of Slots: the maximum number of distinct individuals who could be served during a day or a half-day session in most day support programs. It is the number of slots for which the program or service is staffed.

Appendix C
State Hospital and Training Center Utilization

Individuals Services in State Hospitals, Average Daily Census, Admissions, and Separations -- FY 2009

MH Facility	# Individuals Served	Average Daily Census	# Admissions	# Separations
Eastern State Hospital	589	369	206	251
Western State Hospital	806	227	667	678
Central State Hospital	694	249	490	507
Southwestern VA MHI	1,042	152	1,071	1,104
Northern VA MHI	920	119	1,015	1,028
Southern VA MHI	430	70	489	484
Commonwealth Center for Children and Adolescents	508	30	605	627
Catawba Hospital	312	92	271	283
Piedmont Geriatric Hospital	190	112	70	80
Total	5,306*	1,419	4,884	5,042

Individuals Served by Hiram Davis Medical Center, ADC, Admissions, and Separations -- FY2009

	# Individuals Served	Average Daily Census	# Admissions	# Separations
Hiram Davis Medical Center	122	46	94	96

Individuals Served by Virginia Center for Behavioral Rehabilitation, ADC, Admissions, & Separations -- FY2009

	# Individuals Served	Average Daily Census	# Admissions	# Separations
VCBR	152	114	61	3

Individuals Served in Training Centers, ADC, Admissions, and Separations -- FY2009

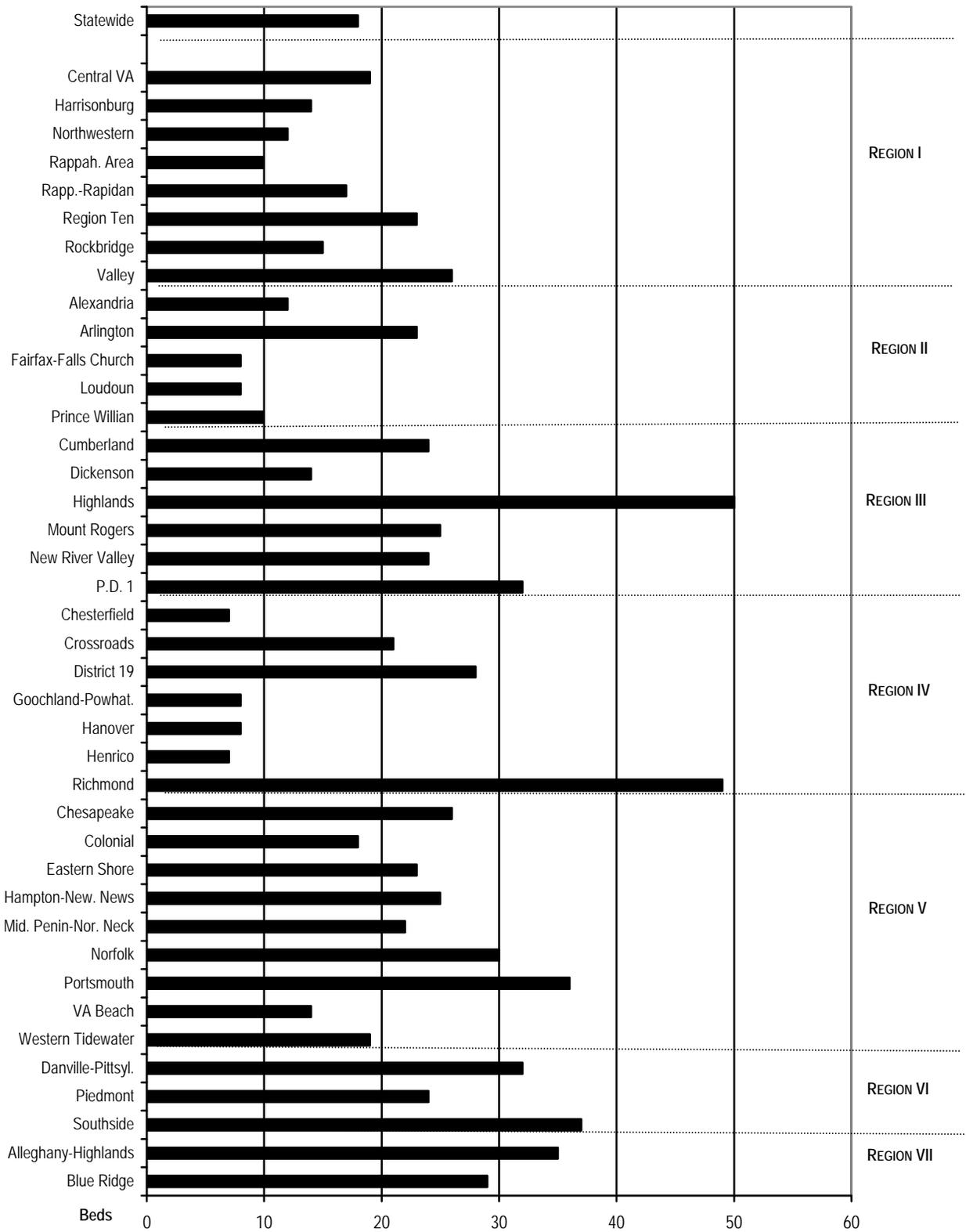
Training Center	# Individuals Served	Average Daily Census	# Admissions	# Separations
Central Virginia TC	474	450	13	35
Northern Virginia TC	186	171	44	44
Southeastern Virginia TC	181	164	10	29
Southside Virginia TC	330	293	23	44
Southwestern Virginia TC	217	199	21	27
Total	1,386*	1,276	111	179

Source: DMHMRSAS AVATAR Information System

*Unduplicated count (unique individuals) by state facility type.

TOTAL UNDUPLICATED COUNT OF INDIVIDUALS SERVED ACROSS ALL STATE FACILITIES: 6,866

**Total State Hospital Bed Utilization by CSB and Region FY 2009
Beds Per 100,000 Population**



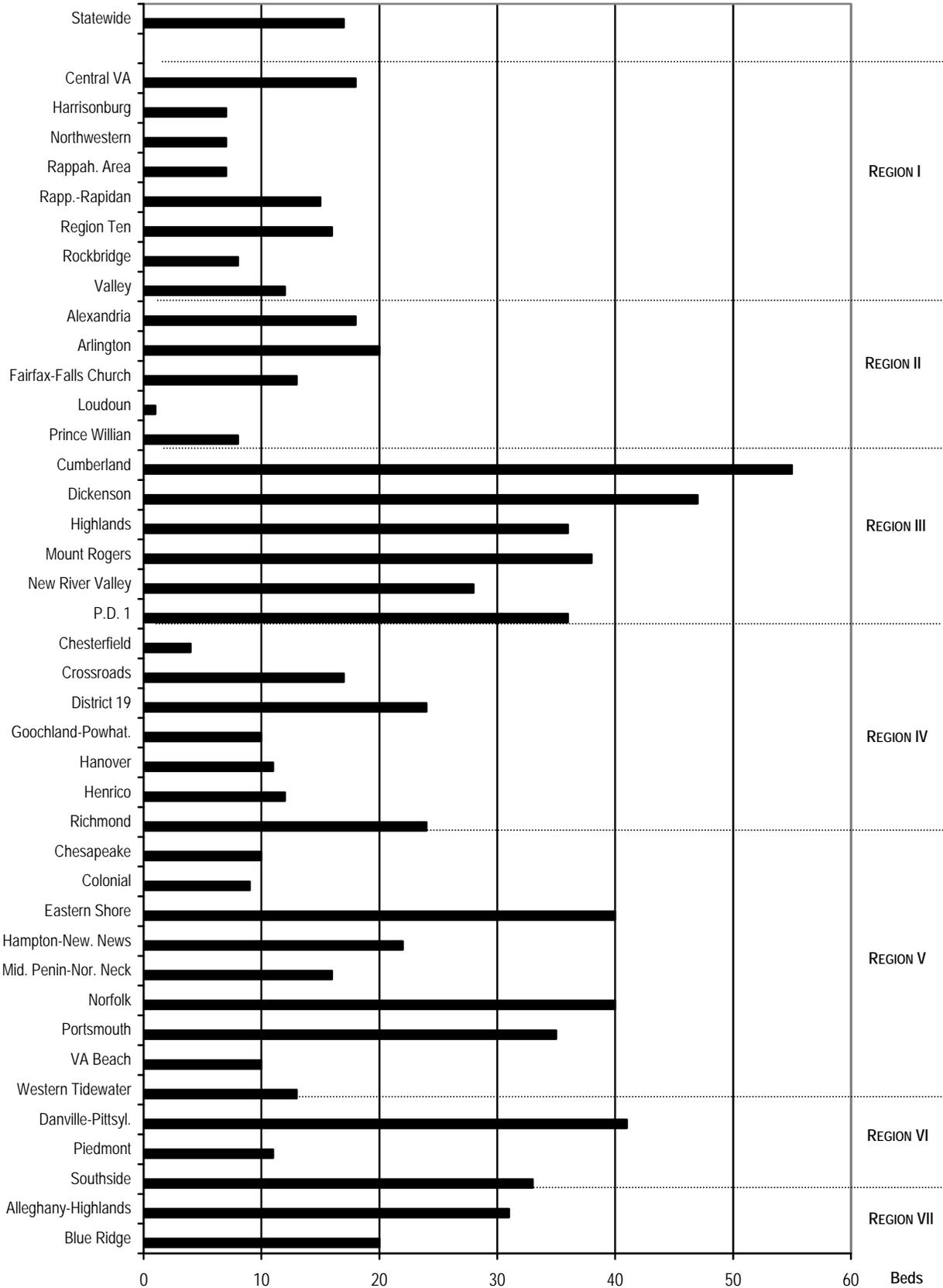
Total State Hospital Facility Utilization by CSB and Region -- FY2009

	CSB	All Bed Days FY 2009	CSB Population	FY 2009 Bed Days Per 100 K Population	FY 2009 Beds Per 100 K Population	Beds Used
I	Central Virginia	16,310	240,191	6,790	18.55	44.56
	Harrisonburg-Rockingham	5,973	118,909	5,023	13.72	16.32
	Northwestern	9,549	213,596	4,471	12.21	26.09
	Rappahannock Area	11,854	314,529	3,769	10.30	32.39
	Rappahannock-Rapidan	10,200	165,879	6,149	16.80	27.87
	Region Ten	18,816	222,265	8,466	23.13	51.41
	Rockbridge Area	2,217	39,875	5,560	15.19	6.06
	Valley	10,925	116,239	9,399	25.68	29.85
II	Alexandria	6,187	136,601	4,529	12.37	16.90
	Arlington	16,846	203,126	8,293	22.66	46.03
	Fairfax-Falls Church	31,517	1,044,086	3,019	8.25	86.11
	Loudoun County	8,335	278,909	2,988	8.17	22.77
	Prince William County	14,725	423,485	3,477	9.50	40.23
III	Cumberland Mountain	8,379	96,605	8,673	23.70	22.89
	Dickenson County	829	16,319	5,080	13.88	2.27
	Highlands	12,932	70,300	18,395	50.26	35.33
	Mount Rogers	10,987	119,187	9,218	25.19	30.02
	New River Valley	15,041	170,018	8,847	24.17	41.10
	Planning District 1	11,131	94,017	11,839	32.35	30.41
IV	Chesterfield	8,081	298,850	2,704	7.39	22.08
	Crossroads	7,658	101,015	7,581	20.71	20.92
	District 19	17,683	170,618	10,364	28.32	48.31
	Goochland-Powhatan	1,398	47,852	2,922	7.98	3.82
	Hanover County	2,891	96,992	2,981	8.14	7.90
	Henrico Area	8,055	313,834	2,567	7.01	22.01
	Richmond BHA	34,943	194,974	17,922	48.97	95.47
V	Chesapeake	20,266	215,906	9,386	25.65	55.37
	Colonial	10,138	150,589	6,732	18.39	27.70
	Eastern Shore	4,484	52,185	8,593	23.48	12.25
	Hampton-Newport News	29,565	325,425	9,085	24.82	80.78
	Middle Pen.-Northern Neck	11,185	140,221	7,977	21.79	30.56
	Norfolk	26,304	235,915	11,150	30.46	71.87
	Portsmouth	12,791	97,851	13,072	35.72	34.95
	Virginia Beach	22,648	430,349	5,263	14.38	61.88
	Western Tidewater	9,665	142,707	6,773	18.50	26.41
VI	Danville-Pittsylvania	12,436	106,306	11,698	31.96	33.98
	Piedmont	12,349	139,303	8,865	24.22	33.74
	Southside	11,556	86,323	13,387	36.58	31.57
VII	Alleghany Highlands	2,872	22,632	12,690	34.67	7.85
	Blue Ridge	25,981	244,789	10,614	29.00	70.99
Out of State/Unknown/Unassigned		2,167				
VIRGINIA STATEWIDE		517,869	7,698,775	6,726.64	18.38	1,414.94

Source: DMHMRSAS AVATAR and 2007 Final Estimates, Weldon Cooper Center for Public Service.

Note: Excludes HRMC and VCBR

**Training Center Bed Utilization by CSB and Region FY 2009
Beds Per 100,000 Population**



State Training Center Utilization by CSB and Region -- FY 2009

	CSB	All Bed Days FY 2009	CSB Population	FY 2009 Bed Days Per 100 K Population	FY 2009 Beds Per 100 K Population	Beds Used
I	Central Virginia	15,739	240,191	6,553	17.95	43.12
	Harrisonburg-Rockingham	2,997	118,909	2,520	6.91	8.21
	Northwestern	5,156	213,596	2,414	6.61	14.13
	Rappahannock Area	7,641	314,529	2,429	6.66	20.93
	Rappahannock-Rapidan	8,873	165,879	5,349	14.66	24.31
	Region Ten	12,655	222,265	5,694	15.60	34.67
	Rockbridge Area	1,094	39,875	2,744	7.52	3.00
	Valley	5,278	116,239	4,541	12.44	14.46
II	Alexandria	8,750	136,601	6,406	17.55	23.97
	Arlington	14,804	203,126	7,288	19.97	40.56
	Fairfax-Falls Church	51,031	1,044,086	4,888	13.39	139.81
	Loudoun County	694	278,909	249	0.68	1.90
	Prince William County	11,614	423,485	2,742	7.51	31.82
III	Cumberland Mountain	19,310	96,605	19,989	54.76	52.90
	Dickenson County	2,811	16,319	17,225	47.19	7.70
	Highlands	9,258	70,300	13,169	36.08	25.36
	Mount Rogers	16,376	119,187	13,740	37.64	44.87
	New River Valley	17,271	170,018	10,158	27.83	47.32
	Planning District 1	12,471	94,017	13,265	36.34	34.17
IV	Chesterfield	4,212	298,850	1,409	3.86	11.54
	Crossroads	6,275	101,015	6,212	17.02	17.19
	District 19	15,056	170,618	8,824	24.18	41.25
	Goochland-Powhatan	1,761	47,852	3,680	10.08	4.82
	Hanover County	3,844	96,992	3,963	10.86	10.53
	Henrico Area	13,508	313,834	4,304	11.79	37.01
	Richmond BHA	17,271	194,974	8,858	24.27	47.32
V	Chesapeake	8,015	215,906	3,712	10.17	21.96
	Colonial	4,712	150,589	3,129	8.57	12.91
	Eastern Shore	7,711	52,185	14,776	40.48	21.13
	Hampton-Newport News	26,030	325,425	7,999	21.91	71.32
	Middle Pen.-Northern Neck	8,370	140,221	5,969	16.35	22.93
	Norfolk	34,044	235,915	14,431	39.54	93.27
	Portsmouth	12,594	97,851	12,871	35.26	34.50
	Virginia Beach	16,298	430,349	3,787	10.38	44.65
	Western Tidewater	6,882	142,707	4,822	13.21	18.85
VI	Danville-Pittsylvania	15,964	106,306	15,017	41.14	43.74
	Piedmont	5,794	139,303	4,159	11.40	15.87
	Southside	10,301	86,323	11,933	32.69	28.22
VII	Alleghany Highlands	2,545	22,632	11,245	30.81	6.97
	Blue Ridge	18,280	244,789	7,468	20.46	50.08
	Out of State/Unknown/Unassigned	2,270				
	VIRGINIA STATEWIDE	465,560	7,698,775	6,047.20	16.52	1,272.02

Source: DMHMRSAS AVATAR and 2007 final estimates, Weldon Cooper Center for Public Service.

FY 2009 Numbers Served by Age and Gender

Age	State Hospitals		Training Centers		Hiram Davis		VCBR		Unduplicated TOTAL		
	Fem.	Male	Fem.	Male	Fem.	Male	Fem.	Male	Fem.	Male	Total
0-17	255	326	3	2	0	0	0		258	328	586
18-22	140	327	5	23	0	4	0	2	145	349	494
23-59	1,306	2,186	437	672	42	45	0	135	1,753	2,995	4,748
60-64	106	122	42	56	3	5	0	8	150	187	337
65-74	143	148	52	47	6	6	0	7	199	205	404
75+	141	106	25	22	6	5	0	0	167	130	297
Total	2,091	3,215	564	822	57	65	0	152	2,672	4,194	6,866

FY 2009 Numbers Served by Race and Age

Race	State Hospitals				Training Centers			
	0-17	18-64	65+	Total	0-17	18-64	65+	Total
Alaskan Native	0	1	0	1	0	0	0	0
American Indian	1	6	1	8	0	1	0	1
Asian/Pacific Islander	8	77	3	88	0	6	0	6
Black/African American	155	1,398	174	1,727	0	321	39	360
Caucasian/White	391	2,517	356	3,264	4	883	107	994
Other	24	157	4	185	1	13	0	14
Not Collected/No Entry Unknown	2	31	0	33	0	11	0	11
Total	581	4,187	538	5,306	5	1,237	146	1,386

Race	Hiram Davis			VCBR			Unduplicated TOTAL			
	18-64	65+	Total	18-64	65+	Total	0-17	18-64	65+	Total
Alaskan Native	0	0	0	0	0	0	0	1	0	1
American Indian	0	0	0	0	0	0	1	7	1	9
Asian/Pacific Islander	0	0	0	0	0	0	8	83	3	94
Black/African American	60	15	75	77	0	77	155	1,807	218	2,180
Caucasian/White	39	7	46	65	7	72	395	3,467	474	4,336
Other	0	1	1	2	0	2	25	171	5	201
Not Collected/No Entry Unknown	0	0	0	1	0	1	2	43	0	45
Total	99	23	122	145	7	152	586	5,579	701	6,866

Source: DMHMRSAS AVATAR Information System

**State Hospital and Training Center Numbers of Admissions, Separations and Average Daily Census
FY 1976 to FY 2009**

	State Hospitals*			Training Centers**		
	Number of Admissions	Number of Separations	Average Daily Census	Number of Admissions	Number of Separations	Average Daily Census
FY 1976	10,319	10,943	5,967	250	639	4,293
FY 1977	10,051	10,895	5,489	418	618	3,893
FY 1978	10,641	11,083	5,218	277	404	3,790
FY 1979	10,756	10,926	5,112	299	416	3,701
FY 1980	10,513	11,345	4,835	296	428	3,576
FY 1981	10,680	11,513	4,486	252	399	3,467
FY 1982	10,212	10,616	4,165	205	301	3,391
FY 1983	10,030	10,273	3,798	162	232	3,309
FY 1984	9,853	10,163	3,576	194	322	3,189
FY 1985	9,456	9,768	3,279	197	314	3,069
FY 1986	8,942	9,077	3,110	172	280	2,970
FY 1987	8,919	8,900	3,004	165	238	2,892
FY 1988	9,549	9,637	3,047	143	224	2,828
FY 1989	9,591	9,605	3,072	146	231	2,761
FY 1990	9,249	9,293	2,956	110	181	2,676
FY 1991	9,323	9,519	2,904	107	162	2,626
FY 1992	9,057	9,245	2,775	116	215	2,548
FY 1993	8,560	8,651	2,588	94	192	2,481
FY 1994	9,187	9,317	2,482	106	193	2,375
FY 1995	8,550	8,774	2,348	87	216	2,249
FY 1996	7,468	7,529	2,222	87	223	2,132
FY 1997	7,195	7,257	2,118	77	210	1,987
FY 1998	7,431	7,522	2,089	78	170	1,890
FY 1999	6,210	6,449	1,914	106	188	1,812
FY 2000	5,069	5,233	1,694	101	194	1,749
FY 2001	5,223	5,176	1,641	101	156	1,680
FY 2002	5,936	5,915	1,654	122	177	1,618
FY 2003	5,946	6,008	1,609	95	132	1,581
FY 2004	5,382	5,599	1,588	73	114	1,568
FY 2005	5,232	5,236	1,478	114	174	1,524
FY 2006	5,334	5,293	1,490	112	188	1,451
FY 2007	5,146	5,149	1,511	128	182	1,389
FY 2008	4,960	5,025	1,501	134	196	1,328
FY 2009	4,884	5,042	1,419	111	179	1,276

* Excludes Hiram Davis Medical Center and the Virginia Center for Behavioral Rehabilitation. State Mental Health Facilities counts include the Virginia Treatment Center for Children (VTCC) through FY 1991 when the VTCC was transferred to MCV.

** Operations at SVTC began in 1971, NVTC began in 1973, SWVTC in 1973, and SEVTC began in 1975.

Appendix D Prevalence Estimates by CSB

Estimated Prevalence of Serious Mental Illness by CSB and Region

	CSB	Population Age18+ (2008 Estimate)	Est. Population with SMI (5.4 %)	Lower Limit of SMI Estimate (3.7 %)	Upper Limit of SMI Estimate (7.1 %)
I	Central Virginia	189,744	10,246	7,021	13,472
	Harrisonburg-Rockingham	95,354	5,149	3,528	6,770
	Northwestern	165,775	8,952	6,134	11,770
	Rappahannock Area	233,984	12,635	8,657	16,613
	Rappahannock-Rapidan	84,448	4,560	3,125	5,996
	Region Ten	177,165	9,567	6,555	12,579
	Rockbridge Area	32,563	1,758	1,205	2,312
	Valley	92,559	4,998	3,425	6,572
II	Alexandria	111,559	6,024	4,128	7,921
	Arlington	169,951	9,177	6,288	12,067
	Fairfax-Falls Church	789,447	42,630	29,210	56,051
	Loudoun County	205,350	11,089	7,598	14,580
	Prince William County	304,716	16,455	11,275	21,635
III	Cumberland Mountain	77,566	4,189	2,870	5,507
	Dickenson County	13,102	708	485	930
	Highlands	56,381	3,045	2,086	4,003
	Mount Rogers	94,612	5,109	3,501	6,717
	New River Valley	140,973	7,613	5,216	10,009
	Planning District 1	74,801	4,039	2,768	5,311
IV	Chesterfield	227,171	12,267	8,405	16,129
	Crossroads	79,960	4,318	2,959	5,677
	District 19	132,355	7,147	4,897	9,397
	Goochland-Powhatan	37,704	2,036	1,395	2,677
	Hanover County	74,261	4,010	2,748	5,273
	Henrico Area	239,773	12,948	8,872	17,024
	Richmond BHA	151,080	8,158	5,590	10,727
V	Chesapeake	160,548	8,670	5,940	11,399
	Colonial	115,348	6,229	4,268	8,190
	Eastern Shore	40,182	2,170	1,487	2,853
	Hampton-Newport News	240,155	12,968	8,886	17,051
	Middle Peninsula-Northern Neck	110,536	5,969	4,090	7,848
	Norfolk	174,474	9,422	6,456	12,388
	Portsmouth	72,135	3,895	2,669	5,122
	Virginia Beach	318,236	17,185	11,775	22,595
	Western Tidewater	107,840	5,823	3,990	7,657
VI	Danville-Pittsylvania	82,697	4,466	3,060	5,871
	Piedmont	110,035	5,942	4,071	7,812
	Southside	67,941	3,669	2,514	4,824
VII	Alleghany Highlands	17,787	960	658	1,263
	Blue Ridge	191,812	10,358	7,097	13,619
	TOTAL	5,862,082	316,552	216,897	416,208

Population estimate source: 2008 Age and Race Estimates, Weldon Cooper Center for Public Service, University of Virginia

Estimated Prevalence of Child/Adolescent Serious Emotional Disturbance by CSB and Region

	CSB	Population Age 9 through 17 (2008 Estimate)	Est. SED, Level of Functioning Score = 50		Est. SED, Level of Functioning Score = 60	
			Lower	Upper	Lower	Upper
I	Central Virginia	28,960	1,448	2,027	2,606	3,186
	Harrisonburg-Rockingham	12,105	605	847	1,089	1,332
	Northwestern	25,955	1,298	1,817	2,336	2,855
	Rappahannock Area	44,977	2,249	3,148	4,048	4,947
	Rappahannock-Rapidan	22,706	1,135	1,589	2,044	2,498
	Region Ten	25,264	1,263	1,768	2,274	2,779
	Rockbridge Area	4,226	211	296	380	465
	Valley	13,535	677	947	1,218	1,489
II	Alexandria	9,100	455	637	819	1,001
	Arlington	16,528	826	1,157	1,488	1,818
	Fairfax-Falls Church	132,211	6,611	9,255	11,899	14,543
	Loudoun County	37,500	1,875	2,625	3,375	4,125
	Prince William County	59,205	2,960	4,144	5,328	6,513
III	Cumberland Mountain	10,492	525	734	944	1,154
	Dickenson County	1,809	90	127	163	199
	Highlands	7,449	372	521	670	819
	Mount Rogers	13,286	664	930	1,196	1,461
	New River Valley	15,354	768	1,075	1,382	1,689
	Planning District 1	10,379	519	727	934	1,142
IV	Chesterfield	41,409	2,070	2,899	3,727	4,555
	Crossroads	12,008	600	841	1,081	1,321
	District 19	21,330	1,066	1,493	1,920	2,346
	Goochland-Powhatan	5,888	294	412	530	648
	Hanover County	12,818	641	897	1,154	1,410
	Henrico Area	38,835	1,942	2,718	3,495	4,272
	Richmond BHA	19,887	994	1,392	1,790	2,188
V	Chesapeake	30,533	1,527	2,137	2,748	3,359
	Colonial	20,992	1,050	1,469	1,889	2,309
	Eastern Shore	6,240	312	437	562	686
	Hampton-Newport News	42,162	2,108	2,951	3,795	4,638
	Middle Pen.-Northern Neck	16,952	848	1,187	1,526	1,865
	Norfolk	27,986	1,399	1,959	2,519	3,078
	Portsmouth	11,958	598	837	1,076	1,315
	Virginia Beach	56,676	2,834	3,967	5,101	6,234
	Western Tidewater	18,988	949	1,329	1,709	2,089
VI	Danville-Pittsylvania	12,909	645	904	1,162	1,420
	Piedmont	16,129	806	1,129	1,452	1,774
	Southside	9,761	488	683	879	1,074
VII	Alleghany Highlands	2,471	124	173	222	272
	Blue Ridge	28,898	1,445	2,023	2,601	3,179
	TOTAL	945,873	47,294	66,211	85,129	104,046

Population estimate source: 2008 Age and Race Estimates, Weldon Cooper Center for Public Service, University of Virginia
 LOF = 50: lower 5%, upper 7%; LOF = 60: lower 9%, upper 11%.

Estimated Prevalence Intellectual and Related Developmental Disabilities by CSB and Region

	CSB	Population Age 0-5 (2008 Estimate)	Estimated # Part C Eligible Infants/Toddlers 3%	Population Age 6+ (2007 Estimate)	Estimated # With ID 1%	General Population	Estimated # With DD 1.8%
I	Central Virginia	15,587	468	227,126	2,271	242,713	4,369
	Harrisonburg-Rockingham	8,560	257	111,907	1,119	120,467	2,168
	Northwestern	16,070	482	199,879	1,999	215,948	3,887
	Rappahannock Area	26,583	798	291,132	2,911	317,716	5,719
	Rappahannock-Rapidan	11,422	343	156,758	1,568	168,180	3,027
	Region Ten	15,497	465	209,884	2,099	225,381	4,057
	Rockbridge Area	2,325	70	37,978	380	40,303	725
	Valley	7,783	233	109,797	1,098	117,579	2,116
II	Alexandria	12,279	368	125,669	1,257	137,947	2,483
	Arlington	15,072	452	191,751	1,918	206,822	3,723
	Fairfax-Falls Church	89,665	2,690	963,038	9,630	1,052,703	18,949
	Loudoun County	30,716	921	256,972	2,570	287,688	5,178
	Prince William County	44,766	1,343	384,421	3,844	429,187	7,725
III	Cumberland Mountain	6,220	187	91,296	913	97,516	1,755
	Dickenson County	994	30	15,448	154	16,441	296
	Highlands	4,521	136	66,140	661	70,662	1,272
	Mount Rogers	7,885	237	111,935	1,119	119,820	2,157
	New River Valley	10,750	323	161,355	1,614	172,105	3,098
	Planning District 1	6,318	190	88,402	884	94,720	1,705
IV	Chesterfield	22,778	683	280,760	2,808	303,538	5,464
	Crossroads	6,637	199	95,361	954	101,998	1,836
	District 19	13,182	395	160,069	1,601	173,251	3,119
	Goochland-Powhatan	3,125	94	45,329	453	48,453	872
	Hanover County	5,689	171	92,095	921	97,785	1,760
	Henrico Area	25,019	751	291,096	2,911	316,114	5,690
	Richmond BHA	15,322	460	180,141	1,801	195,463	3,518
V	Chesapeake	17,190	516	199,432	1,994	216,622	3,899
	Colonial	9,400	282	142,508	1,425	151,908	2,734
	Eastern Shore	3,888	117	48,334	483	52,222	940
	Hampton-Newport News	29,604	888	295,578	2,956	325,182	5,853
	Middle Pen.-Northern Neck	9,075	272	132,126	1,321	141,201	2,542
	Norfolk	22,891	687	212,201	2,122	235,092	4,232
	Portsmouth	9,224	277	88,375	884	97,599	1,757
	Virginia Beach	37,609	1,128	393,842	3,938	431,451	7,766
	Western Tidewater	11,311	339	132,523	1,325	143,835	2,589
VI	Danville-Pittsylvania	7,857	236	99,548	995	107,406	1,933
	Piedmont	9,422	283	130,892	1,309	140,314	2,526
	Southside	5,895	177	80,656	807	86,551	1,558
VII	Alleghany Highlands	1,571	47	21,145	211	22,716	409
	Blue Ridge	16,786	504	229,702	2,297	246,488	4,437
	TOTAL	616,488	18,495	7,152,601	71,526	7,769,089	139,844

Population estimate source: 2008 Age and Race Estimates, Weldon Cooper Center for Public Service, University of Virginia

Estimated Prevalence of Drug and Alcohol Dependence by CSB and Region

	CSB	Population 12+ (2008 Estimate)	Estimated Drug Dependence 1.97 %	Estimated Alcohol Dependence 3.17 %	Total Estimated # Drug/Alcohol Dependence*
I	Central Virginia	209,396	4,125	6,638	10,763
	Harrisonburg-Rockingham	103,446	2,038	2,648	4,686
	Northwestern	183,217	3,609	4,690	8,300
	Rappahannock Area	264,698	5,215	6,776	11,991
	Rappahannock-Rapidan	115,162	2,269	2,948	5,217
	Region Ten	194,343	3,829	4,975	8,804
	Rockbridge Area	35,460	699	908	1,606
	Valley	101,768	2,005	2,605	4,610
II	Alexandria	116,844	2,302	2,991	5,293
	Arlington	180,585	3,558	4,623	8,181
	Fairfax-Falls Church	878,372	17,304	22,486	39,790
	Loudoun County	229,691	4,525	5,880	10,405
	Prince William County	344,061	6,778	8,808	15,586
III	Cumberland Mountain	84,601	1,667	2,166	3,832
	Dickenson County	14,344	283	367	650
	Highlands	61,390	1,209	1,572	2,781
	Mount Rogers	103,515	2,039	2,650	4,689
	New River Valley	151,328	2,981	3,874	6,855
	Planning District 1	81,824	1,612	2,095	3,707
IV	Chesterfield	256,203	5,047	6,559	11,606
	Crossroads	88,123	1,736	2,256	3,992
	District 19	146,702	2,890	3,756	6,646
	Goochland-Powhatan	41,646	820	1,066	1,887
	Hanover County	83,029	1,636	2,126	3,761
	Henrico Area	265,864	5,238	6,806	12,044
	Richmond BHA	164,399	3,239	4,209	7,447
V	Chesapeake	181,574	3,577	4,648	8,225
	Colonial	129,598	2,553	3,318	5,871
	Eastern Shore	44,419	875	1,137	2,012
	Hampton-Newport News	268,476	5,289	6,873	12,162
	Middle Peninsula-Northern Neck	122,200	2,407	3,128	5,536
	Norfolk	193,041	3,803	4,942	8,745
	Portsmouth	80,126	1,578	2,051	3,630
	Virginia Beach	356,598	7,025	9,129	16,154
	Western Tidewater	120,791	2,380	3,092	5,472
VI	Danville-Pittsylvania	91,466	1,802	2,342	4,143
	Piedmont	120,991	2,384	3,097	5,481
	Southside	74,493	1,468	1,907	3,375
VII	Alleghany Highlands	19,410	382	497	879
	Blue Ridge	211,371	4,164	5,411	9,575
	TOTAL	6,514,564	128,337	168,050	296,387

Population estimate source: 2008 Age and Race Estimates, Weldon Cooper Center for Public Service, University of Virginia

*Note: Total includes a duplicated count of persons with co-occurring drug and alcohol dependence.

Appendix E
Individuals on Waiting Lists for Services by CSB

Adults on CSB Mental Health Services Waiting Lists -- January - April 2009

	CSB	Adult SMI Prevalence	Unduplicated # Served (FY 2008 4 th Quarter Rept.)			On CSB Waiting Lists		Total on CSB Waiting List
			# Served	# SMI	% with SMI	Receiving CSB Svcs	Not Receiving CSB Svcs	
I	Central Virginia	10,246	2,438	1,851	76%	126	2	128
	Harrisonburg-Rockingham	5,149	1,253	561	45%	137	6	143
	Northwestern	8,952	1,566	701	45%	2	0	2
	Rappahannock Area	12,635	2,855	989	35%	38	0	38
	Rappahannock-Rapidan	4,560	1,957	699	36%	104	0	104
	Region Ten	9,567	2,262	1,213	54%	13	0	13
	Rockbridge	1,758	710	329	46%	0	0	0
	Valley	4,998	1,567	591	38%	0	0	0
II	Alexandria	6,024	1,525	668	44%	243	36	279
	Arlington	9,177	1,936	1,063	55%	51	0	51
	Fairfax-Falls Church	42,630	4,773	3,968	83%	190	9	199
	Loudoun	11,089	1,380	532	39%	54	48	102
	Prince William	16,455	2,040	1,459	72%	120	18	138
III	Cumberland Mountain	4,189	1,146	997	87%	241	0	241
	Dickenson County	708	550	440	80%	0	0	0
	Highlands	3,045	2,212	882	40%	19	0	19
	Mount Rogers	5,109	2,546	2,176	85%	610	125	735
	New River Valley	7,613	2,195	864	39%	125	33	158
	P.D. 1	4,039	2,998	1,869	62%	73	0	73
IV	Chesterfield	12,267	2,414	1,523	63%	77	9	86
	Crossroads	4,318	1,917	855	45%	52	36	88
	District 19	7,147	1,841	725	39%	4	51	55
	Goochland-Powhatan	2,036	269	120	45%	0	1	1
	Hanover	4,010	730	368	52%	52	0	52
	Henrico	12,948	2,134	1,320	62%	99	17	116
	Richmond BHA	8,158	2,714	1,672	62%	121	21	142
V	Chesapeake	8,670	1,382	598	43%	35	0	35
	Colonial	6,229	1,457	572	39%	83	2	85
	Eastern Shore	2,170	930	399	43%	0	11	11
	Hampton-Newport News	12,968	4,742	2,402	51%	103	11	114
	Middle Pen.-Northern Neck	5,969	1,948	946	49%	48	89	137
	Norfolk	9,422	1,837	1,469	80%	291	39	330
	Portsmouth	3,895	1,708	822	48%	12	0	12
	Virginia Beach	17,185	2,090	1,464	70%	133	73	206
	Western Tidewater	5,823	958	688	72%	67	12	79
VI	Danville-Pittsylvania	4,466	1,082	710	66%	49	3	52
	Piedmont	5,942	2,075	1,416	68%	9	54	63
	Southside	3,669	1,130	660	58%	0	32	32
VII	Alleghany Highlands	960	552	295	53%	0	0	0
	Blue Ridge	10,358	2,286	1,653	73%	26	1	27
	TOTAL	316,552	74,105	42,529	57%	3,407	739	4,146

Population estimate source: 2008 Age and Race Estimates, Weldon Cooper Center for Public Service, University of Virginia

Children and Adolescents on CSB Mental Health Services Waiting Lists – January - April 2009

CSB	SED Prevalence (LOF = 50 Upper Range)	Unduplicated # Served (FY 2008 4 th Quarter Report.)			On CSB Waiting Lists		Total on CSB Waiting List	
		# Served	# SED	% with SED	Receiving CSB Svs	Not Receiving CSB Svs		
	Central Virginia	2,027	1,987	1,677	84%	111	13	124
	Harrisonburg-Rockingham	847	419	283	68%	33	0	33
	Northwestern	1,817	546	332	61%	6	1	7
	Rappahannock Area	3,148	1,479	804	54%	35	0	35
	Rappahannock-Rapidan	1,589	564	317	56%	8	0	8
	Region Ten	1,768	948	621	66%	1	1	2
	Rockbridge	296	279	250	90%	0	0	0
	Valley	947	528	248	47%	0	0	0
II	Alexandria	637	436	221	51%	4	8	12
	Arlington	1,157	358	249	70%	8	30	38
	Fairfax-Falls Church	9,255	1,744	1,191	68%	45	12	57
	Loudoun	2,625	403	243	60%	13	6	19
	Prince William	4,144	292	131	45%	9	14	23
III	Cumberland Mountain	734	680	649	95%	384	10	394
	Dickenson County	127	121	105	87%	0	0	0
	Highlands	521	792	641	81%	0	0	0
	Mount Rogers	930	942	851	90%	230	0	230
	New River Valley	1,075	1,451	1,070	74%	35	36	71
	P.D. 1	727	1,283	911	71%	0	0	0
IV	Chesterfield	2,899	597	348	58%	64	36	100
	Crossroads	841	713	329	46%	30	11	41
	District 19	1,493	649	434	67%	3	22	25
	Goochland-Powhatan	412	65	33	51%	0	0	0
	Hanover	897	382	273	71%	8	0	8
	Henrico	2,718	1,126	435	39%	93	31	124
	Richmond BHA	1,392	1,315	1,107	84%	75	8	83
V	Chesapeake	2,137	228	83	36%	0	0	0
	Colonial	1,469	357	196	55%	0	0	0
	Eastern Shore	437	277	184	66%	0	0	0
	Hampton-Newport News	2,951	2,302	2,037	88%	0	0	0
	Middle Pen.-Northern Neck	1,187	893	526	59%	58	88	146
	Norfolk	1,959	283	133	47%	11	5	16
	Portsmouth	837	134	90	67%	0	0	0
	Virginia Beach	3,967	327	234	72%	12	11	23
	Western Tidewater	1,329	479	372	78%	61	6	67
VI	Danville-Pittsylvania	904	274	173	63%	4	37	41
	Piedmont	1,129	723	644	89%	11	118	129
	Southside	683	180	107	59%	4	42	46
VII	Alleghany Highlands	173	193	120	62%	0	0	0
	Blue Ridge	2,023	942	796	85%	13	11	24
TOTAL		66,211	27,691	19,448	70%	1,369	557	1,926

Population estimate source: 2008 Age and Race Estimates, Weldon Cooper Center for Public Service, University of Virginia

Individuals on CSB Developmental Services Waiting Lists – January - April 2009

	CSB	ID Prevalence Age 6 and Over	Unduplicated # Served (FY 2008 4 th Qtr. Rept.)	On CSB Waiting Lists				Totals on CSB Adult and Children/Adolescents Waiting Lists		
				Receiving CSB Services		Not Receiving Some CSB Services		Adult	C/A	Total
				Adult	C/A	Adult	C/A			
I	Central Virginia	2,271	1,085	93	20	0	0	93	20	113
	Harrisonburg-Rockingham	1,119	417	59	26	11	2	70	28	98
	Northwestern	1,999	693	71	21	27	20	98	41	139
	Rappahannock Area	2,911	1,143	113	34	33	32	146	66	212
	Rappahannock-Rapidan	1,568	493	29	15	0	3	29	18	47
	Region Ten	2,099	565	81	22	29	11	110	33	143
	Rockbridge	380	284	12	9	1	0	13	9	22
	Valley	1,098	439	87	41	5	4	92	45	137
II	Alexandria	1,257	562	11	18	4	5	15	23	38
	Arlington	1,918	853	46	1	2	2	48	3	51
	Fairfax-Falls Church	9,630	1,747	423	30	187	223	610	253	863
	Loudoun	2,570	780	2	0	1	0	3	0	3
	Prince William	3,844	769	114	7	83	41	197	48	245
III	Cumberland Mountain	913	511	39	33	1	1	40	34	74
	Dickenson County	154	23	2	0	0	0	2	0	2
	Highlands	661	222	19	12	5	6	24	18	42
	Mount Rogers	1,119	812	81	134	0	1	81	135	216
	New River Valley	1,614	434	29	54	15	17	44	71	115
	P.D. 1	884	310	8	4	9	8	17	12	29
IV	Chesterfield	2,808	1,187	655	385	0	1	655	386	1,041
	Crossroads	954	201	13	7	27	17	40	24	64
	District 19	1,601	474	67	38	2	1	69	39	108
	Goochland-Powhatan	453	101	8	4	10	7	18	11	29
	Hanover	921	399	62	19	7	16	69	35	104
	Henrico	2,911	1,182	321	203	0	0	321	203	524
	Richmond Behavioral	1,801	953	114	130	2	3	146	133	279
V	Chesapeake	1,994	785	78	7	12	12	90	19	109
	Colonial	1,425	262	49	4	1	28	50	32	82
	Eastern Shore	483	311	7	5	9	3	16	8	24
	Hampton-Newport News	2,956	992	105	103	7	8	112	111	223
	Middle Pen.-Northern Neck	1,321	302	42	35	28	9	70	44	114
	Norfolk	2,122	1,074	134	19	28	17	162	36	198
	Portsmouth	884	468	14	5	13	3	27	8	35
	Virginia Beach	3,938	1,414	128	45	47	111	175	156	331
	Western Tidewater	1,325	622	137	56	7	2	144	58	202
VI	Danville-Pittsylvania	995	507	63	23	19	14	82	37	119
	Piedmont	1,309	484	42	6	14	8	56	14	70
	Southside	807	304	9	3	6	3	15	6	21
VII	Alleghany Highlands	211	212	4	7	2	5	6	12	18
	Blue Ridge	2,297	677	119	11	24	20	143	31	174
	TOTAL	71,526	25,053	3,520	1,596	678	664	4,198	2,260	6,458

Population estimate source: 2008 Age and Race Estimates, Weldon Cooper Center for Public Service, University of Virginia

Adults and Adolescents on CSB Substance Abuse Services Waiting Lists – January - April 2009

	CSB	Drug & Alcohol Dependence Prevalence	Unduplicated # Served (FY 2008 4 th Qtr. Rept.)	On CSB Waiting Lists				Totals on CSB Adult and Adolescent Waiting Lists		
				Receiving CSB Services		Not Receiving Some CSB Services		Adult	Adolescent	Total
				Adult	Adol.	Adult	Adol.			
I	Central Virginia	6,722	1,144	0	0	0	1	0	1	1
	Harrisonburg-Rockingham	3,321	375	63	1	1	0	64	1	65
	Northwestern	5,881	703	1	0	0	0	1	0	1
	Rappahannock Area	8,497	1,946	4	0	36	1	40	1	41
	Rappahannock-Rapidan	3,697	1,075	9	0	0	0	9	0	0
	Region Ten	6,238	1,445	0	0	0	0	0	0	0
	Rockbridge	1,138	273	0	0	0	0	0	0	0
Valley	3,267	1,273	0	0	0	0	0	0	0	
II	Alexandria	3,751	1,221	32	0	18	1	50	1	51
	Arlington	5,797	1,146	34	3	1	10	35	13	48
	Fairfax-Falls Church	28,196	4,132	46	17	65	43	111	60	171
	Loudoun	7,373	1,073	58	10	157	4	215	14	229
	Prince William	11,044	1,571	21	0	2	0	23	0	23
III	Cumberland Mountain	2,716	1,551	6	12	0	1	6	13	19
	Dickenson County	460	221	7	0	5	0	12	0	12
	Highlands	1,971	809	0	0	0	0	0	0	0
	Mount Rogers	3,323	611	21	4	7	0	28	4	32
	New River Valley	4,858	793	1	3	23	5	24	8	32
	P.D. 1	2,627	1,111	85	0	5	0	90	0	90
IV	Chesterfield	8,224	1,393	438	10	101	1	539	11	550
	Crossroads	2,829	621	11	1	25	1	36	2	38
	District 19	4,709	1,058	0	0	2	0	2	0	2
	Goochland-Powhatan	1,337	134	0	0	9	0	9	0	9
	Hanover	2,665	339	18	0	0	0	18	0	18
	Henrico	8,534	2,555	0	3	0	0	0	3	3
	Richmond Behavioral	5,277	1,538	50	16	33	5	83	21	104
V	Chesapeake	5,829	1,246	38	1	4	0	42	1	43
	Colonial	4,160	786	32	0	0	0	32	0	32
	Eastern Shore	1,426	292	0	0	0	0	0	0	0
	Hampton-Newport News	8,618	1,938	0	0	0	0	0	0	0
	Middle Pen.-Northern Neck	3,923	1,000	1	0	0	0	1	0	1
	Norfolk	6,197	2,185	106	0	4	0	110	0	110
	Portsmouth	2,572	1,164	63	0	0	0	63	0	63
	Virginia Beach	11,447	1,021	9	0	116	9	125	9	134
Western Tidewater	3,877	429	5	0	6	0	11	0	11	
VI	Danville-Pittsylvania	2,936	866	12	2	0	2	12	4	16
	Piedmont	3,884	649	1	1	34	6	35	7	42
	Southside	2,391	366	0	0	4	0	4	0	4
VII	Alleghany Highlands	623	222	0	0	0	0	0	0	0
	Blue Ridge	6,785	1,382	9	0	35	1	44	1	45
	TOTAL	209,118	43,657	1,181	84	693	91	1,874	175	2,049

Population estimate source: 2008 Age and Race Estimates, Weldon Cooper Center for Public Service, University of Virginia

Appendix F
Proposed State Facility Capital Projects Priority Listing 2010 – 2016

Proposed Capital Projects		Estimated Resource Requirements
2010-12 Biennium (FY 2011 and FY 2012)	Replace facility roofs and building envelopes (phase 1)	\$12,411,000
	Repair/replace campus infrastructure (phase 1)	\$9,034,000
	Repair/replace boilers, heat distribution and HVAC systems (phase 1)	\$19,777,000
	Abate hazardous materials	\$5,830,000
	Construct new sexually violent predator facility (phase 1)	\$28,976,000
	Replace support service facility at Eastern State Hospital	\$17,460,000
	Replace forensic unit at Central State Hospital	\$5,856,000
	Renovate bathrooms at Northern Virginia Training Center	\$2,901,000
	Construct replacement facility for Piedmont Geriatric Hospital	\$54,637,000
	Renovate buildings 10 and 47 at Central Virginia Training Center	\$14,393,000
	2010-2012 Estimated Resource Requirements Subtotal	\$171,275,000
2012-14 Biennium (FY 2013 and FY 2014)	Replace facility roofs and building envelopes (phase 2)	\$10,158,000
	Repair/replace campus infrastructure (phase 2)	\$15,940,000
	Repair/replace boilers, heat distribution and HVAC systems (phase 2)	\$26,309,000
	Abate hazardous materials	\$2,140,000
	Construct new sexually violent predator facility (phase 2)	\$56,646,000
	Replace support service facility at Eastern State Hospital	\$12,161,000
	Replace forensic unit at Central State Hospital	\$93,233,000
	2012-2014 Estimated Resource Requirements Subtotal	\$216,587,000
2014-16 Biennium (FY 2015 and FY 2016)	Repair/replace boilers, heat distribution and HVAC systems (phase 3)	\$13,731,000
Project Total Resource Requirements	Replace facility roofs and building envelopes	\$22,569,000
	Repair/replace campus infrastructure	\$24,974,000
	Repair/replace boilers, heat distribution and HVAC systems	\$59,817,000
	Abate hazardous materials	\$7,970,000
	Construct new sexually violent predator facility	\$85,622,000
	Replace support service facility at Eastern State Hospital	\$29,621,000
	Replace forensic unit at Central State Hospital	\$99,089,000
	Renovate bathrooms at Northern Virginia Training Center	\$2,901,000
	Construct replacement facility for Piedmont Geriatric Hospital	\$54,637,000
	Renovate buildings 10 and 47 at Central Virginia Training Center	\$14,393,000
Six Year Resource Requirements Total		\$401,593,000

Appendix G

Current and Proposed CSB and State Facility Accountability Measures

A. Virginia Performs Goals: Currently on the web site

These systemic measures for the public behavioral health (mental health and substance abuse) and developmental (mental retardation) services system are already collected and reported annually for the preceding fiscal year. Data since FY 2005 is included in the web site to show trends.

1. **Increase the proportion of individuals served in intensive community-based services per occupied state facility bed.** Intensive community-based services are: local mental health and substance abuse inpatient services, Programs of Assertive Community Treatment (PACT), Assertive Community Treatment (ICT), Discharge Assistance Plans, mental health and developmental highly intensive residential services, ambulatory and residential crisis stabilization, and Medicaid mental retardation waiver services.
2. **Increase community tenure of individuals served in state facilities.** The percent of individuals receiving services in a state facility (except Hiram Davis Medical Center or the Virginia Center for Behavioral Rehabilitation) for a long term (i.e., 60 days or longer) who were readmitted within 365 days.

B. Data on Individuals Served: Currently on the web site

The following data will be **reported annually** for the preceding fiscal year statewide and for each CSB or state facility, as appropriate.

1. **Numbers of Individuals Receiving CSB Services:** total unduplicated numbers of individuals served and total unduplicated numbers of individuals served by program area (MH, MR, SA, and Other Services [Services Outside of a Program Area]) and by core service; reported for all CSBs (statewide totals) and, using drill down techniques, for each CSB. The Other Services Program Area, services that individuals receive regardless of disability or diagnosis, consist of emergency, motivational treatment, consumer monitoring, assessment and evaluation, early intervention, and consumer-run services. Individuals served means they received valid services during the reporting period. Unduplicated numbers are at the CSB level; without a master patient index or really unique identifier for each individual, there is no reliable way to produce truly unduplicated statewide numbers.
2. **Demographic Characteristics of Individuals Receiving CSB Services:** total numbers of unduplicated individuals who received valid services during the reporting period by age, gender, race, and Hispanic Origin statewide and by program area; reported as percentages rather than as numbers of individuals for all CSBs (statewide totals) and for each CSB only due to HIPAA concerns.
3. **CSB Penetration Rates:** calculated initially as total unduplicated number of individuals who received valid services during the reporting period divided by the total population of the CSB's service area, reported statewide for all CSBs and for each CSB, expressed as a number of individuals served per 100,000 people. Penetration rate measures the percentage of people in the total population who receive CSB services. Rates are displayed separately for urban and rural CSBs to reflect the disproportionate presence of private providers in urban areas.
4. **Consumer Satisfaction with CSB Services:** a link to the reports of the adult mental health and substance abuse, child and family, and intellectual disability surveys for the previous year that are posted on the Department's web site.
5. **Numbers of Individuals Receiving State Facility Services:** total unduplicated numbers of individuals served in state facilities; reported for all facilities, for all state hospitals and all training centers, and for each state hospital or training center.
6. **Demographic Characteristics of Individuals Receiving State Facility Services:** total numbers of unduplicated individuals served in state facilities by age, gender, race, and Hispanic origin; reported for all state facilities, all state hospitals and all training centers, but not each state hospital or training center due to HIPAA concerns.

C. Outcomes for Each Region: Proposed for implementation during FY 2010

The following measures would be **reported quarterly** for each of the seven Planning Partnership Regions, using data for the preceding quarter, displayed for the last four quarters.

1. **State Hospital Length of Stay:** percent of adult discharges from state hospitals, excluding VCBR, HDMC, the maximum security forensic unit at Central State Hospital (CSH), identified using case management CSBs,

with lengths of stay of less than six days (current LIPOS average length of stay is 5.31 days for local psychiatric beds).

2. **TDO State Hospital Admissions:** percent of all adult admissions to state hospitals, excluding VCBR, HDMC, the maximum security forensic unit at Central State Hospital (CSH), identified using case management CSBs, admitted on temporary detention orders (TDOs).

D. Outcomes for Each CSB or State Facility: Proposed for implementation during FY 2010

The following measures, derived from the specified sources, would be reported **quarterly** for each CSB or state facility, as appropriate, using data for the preceding quarter.

1. **State Hospital Use by CSBs:** bed days from admission through discharge used in adult civil inpatient beds by each CSB per 100,000 people, excluding VCBR, HDMC, the maximum security forensic unit at Central State Hospital (CSH). Bed days are assigned by case management CSB.
2. **State Training Center Use by CSBs:** bed days from admission through discharge used by each CSB per 100,000 people. Bed days are assigned by case management CSB.
3. **Continuity of Care:** percent of individuals with valid social security numbers referred to each CSB (defined as the case management CSB for that individual) who keep a face-to-face (non-emergency) service visit within seven business days after having been discharged from a state hospital, a private psychiatric hospital, or a psychiatric unit in a public or private hospital, following involvement in the civil involuntary admission process; this includes all individuals who were under a temporary detention order or an involuntary commitment order or who were admitted voluntarily from a commitment hearing.
4. **Individuals with Co-Occurring Disorders:** percent of individuals served by each CSB or state hospital identified with co-occurring disorders, reported quarterly using year-to-date data.
 - a. An individual receiving services from a CSB will be identified as having co-occurring mental health and substance use disorders if there is:
 - (1) an Axis I or Axis II mental health diagnosis **AND** (a) an Axis I substance use disorder diagnosis or (b) admission to the substance abuse program area, or
 - (2) an Axis I substance use disorder diagnosis **AND** (a) an Axis I or Axis II mental health diagnosis or (b) admission to the mental health program area.
 - b. An individual receiving services from a state hospital will be identified as having co-occurring mental health and substance use disorders if there is an Axis I or Axis II mental health diagnosis **AND** an Axis I substance use disorder diagnosis.
5. **Intensity of Engagement in Services:** percent of individuals admitted to the mental health program area or to the substance abuse program area and receiving outpatient or case management services or a combination of both who received more than one unit of outpatient, case management, or a combination of both within 30 days of each admission, reported separately for admissions to each program area.
6. **Time Waiting to Enter Treatment:** average number of calendar days from the first contact or request for substance abuse services by an individual until the first scheduled appointment accepted by the individual for individuals admitted to the substance abuse program area.
7. **Seclusion:** hours of seclusion use at each state hospital and HDMC, per 1,000 hours of inpatient services. For CSH, maximum security forensic beds in buildings 39 and 96 will be reported separately from the CSH figure as CSB Maximum Security forensic beds.
8. **Restraint:** hours of physical restraint use at each state facility (state hospitals, HDMC, and training centers) per 1,000 hours of inpatient services. For CSH, maximum security forensic beds in buildings 39 and 96 will be reported separately from the CSH figure as CSH Maximum Security forensic beds.
9. **Individual and Family Member Involvement and Participation:** Two measures currently collected through the Community Services Performance Contract provide some initial measures of involvement and participation by individuals receiving services and their family members in CSB policy making and service delivery.
 - a. **CSB Appointments:** the number of individuals who are currently receiving or have previously received any public or private behavioral health or developmental services and the number of family members of individuals who are currently receiving or have previously received any public or private behavioral health or developmental services and the percent of total filled CSB appointments these individuals represent.
 - b. **Peers Employed by the CSB:** the number of individuals who identify themselves as (1) having mental health, substance use, or co-occurring disorders or intellectual disability, (2) receiving or having received public or private behavioral health or developmental services, and (3) peers of individuals with mental

health, substance use, or co-occurring disorders or intellectual disability and are employed by the CSB in designated peer positions or traditional direct service positions.

E. Outcomes for Each CSB or State Facility: Proposed for implementation during FY 2011

1. **Length of Engagement in Community Services:** average length of an episode of care in the substance abuse program area for each CSB. Length of an episode is measured from the date of admission to the substance abuse program area to the date of the discharge from the substance abuse program area or the last substance abuse service received without another substance abuse service being received within 90 days; reported annually for the preceding fiscal year.
2. **NOMS Mental Health Performance Measures:** individuals admitted up to 90 days before or during the first nine months of the reporting period (fiscal year) to the mental health program area who have remained an open case for at least 90 days and have received at least one unit of a valid mental health service who show positive changes in the following National Outcomes Measures (NOMS) indicators:
 - a. **Employment Status:** positive change in employment status defined as the number of individuals who are at first not employed during the reporting period (fiscal year) who have any employment experience at any later time during the reporting period;
 - b. **Housing Status:** positive change in housing status defined as the number of individuals who are at first in unstable housing or in an institution during the reporting period (fiscal year) who later become housed in a private residence, boarding home, foster home/family sponsor, assisted living facility, or CSB residential service at any time later in the reporting period; and
 - c. **Alcohol and Drug Abuse:** positive change in drug or alcohol use defined as the number of individuals who are at first using a primary drug of abuse with any frequency during the reporting period (fiscal year) who have used no drugs or alcohol in the past month at any later time during the reporting period.

These measures are reported annually for the preceding fiscal year.

3. **NOMS Substance Abuse Performance Measures:** individuals admitted during the reporting period (fiscal year) to the substance abuse program area for 30 days or more showing changes in the following National Outcomes Measures (NOMS) indicators:
 - a. **Employment Status:** change in employment status (percent employed full-time or part-time or in supported employment settings) between admission to and discharge from the program area;
 - b. **Housing Status:** change in housing stability (percent housed in a private residence, boarding home, assisted living facility, or CSB residential service) between admission to and discharge from the program area;
 - c. **Criminal Justice Involvement:** change in arrest status (percent not arrested) between admission to and discharge from the program area; and
 - d. **Alcohol and Drug Abuse:** change in drug or alcohol use (percent of individuals who used drugs or alcohol less frequently) between admission to and discharge from the program area.

These measures are reported annually for the preceding fiscal year.

4. **Consumers on Ready for Discharge Lists:** individuals receiving services in a state hospital who have been identified as ready for discharge by the case management CSB and the person's treatment team in the state hospital; excluding individuals in an NGRI status and individuals at HDMC and VCBR. This is reported **quarterly** for each CSB or state hospital, as appropriate, using data for the preceding quarter.
 - a. **For each CSB:** the number of individuals in state hospitals for whom the CSB is the case management CSB who have been on a ready for discharge list for more than 30 days.
 - b. **For each state hospital:** the average number of days individuals receiving services from the state hospital have been on the hospital's ready for discharge list.
5. **Recovery Orientation:** The Department and the Performance Expectations Steering Committee will review the Recovery Oriented Systems Indicators (ROSI) Consumer Survey (42 items) and the ROSI Provider Survey (23 item Administrative Profile) and develop a meaningful display of data about each CSB's recovery orientation, based on the results of the two instruments that are **reported annually** by each CSB.

Appendix H

Glossary of Services and Services System Terms and Acronyms

<u>Acronym/Term</u>	<u>Name</u>
AA	Alcoholics Anonymous
AAIDD	American Association on Intellectual and Developmental Disabilities
ABS	Adaptive Behavior Scale (ID)
ACF	Administration on Children and Families (U.S.)
ACT	Assertive Community Treatment
ADA	Americans with Disabilities Act (U.S.) or Assistant Director Administrative (DBHDS facility position)
ADC	Average Daily Census
ADD	U.S. Administration on Developmental Disabilities (U.S.)
ADRDA	Alzheimer's Disease and Related Disorders Association
ADSCAP	AIDS Control and Prevention Project
AHCPR	Agency for Health Care Policy and Research (U.S.)
AHP	Advocates for Human Potential
AITR	Agency Information Technology Resource (Virginia)
ALF	Assisted Living Facility (formerly Adult Care Residence)
ALOS	Average Length of Stay
ALOT	Advancing Leadership and Organization Transformation (DBHDS-wide HPO team)
AMA	Against Medical Advice or American Medical Association
AOD	Alcohol and Other Drugs
AODA	Alcohol and Other Drug Abuse
APA	Administrative Process Act (Virginia), American Psychiatric Association, or American Psychological Association
AR	Authorized Representative
Arc of Virginia	Advocacy group for individuals with intellectual disability
ARMICS	Agency Risk Management and Internal Controls
ARR	Annual Resident Review
ASD	Autism Spectrum Disorder
ASAM	American Society of Addiction Medicine
ASFA	Adoption and Safe Families Act of 1997 (U.S.)
ASI	Addiction Severity Index
AT	Assistive Technology
ATOD	Alcohol, Tobacco and Other Drugs
ATTC	Addiction Technology Transfer Center
AVATAR	State Facility Information Patient/Billing System (DBHDS information system)
AWOP	Absent Without Permission
BH	Behavioral Health
BHA	Behavioral Health Authority
C&A	Child and Adolescent
CAFAS	Child and Adolescent Functional Assessment Scale
CAPTA	Child Abuse Prevention Treatment Act (U.S.)
CARF	Commission on Accreditation of Rehabilitation Facilities
CARS	Community Automated Reporting System (DBHDS)
CASA	National Center on Addiction and Substance Abuse at Columbia University
CBT	Cognitive Behavioral Therapy
CCCA	Commonwealth Center for Children and Adolescents (DBHDS facility located in Staunton)
CCISC	Comprehensive, Continuous, Integrated System of Care model
CCS	Community Consumer Submission (DBHDS community information extract application)
CDC	Centers for Disease Control and Prevention (U.S.)
CDS	College of Direct Support

CELT	Consumer Education and Leadership Training
CH	Catawba Hospital (DBHDS facility located near Salem)
CHAP	Child Health Assistance Program
CHRIS	Comprehensive Human Rights Information System (DBHDS human rights application))
CLAS	Culturally and Linguistically Appropriate Services (HHS National Standards)
CM	Case Management
CMHS	Center for Mental Health Services (U.S.)
CMS	Centers for Medicare and Medicaid Services (U.S.)
CO	Central office (DBHDS)
Coalition	Coalition for Virginians with Mental Disabilities
COBRA	Comprehensive Omnibus Budget Reconciliation Act (also OBRA)
CODIE	Central office Data and Information Exchange (DBHDS intranet)
COPN	Certificate of Public Need
CORE	Council on Reform (Virginia Children's Services System Transformation)
COSIG	Co-Occurring State Incentive Grant
COY	Commission on Youth (Virginia)
COV	Commonwealth of Virginia
CPI	Consumer Price Index
CPP	Certified Prevention Professional
CPMT	Community Policy and Management Team (Virginia CSA)
CRC	Commitment Review Committee (DBHDS)
CRF	Classification Rating Form (MH-Adult)
CRIPA	Civil Rights of Institutionalized Persons Act (U.S.)
CSA	Comprehensive Services Act for Troubled Children and Youth (Virginia)
CSAO	Consortium of Substance Abuse Organizations (Virginia)
CSAP	Center for Substance Abuse Prevention (U.S.)
CSAT	Center for Substance Abuse Treatment (U.S.)
CSB	Community Services Board
CSH	Central State Hospital (DBHDS facility located in Dinwiddie)
CSP	Community Support Program
CSS	Community Support System
CVTC	Central Virginia Training Center (DBHDS facility located near Lynchburg)
DAD Project	Discharge Assistance and Diversion Project (Northern Virginia)
DAP	Discharge Assistance Project
DBHDS	Department of Behavioral Health and Developmental Services (the Department) (Virginia)
DBSA	Depression and Bipolar Support Alliance
DCHVP	Domiciliary Care for the Homeless Veterans Program
DCJS	Department of Criminal Justice Services (Virginia)
DD	Developmental Disability
DDHH	Department for the Deaf and Hard of Hearing (Virginia)
DFA	Division of Finance and Administration (DBHDS central office)
DHCD	Department of Housing and Community Development (Virginia)
DHHS	Department of Health and Human Services (U.S.) (or HHS)
DI	Departmental Instruction (DBHDS internal policy and procedures)
DJJ	Department of Juvenile Justice (Virginia)
DMAS	Department of Medical Assistance Services (Virginia)
DMC	Data Management Committee of the VACSB
DOC	Department of Corrections (Virginia)
DOD	Department of Defense (U.S.)
DOE	Department of Education (Virginia)
DOJ	Department of Justice (U.S.)
DPB	Department of Planning and Budget (Virginia)

DPSP	Division of Programs for Special Populations (U.S.)
DRGs	Diagnosis-Related Groups
DRS	Department of Rehabilitative Services (Virginia)
DSM-IV	Diagnostic and Statistical Manual (Mental Disorders), Fourth Edition
DVH	Department for the Visually Handicapped (Virginia)
DVS	Department of Veterans Services (Virginia)
EBP	Evidence-Based Practice
ECA	Epidemiologic Catchment Area
ECO	Emergency Custody Order (Virginia)
ED Forum	Executive Directors Forum of the VACSB (Virginia)
EHR	Electronic Health Record
EI	Early Intervention
EMTALA	Emergency Medical Treatment and Active Labor Act (U.S.)
EO	Executive Order (Virginia)
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment (CMS)
ER	Emergency Room
ESH	Eastern State Hospital (DBHDS facility located in Williamsburg)
FAPT	Family Assessment and Planning Team
FAS	Fetal Alcohol Syndrome
FFP	Federal Financial Participation (Medicaid)
FFS	Fee-for-Service
FFY	Federal Fiscal Year
FHA	Federal Housing Administration (U.S.)
FMLA	Family and Medical Leave Act (U.S.)
FMR	Fair Market Rent (U.S. Housing and Urban Development)
FMS	Financial Management System (DBHDS financial information system)
FRP	Forensic Review Panel (DBHDS)
FSO	Facility Security Officer (DBHDS)
FTE	Full Time Equivalent
FY	Fiscal Year (State- July 1 to June 30; Federal - October 1 to September 30)
GA	General Assembly (Virginia)
GAF	Global Assessment of Functioning
GOSAP	Governor's Office for Substance Abuse Prevention (Virginia)
HD	House Document (Virginia)
HGTC	Hancock Geriatric Treatment Center (at Eastern State Hospital in Williamsburg)
HHR	Health and Human Resources Secretariat (Virginia)
HIE	Health Information Exchange or Homeless Information Exchange
HIPAA	Health Insurance Portability and Accountability Act of 1996
HJR	House Joint Resolution (also HJ) (Virginia)
HMO	Health Maintenance Organization
HPO	High Performance Organization
HPR	Health Planning Region (Virginia)
HPSA	Health Professional Shortage Area
HRIS	Human Resources Information System (Virginia)
HRSA	Health Resources and Services Administration (U.S.)
HSA	Health Services Area
HUD	Housing and Urban Development (U.S.)
HVAC	Heating, Ventilation, and Air Conditioning
HWDMC	Hiram W. Davis Medical Center (DBHDS facility located in Dinwiddie)
I&R	Information and Referral
IAPSRs	International Association of Psychosocial Rehabilitation Services
ICD	International Classification of Diseases

ICF	Intermediate Care Facility (CMS)
ICF/MR	Intermediate Care Facility for the Mentally Retarded (CMS)
ICT	Intensive Community Treatment
ID	Intellectual Disability
ID/MI	Intellectual Disability/Mental Illness (co-occurring diagnosis)
IDDT	Integrated Dual Disorders Treatment
IDEA	Individuals with Disabilities Education Act (U.S.)
ID waiver	Medicaid Home and Community-Based Waive, formerly the MR waiver (CMS)
ILPPP	University of Virginia Institute of Law, Psychiatry and Public Policy
IM	Investigations Manager (DBHDS central office)
IMD	Institution for the Mentally Disabled (CMS)
IM&R	Illness Management and Recovery
IP	Inpatient
IPA	Independent Practice Association
IQ	Intelligence Quotient
IS	Information Systems
ISN	Integrated Service Network
ISO	Information Security Officer (DBHDS central office)
ISP	Individualized Services Plan or Integrated Strategic Plan (DBHDS plan)
IT	Information Technology
ITIB	Information Technology Investment Board (DBHDS)
ITOTS	Infant and Toddler Information System (DBHDS application)
JAIBC	Juvenile Accountability Incentive Block Grant (U.S.)
JCHC	Joint Commission on Health Care (Virginia legislative commission))
JJDPA	Juvenile Justice Delinquency Prevention Act (U.S.)
JLARC	Joint Legislative Audit and Review Commission (Virginia legislative commission)
LEEP	Leading through Empowerment, Excellence, and Partnership (DBHDS central office HPO team)
LEP	Limited English Proficiency
LGD	Local Government Department (a type of CSB)
LHRC	Local Human Rights Committee (Virginia)
LICC	Local Interagency Coordinating Council (Part C) (Virginia)
LOF	Level of Functioning
LOS	Length of Stay
LSC	Life Safety Code
LTC	Long Term Care
MCH	Maternal and Child Health
MCO	Managed Care Organization
MDR	Multidrug-Resistant
Medicaid DSA	Medicaid Disproportionate Share Adjustments
Medicaid DSH	Medicaid Disproportionate Share Hospital
MedIs	Medication Information System (DBHDS application)
MESA	Mutual Education, Support, and Advocacy
MET	Motivational Enhancement Therapy
MFP	Money Follows the Person (CMS initiative)
MH	Mental Health
MHT SIG	Mental Health Transformation State Incentive Grant
MHA-V	Mental Health America – Virginia (formerly Mental Health Association of Virginia)
MHI	Mental Health Institute
MHPC	Mental Health Planning Council
MHPRC	Mental Health Policy Resource Center
MHSIP	Mental Health Statistics Improvement Program
MIC	Maternal and Infant Care

Mid-ATTC	Mid Atlantic Addiction Technology Transfer Center
MI/ID	Mental Illness/Intellectual Disability (co-occurring diagnosis)
MI/SUD	Mental Illness/Substance Use Disorder (co-occurring diagnosis)
MMWR	Morbidity and Mortality Weekly Report
MOA	Memorandum of Agreement
MOT	Mandatory Outpatient Treatment
MOU	Memorandum of Understanding
MRC	Medical Reserve Corps
MST	Multi-systemic Therapy
MUA	Medically Underserved Area
NA	Narcotics Anonymous
NADD	National Association for the Dually Diagnosed
NAEH	National Alliance to End Homelessness
NAFARE	National Association for Family Addiction, Research and Education
NAMI	National Alliance for the Mentally Ill
NAMI -VA	National Alliance for the Mentally Ill - Virginia
NAPH	National Association of Public Hospitals
NAPWA	National Association of People with AIDS
NASADAD	National Association of State Alcohol and Drug Abuse Directors
NADDDSD	National Association of Directors of Developmental Disabilities Services
NSDUH	National Household Survey on Drug Use and Health
NASMHPD	National Association of State Mental Health Program Directors
NASTAD	National Alliance of State and Territorial AIDS Directors
NCADD	National Council on Alcoholism and Drug Dependence
NCADI	National Clearinghouse for Alcohol and Drug Information
NCSACW	National Center for Substance Abuse and Child Welfare
NCCAN	National Center on Child Abuse and Neglect
NCH	National Coalition for the Homeless
NCS	National Comorbidity Survey
NCSACW	National Center for Substance Abuse and Child Welfare
NF	Nursing Facility
NGF	Non-general Funds (Virginia)
NGRI	Not Guilty by Reason of Insanity
NHCHC	National Health Care for the Homeless Council
NHIS-D	National Health Interview Survey Disability Supplement
NHSDA	National Household Survey on Drug Abuse
NIAAA	National Institute on Alcohol and Alcohol Abuse (U.S.)
NIDA	National Institute on Drug Abuse (U.S.)
NIH	National Institutes of Health (U.S.)
NIMH	National Institute on Mental Health (U.S.)
NOMS	National Outcomes Measures (SAMHSA)
NVMHCA	Northern Virginia Mental Health Consumers Association
NVMHI	Northern Virginia Mental Health Institute (DBHDS facility located in Falls Church)
NVTC	Northern Virginia Training Center (DBHDS facility located in Fairfax)
OAE	Office of Architectural and Engineering Services (DBHDS central office)
OAG	Office of the Attorney General (Virginia)
OBRA	Omnibus Budget Reconciliation Act of 1989 (U.S.)
OBS	Organic Brain Syndrome
OIG	Office of the Inspector General for Behavioral Health and Developmental Services (Virginia)
OLIS	Office of Licensing Information System (DBHDS licensing application)
OMHRC	Office of Minority Health Resource Center (U.S.)
ONAP	Office of National AIDS Policy (U.S.)

OP	Outpatient
OT	Occupational Therapy
PACT	Program of Assertive Community Treatment
PAIMI	Protection and Advocacy for Individuals with Mental Illnesses Act (U.S.)
PAIR	Parents and Associates of the Institutionalized Retarded
Part C	Part C of the IDEA (Federal funds for early intervention services)
PASARR	Pre-Admission Screening/Annual Resident Review
PATH	Projects for Assistance in Transition from Homelessness (federal grant)
PBPS	Performance-Based Prevention System
PBS	Positive Behavioral Supports
PCP	Person Centered Planning
PEATC	Parent Educational Advocacy Training Center
PGH	Piedmont Geriatric Hospital (DBHDS facility located in Burkeville)
PHA	Public Health Association
PHS	Public Health Service (U.S.)
PIP	Program Improvement Plan
PKI	Public Key Infrastructure
PL	Public Law (U.S.)
PMPM	Per Member Per Month
POIS	Purchase of Individualized Services
Pony Walls	Half-Height Walls in State Facility Patient Living Areas
POS	Purchase of Services
PPAC	Prevention and Promotion Advisory Council
PPC	Patient Placement Criteria
PPEA	Public Private Educational and Infrastructure Act of 2002 (Virginia)
PPO	Preferred Provider Organization
PPW	Pregnant and Postpartum Women
PRWORA	Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (U.S)
PRAIS	Patient Resident Automated Information System (DBHDS application, now AVATAR))
PRC	Perinatal Resource Center
PSR	Psychosocial Rehabilitation
PT	Physical Therapy
PTSD	Post Traumatic Stress Disorder
PWA	Persons with AIDS
QA	Quality Assurance
QI	Quality Improvement
QMHP	Qualified Mental Health Professional
QMRP	Qualified Mental Retardation Professional
RCSC	Regional Community Support Center
REACH	Recovery, Education and Creative Healing
Region I	Northwest Virginia
Region II	Northern Virginia
Region III	Far Southwestern Virginia
Region IV	Central Virginia
Region V	Eastern Virginia
Region VI	Southside Virginia
Region VII	Catawba Virginia
RM	Risk Management
RPP	Regional Planning Partnership
SA	Substance Abuse
SAARA	Substance Abuse and Addiction Recovery Alliance (Virginia)
SAC	State Adolescent Treatment Coordination Grant

S+C	Shelter Plus Care
SACAVA	Substance Abuse Certification Alliance of Virginia
SAMHSA	Substance Abuse and Mental Health Services Administration (U.S.)
SANAP	Substance Abuse Needs Assessment Project
SAPT	Substance Abuse Prevention and Treatment (federal block grant)
SD	Senate Document (Virginia)
SDLC	System Development Life Cycle
SE	Supported Employment
SEC	State Executive Council (of Comprehensive Services Act)
SED	Serious Emotional Disturbance
SELN	Supported Employment Leadership Network
SERG	State Emergency Response Grant (U.S.)
SEVTC	Southeastern Virginia Training Center (DBHDS facility located in Chesapeake)
SFY	State Fiscal Year (Virginia)
SGF	State General Funds
SHRC	State Human Rights Committee
SIS	Supports Intensity Scale
SJR	Senate Joint Resolution (also SJ)
SMHA	State Mental Health Authority
SMI	Serious Mental Illness
SMSA	Standard Metropolitan Statistical Area
SNF	Skilled Nursing Facility (CMS)
SOCAT	System of Care Advisory Team (Virginia)
SPMI	Serious and Persistent Mental Illness
SPO	State Plan Option (CMS), Single Room Occupancy, or School Resource Officer
SSA	Social Security Administration (U.S.)
SSDI	Social Security Disability Insurance
SSI	Supplemental Security Income
State Board	State Board of Behavioral Health and Developmental Services (Virginia)
STD	Sexually Transmitted Disease
STI	System Transformation Initiative (Virginia)
SUD	Substance Use Disorder (alcohol or other drug dependence or abuse)
SVMHI	Southern Virginia Mental Health Institute (DBHDS facility located in Danville)
SVP	Sexually Violent Predator
SVTC	Southside Virginia Training Center (DBHDS facility located in Dinwiddie)
SWVBHB	Southwest Virginia Behavioral Health Board
SWVMHI	Southwestern Virginia Mental Health Institute (DBHDS facility located in Marion)
SWVTC	Southwestern Virginia Training Center (DBHDS facility located in Hillsville)
TACIDD	The Advisory Consortium on Intellectual and Developmental Disabilities
TANF	Temporary Assistance for Needy Families (federal block grant)
TB	Tuberculosis
TBI	Traumatic Brain Injury
TC	Training Center (state ICF/MR)
TDO	Temporary Detention Order (Virginia)
TEDS	Treatment Episode Data Set
TFSASO	Task Force on Substance Abuse Services for Offenders (Virginia)
TIP	Treatment Improvement Protocols (CSAT)
TJC	The Joint Commission (formerly the Joint Commission on Accreditation of Healthcare Organizations)
TOVA	Therapeutic Options of Virginia
TWWIIA	Ticket to Work and Work Incentives Improvement Act of 1999 (U.S.)
UAI	Uniform Assessment Instrument
UM	Utilization Management

UR	Utilization Review
URICA	University of Rhode Island Change Assessment
U.S.	United States
VA	Department of Veterans Affairs (U.S.)
VaACCESS	Virginia Association of Community Rehabilitation Programs
VAADAC	Virginia Association of Alcoholism and Drug Abuse Counselors
VACSB	Virginia Association of Community Services Boards
VACO	Virginia Association of Counties
VADAP	Virginia Association of Drug and Alcohol Programs
VAFC	Virginia Association of Free Clinics
VAFOF	Virginia Federation of Families
VAHA	Virginia Adult Home Association
VAHMO	Virginia Association of Health Maintenance Organizations
VALHSO	Virginia Association of Local Human Services Officials
VANHA	Virginia Association of Nonprofit Homes for the Aging
VASAP	Virginia Alcohol Safety Action Program (Commission on)
VASIP	Virginia Service Integration Program (formerly COSIG)
VASH	Veterans Administration Supported Housing
VATTC	Virginia Addictions Technology Transfer Center
VBPD	Virginia Board for People with Disabilities
VCBR	Virginia Center for Behavioral Rehabilitation (DBHDS facility located in Burkeville)
VDEM	Virginia Department of Emergency Management (Virginia)
VDMDA	Virginia Depressive and Manic-Depressive Association
VEAD	Virginia Enterprise Architecture Division (Virginia) (formerly Virginia Enterprise Architecture Program)
VEC	Virginia Employment Commission (Virginia)
VHHA	Virginia Hospital and Healthcare Association
VHCA	Virginia Health Care Association
VHDA	Virginia Housing Development Authority (Virginia)
VHST	Virginia Human Services Training Center
VICC	Virginia Interagency Coordinating Council
VIACH	Virginia Interagency Action Council on Homelessness
VICH	Virginia Interagency Council on Homelessness
VIPACT	Virginia Institute for Professional Addictions Counselor Training
VITA	Virginia Information Technologies Agency (Virginia)
VITC	Virginia Intercommunity Transition Council
VML	Virginia Municipal League
VNPP	Virginia Network of Private Providers
VOCAL	Virginia Association of Consumers Asserting Leadership
VOPA	Virginia Office for Protection and Advocacy (Virginia)
VPCA	Virginia Primary Care Association
VPN	Virtual Private Network
VR	Vocational Rehabilitation
VRHRC	Virginia Rural Health Resource Center
VVC	Voices for Virginia's Children
WIB	Workforce Investment Board
WRAP	Wellness Recovery Action Plan
WSH	Western State Hospital (DBHDS facility located in Staunton)

Appendix I
Comprehensive State Plan 2008-2014 Reference Documents

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