

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

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

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

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

Department of Behavioral Health and Developmental Services

Community Services Boards

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

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

Table 1. Service Categories in Comprehensive System of Care

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

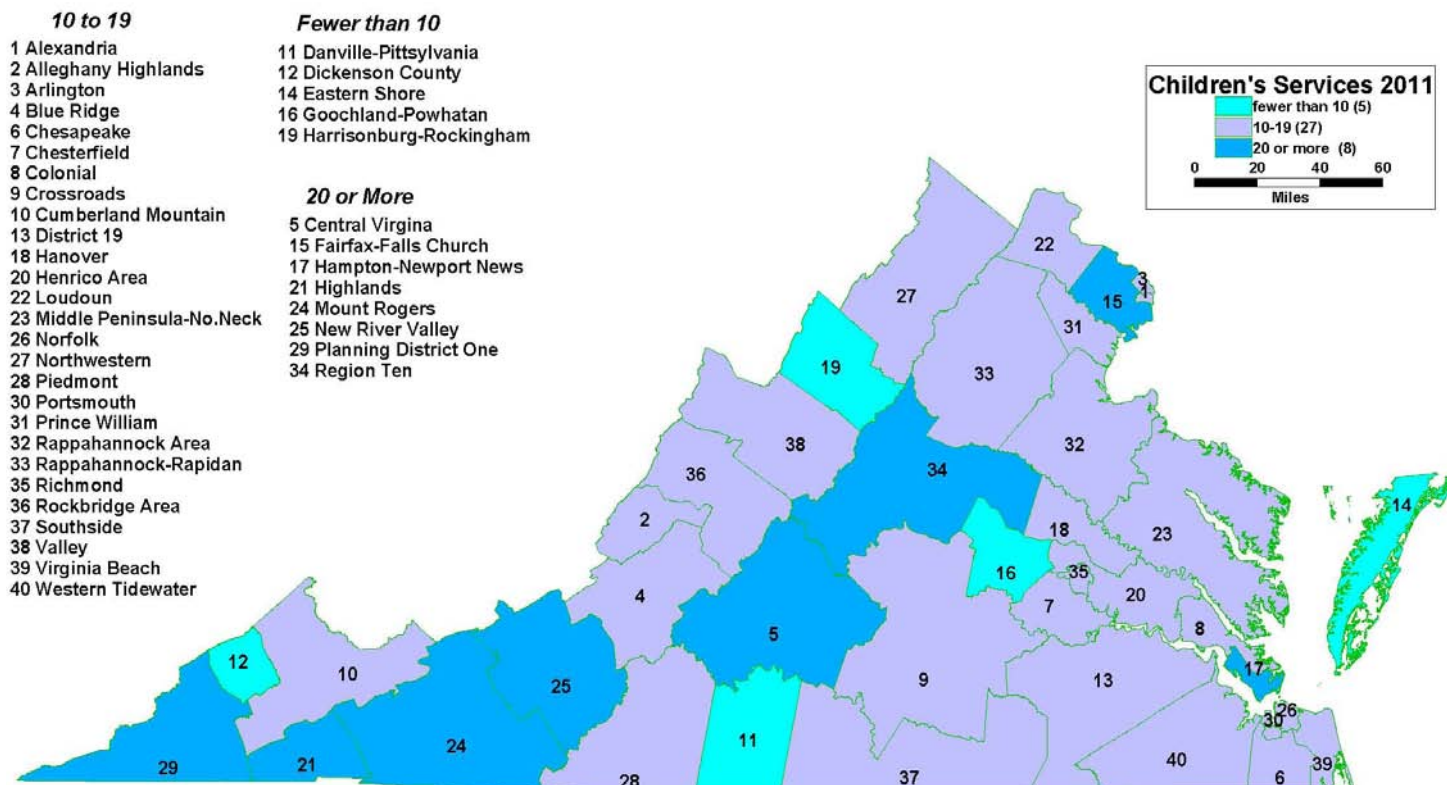
*The four services identified in the report as base services that should be available to children statewide.

Source: Virginia Department of Behavioral Health and Developmental Services

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

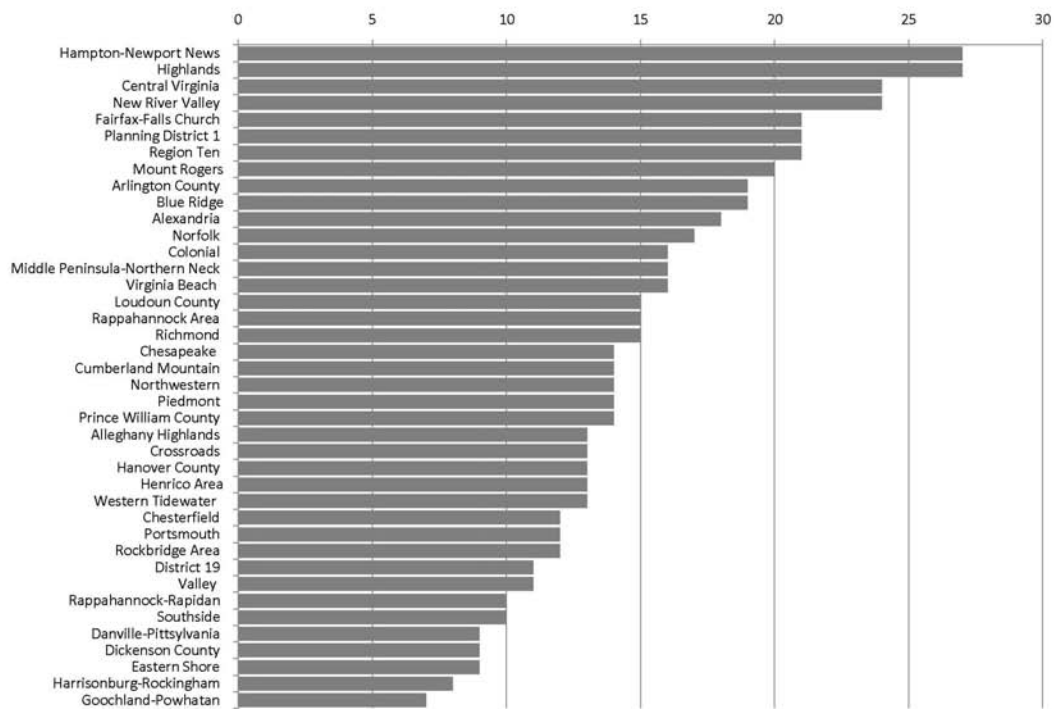
The report found that CSBs in every area of the state lack the full array of 39 services and that there is a great deal of variability in the amount and types of services available from one region to the next. Eight of the 40 CSBs (20%) provide 20 or more services. Five of the CSBs (13%) provide fewer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

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



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

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



Department of Behavioral Health and Developmental Services

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

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

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

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

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

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

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

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

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

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

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

Acute Inpatient Psychiatric Hospitalization

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

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

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

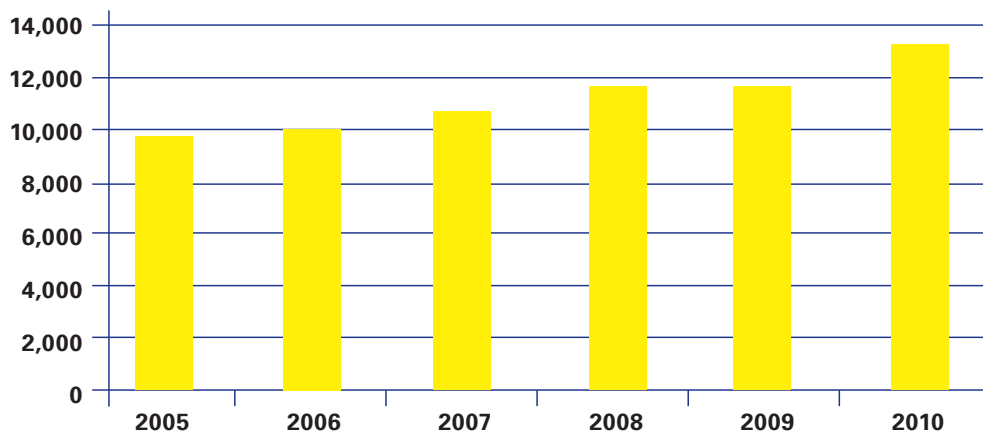
In the first eight months of FY11, CCCA admitted 469 children and youth for a total of 8,091 bed days. The average daily census for this eight-month period of time was 33.3 children, although February represented a peak month with an average daily census of 39.6. Of the total number of children admitted,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

Early Intervention

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

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

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



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

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

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

Office of Comprehensive Services

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

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

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

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

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

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

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

Table 3. CSA Residential Costs as Percentage of Total Expenditures

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

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

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

Department of Medical Assistance Services

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

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

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

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

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

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

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

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

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

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

Juvenile Justice System

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

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

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

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

Conclusions and Implications

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

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

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

Voices' Impact on Child Mental Health in Virginia

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

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

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

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

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

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

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

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- 1 U.S. Department of Health and Human Services. (1999). Mental Health: A Report of the Surgeon General. Chapter 3, Section 1. Retrieved from <http://mentalhealth.samhsa.gov/features/surgeongeneralreport/chapter3/sec1.asp>.
- 2 Virginia Department of Behavioral Health and Developmental Services. Draft Comprehensive State Plan 2010-2016. Retrieved from <http://www.dbhds.virginia.gov/documents/opd-CompStatePlan-2010-2016.pdf>.
- 3 U.S. Department of Health and Human Services, supra note 1.
- 4 U.S. Department of Health and Human Services. (1999). Mental Health: A Report of the Surgeon General. Chapter 3, Section 8. Retrieved from <http://mentalhealth.samhsa.gov/features/surgeongeneralreport/chapter3/sec8.asp>.
- 5 Code of Virginia, Section 37.2-500. Retrieved from <http://leg1.state.va.us/cgi-bin/legp504.exe?000+cod+37.2-500>.
- 6 Virginia Department of Behavioral Health and Developmental Services. Item 304.M – Interim Report: A Plan for Community-Based Children's Behavioral Health Services in Virginia, To the Chairs of the House Appropriations and Senate Finance Committees, October 1, 2010. Retrieved from <http://www.dbhds.virginia.gov/documents/OLPR-Item304M-Interim-Childrens-Plan-Oct-1-2010.pdf>.
- 7 Personal communication on 3/25/11 with Commissioner Jim Stewart, John Pezzoli and Janet Lung, Virginia Department of Behavioral Health and Developmental Services.
- 8 Virginia Department of Behavioral Health and Developmental services, supra note 6.
- 9 Virginia Department of Behavioral Health and Developmental Services. (2010, December). Item 304 N – Fiscal Year 2010 Annual Report. Retrieved from <http://www.dbhds.virginia.gov/documents/olpr-Item304N-Annual-DBHDS-Rep-2010-10.pdf>.
- 10 Personal communication on 3/17/11 with Paul Gilding, Virginia Department of Behavioral Health and Developmental Services.
- 11 Virginia Department of Behavioral Health and Developmental services, supra note 6.
- 12 Ibid.
- 13 Voices for Virginia's Children. (2010, July). Virginians Speak Out: A Report from the Campaign for Children's Mental Health. Retrieved from <http://1in5kids.org/meetings-and-events/forum%20report%20FINAL.pdf>.
- 14 Virginia Department of Behavioral Health and Developmental services, supra note 6.
- 15 Virginia Office of the Inspector General for Mental Health, Mental Retardation and Substance Abuse Services. (2008, September). Review of Community Services Board Child and Adolescent Services. Retrieved from <http://www.oig.virginia.gov/documents/SS-CACM-149-08.pdf>.
- 16 Virginia Department of Behavioral Health and Developmental Services, supra note 9.
- 17 Personal communication on 1/6/11 with Paul Gilding, Virginia Department of Behavioral Health and Developmental Services.

- 18 Annie E. Casey Foundation. KIDS COUNT Data Center. Retrieved from <http://datacenter.kidscount.org/data/acrossstates/Default.aspx>.
- 19 Personal communication on 3/30/11 with Paul Gilding, Virginia Department of Behavioral Health and Developmental Services.
- 20 Personal communications throughout March 2011 with numerous Community Services Boards.
- 21 Virginia Department of Behavioral Health and Developmental Services. Parent Perceptions of Services at Community Services Boards, reports for 2005-2008. Retrieved from <http://www.dbhds.virginia.gov/CFS-UsefulInformation.htm#cfs4>.
- 22 Virginia Department of Behavioral Health and Developmental Services. Parent Perceptions of Services at Community Services Boards, 2008. Retrieved from <http://www.dbhds.virginia.gov/documents/reports/OMH-yssf2008survey.pdf>.
- 23 Nimmo, Margaret L. (2000, October). Action Alliance for Virginia's Children and Youth, Special Report: Issues in Children's Mental Health. Retrieved from http://vakids.org/pubs/Health/mh_paper.pdf.
- 24 Personal communication throughout March 2011 with Barbara Shue, Commonwealth's Center for Children and Adolescents.
- 25 Infant and Toddler Connection. Retrieved from <http://www.infantva.org/>
- 26 Virginia Department of Behavioral Health and Developmental Services. (2009, December). Comprehensive State Plan 2010-2016. Retrieved from <http://www.dbhds.virginia.gov/documents/reports/opd-StatePlan2010thru2016.pdf>.
- 27 Personal communication on 11/19/09 and 3/11/11 with David Mills, Virginia Department of Behavioral Health and Developmental Services.
- 28 Penfield, Randall D. (2010, November). Analysis of the Virginia Family Survey Data Addressing Part C SPP/APR Indicator #4: Final Report. Retrieved from <http://www.infantva.org/documents/sup-FamilySurvey-2010.pdf>.
- 29 Annie E. Casey Foundation. KIDS COUNT Data Center. Retrieved from <http://datacenter.kidscount.org/data/acrossstates/Rankings.aspx?ind=103>.
- 30 Penfield, Randall D. (2008, November). Analysis of the Virginia Family Survey Data Addressing Part C SPP/APR Indicator #4: Final Report. Retrieved from http://www.infantva.org/documents/FamilySurveyReport_2008.pdf.
- 31 Penfield, Randall D., supra note 28.
- 32 Office of Comprehensive Services. Statewide Summary of Census Expenditures FY 1994- 2010. Retrieved from http://www.csa.virginia.gov/publicstats/csastats09/profiles.cfm?RequestTimeout=500&export_fyqtr=20104.
- 33 Office of Comprehensive Services. CSA Data Set, FY10 Q4, Statewide Profile. Retrieved from http://www.csa.virginia.gov/cdb09/profiles/snapshot_combined_20104.htm.
- 34 Ibid.
- 35 Office of Comprehensive Services. CSA Data Set, FY10 Q4: Percent of children that have a DSM Diagnosis. Retrieved from http://www.csa.virginia.gov/publicstats/csastats09/rankings/dsmiv_child_locality.cfm?RequestTimeout=500&export_fyqtr=20104.
- 36 Office of Comprehensive Services, supra note 33.
- 37 Annie E. Casey Foundation, supra note 18.
- 38 Office of Comprehensive Services, supra note 33.
- 39 Virginia Department of Social Services. (2011, April). Retrieved from http://www.dss.virginia.gov/files/about/reports/children/foster_care/2011/children_demographic/fc_demo_2011-02.xls.
- 40 Virginia Office of Comprehensive Services for At-Risk Youth and Families. (2010, December). Residential Services for Children in the Comprehensive Services Act: Utilization, Length of Stay and Expenditures Statewide and by Locality, Program Year 2010. Retrieved from [http://leg2.state.va.us/dls/h&sdocs.nsf/By+Year/RD3682010/\\$file/RD368.pdf](http://leg2.state.va.us/dls/h&sdocs.nsf/By+Year/RD3682010/$file/RD368.pdf).
- 41 Virginia Department of Medical Assistance Services. Psychiatric Services Provider Manual. Retrieved from <https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual>.
- 42 Virginia Department of Medical Assistance Services. Community Mental Health Rehabilitation Services Provider Manual. Retrieved from <https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual>.
- 43 Personal communication on 3/22/11 with Steve Ford, Department of Medical Assistance Services.
- 44 Massart, Susan E. (2010, November). Costs and Trends in the Virginia Medicaid Program: Presentation to House Appropriations Committee. Retrieved from http://hac.virginia.gov/committee/files/2010/11-17-10/VA_%20Medicaid_Program_Costs_and_Trends.pdf.
- 45 Personal communication on 3/15/11 with Mendy Meeke, Department of Medical Assistance Services.
- 46 Personal communication on 3/21/11 with Karen Lawson, Department of Medical Assistance Services.
- 47 Personal communication on 3/28/11 with Laurie Meyer, Alexandria Community Services Board.
- 48 Nimmo, Margaret L., supra note 23.
- 49 Virginia Department of Juvenile Justice. (2010, December). Data Resource Guide: Fiscal Year 2010. Retrieved from http://www.djj.virginia.gov/About_Us/Administrative_Units/Research_and_Evaluation_Unit/pdf/Commitment_to_the_State_2010.pdf.
- 50 Virginia Department of Juvenile Justice. (2010, April). Profiles of Committed Juveniles, Fiscal Years 2004-2008. Retrieved from http://www.djj.virginia.gov/Resources/DJJ_Publications/pdf/Profiles_of_Committed_Juveniles.pdf.
- 51 Personal Communication on 4/6/11 with Marilyn Miller, Virginia Department of Juvenile Justice.
- 52 Virginia Department of Juvenile Justice, supra note 50.
- 53 Hartney, Christopher, and Vuong, Linh. (2009, March). National Council on Crime and Delinquency. Created Equal: Racial and Ethnic Disparities in the US Criminal Justice System. Retrieved from <http://www.nccd-crc.org/nccd/pdf/CreatedEqualReport2009.pdf>.

