Comprehensive State Plan

2014-2020

Virginia Department of Behavioral Health and Developmental Services

December 2013

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DRAFT Comprehensive State Plan 2014-2020

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Comprehensive State Plan 2014-2020
Executive Summary

Section 37.2-315 of the C*ode 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; 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 Commonwealth's public 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 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 nine state hospitals, five training centers (one of which provides administration services to a medical center), and a sexually violent predator rehabilitation center that are operated by the Department and 39 community services boards and one behavioral health authority (referred to as CSBs) established by local governments.

- CSBs deliver community behavioral health (BH) and developmental (DEV) services, either directly or through contracts with private providers. BH services are provided to individuals with mental health or substance use disorders and DEV services are provided to individuals with intellectual disability. CSBs are single points of entry into the 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 2013, the total unduplicated count of individuals receiving behavioral health or developmental services was 213,902. CSBs provided mental health services to 112,121 individuals, developmental services to 20,248 individuals, substance abuse services to 34,382 individuals, emergency services to 58,300 individuals, and ancillary services (motivational treatment, consumer-monitoring, and early intervention and assessment and evaluation services) to 67,735 individuals. Additionally, 6,928 individuals received services in a consumer-run program.

  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 2013, 13,685 individuals were waiting to receive at least one CSB service.

- State facilities provide highly structured intensive inpatient treatment and habilitation services. On September 12, 2013, state facility operating capacities included:
  - 1,487 beds in state hospitals, of which 1,200 beds were occupied;
  - 999 beds in training centers, of which 744 beds were occupied;
  - 87 beds at Hiram Davis Medical Center, of which 61 beds were occupied; and
  - 450 beds at the Virginia Center for Behavioral Rehabilitation, of which 311 beds were occupied.

In FY 2013, state facilities served 5,772 individuals, down from 6,238 in July 2012 and 6,338 in July 2011.

In FY 2013, services system total funding was $2.492 billion:

- Community services funding for services was $1,863.1 million or 75 percent of total system funding,
- Facility services funding was $589.1 million or 24 percent of total system funding, and
- Department central office funding was $40.0 million or one percent of total system funding.

Services system funding comes from a variety of sources, including state general funds, local matching dollars, federal grants, and fees.

Estimated Prevalence: By applying prevalence rates from national epidemiological studies and the National Household Surveys on Drug Use and Health to Weldon Cooper Center for Public Service Age & Sex estimates for 2012, the Department estimates that:

- Approximately 341,773 adults in Virginia have had a serious mental illness.
- Between 117,592 and 143,724 children and adolescents have a serious emotional disturbance, with between 65,329 and 91,461 exhibiting extreme impairment.
- Approximately 147,346 individuals are conservatively estimated to have a developmental disability, of which 76,763 (ages 6 and older) have intellectual disability and 1 in 88 children have an autism spectrum disorder.
- Approximately 116,190 infants, toddlers, and young children (birth through age 3) have developmental delays requiring early intervention services.
- Approximately 175,234 adults and adolescents abuse or are dependent on any illicit drug, with 122,112 meeting the criterion for dependence, and 477,409 adults and adolescents abuse or are dependent on alcohol, with 209,729 meeting the criterion for dependence.

However, 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.

CSB Waiting Lists: During the first quarter of calendar year 2013, CSBs completed a point-in-time survey of each person identified by the CSB as being in need of specific services. To be included on the waiting list for CSB services, a person 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 who were not receiving all of the amounts or types of services that they needed. CSBs identified a total of 13,685 individuals who were waiting for services. In addition, for the first time, service needs of 6,674 individuals on the Medicaid ID waiver waiting list were available. Individuals documented as waiting for services included:

- 4,486 (3,218 adults and 1,268 children and adolescents) were reported by CSBs as needing mental health services;
- 8,095 (5,100 adults and 2,995 children and adolescents) were reported by CSBs as needing developmental services; and
- 1,104 (558 adults and 546 adolescents) were reported by CSBs as needing substance abuse treatment services.

This count includes 85 individuals who were on mental health and substance abuse treatment services waiting lists, 11 individuals who were on mental health and developmental services waiting lists, and one person who was on waiting lists for developmental and substance abuse treatment services.

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.

Services System Strategic Initiatives: Behavioral health and developmental services system strategic initiatives included in the Comprehensive State Plan 2014-2020 incorporate the *Creating Opportunities: A Plan for Advancing Community-Focused Services in Virginia* focus areas and include other critical issues facing the Commonwealth and Departmental strategic initiatives:

Systemwide

1. Services system implementation of health care reform
2. Services system quality improvement and accountability
3. Case management;
4. Independent housing; and
5. Employment First initiative.

Behavioral Health Services

1. Mental health services capacity;
2. Child and adolescent behavioral health services capacity;
3. Substance abuse treatment services capacity;
4. Peer services and peer-provided recovery supports; and
5. State hospital service effectiveness and efficiency.

Developmental Services

1. Developmental services community capacity development; and
2. Training center discharge planning and community integration.

Civil Commitment of Sexually Violent Predators

Department Initiatives

1. Information technology solutions
2. Workforce development; and
3. State facility capital infrastructure and energy efficiency.

Summary of Resource Requirements: The following capacity development priorities respond to critical issues facing Virginia's behavioral health and developmental services system. Implementation of these capacity development priorities is contingent on resource availability.

Behavioral Health Services Investment Priorities

- Expand statewide mental health services capacity to fill identified services gaps, including individual and group psychotherapy, family counseling, supportive counseling, psychiatry and medication services for older teens and young adults during the difficult period of transition from school to adulthood; Programs of Assertive Community Treatment (PACT) teams in communities that now lack this essential intensive service; therapeutic assessment centers (drop-off centers); early intervention services (Part C); discharge assistance for individuals receiving services in state hospitals whose discharges have been delayed because they need services that are not otherwise available; permanent supportive housing assistance; extended care for individuals under a temporary detention order; and enhanced forensic-related evaluation rates.
- Expand statewide substance abuse intensive outpatient treatment, including earlier access to assessment and intensive outpatient services within the Systems of Care framework for youth with substance abuse and co-occurring disorders; rehabilitation and employment capacity to help persons in recovery from alcohol and drug addiction find and keep jobs; and community-based residential medical detoxification.
- Expand peer support recovery services for persons with mental health, substance use, or co-occurring disorders to include peer support groups; education in illness and wellness management; job-readiness training; coaching and mentoring; assistance with social services and entitlements; drop-in and socialization opportunities, and residential supports.

- Cover increased WSH operating costs incurred when new facility opened in October 2013, including increased IT requirements and VITA charges, security, and operations and increased CCCA security and IT costs associated with WSH's move to a new building.
- Offset lost Medicaid revenues associated with the diminishing geriatric population at ESH with state general funds.

Developmental Services Investment Priorities

- Collaborate with the Department of Medical Assistance Services (DMAS) to expand waiver capacity, modify existing or create new waivers, and address waiver rate structures.
- Expand developmental services capacity to implement the settlement agreement with the U.S. Department of Justice (DOJ). This includes family supports, rental subsidies, crisis stabilization, and quality management and independent review.
- Establish community-based regional Developmental Disability Health Supports Network clinical teams to provide or facilitate access to local professionals providing medical, dental, and other clinical services; behavioral and other supports; and specialized equipment.
- Provide housing bridge funds to support transition of individuals residing at NVTC to the most integrated community setting of their choice by offsetting the gap between their monthly Social Security income and the projected fair market cost of housing in the region.

Civil Commitment of Sexually Violent Predators Investment Priority

- Cover conditional release services and supervision at the point that an individual's probation obligation by the Department of Corrections (DOC) ends.

Systemwide Investment Priorities

- Support ongoing operation of the Department's electronic health record system (EHRS).
- Upgrade regional IT security staffing and processes to meet federal and state requirements.
- Support Department's interface with the state's new financial information system.

Conclusion: Successful implementation of these strategic initiatives will continue Virginia's progress in advancing a community-focused system of recovery-oriented and person-centered services and supports that promote the highest possible level of participation by individuals receiving behavioral health or developmental services in all aspects of community life including work, school, family, and other meaningful relationships. They also will enhance the ability of the services system to perform its core functions in a manner that is effective, efficient, and responsive to the needs of individuals receiving services and their families.

On December 10, 2013, Governor McDonnell announced a number of budget proposals totaling more than $38 million over the 2014-2015 biennium to improve Virginia's response to mental health crisis services and behavioral health treatment and support services to prevent crises from developing and issued an executive order (Executive Order # 68) creating the Task Force on Improving Mental Health Services and Crisis Response. Also announced was separate funding to the Department and related Department of Medical Assistance Services (DMAS) resources totaling $95.8 million for the biennium to fund developmental supports and services required under the Settlement Agreement with the U.S. Department of Justice. The governor reported that the governor-elect was fully supportive of the proposed changes and investments and would continue the task force during his term.

The Department's executive leadership will continue to monitor implementation of the strategic initiatives and major agency activities identified in the *Comprehensive State Plan 2014-2020*.

Comprehensive State Plan
2014 - 2020

I. INTRODUCTION

Section 37.2-315 of the C*ode 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; 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 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 Plan1996-2002*. Biennial updates to the Comprehensive State Plan were reinstated in 1997 with the completion of the 1998-2004 Plan.

The 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 and developmental 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.

The *Comprehensive State Plan 2014-2020* continues to focus on the strategic initiatives described in the Department's *Creating Opportunities: A Plan for Advancing Community-Focuses Services in Virginia* (Creating Opportunities Plan) issued on June 25, 2010. This plan identifies behavioral health and developmental services strategic initiatives and major Department activities to:

- Support the Commonwealth's realization of a Commonwealth of Opportunity for all Virginians, including individuals receiving behavioral health or developmental services;
- Continue progress in advancing the vision of self-determination, empowerment, recovery, resilience, health, and participation by individuals receiving behavioral health and developmental services in all aspects of community life;

- Promote efficient and effective management of services system core functions and responsiveness to the needs of individuals receiving services and their families; and
- Communicate the Department's strategic agenda and priority initiatives to key decision-makers in state government, individuals receiving services and their families, public and private providers, advocates, and other interested stakeholders.

The Creating Opportunities Plan builds on the recommendations of the Department's Integrated Strategic Plan (ISP), which was the product of a two-year strategic planning process that involved hundreds of interested Virginians and provided a framework for transforming Virginia's publicly funded behavioral health and developmental services system.

Comprehensive State Plan 2014-2020 initiatives have been incorporated in the Agency Strategic Plan (ASP) and associated Service Area Plans prepared as part of the 2014-2016 performance budgeting submission to the Virginia Department of Planning and Budget (DPB). Using a uniform structure and cross-agency taxonomy of state programs and activities provided by DPB, the Department's ASP aligns 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.

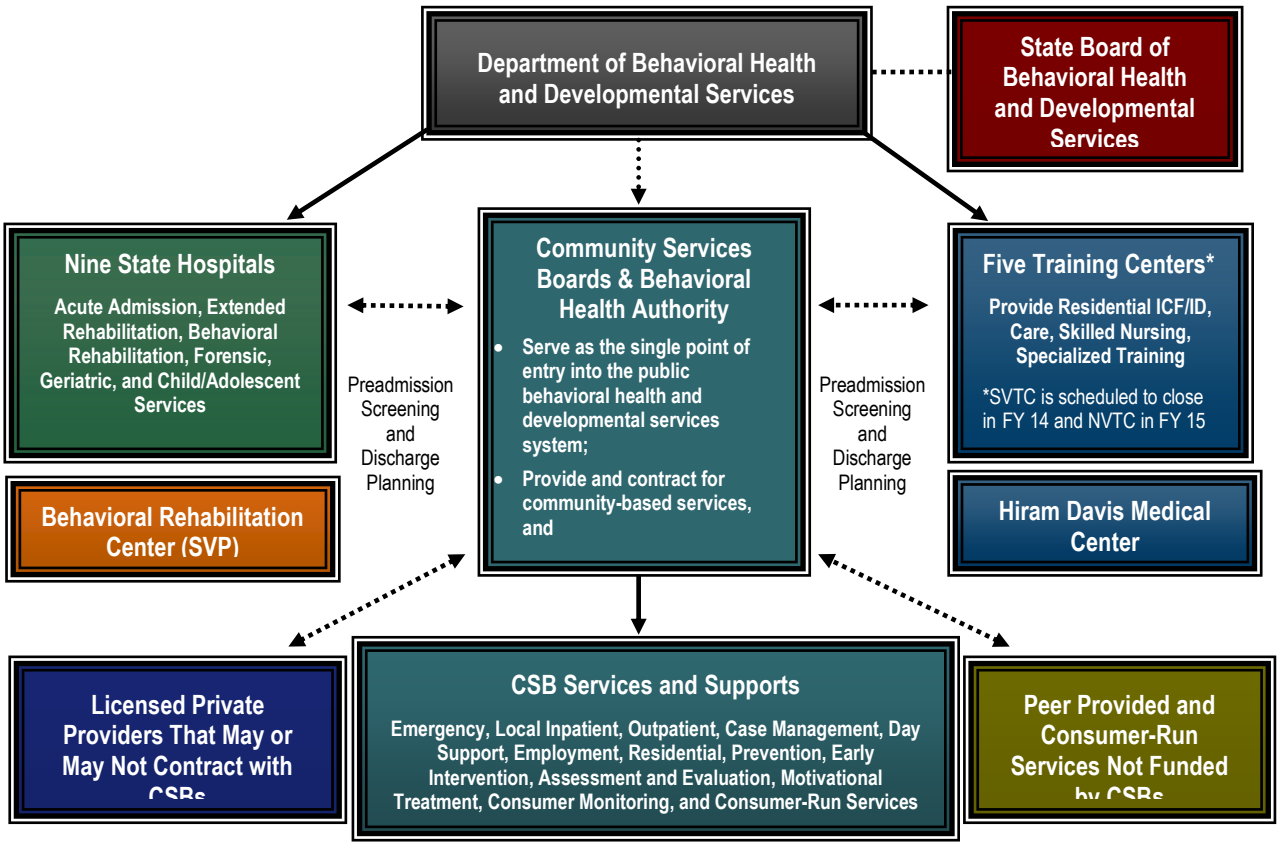
The draft *Comprehensive State Plan 2014-2020* was placed on the Department's website for public review and comment on October 11, 2013. Copies also were provided to individuals upon request. The Department received five comments by mail or email. At its December 5, 2013 meeting, the State Board reviewed these comments and considered changes proposed by the Department in response to this public comment.

II. SERVICES SYSTEM OVERVIEW

Services System Structure and Statutory Authority

The public behavioral health and developmental services system in Virginia includes the Department; a state policy board appointed by the Governor; nine state hospitals, five training centers, a medical center, and a behavioral rehabilitation center for sexually violent predators (SVP) 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 illustrates 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 (BH) and developmental (DEV) services system. BH services are provided to individuals with mental health or substance use disorders and DEV services are provided to individuals with intellectual disability. By statute, the State Board provides policy direction for Virginia's services system. Descriptions of populations receiving BH or DV services are provided in Appendix B.

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 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.

Community Services Boards Characteristics and Trends

Community services boards (CSBs) are established by the 134 local governments in Virginia pursuant to Chapters 5 or 6 of Title 37.2 of the *Code of Virginia* and may serve single or multiple jurisdictions. CSBs provide services directly and through contracts with private providers, which are vital partners in delivering behavioral health and developmental services. CSBs function as the single points of entry into publicly funded behavioral health and developmental services, including access to state facility services through preadmission screening, case management and coordination of services, and discharge planning for individuals leaving state facilities. CSBs advocate for individuals who are receiving services or who are in need of services, act as community educators, organizers, and planners, and advise their local governments about behavioral health and developmental services and needs.

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. 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. Numbers of CSBs that function as local government departments (LGDs) and that serve single or multiple jurisdictions by CSB classification follow:

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.

While not part of the Department, CSBs are key operational partners with the Department and its state facilities in Virginia's public behavioral health and developmental services system. 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. More information about CSBs is available in the *2012* *Overview of Community Services in Virginia*.

CSB Mental Health Services

In FY 2013, 112,121 individuals received CSB mental health (MH) services. This represents an unduplicated count of all individuals receiving any MH services.

Number of Individuals Receiving Mental Health Core Services in FY 2013

Core Service	# Served	Core Service	# Served
Local Inpatient Services		Group Supported Employment	76
Outpatient Services	93,564	**TOTAL Employment Services**	**1,282**
Assertive Community Treatment	2,992	Highly Intensive Residential	78
TOTAL Outpatient Services	**96,556**	Residential Crisis Stabilization	4,609
Case Management Services	**57,341**	Intensive Residential	528
Day Treatment/Partial Hospitalization	4,929	Supervised Residential	902
Ambulatory Crisis Stabilization Services	1,397	Supportive Residential	6,099
Rehabilitation Services	4,453	**TOTAL Residential Services**	**12,216**
TOTAL Day Support Services	**10,779**	**TOTAL Individuals Served**	**178,174**
Sheltered Employment Services	37	**TOTAL Unduplicated Individuals**	**112,121**
Supported Employment	1,169		

Source: 2013 Community Services Performance Contract Annual Reports, DBHDS.

Between FY 1986 (the first year that annual performance contract data was submitted by CSBs) and FY 2013, the numbers of individuals receiving various CSB mental health services grew from 135,182 to 178,174 (32 percent). In FY 2008, the Department created a new service category that includes Emergency and ancillary services (e.g., Motivational Treatment, Consumer Monitoring, Early Intervention, Assessment and Evaluation, and Consumer-Run Programs), which previously had been classified separately by program area. Between FY 2008 and FY 2013, the unduplicated number of individuals receiving CSB MH services increased from 101,796 to 112,121 (10.1 percent).

In FY 2013, of the 80,453 adults receiving mental health services, 49,471 adults (60.44 percent) had a serious mental illness and of the 33,075 children receiving mental health services, 25,931 (77.66 percent) had or were at risk of having a serious emotional disturbance.

CSB Developmental Services

In FY 2013, 20,248 individuals received CSB developmental (DEV) services. This represents an unduplicated count of all individuals receiving any DEV services.

Number of Individuals Receiving Developmental Core Services in FY 2013

Core Service	# Served	Core Service	# Served
Outpatient Services	**645**	Highly Intensive Residential	206
Case Management Services	**18,466**	Intensive Residential	844
Rehabilitation or Habilitation	2,490	Supervised Residential	379
TOTAL Day Support Services	**2,490**	Supportive Residential	1,251
Sheltered Employment Services	598	**TOTAL Residential Services**	**2,680**
Transitional or Supported Employment	934	**TOTAL Individuals Served**	**26,236**
Group Supported Employment	423	**TOTAL Unduplicated Individuals**	**20,248**
TOTAL Employment Services	**1,955**		

Source: 2013 Community Services Performance Contract Annual Reports, DBHDS

Between FY 1986 and FY 2013, the numbers of individuals receiving various CSB developmental services increased from 20,329 to 26,236 (29 percent).

CSB Substance Abuse Services

In FY 2013, 34,382 individuals received substance abuse (SA) services from CSBs. This represents an unduplicated count of all individuals receiving any SA services.

Number of Individuals Receiving Substance Abuse Core Services in FY 2013

Core Service	# Served	Core Service	# Served
Local Inpatient	39	Highly Intensive Residential Services	2,735
Community-Based SA Medical Detox Inpatient	237	Residential Crisis Stabilization Services	338
TOTAL Local Inpatient Services	**285**	Intensive Residential Services	3,288
Outpatient Services	26,591	Supervised Residential Services	268
Medication Assisted Treatment	2,088	Supportive Residential Services	62
TOTAL Outpatient Services	**28,679**	**TOTAL Residential Services**	**6,691**
Case Management Services	**10,166**	**TOTAL Individuals Served**	**46,588**
Day Treatment/Partial Hospitalization	**767**	**TOTAL Unduplicated Individuals**	**34,382**
TOTAL Day Support Services	**767**		

Source: 2013 Community Services Performance Contract Annual Reports, Department.

Between FY 1986 and FY 2013, the numbers of individuals receiving various CSB substance abuse services declined from 52,942 to 46,588 (12 percent). In FY 2008, the Department created a new service category that includes Emergency and ancillary services (e.g., Motivational Treatment, Consumer Monitoring, Early Intervention, Assessment and Evaluation, and Consumer-Run Programs), which previously had been classified separately by program area., which previously had been classified separately by program area. Between FY 2008 and FY 2013, the unduplicated number of individuals receiving CSB substance abuse services decreased from 43,657 to 34,382 (21 percent).

CSB Emergency and Ancillary Services

In FY 2013, 58,300 individuals (unduplicated) received CSB emergency services and 67,735 received the following ancillary services. Additionally, 6,928 individuals received services in a consumer-run program.

Number of Individuals Receiving Ancillary Services in FY 2012

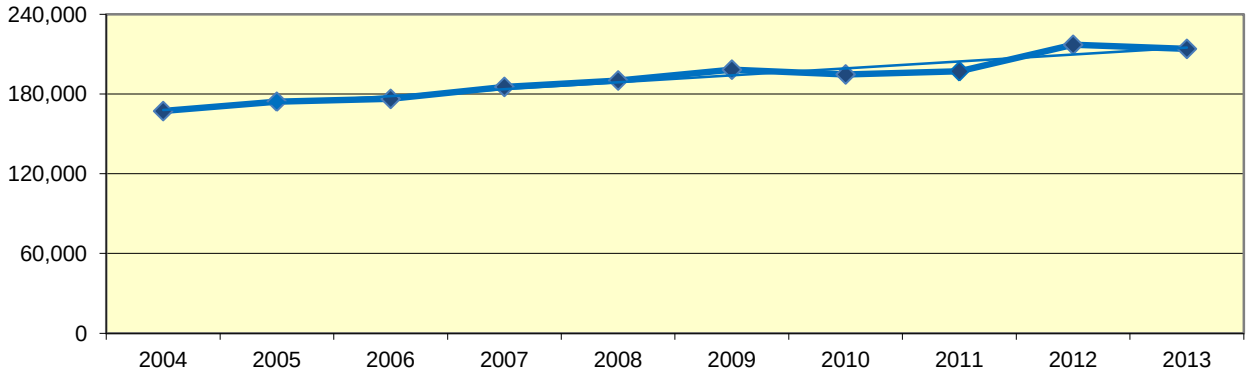
Core Service	# Served	Core Service	# Served
Motivational Treatment	4,541	Early Intervention Services	2,429
Consumer Monitoring Services	7,685	**TOTAL Individuals Served**	**71,852**
Assessment and Evaluation	57,197	**TOTAL Unduplicated Individuals**	**67,735**

Source: 2013 Community Services Performance Contract Annual Reports, DBHDS

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 2013, the total unduplicated count of individuals served was 213,902.

Trends in Unduplicated Numbers of Individuals Receiving CSB Services FY 2004 - FY 2012



Appendix C contains detailed information on CSB service utilization trends. Core services definitions are at Core Services Taxonomy 7.2.

State Facility Characteristics and Trends

State Hospitals

The Department operates eight state hospitals for adults: Catawba Hospital (CH) in Catawba (near Salem), Central State Hospital (CSH) in Petersburg, Eastern State Hospital (ESH) in Williamsburg, Piedmont Geriatric Hospital (PGH) in Burkeville, Northern Virginia Mental Health Institute (NVMHI) in Falls Church, Southern Virginia Mental Health Institute (SVMHI) in Danville, Southwestern Virginia Mental Health Institute (SWVMHI) in Marion, and Western State Hospital (WSH) in Staunton. The Department also operates one behavioral facility for children with serious emotional disturbance: the Commonwealth Center for Children and Adolescents (CCCA) in Staunton.

State hospitals provide highly structured intensive inpatient services, including a range of psychiatric, psychological, psychosocial rehabilitation, nursing, support, and ancillary services. All facilities are accredited by The Joint Commission as meeting standards of quality care to provide assessment, stabilization and comprehensive treatment. Specialized programs are provided to older adults, children and adolescents, and individuals with a forensic status. State hospital operating (staffed) bed capacities and FY 2013 average daily census (ADC) follow.

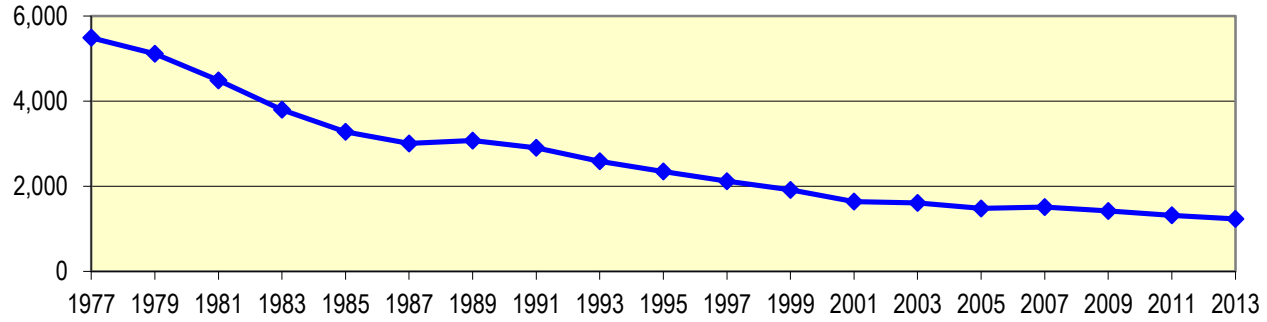
State Hospital Operating Capacities* and FY 2013 Average Daily Census

MH Facility	Beds	ADC	MH Facility	Beds	ADC
Catawba Hospital	120	92	Piedmont Geriatric	135	102
Central State Hospital	279	204	Southern VA MHI	72	65
CCCA	48	32	Southwestern VA MHI	162	149
Eastern State Hospital	302	258	Western State Hospital	246	214
Northern VA. MHI	123	116	**Total Operating Capacity (Beds) & ADC**	**1,487**	**1,233**

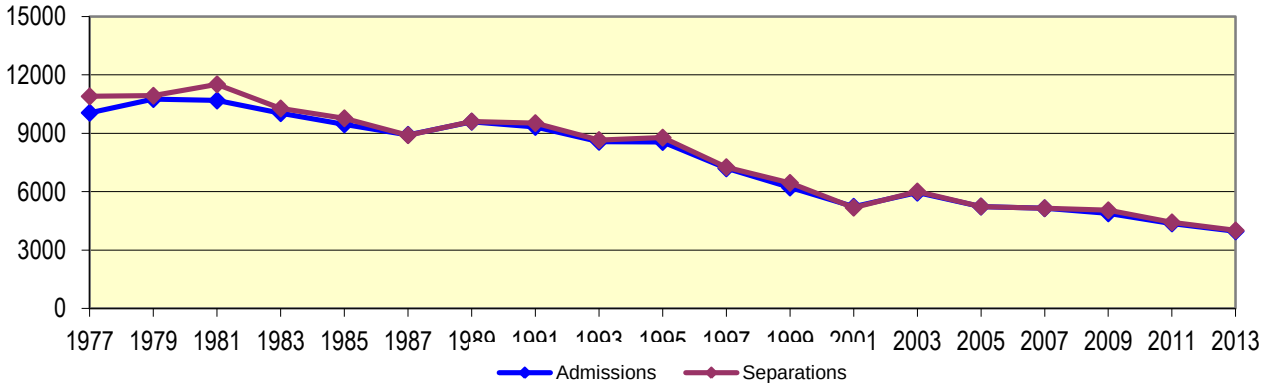
* As of 9/12/2013. Note: HDMC, with an operating capacity of 87 beds and an ADC of 57 is not included in this table.

Additionally, the Department also operates Hiram Davis Medical Center (HDMC) in Petersburg to provide medical services for patients. Between FY 2003 and FY 2013, the state hospital average daily census, excluding HDMC, declined by 376 or 23 percent (from 1,609 to 1,233). Admissions, excluding the HDMC, declined by 33 percent (from 5,946 to 3,959) and separations (discharges) declined by 33 percent (from 6,008 to 4,005).

Trends in State Hospital Average Daily Census (ADC) FY 1977 - FY 2013



Trends in State Hospital Admissions and Separations FY 1977 - FY 2013



Note: Includes Virginia Treatment Center for Children from 1977 - 1991, when it transferred to the Medical College of Virginia.

Training Centers

The Department operates five training centers to serve individuals with intellectual disability: Central Virginia Training Center (CVTC) in Lynchburg, Northern Virginia Training Center (NVTC) in Fairfax, Southside Virginia Training Center (SVTC) in Petersburg, Southeastern Virginia Training Center (SEVTC) in Chesapeake, and Southwestern Virginia Training Center (SWVTC) in Hillsville. 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 intellectual disability.

All training centers are certified by the U.S. Centers for Medicare and Medicaid as meeting Medicaid Intermediate Care Facility for Individuals with Intellectual Disability (ICF/ID) standards of quality. CVTC also provides skilled nursing services. July 2013 operating (staffed) bed capacities and FY 2013 average daily census (ADC) for each training center follow.

Training Center Operating Capacities* and FY 2013 Average Daily Census

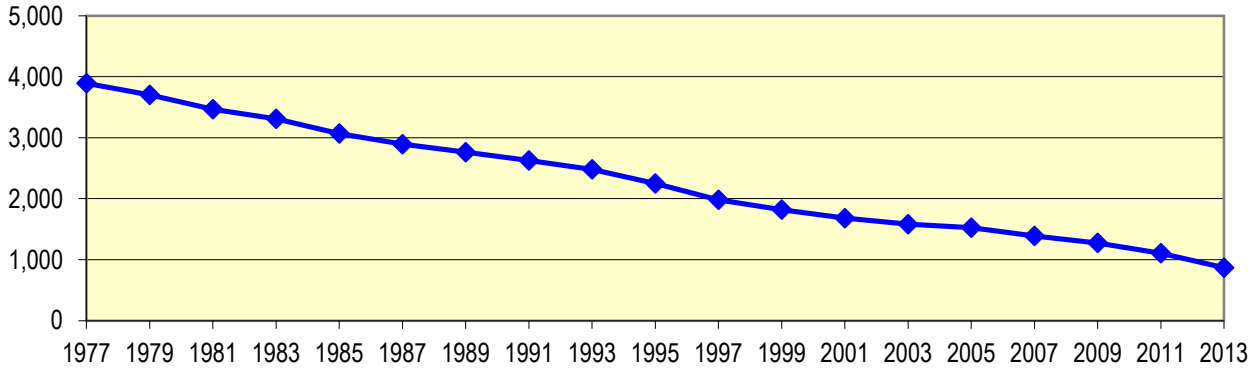
Training Center	Beds	ADC	Training Center	Beds	ADC
Central Virginia Training Center	346	314	Southside Virginia Training Center	129	156
Northern Virginia Training Center	152	142	Southwestern Virginia Training Center	186	163
Southeastern Virginia Training Center	186	92	**Total Operating Capacity (Beds) & ADC**	**999**	**868**

* As of 9/12/2013. On 11/21/13, SEVTC had 85 operational beds and 81 residents. SVTC had 67 residents at the center.

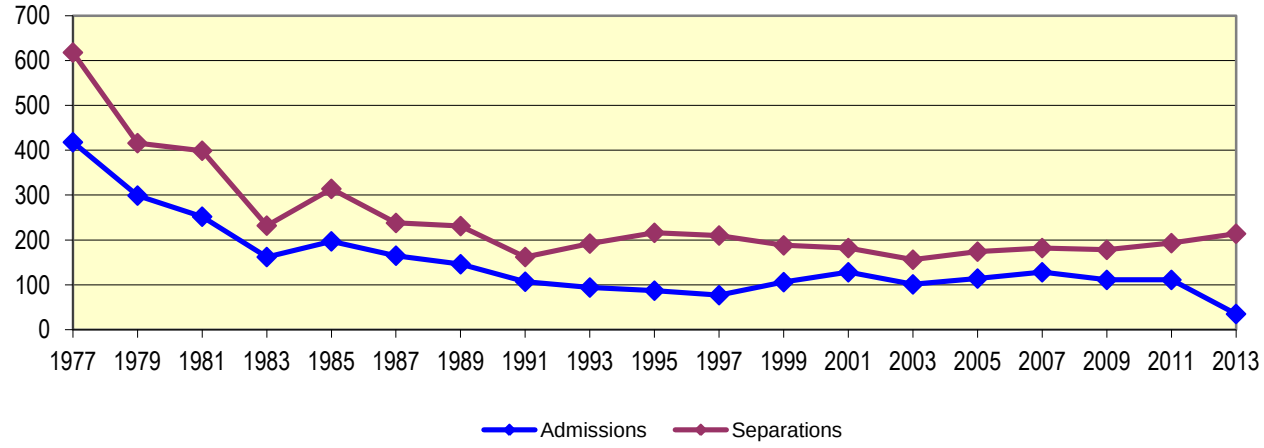
In FY 1976 the ADC for all training centers was 4,293. By 2013, the total ADC for all centers was 868, an 80 percent reduction. In July 2013, the number of occupied training center beds

was 772, down from 947 in July 2012 and 1,063 in July 2011. The following graphs depict ADC, admission, and separation trends since 1977.

Trends in Training Center Average Daily Census (ADC) FY 1977 - FY 2013



Trends in Training Center Admissions and Separations FY 1977 - FY 2013



Note: FY 2013 training center admissions include 20 for respite, 12 emergency admissions, and 3 long-term admissions.

Virginia Center for Behavioral Rehabilitation

The Department operates the Virginia Center for Behavioral Rehabilitation (VCBR) in Burkeville to provide treatment of sexually violent predators. The VCBR operating (staffed) bed capacity was 450 and its FY 2013 average daily census (ADC) was 296. In FY 2013, VCBR experienced 48 admissions and 31 separations. Between FY 2008, when the VCBR moved to its new location in Burkeville, and FY 2013, the VCBR average daily census increased more than 400 percent (from 57 to 296).

Profile of Individuals Receiving Services and Supports in State Facilities

In FY 2013, 5,772 individuals were served in state facilities. Of these, 4,408 unduplicated individuals received 5,230 episodes of care in state hospitals; 986 unduplicated individuals received 1,013 episodes of care in training centers, and 344 unduplicated individuals were served at VCBR. In general, the individuals served in state facilities are white (61 percent), male (63 percent), between 18 and 64 years of age (79 percent), and receiving mental health support services (76 percent).

The average age of individuals served in training centers was 52 years of age and their average length of stay was 33 years, with 31 (nine percent) of the episodes of care being three weeks or less and 141 (14 percent) being more than 50 years.

During FY 2013, 48 individuals were admitted to VCBR and 31 individuals were discharged. All of the individuals were male and 96 percent were between 21 to 64 years of age.

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

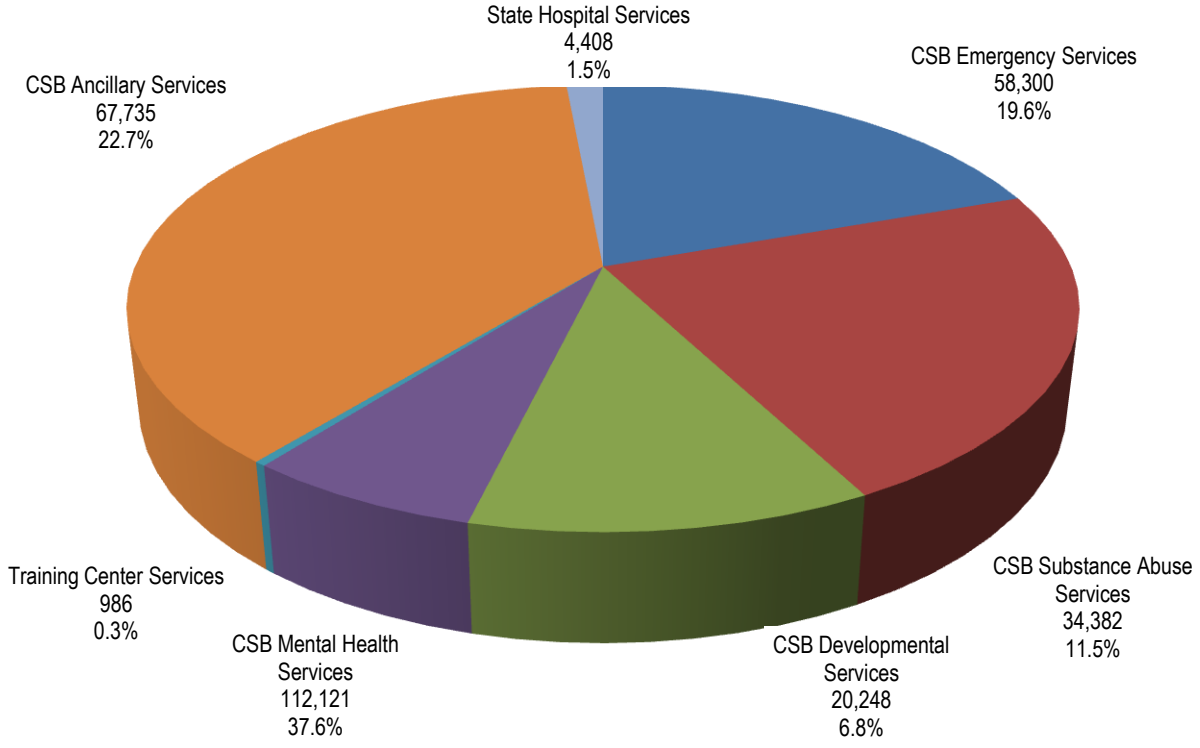
Unduplicated Count of Individuals Receiving Public Behavioral Health or Developmental Services

In FY 2013, 219,694 individuals received services in the public behavioral health and developmental services system through CSBs, which served 213,902 individuals, or state facilities, which served 5,772 individuals. These figures are unduplicated within each CSB or state facility, but they are not unduplicated:

- Across CSBs, that is, a person may receive services from more than one CSB; or
- Between CSBs and state facilities.

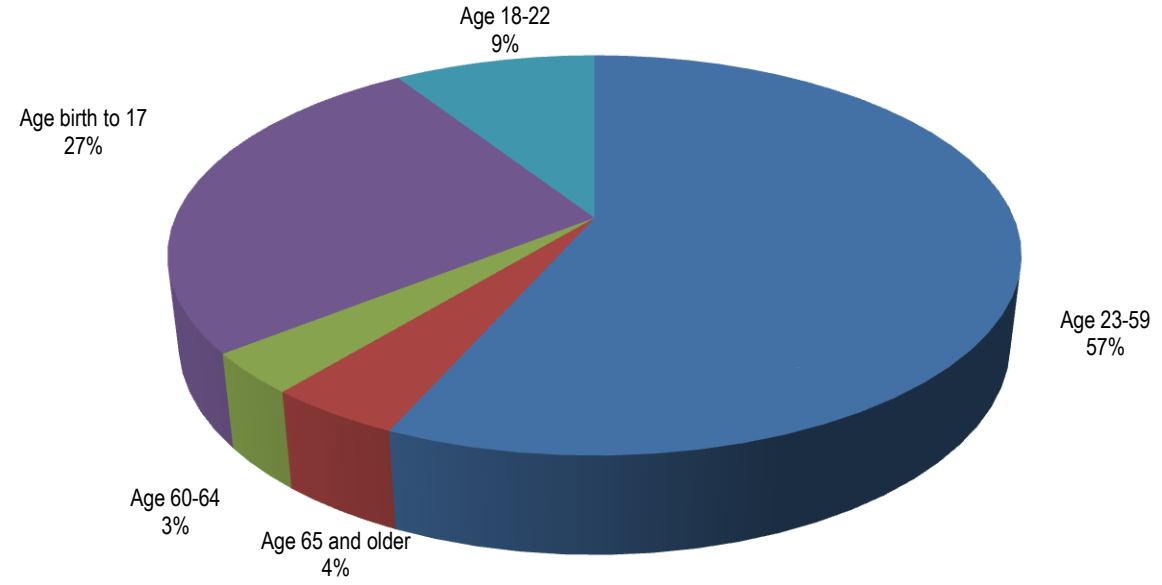
The following pie charts depict the numbers, age distribution, and racial distribution of individuals receiving services from CSBs or state facilities in FY 2013. These charts do not include individuals receiving Part C infant and toddler services.

Individuals Receiving Services From CSBs and State Facilities

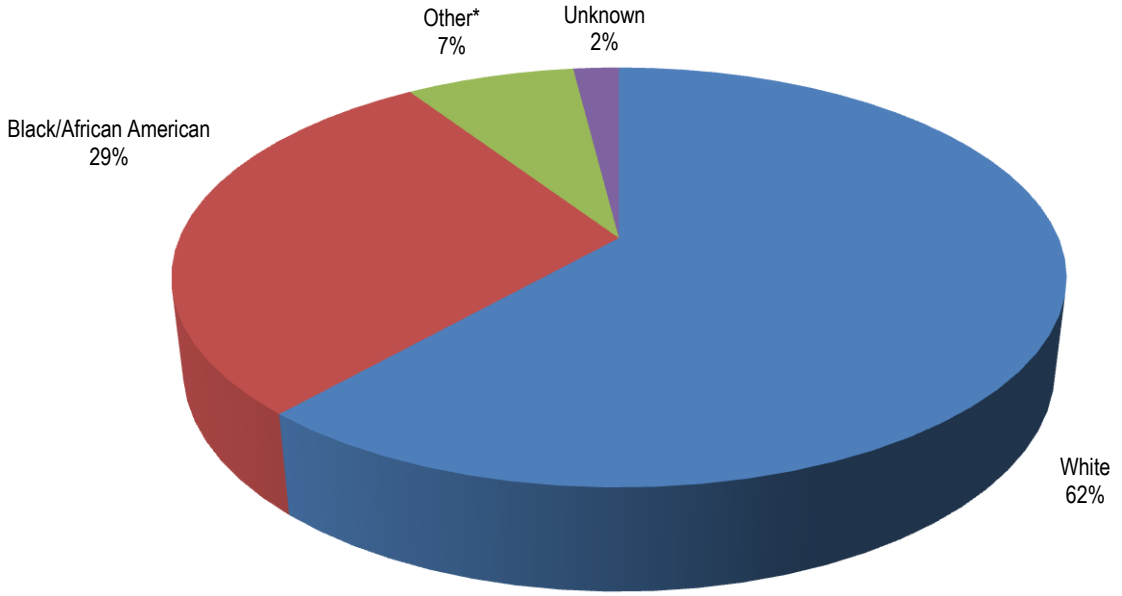


As of November 22, 2013, the number of individuals receiving Medicaid Intellectual Disability Home and Community-Based Waiver (ID waiver) services totaled 9,804. This chart includes 3,853 individuals who received these services from CSBs in FY 2013. Also included are 2,278 individuals who received acute, short term mental health inpatient psychiatric services through local inpatient purchase of services funding in their communities.

Age Distribution of Individuals Receiving CSB and State Facility Services



Racial Distribution of Individuals Receiving CSB and State Facility Services



* Combines American Indian, Alaskan Native, Asian, Multi-Racial and Other Racial categories

The racial and ethnic diversity of the population served by CSBs is greater than that of the state facilities, with higher percentages of individuals from multi-racial and other classifications receiving services compared to individuals served in state facilities. Numbers and percentages of individuals of Hispanic origin receiving services totaled 12,138 (5.7 percent) in CSBs and 158 (2.7 percent) in state facilities. According to the 2010 Census, 7.9 percent of Virginia's population is of Hispanic origin.

Licensed Providers of Behavioral Health or Developmental Services

In FY 2013, the Department licensed 844 providers of behavioral health, developmental, developmental disability waiver, and residential brain injury services. Collectively, these entities provided 2,038 services in 7,063 locations. Between FY 2012 and FY 2013, the number of

licensed providers increased by nine percent, licensed services increased by 10 percent, and licensed service locations increased by 12 percent. Licensed providers must meet and adhere to regulatory standards of health, safety, service provision, and individual rights.

Services System Partnerships

State Level Partnerships

The Department continues to strengthen its partnerships with many state agencies and other organizations that are involved in the provision of services and supports to or interact with individuals with mental health or substance use disorders, intellectual or other developmental disabilities, 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: Medicaid is the largest single source of funds for community behavioral health and developmental services. The Department and the Department of Medical Assistance Services (DMAS) work closely in policy development, provider expansion, provider education and training, development of quality assurance measures, and provider oversight.

Social Services: The Department and the Department of Social Services (DSS) collaborate through a variety of programs and services to help individuals cope with and recover from the effects of poverty, abuse, or neglect and achieve self-sufficiency. This includes services to families who are TANF recipients, to families confronting child custody issues, and to substance-exposed infants and their families.

Housing: The Department partners with the Virginia Housing Development Authority (VHDA) and Department of Housing and Community Development (DHCD) to promote, enhance, and develop housing opportunities for individuals receiving behavioral health services. It also works with the Virginia Coalition to End Homelessness and supports Projects for Assistance in Transition from Homelessness (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.

Primary Health Care: The Department partners with a number of agencies and entities, including the Virginia Department of Health (VDH), Department of Health Professions (DHP), the 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 to promote access to integrated primary and behavioral health care.

Employment Services and Supports: Mental health and substance abuse employment initiatives with the Department for Aging and Rehabilitative Services (DARS) provide specialized vocational assistance services in CSBs. A multi-agency initiative involving the Department, DARS, DMAS, and the academic community created Virginia-specific WorkWORLD™ software to support people with disabilities who are making decisions about gainful work activity and the use of work incentives. Department support has expanded training on Social Security work incentives and other benefits counseling to support its use.

***Criminal Justice and Juvenile Justice Service*s:** The Department works with the Department of Corrections (DOC), Department of Juvenile Justice (DJJ), and Department of Criminal Justice Services (DCJS) 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. This includes support for jail diversion programs such as Crisis Intervention Teams (CITs) and CSB provision of short-term behavioral health services in jails and juvenile detention centers.

DCJS and the Department have jointly provided training in behavioral health evaluation and treatment methods for law enforcement personnel, including jail security staff.

Education: The Department partners with the Department of Education (DOE) to support collaborative activities between schools and the behavioral health and developmental services system. For children from birth to three, the Department is the lead agency for 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. For the school age population, intensive efforts continue with DOE to keep children in their homes and community schools and to improve in-school support for children with behavioral health problems.

Advocacy: The Department central office and state facilities work cooperatively with the disAbility Law Center of Virginia (dLCV) (formerly the Virginia Office for Protection and Advocacy) to protect and advocate for the human and legal rights of individuals receiving behavioral health or developmental services. Section 51.5-37.1 of the *Code of Virginia* requires the Department to report all deaths and critical incidents to the dLCV within 48 hours of occurrence or discovery and provide follow-up reports.

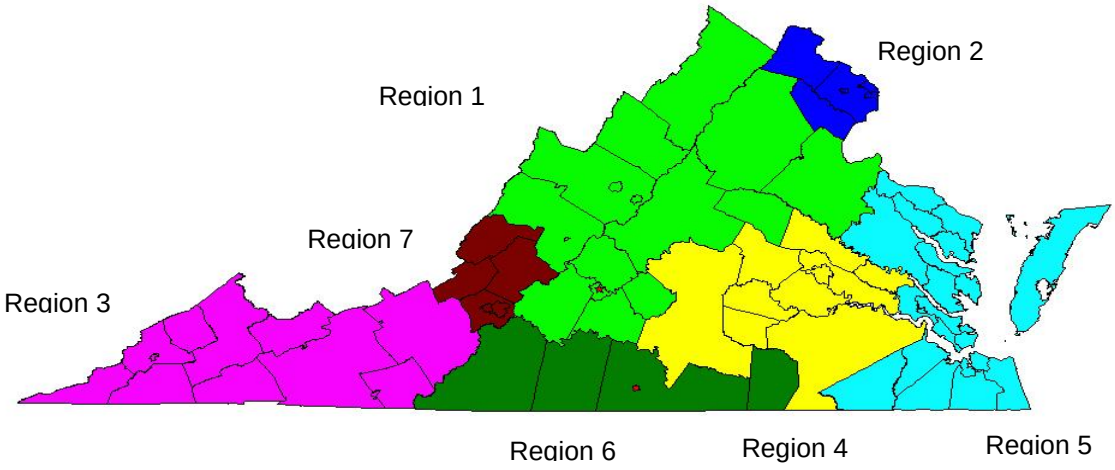
Local Interagency and Regional Planning Partnerships

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 Department through the CSBs that they established and maintain and through their financial and other support of services offered by those CSBs.

CSBs maintain critical interagency partnerships with local agencies, including school systems, social services, local health departments, and area agencies on aging. Services provided by these local agencies include 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. Local agencies also may participate on Part C local interagency coordinating councils and provide Part C services to infants and toddlers.

Seven regional partnerships have been established to facilitate regional services planning and promote regional utilization management. A map of these regional partnership areas follows.

Regional Planning Partnerships



These partnerships provide forums to address regional challenges and service needs and collaboratively plan and implement regional initiatives. Partnership participants include CSBs, state facilities, community inpatient psychiatric hospitals and other private providers, individuals receiving services, family members, advocates, and other stakeholders. Each regional partnership has established a regional utilization review team or committee to manage the region's use of inpatient beds.

Partnerships with Private Providers

Private provider participation is another major strength of the Commonwealth's behavioral health and developmental services system. This participation has grown dramatically in recent years and private sector is a vital partner with CSBs in serving people with mental health or substance use disorders, intellectual disability, or co-occurring disorders. Private providers serve have contracts with CSBs to provide a range of services and supports, including acute inpatient psychiatric services purchased by CSBs from psychiatric hospitals or hospitals with psychiatric units for individuals receiving CSB services. Private providers also serve thousands of other individuals directly. In 2011, the percent of Medicaid payments received for covered mental health, developmental, and substance abuse services by private providers (PPs) compared to CSBs follows:

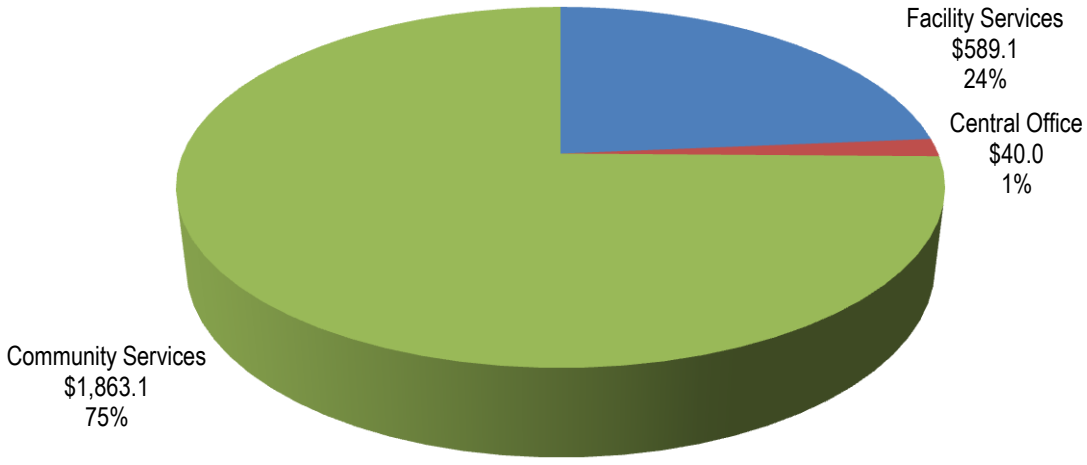
Medicaid Payments to:				Medicaid Payments to:	
Medicaid Services	PPs	CSBs	Medicaid Services	PPs	CSBs
MH Rehabilitation Services	76%	24%	Habilitation (ID Waiver) Services	79%	21%
MH Clinic Services	5%	95%	Total Medicaid Reimbursements	68%	32%
SA Services	12%	88%			

The continued expansion of Medicaid waiver services and some Medicaid rehabilitation services have been major factors influencing growth in the number of private providers. Also, local private psychiatric hospitals and hospital emergency departments often serve as the front line in the delivery of emergency response services to individuals with mental health or substance use disorders or intellectual disability.

Services System Funding and Trends

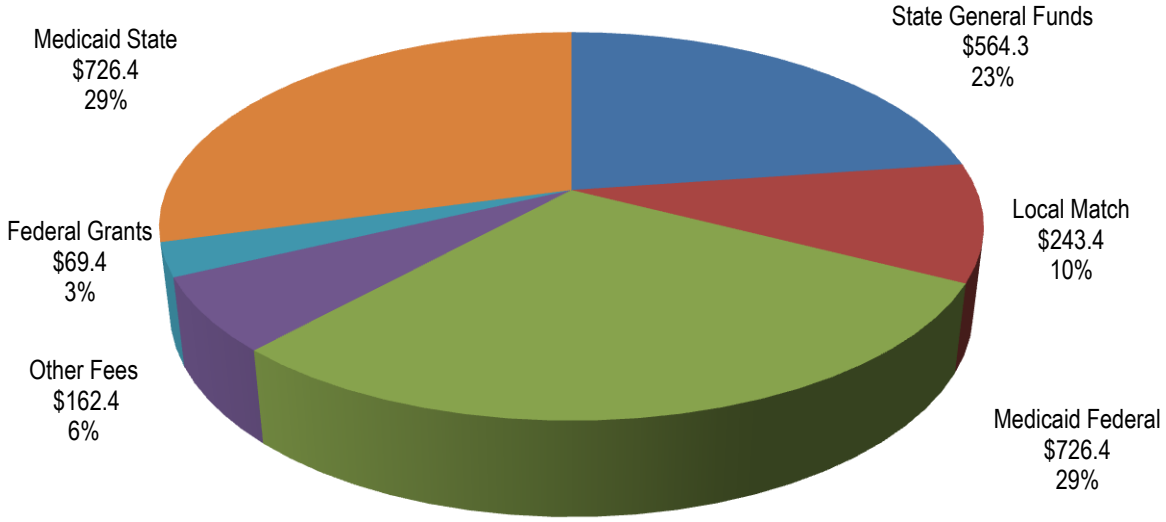
Charts depicting the services system's total resources in the public behavioral health and developmental services system for **FY 2013** from **ALL SOURCES** (rounded and in millions), including the Department's final adjusted appropriation, local matching funds, all fees, and Medicaid payments to private vendors follow.

Total FY 2013 Behavioral Health and Developmental Services System Funding: $2.492 Billion



Community services funding includes CSB expenditures and private providers of Medicaid funds for community services. CSB funding includes state general funds, federal funds, local government appropriations, charitable donations, in-kind contributions, and fees. The overwhelming share of local funds is provided by the 134 cities or counties that established the 40 CSBs. Fees include Medicaid, Medicare, and private insurance payments and payments from individuals receiving services. Other funds include workshop sales, retained earnings, and one-time funds. State facility funding includes state general funds, federal funds, Medicaid, Medicare, commercial insurance, private payments, MH Commitment Fund, and other revenues. The Department's central office funding includes state general funds, federal funds, and special funds.

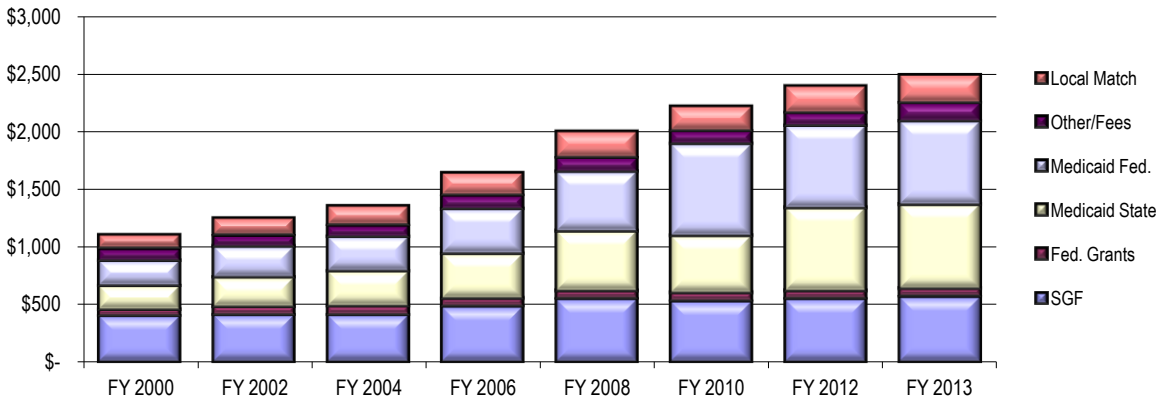
Total FY 2013 Services System Funding by Fund Source: $2.492 Billion



Total Services System Funding Trends by Funding Source
FY 2000 – FY 2013

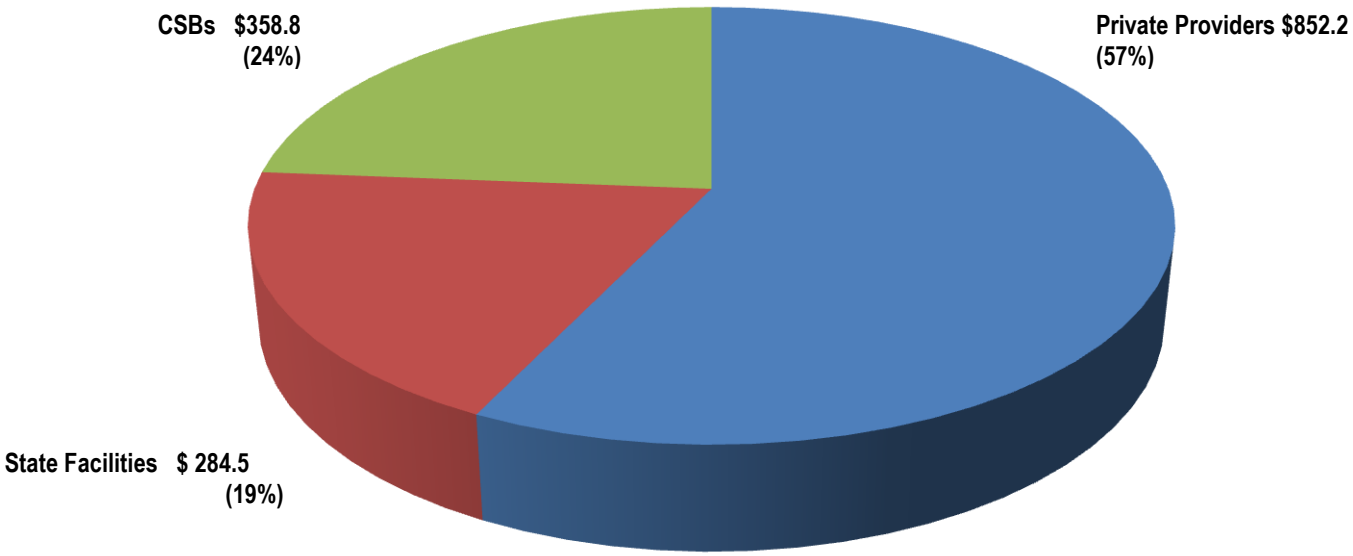
	FY 2000	FY 2002	FY 2004	FY 2006	FY 2008	FY 2010	FY 2012	FY 2013
State General Funds	399.90	408.20	408.70	482.40	544.90	526.60	545.80	564.3
Federal Grants	56.20	72.20	78.70	68.50	70.00	70.70	69.80	69.4
Medicaid - State	209.00	256.90	302.10	390.90	518.60	497.00	716.40	726.4
Medicaid - Federal	223.20	273.30	303.70	390.90	518.60	797.00	716.40	726.4
Other/Fees	102.00	92.80	99.00	115.80	124.10	115.80	114.30	162.4
Local Match	115.90	149.30	166.20	196.20	227.60	214.50	234.30	243.4
Total	$1,106.20	$1,252.70	$1,358.40	$1,644.80	$2,004.00	$2,221.60	$2,397.00	$2,492.2

The dollars in the table above and the chart on the next page are in millions



The chart below depicts Medicaid payments for behavioral health and developmental services by provider.

FY 2013 DMAS Medicaid Payments for Behavioral Health and Developmental Services
Funding: $1.4907 Billion



III. PREVALENCE ESTIMATES

When planning for needed behavioral health and developmental services, it is important to have a sense of how many individuals could potentially need care. This section uses national epidemiological studies to extrapolate the prevalence in Virginia of adults with serious mental illnesses, children and adolescents with serious emotional disturbance, individuals with intellectual disability or developmental disability, and individuals with substance use disorders. The source of Virginia population counts for the following estimates is the Weldon Cooper 2012 age-sex estimate, released July 2013.

Only a portion of these individuals will seek services from the public behavioral health and developmental services system. Some will not seek services and others will be served by private providers.

Estimated Prevalence for Adults with Serious Mental Illnesses: Using Virginia results from the September 2012 report by the National Association of State Mental Health Program Directors Research Institute State Data Infrastructure Coordinating Center) for the U.S. Center for Mental Health Services (CMHS) 341,773 (5.4 percent) of Virginia adults have a serious mental illness.

Estimated Prevalence for Children and Adolescents With Serious Emotional Disturbance: Using the methodology published by CMS in the Federal Register, Volume 63, No. 137, Friday, July 17, 1998, between 117,592 and 143,724 Virginia children and adolescents (ages 9-17) have a serious emotional disturbance (level of functioning score of 60) and between 65,329 and 91,461 have serious emotional disturbance with extreme impairment (level of functioning score of 50).

Estimated Prevalence for Individuals with 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 a 1 percent rate) estimates that 76,763 individuals age 6 and over in Virginia have intellectual disability.

Estimated Prevalence for Individuals with Developmental Disabilities: Using the 1.8 percent rated recommended by the U.S. Centers for Disease Control and Prevention (CDC) and the U.S. Administration on Developmental Disabilities (ADD) to state DD Councils, 147,346 Virginians may have a developmental disability. Recent estimates by the CDC's National Center for Health Statistics are that one in 88 children have an autism spectrum disorder.

Estimated Prevalence for Infants and Toddlers in Need of Early Intervention Services: The Department estimates that 116,190 Virginia's infants and toddlers ages 0 to 3 are potentially eligible for Part C services. This is based on national and Virginia studies of children with specific diagnoses, 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.

Estimated Prevalence for Individuals with Substance Use Disorders: Using Virginia results from the 2010 and 2011 NSDUHs, prevalence estimates of substance abuse and dependence in the past year for individuals ages 12 and over from the follow:

- Dependence on or abuse of any illicit drug – 175,234 (2.54 percent) Virginians are dependent on or abuse illicit drugs. Of these 122,112 met the criterion for dependence.
- Dependence on or abuse of alcohol – 477,409 (6.92 percent) Virginians are dependent on or abuse alcohol. Of these 209,729 met the criterion for dependence.

Appendix E provides 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

Waiting Lists for Services Provided by CSBs

To document existing service demands, CSBs were asked to complete a point-in-time CSB survey during the first quarter of calendar year 2013. Also, for individuals on the Intellectual Disability (ID) and Day Support (DS) waivers, CSBs could enter or update specific services and supports needs in the Department's IDOLS (Intellectual Disability On-Line System) database. The following table displays the number of individuals who were identified as waiting for services and supports.

Numbers of Individuals on Waiting Lists for Mental Health, Developmental, or Substance Abuse Services - 2013

Numbers Waiting for Services and Supports by Population	Numbers Receiving Some CSB Services	Numbers Receiving No CSB Services	Total
Mental Health Services Waiting List Count			
Adults	2,646	572	3,218
Children and Adolescents	895	373	1,268
Total Waiting for Mental Health Services	3,541	945	4,486
Developmental Services Waiting List Count			
Adults on ID/DS Waiver Waiting Lists (IDOLS)*			3,883
Children and Adolescents on ID/DS Waiver Waiting Lists (IDOLS)*			2,791
Other Adults Not on ID/DS Waiver Waiting Lists	1,101	116	
Children and Adolescents Not on ID/DS Waiver Waiting Lists	164	40	
Total Reporting CSB Service Status	1,265	156	1,421**
Total Waiting for Developmental Services			8,095
Substance Abuse Services Waiting List Count			
Adults	507	514	1,021
Adolescents	51	32	83
Total Waiting for Substance Abuse Services	558	546	1,104
Grand Total on All CSB Services Waiting Lists			**13,685**

*As of May 1, 2013.

**Of the 1,421 adults and children not on waiver wait lists, 141 were on the ID planning wait list (Medicaid eligible), 885 were not eligible for or had not yet been placed on waiver waiting lists, 31 had a waiver slot but were waiting for services or supports not funded by the waiver; and 364 had a waiver slot but continued to wait for waiver services.

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 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.

Of those waiting for services, 85 individuals are on mental health services and substance abuse services waiting lists, 11 are on mental health services and developmental services waiting lists, and only one individual was on developmental services and substance abuse services waiting lists. Appendix F depicts numbers of individuals on waiting lists for mental health, developmental, and substance abuse services by CSB.

Numbers of Individuals on CSB Mental Health Services Waiting Lists
Diagnostic Information - 2013

Diagnosis	Adult	C & A	Diagnosis	Adult	C & A
Serious Mental Illness (SMI)	2,361		Co-occurring MI/ID	83	7
Serious Emotional Disturbance (SED)		840	Co-occurring MI/ID/SUD	17	1
At Risk for SED		143	Developmental Disability (Not ID)	23	17
Any Other MI Diagnosis	257	107	Not Known at This Time	208	220
Co-occurring MI/SUD	734	29			

Numbers of Individuals on CSB Developmental Services Waiting Lists
Diagnostic Information - 2013

Diagnosis	Adult	C & A	Diagnosis	Adult	C & A
Intellectual Disability	1,769	611	Co-occurring ID/MI/SUD	8	0
Cognitive Developmental Delay	6	89	Autism Spectrum Disorder	80	90
At Risk for Cognitive Developmental Delay		15	Developmental Disability (Not ID/or Autism)	33	32
Co-occurring ID/MI	267	43			
Co-occurring ID/SUD	10	0	Not Known at This Time	4	13

Numbers of Individuals on CSB Substance Abuse Services Waiting Lists
Diagnostic Information - 2013

Diagnosis	Adult	Adol.	Diagnosis	Adult	Adol.
Substance Dependence	495	13	Co-occurring SUD/ID	10	
Substance Abuse	260	20	Co-occurring SUD/MI/ID	2	
Any Other SA Diagnosis	37	3	Developmental Disability (Not ID)	1	
Co-occurring SUD/MI	292	28	Not Known at This Time	111	33

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 - 2013

	MH Services		DEV Services		SUD Services		Total
	Adult	C & A	Adult	C & A	Adult	Adol.	
0 to 3 Months	1,704	747	416	304	632	60	**3,863**
4 to 12 Months	978	445	639	338	337	21	**2,758**
13 to 24 Months	273	55	761	388	33	1	**1,511**
25 to 36 Months	115	3	552	315	8	0	**993**
37 to 48 Months	63	2	485	345	4	0	**899**
49 to 60 Months	26	0	433	323	1	0	**783**
61 to 72 Months	12	2	364	285	1	0	**664**
73+ Months	24	2	513	1,466	2	1	**2,008**
Total	**3,195**	**1,256**	**4,088**	**3,718**	**1,018**	**83**	**13,358**

For adults and adolescents reported to be on CSB waiting lists for 60 or more months, the most frequently reported mental health or developmental services follow:

- Mental health services: medication management, psychiatric services, and case management; and
- Developmental services: supportive services and case management.

Tables depicting specific service needs and average wait times reported by CSBs follow.

Numbers of Individuals Identified as Waiting for Specific Mental Health Services by Service - 2013

Service	Adult	C &A	Service	Adult	C&A
Outpatient Services					
Psychiatric Services	1,152	506	Intensive In-Home		147
Medication Management	1,107	295	Assertive Community Treatment	121	7
Counseling and Psychotherapy	1,226	672			
Case Management					
Case Management	770	217			
Day Support Services					
Day Treatment/Partial Hospitalization	157	151	Rehabilitation	368	6
Employment Services					
Sheltered Employment	70	1	Group Supported Employment	32	
Individual Supported Employment	324	10			
Residential Services					
Highly Intensive	76	4	Supervised	240	12
Intensive	113	8	Supportive	708	112

Numbers of Individuals Identified as Waiting for Specific Developmental Services by Service - 2013

Service	Adult	C & A	Service	Adult	C&A
Outpatient Services					
Psychiatric Services	211	75	Behavior Management	182	96
Medication Management	235	107			
Case Management					
Case Management	271	695			
Day Support Services					
Habilitation (Center Non-Center)	1,574	1,403			
Employment Services					
Sheltered Employment/Prevocational	128	96	Group Supported Employment	81	88
Individual Supported Employment	925	575			
Residential Services					
Highly Intensive (ICF/ID)	70	20	Supportive (Supported Living, In-Home, Personal Assistance, Companion Services, Respite)	1,601	2,908
Intensive (Congregate)	2,023	2,647			
Supervised (Congregate)	191	61			
Other Supports					
Nursing Services	83	232	Environmental Modifications	350	1,050

Service	Adult	C & A	Service	Adult	C&A
Assistive Technology	686	1,804	Personal Response System (PERS)	51	135
Therapeutic Consultation	355	1,044			

Numbers of Individuals Identified as Waiting for Specific Substance Abuse Services by Service – 2013

Service	Adult	Adol.	Service	Adult	Adol.
Outpatient Services					
Intensive SA Outpatient	307	17	Medication Assisted Treatment	150	13
Outpatient	468	47			
Case Management					
Case Management	248	16			
Day Support Services					
Day Treatment	37	4	Rehabilitation	27	
Partial Hospitalization	22	0			
Employment Services					
Sheltered Employment	6	0	Group Supported Employment	3	0
Individual Supported Employment	56	0			
Residential Services					
Highly Intensive	29	2	Supervised	13	3
Intensive	111	4	Supportive	49	5

A total of 187 individuals on CSB waiting lists were age 65 or older, including 117 waiting for mental health services, 64 waiting for developmental services, and 6 waiting for substance abuse services. Of these, 24 were not currently receiving CSB services and 163 were receiving at least one CSB service.

Average Wait Times in Weeks for CSB 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 for specific services follow.

	MH Services		DEV Services		SUD Services	
Service	Adults	C & A	Adults	C & A	Adults	Adolescents
Outpatient Services						
Medication Services	6	5.75	4.82	5.94	6.48	5.74
Psychiatric Services	5.9	6.07	5.4	6.16	6.12	5.95
Counseling & Psychotherapy	6.38	4.28			4.48	3.83
Behavior Management			45.36	4.5		
Intensive SA Outpatient					1.63	2
Intensive In-Home		3.33				
Medication Assisted Treatment					9.25	1
Assertive Community Treatment	11.24					
Case Management Services						
Case Management Services	5.87	2.73	2.89	2.95	5.46	5.07

Service	MH Services		DEV Services		SUD Services	
	Adults	C & A	Adults	C & A	Adults	Adolescents
Day Support Services						
Day Treatment/Partial Hospitalization	2	2.6			3	
Ambulatory Crisis Stabilization Services	2	N/R*				
Rehabilitation or Habilitation	6.39	2	56.73	63.8	2	N/R*
Employment Services						
Sheltered Employment	12.83		68.00	150.00	22.00	N/R*
Group Supported Employment	11.50		86.00	285	20.50	N/R*
Individual Supported Employment	10.22	2	36	N/R*	15	N/R*
Residential Services						
Highly Intensive Residential Services	13.00	2	80.9	55.50	3.33	7.00
Residential Crisis Stabilization Services	1	1	25.33	2	N/R*	N/R*
Intensive Residential Services	21.40	2	79.69	81	4.38	4.50
Supervised Residential Services	53.73	1.5	66.10	112.00	1.5	N/R*
Supportive Residential Services	21.83	3	62.18	70.63	13.5	2.00
ID Waiver Services						
Nursing Services			80.86	49.67		
Environmental Modifications			42.93	26.93		
Assistive Technology			66.35	40.5		
Personal Response System (PERS)			144.26	64		
Therapeutic Consultation			60.5	24.21		

Limited Services	Average Wait Time
Motivational Treatment Services	2.50
Consumer Monitoring Services	15.00
Assessment and Evaluation Services	3.67
Early Intervention Services	2.83
Consumer Run Services	2.00

* N/R indicates that CSBs did not provide any information regarding wait times for this service.

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 December 1, 2010 counts identified 9,562 students ages six to 22+ with a primary disability (as defined by special education law) of emotional disturbance and 9,784 students with intellectual disability who are receiving special education services. Counts for children age three to five identified 8,244 children with a developmental disability and 935 children with an autism spectrum disorder. The total number of students identified with an autism spectrum disorder was 11,703.
- On January 24, 2013, Virginia communities participated in a statewide one-day point-in-time count and found 7,625 homeless persons. Of these, 1,262 individuals (17 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.

Anticipated Changes Influencing Future Demand for Behavioral Health and Developmental Services

The Department anticipates a variety of factors will affect future 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 population growth in Northern, Central, 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 and linguistic diversity of Virginia's population;
- Continuing growth in the number of individuals on the urgent and non-urgent waiting lists for Medicaid intellectual disability waiver services and supports;
- Increasing referrals to the services system and changing responsibilities for it resulting from Patient Protection and Affordable Care Act (PPACA) implementation, including changes to Virginia's Medical Assistance Program and the federal Mental Health and Substance Abuse Administration (SAMHSA) block grants;
- Growing 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;
- Growing numbers of individuals receiving behavioral health or developmental services who have complex medication regimes or serious medical conditions requiring specialized health services;
- Escalating pressures to provide services in a secure environment to individuals who are civilly committed to the Department as sexually violent predators;
- Emerging responsibilities to serve individuals with developmental disabilities, including autism spectrum disorders;
- Increasing numbers of veterans returning to Virginia from Iraq and Afghanistan who have behavioral health service needs;
- Increasing numbers of adults and juveniles in the criminal justice system with identified behavioral health service needs; and
- Additional demands for specialized services resulting from the aging of current caregivers.

V. SERVICES SYSTEM TRANSFORMATION – VISION, VALUES, AND STRATEGIC DIRECTIONS

Integrated Strategic Plan for Virginia's Services System

In 2006, the then Department of Mental Health, Mental Retardation and Substance Abuse Services adopted Envision the Possibilities: An Integrated Strategic Plan for Virginia's Mental Health, Mental Retardation, and Substance Abuse Services System (ISP) to provide a strategic blueprint for transforming Virginia's publicly-funded services system. The ISP includes values, critical success factors, and implementation action steps that are essential building blocks for the realization of 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 consumer participation in all aspects of community life including work, school, family and other meaningful relationships" (State Board Policy 1036 (SYS) 05-3). The vision and strategic framework provided in the ISP respond to the U.S. Supreme Court Olmstead [Olmstead v. L.C., 119 S. Ct. 2176 (1999)] and continue to provide strategic direction for Virginia's behavioral health and developmental services system.

The ISP affirms that 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. It includes the overarching goal 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.

The ISP articulated the following services system values and principles.

- Services and supports are person-centered, with the specific needs of each individual at the center of service planning and care coordination. Regardless of where an individual lives in Virginia, there is access to a broad array of services and supports that promote independence and enable individuals to live in their own homes wherever possible. 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 services and supports is available across the system, with timely access to needed services. Services and supports are available and delivered as close as possible to the individual's home community in the least restrictive setting possible, are culturally and age sensitive and appropriate, and are fully integrated and coordinated with other community services. Services are universally and equally accessible regardless of the individual's payment source.
- 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. Prevention, early intervention, and family support services are critical components of the services system. Crisis services are available 24 hours per day and seven days a week.
- Funding follows the individual to the extent possible and not a specific provider or service. Integrated funding reduces complexity and provides flexibility to create choices among services and supports that address an individual's unique needs.

- Adults and children requiring services and supports from multiple agencies are provided care that is coordinated across agencies.
- Services are of the highest possible quality and are based upon best and promising practices where they exist. Emphasis is placed on continuous quality improvement, workforce training and development, and use of technologies that promote efficiency and cost effectiveness at the provider and system levels.

The ISP described the public safety net and serves as the conceptual basis for State Board Policy 1038 (SYS) 05-5 The Safety Net of Public Services, which 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.

Creating Opportunities: A Plan for Advancing Community-Focused Services in Virginia

The Department's Creating Opportunities strategic planning process involved broad stakeholder participation on initial behavioral health and developmental planning teams that were co-led by Department staff and community stakeholders and included individuals receiving services, family members, advocacy organizations, and representatives of public and private services providers, provider associations, universities, and state and local agencies. Creating Opportunities: A Plan for Advancing Community-Focused Services in Virginia, completed in June 2010, builds on the vision, values, and the critical success factors in the ISP and continues recent services system reform and transformation initiatives to advance a recovery and resilience-oriented and person-centered system of behavioral health and developmental services and supports.

The purposes of the Creating Opportunities Plan are to define strategic initiatives to:

- Support the Commonwealth's realization of a Commonwealth of Opportunity for all Virginians, including individuals receiving behavioral health or developmental services;
- Continue progress in advancing the vision of self-determination, empowerment, recovery, resilience, health, and participation by individuals receiving services in all aspects of community life;
- Promote efficient and effective management of services system core functions and responsiveness to the needs of individuals receiving services and their families; and
- Communicate the Department's strategic agenda and priority initiatives to the key decision-makers in state government, individuals receiving services and their families, public and private providers, advocates, and other interested stakeholders.

Activities to implement the strategic initiatives identified in the Creating Opportunities plan have been incorporated in the Comprehensive State Plan 2014-2020.

VI. SERVICES SYSTEM CRITICAL ISSUES AND STRATEGIC INITIATIVES

Systemwide

A. Services System Implementation of Health Care Reform

Patient Protection and Affordable Care Act

The Patient Protection and Affordable Care Act (PPACA), passed in March 2010, has three primary components that are intended to improve health delivery systems by focusing on effective health care rather than volume; expand affordable insurance coverage to all individuals who are legally in the United States; and implement private insurance reforms that emphasize good care and customer service rather than denials of care:

- ***Public health*** - Public Health Trust Fund; national public health and prevention/wellness strategy; funding for new evidence-based prevention and wellness, with a focus on rural and frontier communities; coverage for preventive care at no cost in many private and private plans; and grants to employers for wellness programs;
- ***Access to coverage and care*** - Medicaid expansion; new insurance regulations; federal-or state-based health insurance exchanges for individuals and small businesses; individual mandates; and employer penalties; and
- ***Cost containment, payment, and delivery reform*** - bundled payment and value-based purchasing initiatives; greater waste, fraud, and abuse measures; medical malpractice demonstration grants; quality/outcome reporting by private insurances; and comparative effectiveness research, non-profit patient-centered outcomes research institute. (Source: Department of Medical Assistance, October 2013)

PPACA implementation to date has provided a number of private health insurance protections. Individuals can stay on their parents plan until their 26th birthday. Lifetime dollar caps have ended and annual limits are being phased out. Denial of coverage for children with pre-existing conditions and co-pays or other out-of-pocket expenses for preventive care have ended (with some exceptions). On January 1, 2014, other major components of the PPACA will become effective, including the:

- state option for expanded Medicaid adult coverage;
- creation of Health Benefit Exchanges (marketplaces);
- employer and individual mandates; and
- coverage for adults with pre-existing conditions.

Virginia has elected to use the federally-facilitated health benefits exchange to compare and purchase private health insurance. Participating plans are required to provide standardized essential health benefits, including mental health/substance abuse services, to individuals without affordable job-based coverage and small employers. Premium assistance (tax credits) is available based on income. Almost 518,000 Virginians should be eligible for sliding scale federal tax subsidies (http://kff.org/report-section/state-by-state-estimates-of-the-number-of-people-eligible-for-premium-tax-credits-under-the-affordable-care-act-table-1/).

Virginia's Medicaid Program

Enrollment in the Virginia Medical Assistance Program (Medicaid) has increased significantly during the past decade, even though its eligibility criteria are among the strictest in the nation. In 2012, the state's Medicaid population was comprised of 604,442 children, 195,681 parents or caregivers of children and pregnant women, 79,613 elderly individuals, and 216,734 individuals with a disability, including those with intellectual or developmental disabilities, adults with serious mental illness, or children with serious emotional disturbance. Older adults and individuals with disabilities represented 27 percent of the state's Medicaid population but

accounted for 70 percent of Medicaid spending because their intensive needs require more costly acute and long-term services.

Medicaid expenditures increased from just over $3 billion in FY 2002 to $7 billion in FY 2012. The Department of Medical Assistance Services (DMAS) identifies top expenditure drivers as (1) enrollment growth that expanded coverage to over 400,000 new members in 10 years (an 80 percent increase); (2) growth in the cost of health care; and (3) significant growth in expenditures for home and community based services (HCBS) waivers and community behavioral health services. Although its rate of growth in expenditures is comparable to other states, Virginia's program ranks near the lowest levels nationally in spending per capita (48th).

The Virginia Medicaid program currently ranks 44th in parent eligibility and has no coverage for childless adults. Small Area Health Insurance Estimates compiled by the U.S. Census in 2010 reported that 1,009,463 nonelderly adults (ages 18-64) in Virginia are uninsured. If Virginia's Medicaid program were expanded to cover individuals up to 138 percent of the federal poverty level (FPL), up to 350,000 low income working parents and other adults could be covered, including individuals receiving CSB services, children aging out of Medicaid, and individuals with disabilities who are waiting for Medicare.

Virginia's behavioral health and developmental services system has increasingly relied on the Medicaid to support several core CSB services through "State Plan Option" and HCBS waivers. Reforms to the state Medicaid program will have a significant effect on the services system. In FY 2012, CSBs reported that 101,812 unduplicated individuals receiving CSB services were Medicaid enrollees. Of those, 63,910 were receiving mental health services, 17,194 were receiving developmental services, 8,314 were receiving substance abuse services, and 46,804 were receiving other services outside a program area. An October 2012 survey by the Virginia Association of Community Services Boards found that of the 48,367 uninsured individuals over age 18 receiving CSB services on October 1, 2012, 21,880 would be eligible for Medicaid expansion (if mandated in Virginia) and 5,567 would be in the Health Insurance Exchange population.

SAMHSA estimates that of individuals who would be eligible through a Medicaid expansion, about 11.5 percent would have a serious mental illness, 22.3 percent would have serious psychological distress, and 20.8 percent would have a substance use disorder. Among the Health Insurance Exchange population, about 7.5 percent would have a serious mental illness, 20.9 percent would have serious psychological distress, and 23.0 percent would have a substance use disorder.

Without expanding Virginia's Medicaid coverage, approximately 195,000 Virginians will not fit any of Virginia's current Medicaid eligibility groups and have incomes too low to qualify for Federal subsidies.

Reforms to the Virginia Medicaid Program

With the passage of the PPACA, the Commonwealth launched the Virginia Health Reform Initiative (VHRI) to prepare the state for federal health reform implementation and pursue other innovative healthcare solutions to leverage the strengths of the state's health care delivery system. Goals of this initiative, which involves a wide range of citizen, provider, and business stakeholders, include:

- promoting health care delivery system innovations to improve quality and cost-effectiveness, including ways to reduce the cost of the Medicaid program;
- continuing to provide care to the Commonwealth's most vulnerable citizens;
- making it easier for Virginians to be healthier through health promotion and disease prevention incentives that would encourage individuals to remain healthy;
- facilitating consumer-directed healthcare that would encourage individuals to make

informed healthcare decisions and purchase and retain health insurance; and
- seeking to reduce the regulatory burden on all Virginians.

The VHRI continues to assess and make recommendations in areas of Medicaid reform, insurance reform, capacity, delivery and payment reform, and technology.

The 2013 General Assembly passed a phased program to implement Medicaid reforms to improve service delivery, improve administration, and increase benefit engagement prior to expansion. Planned activities in each phase follow.

Phase 1: Advancing Reforms in Progress

- Initiate the Virginia Dual Eligible Demonstration: Commonwealth Coordinated Care Program, to coordinate and manage health care, behavioral health, and long term services and supports for individuals who are eligible for both Medicaid and Medicare;
- Enhance Medicaid program integrity through various audits, fraud control, and claims processing edits;
- Transition children in foster care and adoption assistance programs from Medicaid fee-for-service (FFS) into DMAS-contracted MCOs;
- Implement a new Eligibility and Enrollment System that simplifies administrative processes and service access;
- Improve access to comprehensive federal Veteran's benefits for qualifying Medicaid benefits; and
- Contract with a Behavioral Health Services Administrator (BHSA) to oversee the community behavioral health provider network, authorize services not currently provided through Medicaid MCOs, and reimburse providers for services delivered.

Phase 2: Improvements in Current Managed Care and FFS Programs

- Establish commercial-like benefit packages and service limits;
- Implement cost sharing and wellness innovations in collaboration with the MCOs;
- Coordinate behavioral health and medical services through the BHSA and DMAS-contracted MCOs;
- Define limited provider networks and medical homes;
- Develop quality payment incentives;
- Implement managed care data improvements;
- Standardize administrative and other processes for providers;
- Support the health information exchange;
- Implement agency administration simplification; and
- Seek CMS approval of parameters for demonstration projects.

Phase 3: Moving Forward with Coordination of Long-Term Services and Supports

- Transition the remaining long-term care populations and waivers into cost-effective and coordinated delivery models.
  - ID/DD Waiver redesign – July 2014 – July 2015;
  - All HCBCS Waiver enrollees in managed care for medical needs (waiver services remain out) – October 2014
  - PACE Program for ID/DD or other pilot programs (health homes) – July 2015
  - Inclusive coordinated care for HCBS Waiver clients – July 2016
  - Statewide Coverage of the Commonwealth Coordinated Care Program – July 2018

The Medicaid Innovation and Reform Commission (MIRC) was established by the 2013 General Assembly to review, recommend, and approve innovation and reform proposals affecting the Virginia Medicaid and Family Access to Medical Insurance Security (FAMIS) programs. DMAS

must report to the 2014 General Assembly on its design and implementation plans. In June 2013, the VHRI provided feedback on DMAS plans to implement Medicaid reform. In August 2013, DMAS sent a Medicaid reform concept paper to CMS entitled *"Implementing Medicaid Reform in Virginia: A Summary of Planned Reforms for Review by the Centers for Medicare and Medicaid Services and Interested Stakeholders."*

Primary Care-Behavioral Health Integration

The "*A New Lease on Life"* (ANLOL) integrated primary care and behavioral health care initiative began as a collaborative effort of the Virginia Health Care Foundation, Virginia Association of Community Services Boards (VACSB), Virginia Association of Free Clinics (VAFC), and the Virginia Community Healthcare Association (VCHA) to improve care integration for physical and behavioral heath services. In December 2009, the Virginia Health Care Foundation awarded $2 million over three years to nine collaboratives made up of 13 CSBs, seven free clinics, and six community health centers.

ANLOL has provided a unique coupling of public and private human services organizations that have mental health expertise and free clinics and federally-qualified heath centers that have health safety net expertise to jointly serve individuals with co-occurring physical and behavioral health needs. This successful integrated care model focuses on bi-directional referrals and coordination of care, including information exchange; health promotion and wellness; building self-management skills in the population; and measuring outcomes. Health safety net patients are assessed for basic mental health services and individuals with serious mental illness are receiving primary medical care. ANLOL project results have found that treatment of basic mental illnesses such as depression and anxiety delivers a huge return on the limited dollars invested. The project has:

- *Improved access to services* – Individuals who previously had difficulty accessing behavioral or primary health care on their own are now receiving needed services and supports. After 30 months, 6,263 patients had received 18,276 patient visits and $6.7 million in free medications.
- *Improved the quality of services* – Integration of primary and behavioral health care has allowed providers with specific clinical expertise to work together to treat the entire person and to emphasize wellness and preventive care.
- *Improved health outcomes* - Behavioral health services are being provided to people with previously unrecognized or untreated mental health problems. Similarly, the health status of individuals receiving behavioral health services has improved as previously undiagnosed medical conditions are being treated and chronic health conditions are successfully managed. Results include improvements in blood pressure, cholesterol levels, body weight indexes, metabolic functions, and diabetes control.
- *Improved cost efficiency or cost effectiveness* – Cost efficiencies have been realized by bringing Virginia's primary and behavioral health safety net systems of care together. By accessing expertise available in the other system, each system has enhanced services through efficient utilization of limited funds. Primary care physicians are being trained in the management of co-morbid mental health conditions and mental health case management services are being provided to free clinic patients with chronic diseases.

CSBs participating in ANLOL projects include Alexandria CSB, Arlington CSB, Colonial Behavioral Health Board, Eastern Shore CSB, Henrico Area Mental Health and Developmental Services, Middle Peninsula/Northern Neck CSB, Danville-Pittsylvania Community Services, Prince William County CSB, Richmond Behavioral Health Authority, Chesterfield CSB, Goochland-Powhatan Community Services, Rockville Area Community Services, and Alleghany Highlands CSB. In addition, the Fairfax-Falls Church CSB deploys psychiatrists to three community health centers and collaborates with two managed care organizations to coordinate health and primary care for shared Medicaid clients and the Norfolk CSB is using federal grant

funds to establish integrated care at the behavioral health site. Emerging CSB partnerships to integrate care with community health organizations are underway in Northwestern Community Services, Harrisonburg-Rockingham CSB, Region Ten CSB, Horizon Behavioral Health, Chesapeake CSB, Hampton-Newport News CSB, Loudoun County CSB, and Western Tidewater CSB.

Goal, Objectives, and Implementation Action Steps

Goal: Implement the Patient Protection and Affordable Care Act and other health care reforms in ways that protect the existing health care safety net for individuals with behavioral health or developmental service needs.

Objectives and Implementation Action Steps

1. Work with DMAS and stakeholders to identify, pilot test, and implement effective models of delivery and payment reforms.

a. Provide information to the Office of Health and Human Resources, Virginia Health Reform Initiative Advisory Council, and DMAS regarding the effects of various reform proposals on Virginia's behavioral health and developmental services system.

b. Support DMAS efforts to seek behavioral health and developmental services system input on proposed Medicaid reform activities.

c. Work with CSBs, DMAS, and the Behavioral Health Services Administrator to strengthen community behavioral health services standards and provider qualifications and assure access to quality services and supports.

d. Participate in the cross-agency eHHR effort led by the Office of Health and Human Resources.

e. Participate with DMAS and other stakeholders in planning and transitioning Medicaid long-term services into comprehensive managed and coordinated delivery systems.

2. Promote implementation of integrated care primary care and behavioral health care delivery models across the Commonwealth.

a. Support existing and emerging CSB initiatives that partner with community health organizations to integrate primary care and behavioral health care.

b. Track and communicate positive outcomes of integrated primary care and behavioral health care initiatives.

B. Services System Quality Improvement and Accountability

Provider Oversight and Individual Protections

The Department performs a number of oversight and accountability activities, including:

- Licensing of all behavioral health (mental health and substance use disorder), developmental services, developmental disability waiver, and residential brain injury services to ensure that providers meet and adhere to regulatory standards of health, safety, service provision, and individual rights;
- Protecting individual human rights through a statewide program established to protect the fundamental rights of individuals receiving services from state facilities and services licensed or funded by the Department;
- Complying with Agency Risk Management and Internal Controls (ARMICS) Standards pertaining to compliance with laws, regulations, and practices that assure appropriate stewardship over the Commonwealth's assets;
- Conducting state facility annual consultative audits that use a peer review process involving teams of colleagues from other state facilities, individuals receiving services, and central office staff to review and provide feedback on facility operations and

compliance with oversight and accreditation requirements and to provide cross-facility mutual sharing of ideas and tools;

- Entering into and monitoring compliance with the biennial Community Services Performance Contract, which serves as the primary accountability and funding mechanism between the Department and the CSBs; and
- Performing CSB operational reviews to improve service quality and monitor SAMHSA block grant compliance.

Comprehensive Quality Improvement System

The Department is establishing a comprehensive quality improvement system to ensure that individuals who are receiving behavioral heath and developmental services in Virginia obtain services and supports that are available and accessible, are of good quality, and meet the needs of individuals. This comprehensive system is being designed to: identify and address risks of harm; ensure the sufficiency, accessibility, and quality of services to meet individuals' needs; collect and evaluate data to document individual outcomes; and identify and respond to trends to ensure continuous quality improvement.

To meet DOJ Settlement Agreement requirements, initial efforts to develop and implement a comprehensive quality improvement system are focused on individuals receiving developmental services and supports under the Agreement. The Agreement requires the collection and analysis of reliable data in the following areas:

- Safety and freedom from harm (e.g., neglect and abuse, injuries, use of seclusion or restraints, deaths, effectiveness of corrective actions, licensing violations);
- Physical, mental, and behavioral health and well being (e.g., access to medical care (including preventative care), timeliness and adequacy of interventions (particularly in response to changes in status);
- Avoiding crises (e.g., use of crisis services; emergency room, hospital or training center/congregate setting admissions; or contact with criminal justice system);
- Stability (e.g., maintenance of chosen living arrangement, change in providers, work/other day program stability);
- Choice and self-determination (e.g., person centered service plans, choice of services and providers, individualized goals, self-direction of services);
- Community inclusion (e.g., community activities, integrated work opportunities and living options, educational opportunities, relationships with non-paid individuals);
- Access to services (e.g., waitlists, outreach efforts, identified barriers, service gaps and delays, adaptive equipment, transportation, availability of services geographically, cultural and linguistic competency); and
- Provider capacity (e.g., caseloads, training, staff turnover, provider competency).

Data collection to identify service quality and accessibility trends, patterns, strengths, and problems at the individual, service delivery, and systemic levels; develop preventative, corrective, and improvement measures to address identified problems; track the efficacy of preventative, corrective, and improvement measures; and enhance outreach, education, and training must begin within twelve months of the effective date of the Agreement. This data will come from a wide variety of sources, including:

- Service plans for individuals receiving waiver services;
- Training center discharge plans;
- Case manager reports on case manager contacts and individual health, safety, and community integration outcomes;
- "Employment First" initiative reports;
- Crisis system reports;

- Risk management/incident reporting system reports;
- Licensing inspection assessments;
- Provider quality improvement plans;
- Community Integration Manager and Regional Support Team reports; and
- Quality service reviews (QSRs).

Inspections of Community Providers:

The Department conducts regular, unannounced licensing inspections of community providers. To meet Settlement Agreement requirements, the Department has developed enhanced visit protocols and is conducting more frequent licensure inspections of community developmental services providers serving individuals who are in high-risk categories to ensure the adequacy of individual services and supports provided to them. High-risk categories include those who:

- Are receiving services from providers having conditional or provisional licenses;
- Have more intensive behavioral or medical needs;
- Have an interruption in service of greater than 30 days;
    - Encounter the crisis system for a serious crisis or for multiple less serious crises in a three-month period;
    - Have transitioned from a training center within the previous 12 months; or
- Reside in congregate settings with five or more individuals.

In addition, the Department will be upgrading or replacing the current web-based Licensing Information System (OLIS).

Provider Quality Improvement and Risk Management Triggers and Thresholds:

The Settlement Agreement requires training centers, CSBs, and other community developmental services residential and day services providers to develop and implement quality improvement programs to identify and address significant service issues in areas such as health and safety and community integration. The Department is working with a team of stakeholders to develop guidance for enhanced risk management processes that include uniform risk triggers and thresholds related to individual deaths (including suicide and homicide), use of restraint, medication errors, falls, fractures, choking, aspiration pneumonia, constipation, self-injurious behavior, decubitus ulcer, protective services referrals, injuries or accidents requiring medical treatment beyond first aid. To successfully implement these risk triggers and thresholds, the Department will offer training to providers on proactively identifying and addressing risks of harm; conducting root cause analysis; and developing and monitoring corrective actions.

Incident Reporting:

The Department has enhanced its Computerized Human Rights Information System (CHRIS) and has upgraded what was a paper process to a real time, web-based incident reporting system to monitor and investigate any suspected or alleged incident of abuse or neglect, serious injury, or deaths. The new incident reporting protocol, which became operational on March 27, 2013, requires that any staff of a training center, CSB, or community provider aware of such incidents directly report such information into CHRIS.

Mortality Review:

The Department has established a mortality review team and is conducting monthly mortality reviews for unexplained or unexpected deaths reported through CHRIS within 90 days of the death. This team interviews, as warranted, any persons having information regarding the individual's care and reviews or documents the unavailability of:

- medical records, including physician case notes and nurses notes, and all incident reports, for the three months preceding the individual's death;

- the most recent individualized program plan and physical examination records;
- the death certificate and autopsy report; and
- any evidence of maltreatment related to the death.

Following the review, the team then prepares and delivers a report of deliberations, findings, and recommendations, if any, to the Commissioner. In addition, the team is collecting and analyzing mortality data to identify trends, patterns, and problems at the individual service-delivery and systemic levels and is initiating quality improvement initiatives to reduce mortality rates to the fullest extent practicable.

Quality Service Reviews:

The Settlement Agreement requires annual QSRs to evaluate services quality and the extent to which services and supports received by individuals served under the Agreement are provided in the most integrated setting appropriate to individuals' needs and choices. The QSR process will collect information through a statistically-significant sample of face-to-face surveys of individuals receiving services under the Agreement, family members, and service providers. Survey results are intended to be used at the state, regional, and local levels to improve practice and the quality of services. The Department has contracted with the VCU Partnership for People with Disabilities to conduct annual QSRs.

State and Regional Quality Review Structures

The Department has established a state Quality Improvement Committee to review and monitor key indicators and other data required under the Settlement Agreement with input from the Regional Quality Councils. In addition, the Quality Improvement Committee will assess the validity of each measure at least annually and update measures accordingly. The five Regional Quality Councils have been established and will be assessing relevant data, identifying trends, and recommending quality improvement initiatives for their regions. The regional councils will be comprised of individuals who are experienced in data analysis, residential and other providers, CSBs, individuals receiving services, families, and other relevant stakeholders.

Data Dashboard

In collaboration with the Office of the Secretary, the Department is developing a multi-agency Health and Human Resources data dash board that includes the following metrics to track positive or negative movement toward the accomplishment of agency strategic goals.

Measure	
Community Services Boards	Employment status of adults admitted to the mental health services program
	Intensity of engagement in mental health case management services
	Intensity of engagement in substance abuse outpatient services
	Retention in community substance abuse services
	Intensity of engagement by newly admitted children in community MH outpatient services
	Developmental services transformation
	Percent receiving face-to-face developmental case management services
	Percent receiving in-home face-to-face developmental case management services
State Hospitals	Use of training centers forensic state hospital bed utilization

The data dashboard, as it continues to evolve, will provide a basic and easy way for performance to be measured in a brief easy to digest "traffic light" format.

Goal, Objectives, and Implementation Action Steps

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

Objectives and Implementation Action Steps

1. Implement a systemwide quality improvement process.

a. Work with the CSBs and other stakeholders to design and implement quality improvement measures with measurable and realizable implementation processes.

b. Support state facility self-monitoring and continuous quality improvement processes.

c. Work with CSBs and state facilities to improve the quality of measurement data.

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

a. Continue to identify program efficiencies to increase the time that licensing specialists have available to perform inspections, issue licenses, and respond to complaints.

b. Continue to make improvements in applicant training.

3. Increase the effectiveness and efficiency of the human rights system.

a. Identify program efficiencies that would increase the time that advocates have available for direct involvement with individuals receiving services.

b. Continue to make improvements in the current human rights organizational structure.

c. Provide guidance and technical assistance on the regulations aimed at promoting treatment in the most integrated settings and enhancing individual decision-making.

4. Establish systems to collect and analyze reliable data about individuals receiving services under the DOJ Settlement Agreement.

a. Implement enhanced licensure inspections of community developmental services providers serving individuals who are included in high-risk categories.

b. Implement uniform risk triggers and thresholds at all CSBs, training centers, and other community developmental services residential and day services providers.

c. Monitor and investigate any suspected or alleged incident of abuse or neglect, serious injury, or deaths reported in the new real-time web-based incident reporting system.

d. Conduct monthly mortality reviews for unexplained or unexpected deaths and analyze mortality trends, patterns, and problems at the individual service-delivery and systemic levels in order to reduce mortality rates to the fullest extent practicable.

e. Conduct Quality Service Reviews (QSRs) that evaluate services quality through annual individual, family, and provider surveys.

f. Review and monitor key indicators and other data required by the Settlement Agreement through the state Quality Improvement Committee and Regional Quality Councils.

5. Implement the Department's section of the Health and Human Resources data dash board.

a. Track and publish data dashboard measures on the Department's website.

b. Add measures to the dashboard as appropriate.

C. Case Management

Case Manager Competencies

Virginians with mental health or substance use disorders or intellectual disability receive case management (service coordination and intensive case management) to help them navigate and make the best use of the publicly funded system of services. This includes connecting with the right level and intensity of services and providing day to day support to assure stable community living. Case management to cover a broad array of services and supports, including:

- *Care Coordination* that manage and broker services for individuals to ensure that needs are met, covered services are not duplicated by the care-providing organization(s), and resources are used most cost effectively. It primarily involves gate-keeping functions,

such as approving care plans and authorizing services, utilization management, providing follow-up, and promoting continuity of care.

- *Basic Case Management* that assess the needs, wants, strengths and preferences of individuals seeking services and supports; create viable plans to assist in referring to, accessing, and utilizing needed services and supports; support and assist in addressing unmet needs; actively monitor the delivery of services and their outcomes; and collaborate and coordinate with others to ensure effectiveness and avoid duplicative services.
- *Targeted Case Management* that includes a full range of care and support that individuals with more severe disabilities require to live successfully in the community. In addition to basic case management, these services include: supportive counseling; crisis intervention; direct assistance with limited activities of daily living; coaching; intake and discharge planning; relationship building; teaching decision making; self-advocacy, and wellness planning; educating regarding the need for medications, primary care, and therapy; promoting continuity of care among various health systems and providers; providing family education and support and generally overcoming barriers for accessing appropriate care.

Because individuals with more serious disabilities are being served in the community, case managers are providing more supportive counseling and crisis intervention, coordinating more complex plans of care and support, and spending more time monitoring the effectiveness of an entire range services to help prevent the need for more intensive and expensive interventions. Strengthening the case manager's role and core competencies is essential to ensure that case managers have the knowledge and expertise needed to provide effective and accountable services and identify and strengthen the individual's natural support systems. Core case management competencies follow.

- *General Competencies:* Cultural and linguistic competence, safety, ethics, and use of technology; and
- *Case Management-Specific Competencies:* Job knowledge, assessment skills, service planning and service access, advocacy, interpersonal and team skills, judgment and analytic ability, adaptability, and organizational skills.

To assure that the persons who are providing case management have the knowledge and skills to effectively perform their responsibilities, the Department adopted a web-based basic case management curriculum and completed protocols to track case management module completion in May 2012.

The Department worked with a stakeholder workgroup to develop the following modules:

- Overview
- Disabilities Defined and Importance of the Integration of Health Care
- Developing and Maintaining Relationships
- Assessment
- Planning
- Services
- Accountability.

Implementation of the first six of the modules on the web-based Knowledge Center began in July 2012 and the final Accountability module was released in February 2013. By May 30, 2013, over 4,100 individuals from CSBs and other organizations had started the case management training; 3,800 had completed the six module curriculum; and 3,100 had completed the new seventh module. By November 21, 2013, approximately 177 additional individuals from CSBs and other organizations had completed all modules. Of the 109 DD case managers, 55 had completed all portions of the training modules as of November 21, 2013. Staff is implementing a protocol to identify Knowledge Center users not expected to complete all

of the modules due to their status as non-case management or staff who are no longer employed.

Even with the case management training curriculum, Virginia does not have a system for formally recognizing the competencies of each case manager and assuring that the persons who provide case management have the knowledge and skills needed to be effective. A case management certification program with basic and advanced disability-specific levels for behavioral health and developmental services case managers could provide this recognition.

Developmental Services Case Management Requirements

The DOJ Settlement Agreement contains specific case management/support coordination requirements for individuals with intellectual or developmental disabilities who receive home and community-based waiver services. Case managers must meet face-to-face with every individual receiving case management services under the Agreement "on a regular basis" (every 90 days consistent with the requirements of the ID and DD Targeted Case Management regulations) and to meet face to face at least once every 30 days with individuals who:

- Receive services from providers having conditional or provisional licenses;
- Have more intensive behavioral or medical needs;
- Have an interruption in service of greater than 30 days;
- Encounter crisis system for a serious crisis or for multiple less serious crises in a 3 month period;
- Have transitioned from a training center within the previous 12 months; or
- Reside in congregate settings with 5 or more individuals.

At least one of these visits must occur in the individual's place of residence every other month. During these visits, the case manager/support coordinator shall observe the individual and his or her environment to assess for previously unidentified risks, injuries, needs, or other changes; assess whether the individual's support plan is being implemented appropriately and remains appropriate for the individual; and ascertain whether implementation of supports and services is consistent with the individual's strengths and preferences and are in the most integrated setting appropriate to the individual's needs. Identified issues or deficiencies must be documented in the record, addressed by the individual's person-centered team, and reported to appropriate entities (including licensing, human rights, or protective services, as appropriate).

In June 2012, the Department established a Case Management Data Work Group that included CSB, DD waiver, and advocacy community representatives to address case management visit number, type, and frequency data requirements. New Phase I case management standards and reporting requirements for 30 CSBs were issued in October 2012 and became effective on March 6, 2013. During May 2013, Department staff completed meetings with 40 CSBs to collect data and review DOJ case management criteria.

The Agreement calls on the Department to establish the capability to collect and assess key health/safety, community integration and choice indicators from case manager visits and ensure that reliable case management data is routinely being collected and analyzed by March 2014. In March 2013, the Department re-convened the Case Management Workgroup to establish a mechanism to meet these Phase II measures and requirements.

Goal, Objectives, and Implementation Action Steps

Goal: Strengthen the capability of the case management system to support individuals receiving behavioral health or developmental services.

Objectives and Implementation Action Steps

1. Enhance the core competencies of persons who provide case management services.

a. Implement the case management training curriculum.
b. Monitor and report to CSBs the number of staff completing each module.
c. Adopt a curriculum for disability-specific case management levels.

2. Promote consistency in the practice of case management across Virginia.

a. Explore options for formally recognizing the competencies of each case manager in the behavioral health and developmental services system.
b. Identify regulatory or other prerequisite requirements for case manager certification.
c. Define case manager certification experience, training, and testing requirements.
d. Create and pilot basic and advanced disability-specific case management certification tests based on competency requirements.
e. Establish a case management credentialing process to administer tests, certify and recertify case managers, and maintain certification databases.
f. Work with provider groups to begin implementation of case management credentialing process.

3. Meet DOJ Settlement Agreement requirements related to the provision of case management/support coordinate for individuals served under the Agreement.

a. Monitor implementation of the Case Management Operational Guidelines.
b. Collect reliable data on the number, type, and frequency of case manager contacts (including face to face visits) with individuals receiving case management services under the Settlement Agreement.
c. Identify key indicators of health, safety, and community integration to be collected during case management face to face visits.
d. Establish a system to collect, report, and analyze key case management indicators.

D. Independent Housing

Creation of Permanent Supportive Housing

Affordable housing and community-based support services are keys to independence for thousands of Virginians with behavioral health or developmental disabilities. Executive Order 10 (2010) describes housing as a major component in determining quality of life for Virginians. The housing policy framework and principles outlined in the Executive Order speak to the importance of:

- Promoting sustainable and vibrant communities, including expanding public-private cooperation in addressing affordable safe housing;
- Ensuring a range of housing options to meet the housing needs of changing populations, including promoting a continuum of quality housing options for special needs populations, matching existing subsidies with areas of housing need, and increasing emphasis on fair housing and eliminating barriers to housing; and
- Increasing capacity to address the needs of homeless Virginians, including focusing on the reduction of chronic homelessness, ensuring the continued viability of the safety net of shelters and services, and investing in transitional and permanent supportive housing.

Permanent supportive housing does not place limits on a person's length of tenancy as long as he or she abides by the conditions of the lease or agreement. The person has access to a flexible array of comprehensive services, including medical and wellness, mental health, substance use management and recovery, vocational and employment, money management, case management, life skills training and assistance, household establishment, and tenant advocacy. However, use of services or programs is not a condition of ongoing tenancy. The permanent supportive housing model involves a working partnership that includes ongoing

communication between supportive services providers, property owners or managers, and housing subsidy programs.

Historically, the behavioral health and developmental services system has tied housing to services. In 2010, the State Board of Behavioral Health and Developmental Services updated its housing policy, Policy 4023 (CSB) 86-24, to include the following principles:

- Individuals should live in stable, decent, and affordable housing of their choice;
- Appropriate, flexible, accessible, and effective support services should be available;
- Housing should be available in integrated settings throughout the community; and
- To ensure choice, the behavioral health and developmental services system has the responsibility to facilitate access to existing housing and stimulate the preservation and development of housing.

Safe, decent, and affordable housing is essential to recovery for individuals with mental health or substance use disorders and housing stability is correlated to lower rates of incarceration and costly hospital utilization. Data reported in "*Priced Out in 2012"* by the Technical Assistance Collaborative (TAC) and the Consortium for Citizens with Disabilities (CCD) Housing Task Force, show that the annual income of a single individual receiving SSI equaled only 15.6 percent of median income in Virginia. To afford a one-bedroom apartment at HUD's fair market rental rates, SSI recipients would have to pay between a low of 70 percent of their income in southwest Virginia to a high of 171 percent in the Northern Virginia region.

Auxiliary Grants subsidize housing for individuals receiving SSI, but are limited to Assisted Living Facilities and Adult Foster Care homes and cannot be used more flexibly in other housing arrangements. Medicaid does not pay for housing.

The Department is participating on the Homeless Outcomes Advisory Committee, established under Executive Order 10 to expand supportive housing, including specialized housing, expand access to mental health and substance abuse services, and improve discharge policies and procedures of jails, hospitals, and the mental health system, and increase flexibility of funding. In addition, the Department funded a statewide "Housing Stability and Mental Illness Summit" with the Virginia Coalition to End Homelessness and NAMI Virginia in July 2012 to promote regional action planning for supportive housing and related services to over 200 participants. It provided one-time mental health and substance abuse block grant funds to help support outreach and services to 118 vulnerable homeless individuals, including 63 individuals with tri-morbidity (mental health issues + serious medical condition + substance use problems) ($100,000) and to expand eight peer support and recovery services programs ($126,000).

Housing Plan Implementation

The Department established a full-time housing coordinator position in March 2012 to lead development of state strategic investment priorities with partner state agencies to align federal, state, local, and private housing resources with the state housing policy and plan; provide the framework for increasing integrated community housing; maximize public-private partnerships; and develop innovative housing and financial models for individuals receiving behavioral health or developmental services.

On March 6, 2013, the Department issued Virginia's Plan to Increase Independent Living Options with the goal of increasing the availability of independent housing options for individuals with intellectual and developmental disabilities. This plan was developed in consultation with an Interagency Housing Committee composed of representatives from the Office of the Secretary of Health and Human Resources, VHDA, DHCD, DMAS, DARS, and the VBPD, as well as stakeholder organizations.

The plan's cornerstone principle is the de-coupling of housing and services so that service provision and housing decisions are separate and distinct and individuals have choices about where they live and where they may obtain services. Increased accessibility to affordable opportunities to live independently will result in more individuals with intellectual or developmental disabilities and their families having more choices of where to live.

Plan goals and strategies focus on expanding inventory of affordable and accessible housing, increasing access to rental subsidies, building understanding and awareness of informed choices, reviewing potential federal and state policy changes, and assessing and advancing coordinated plan implementation. It also includes a provision to establish and distribute rental assistance to individuals with developmental disabilities from a one-time fund of $800,000.

Goal, Objectives, and Implementation Action Steps

Goal: Address housing needs for individuals with mental health and substance use disorders and those with developmental disabilities.

Objectives and Implementation Action Steps:

1. Expand permanent supportive housing options across the Commonwealth.

a. Participate in cross secretarial and interagency activities to:
   - Leverage state and federal funds for housing for individuals with special needs,
   - Establish and align state priorities and program resources,
   - Promote creation of additional Housing First Projects
   - Expand access to non-institutional community housing options,
   - Address local barriers to affordable housing, and
   - Develop goals for achieving housing stability and prevention of homelessness.

b. Develop strategies to implement the State Board housing policy, including promotion of individual preferences and permanent supportive housing.

c. Provide training and consultation to CSBs and other public and non-profit services providers on how to access and leverage federal resources for housing and community-based supports and implement the supportive housing model.

d. Establish and sustain regional planning and collaborative coalitions of CSBs, public housing authorities, planning district commissions, and local housing organizations that implement the supportive housing model.

e. Expand the capacity of public and non-profit homeless services providers to connect individuals receiving services to SSI/SSDI benefits by implementing the SSI Outreach and Recovery (SOAR) evidence-based practice and providing technical assistance and training to homeless services providers.

f. Create, in partnership with CSBs, a mechanism for reporting change in residence information quarterly for individuals receiving CSB mental health or substance abuse case management services to analyze their length of housing tenure and frequency of moves.

g. Develop and monitor benchmarks and housing stability outcomes for individuals receiving CSB mental health or substance abuse case management.

2. Increase the availability of independent housing options outlined in the interagency Housing Plan to Increase Independent Living Options for individuals with intellectual and developmental disabilities served under the Settlement Agreement.

a. Expand the inventory of affordable and accessible rental units for individuals with developmental disabilities.
   - Pursue and leverage increased local, state, and federal rental subsidy opportunities.
   - Provide incentives for developers to build units for individuals with intellectual and developmental disabilities.

b. Increase access to rental subsidies for individuals with developmental disabilities.
    - Partner with state and local public agencies to prioritize rental subsidy needs of individuals with developmental disabilities.
    - Pursue and develop funding sources to expand the availability of rental assistance.
    - Partner with VHDA and DMAS to apply for FY 2013 HUD Section 811 funding and other rental subsidy opportunities that will support the creation of housing options for individuals with intellectual or developmental disabilities.
    - Encourage local public housing agencies to apply for any future incremental federal Housing Choice Voucher assistance.
    - Provide incentives for developers to build units for individuals with intellectual or developmental disabilities.
    - Request HUD approval to provide special admissions preferences for individuals with intellectual or developmental disabilities in VHDA's Housing Choice Voucher program.

c. Build understanding and awareness of informed choices for independent living among individuals with developmental disabilities, families, public and private organizations, developers, and case managers.
    - Implement a communications, advocacy, outreach, and education plan targeted to public and private services providers, individuals and their families, housing developers, public housing agencies, local entitlement communities, private landlords, regional entities, and others.
    - Develop education and training methods to reach individuals and their families with information about available choices and opportunities for independent living.
    - Develop local and regional partnerships necessary to support and sustain the communication strategy and continued availability of independent living options.
    - Build the capacity of public and private agencies to assist individuals with disabilities and their families in making informed choices.

d. Review potential federal and state policy changes that will facilitate increased access and availability of services and supports that permit individuals to choose more independent living options.
    - Evaluate the current ID and DD waiver programs to identify service gaps that create barriers to independent living and recommend strategies to close these gaps.
    - Review potential changes in the Medicaid rate structure that will reduce reliance on larger congregate housing models, community-based intermediate care facilities, and nursing facilities.
    - Review Medicaid in-home payments and skilled nursing rate structure to identify opportunities to enhance support for more independent living options.
    - Review potential modifications to the Medicaid waiver programs to match individual needs to services, and provide individuals with the ability to direct their own waiver resources toward independent living options.
    - Review the Medicaid waiver structure to determine if there are opportunities to expand environmental modification and assistive technology provisions in the current Medicaid ID and DD waiver program to support more independent options.

e. Assess and advance coordinated Housing Plan implementation.
    - Track, evaluate, and continuously improve upon plan implementation progress through establishment of benchmarks, key indicators, and quarterly monitoring formats and processes.
    - Establish an annual review and revision of strategies and action steps.
    - Establish the Interagency Housing Committee as a permanent advisory body to ensure state and local partner implementation of the Plan.
    - Continue to conduct outreach to representatives of agencies at the local level to share the Plan.

E. Employment First Initiative

People who are employed improve their sense of self worth and contribute to the economy. A 2012 University of Virginia Weldon Cooper Center report on working-age (16 to 64 years of age) Virginians with disabilities reported 2011 American Community Survey (ACS) findings that nearly 470,000 (9 percent) of working-age Virginians had at least one disability and of these, 210,000 had two or more disabilities. The 2011 the ACS tracked six dimensions of disability and found that among working-age Virginians with disabilities, 4 percent had a cognitive disability; 3 percent had difficulty with independent living due to a physical, mental, or emotional condition; and 2 percent had difficulty with self care. Of Virginians with disabilities, 60 percent of were out of the labor force - neither working nor looking for work. This proportion was three times higher than for non-disabled working-age Virginians. Among individuals in the labor force, Virginians with disabilities had higher unemployment rates (16 versus 7 percent), greater part-time work (11 versus 8 percent), and lower employment in professional occupations (23 versus 35 percent). The ACS reported that employment outcomes varied significantly by the type of disability, with less than one-third of individuals with cognitive, ambulatory, or independent living disabilities employed full-time.

Adults with serious mental illness make up the single largest diagnostic group (35 percent) on the Supplemental Security Income (SSI) rolls and over one quarter (28 percent) of all Social Security Disability Income (SSDI) recipients. A significant portion of special education students and families believe that if they work, they will lose their SSI benefits. Also, there is a significant lack of awareness of work incentives under SSA for SSI or SSDI recipients. Navigation through the work incentives and benefits available through SSA is laborious and very difficult to achieve in isolation. To address these issues, the Department has provided access and information on SSI and SSDI work incentives and benefits assistance training and has supported the Community Work Incentive Coordinators (CWIC) benefits and assistance program established by the Social Security Administration.

The Department established an employment services coordinator position to implement an Employment First initiative. This initiative emphasizes person-centered planning and, for individuals where employment is an appropriate and viable option, integrated and supported employment over sheltered employment with sub-minimum wages or non-work day activities. The Employment First initiative is based on the following principles:

- Individual supported employment in integrated work settings is the first and priority service option for individuals with intellectual or developmental disabilities receiving day program or employment services from or funded by the Commonwealth;
- The goal of employment services is to support individuals in integrated work settings where they are paid minimum competitive wages; and
- Employment services and goals must be developed and discussed at least annually through a person-centered planning process and included in Individual Support Plans.

The DBHDS Strategic Plan for Employment First includes objectives to increase enrollment in integrated work settings and add integrated day opportunities including supported employment for individuals in the target population receiving services under the Settlement Agreement. As part of this planning activity, efforts are underway to ensure that reliable Employment First data is routinely being collected and analyzed.

The Supported Employment Leadership Network (SELN) project, sponsored by the National Association of State Directors of Developmental Disabilities Services, has provided technical assistance and training opportunities designed to develop and promote supported employment. Approximately 500 public and private services providers, employment services providers, businesses/employers, and state and local agencies have participated in annual Statewide Employment First Summits held in 2011 and 2012, in regional summits, and in other training and technical assistance to CSBs and employment services organizations. In addition, the

Department has developed and integrated training components promoting employment into the case management training modules and provided mental health supported employment on-line and on-site training to 120 participants from CSBs, DARS, and employment services organizations through a SAMHSA funded Supported Employment Initiative grant.

The Department and other agencies are working with the Office of the Secretary of Health and Human Resources to develop a cross-agency plan to implement Executive Order 55 (2012) Supporting Virginians with Disabilities in the Commonwealth's Workforce Importance of Employment for Virginians with Disabilities to identify and develop strategies for expanding the employment of individuals with disabilities in the private sector in the Commonwealth. This plan will highlight the Employment First initiative.

Goal, Objectives, and Implementation Action Steps

Goal: Create employment opportunities for individuals with mental health or substance use disorders and those with developmental disabilities.

Objectives and Implementation Action Steps

1. Implement the Employment First Initiative.

a. Conduct statewide employment first awareness and education activities across Virginia, including annual Employment First Summits.

b. Use state, regional, and local trainings to expose employers to new innovative employment models and train them in how to assist challenging individuals.

c. Conduct workshops to develop cross-agency implementation strategies.

d. Establish employment outcome expectations as a goal of the behavioral health and developmental services system.

e. Create, in partnership with CSBs, a mechanism for monitoring change in CSB service recipients' employment status and reporting key employment outcome indicators established in the employment policy to the Department.

f. Monitor progress towards Employment First Initiative employment targets, benchmarks and outcomes on a quarterly basis.

g. Work with other agencies to identify funding sources.

h. Incorporate changes to current waiver to support supported employment.

i. Conduct training and awareness activities with other involved state agencies, pursuant to Executive Order 55, to inform public and private employers on why and how they can hire employees with disabilities.

2. Expand employment opportunities for individuals receiving behavioral health or developmental services.

a. Expand supported employment evidence-based practice models.

b. Provide training and consultation to services providers on implementing new innovative supported employment practice models and establishing integrated supported employment teams that include CSBs, DARS, and employment services organizations (ESOs).

c. Partner with DARS to provide cross-training for respective staff focused on increasing access to vocational services, job training, and employment supports for individuals with mental health or substance use disorders.

d. Work with DARS to expand Long-Term Employment Support Services (LTESS).

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 through:

- Benefits training;
- Access to qualified work-related incentives/benefits counselors; and
- Use of the VCU Employment Support Institute's WorkWORLD™ software.

f. Work with DMAS to incorporate supported employment evidence-based practice models in Medicaid Day Support, Mental Health Support Services, and Psychosocial Rehabilitation regulations.

g. Work with DMAS to incentivize integrated employment in the ID and IFDDS waivers.

h. Continue to train and certify CSB and IFDDS waiver case managers in each region as work incentive counselors.

i. Identify and, as appropriate, collaborate with DARS 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.

BEHAVIORAL HEALTH SERVICES

A. Mental Health Services Capacity

Recovery-Oriented System of Care

SAMHSA's Working Definition of Recovery defines recovery as "a process through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential." Recovery-oriented systems of care (ROSC) are person-centered and enable individuals to receive the services and supports they need to manage their illnesses themselves. Recovery-oriented systems of care ensure that individuals in recovery from mental health or substance use disorders receive services and supports in the most integrated setting, not separated from the communities in which they live and in the least restrictive manner, whereby care is provided with as few limitations as possible and individual preferences and choices are maximized. Services and supports are provided by a fully integrated and trained workforce, including peers and other providers.

SAMHSA defines ROSC implementation as "a process of change to concretely align the values and principles of a system with recovery and its critical indicators in the major dimensions that most contribute to individuals' recovery: i.e. Home, Health, Purpose, and Community." ROSC values and principals should be evident in system structure, policies, and practices and in the day-to-day behaviors of personnel and service recipients as they plan, deliver, evaluate, and participate in services. Implementation requires transformational culture change at state and local levels among services system stakeholders to build the following ROSC foundations:

- Integration of recovery values, principles, concepts, and language in services system processes and structures;
- Full participation of individuals and their families as partners in all aspects of service planning, delivery, and evaluation;
- Buy-in and support for ROSC at all levels of the behavioral health services system and across various services system stakeholders;
- Engagement and collaboration with policy-makers, funders, and other stakeholders (social services, schools, medical community, corrections, employers) in developing and supporting recovery-focused communities; and
- Implementation of culturally-based and sensitive services and supports that are personalized to meet each individual's unique needs.

To support this transformational change process, SAMHSA has initiated the Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TCS) to support implementation efforts in the states. In April 2012 Virginia was selected to participate with eight other states in a three-day BRSS TCS Policy Academy. Subsequently, Virginia received funds to bring together diverse stakeholders who were considered "early adopters" and "recovery

champions" to identify ways for Virginia to become more recovery oriented in its practices and to create opportunities for these constituencies to collaborate on long-term goals for the system.

A statewide Recovery Forum was convened in June 2013 to focus on essential elements of ROSC such as person-centered care and trauma-informed care. In attendance were 116 leaders from all state mental health facilities, the majority of CSBs, independent peer and advocacy organizations, peers who work in CSBs or facilities, family representatives, and Department and DMAS staff. The Recovery Forum examined potential next steps that Virginia could take, including:

- Adopting and applying ROSC values and principles to program and administrative operation and decision-making processes; and
- Developing a strategic plan for ROSC implementation focused on:
  - integrating a recovery orientation into services system policy, operations, clinical practice, and administrative infrastructure (e.g., finance and billing, human resources and workforce development and training, outcomes, quality improvement, and quality assurance);
  - creating an array of recovery services and supports that incorporate person-centered and trauma informed practices and support "home," "health," "purpose," and "community;" and
  - facilitating systems integration between peers and providers; across various components of the behavioral health services system; and with other health, education, and social services systems.

The BRSS TCS process will continue to unfold over the biennium and will require services system leadership and involvement of key partners as recovery oriented goals and action steps are developed and implemented within and across various parts of Virginia's public behavioral health services system.

Crisis Response and Other Mental Health Services Capacity Development

Virginia's mental health services system faces a number of challenges. Increasingly, individuals seeking mental health treatment have complex conditions, multiple physical and behavioral disorders, significant public safety involvement, or some combinations of these that make it difficult for them to access the range of services and supports they need, even under the best circumstances. The mental health services system has limited capacity to wrap "upstream" services and supports around these individuals to prevent crises and support them in the community. Significant variations in regional and local service availability, and some notable gaps, in important basic services, continue to exist. Most significantly, these include:

- A range of crisis and emergency services for persons experiencing behavioral health crises including acute inpatient care;
- Basic outpatient, case management, and psychiatry services to prevent crises;
- Wrap-around recovery-focused community supports and housing to prevent crises and enable community integration, including enabling individuals to be discharged from state hospitals; and
- Timely access to services in the community and in local jails and effective management of forensic patients involved in the criminal justice system.

Virginia's emergency response and crisis intervention system includes an array of many different types of services ranging from outpatient and ambulatory services to more intensive, restrictive and costly services such as residential crisis stabilization and inpatient services that provide a greater degree of clinical supervision and security, which can be important considerations when an individual's safety is concerned. To enhance the Commonwealth's emergency response and crisis prevention and diversion services capacity, the Department created a crisis specialist position in May 2012 to provide consultation to providers and support

improvements in behavioral health emergency services and the crisis safety net. In the FY2014 budget, the Department received funding to support the implementation of 6 new or expanded Crisis Intervention Team (CIT) therapeutic law enforcement drop off centers (assessment and triage sites). Priority areas for future crisis services development include local acute inpatient hospitalization: detoxification and other substance abuse services; additional crisis intervention teams and similar criminal justice behavioral health interventions, including therapeutic assessment and referral drop-off centers for law enforcement to serve every CIT program in Virginia; and psychiatric evaluations and medication access within 24 hours.

In addition, the Department is working to implement recovery-based emergency and crisis response best practices through service provider training and mentoring to support the use of psychiatric advance directives (ADs) by CSB and state hospital service recipients, and implementation of the 2009 federal Substance Abuse and Mental Health Services Administration (SAMHSA) *Practice Guidelines: Core Elements for Response to Mental Health Crisis*, including access to peer supports. The Department also has funded a Spanish version of NAMI's *"Helping an Individual through a Psychiatric Crisis"* resource guide All CSB residential crisis stabilization units utilize peer providers.

The Department has also identified the following priorities for non-crisis service capacity building: case management, especially intensive case management; mental health services (in-home daily support of individuals); psychiatric services and medication management; PACT (Program of Assertive Community Treatment); peer support; and wrap-around services.

On December 10, 2013, Governor McDonnell announced a number of budget proposals for Virginia's mental health system and issued an executive order (Executive Order # 68) creating the Task Force on Improving Mental Health Services and Crisis Response. The budget proposals of more than $38 million over the 2014-2015 biennium would improve the Commonwealth's response to mental health crisis services and behavioral health treatment and support services to prevent crises from developing and would extend the timeframes for emergency custody orders and temporary detention orders in certain circumstances. The task force, comprised of leaders in the mental health field, law enforcement, the court system, private hospitals, and individuals receiving services and their families, will recommend solutions to improve the services system, including refinements and clarifications of protocols and procedures for CSBs, state hospitals, law enforcement, and receiving hospitals; expansion of a range of services and technologies that respond to individual in mental health crisis and their families, and workforce development activities. In announcing this initiative, the governor reported that the governor-elect was fully supportive of the proposed changes and investments and would continue the task force during his term.

School Safety and Mass Violence Prevention

Recent incidents of mass violence across the country have raised questions about the link between mental illness and violence. Although individuals with mental health disorders in most circumstances are no more likely to commit acts of mass violence than the general population, the high visibility of recent tragedies has brought attention to the nation's readiness and capacity to respond to children and adults who have behavioral health concerns. In December 2012, the Governor established the Governor's Taskforce on School and Campus Safety, a multi-disciplinary task force to review school and campus safety in light of the tragedy at Sandy Hook Elementary School in Newtown, Connecticut. A detailed set of recommendations was endorsed by the taskforce to:

- Expand children's mental health services;
- Develop additional secure drop off centers where law enforcement can transport someone needing mental health evaluation instead of the emergency room or jail;
- Implement Mental Health First Aid, a nationally recognized program, to instruct participants how to identify and respond to warning signs of mental health problems

through a train-the-trainers system that will make the program available to a large number of stakeholders and persons in contact with the public; and

- Expand suicide prevention programs, in partnership with the Department of Health, to promote public education for suicide prevention.

These recommendations were incorporated into the FY 2014 Appropriation Act with a total of $2.9 million in new funding to support implementation.

Suicide Prevention

The Department is Virginia's lead agency for suicide prevention across the life span and continues to provide leadership with the VDH and DVS in cross-agency activities to promote suicide awareness and reduce the incidence of suicide. In 2011, there were 1,067 deaths from suicide in Virginia and the rate of suicide, at 12.6 per 100,000 population, is the highest it has been in 13 years.

Development of an updated Interagency Suicide Prevention Plan for the Commonwealth has been initiated in partnership with state agencies including VDH, DVS, DARS, and DOE; behavioral health services providers; suicide survivors and advocates; and the VCU Department of Epidemiology. In response to a Governor's Taskforce on School and Campus Safety recommendation, the Department received an appropriation of $500,000 in state funds for FY 2014 to expand Virginia's Applied Suicide Intervention Skills Training (ASIST) capacity, support public awareness education, and help increase the capacity of Virginia's communities to address suicide.

Service Availability and Accessibility for Populations with Special Needs

The following populations have particular issues accessing behavioral health services and supports.

Military Veterans and Families - Virginia continues to develop services and supports for veterans with mental disorders and traumatic brain injuries. The behavioral health challenges on the military health system come primarily from two "signature injuries" - post-traumatic stress disorder and traumatic brain injury. Evidence demonstrates that as many as half of military veterans and their families will face significant mental health challenges in the coming years. To improve services and address the continuum of care needs of disabled veterans, the Department and CSBs have formed a strong partnership with the Department of Veterans Services (DVS) across many areas of veterans care.

The Department has partnered with DVS and DARS in implementing a state level strategy, the Virginia Wounded Warrior Program (VWWP), to respond to the behavioral health needs of Virginia veterans. The VWWP was created in 2008 to ensure that services to veterans and their families are readily available in all areas of the state. The VWWP offers services and supports to veterans and their families through a network of community-based services, including emergency and crisis response services, coordinated through regional VWWP consortia made up of community providers, including DVS support services, CSBs, brain injury services providers, VA Medical facilities and other public and private providers.

Given historic trends, Virginia can expect to see more veterans seeking behavioral health services, stressing the capability of the behavioral health resources of the Commonwealth.

Older Adults – Nationally, the older adult population (persons 65 years of age or older) in 2011 accounted for about 13.3 percent of the total population and is projected to increase to 19 percent by 2030. This accelerated growth by individuals with proportionately greater and more expensive healthcare needs will place increased pressure on health care services, including Virginia's behavioral health services system. Treatment models for older adults with mental health or substance use disorders 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 are not the answer to the burgeoning geriatric population as more individuals demand alternative "aging in place" community and home-based services. This includes a focus on 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 provide Medicaid coverage of psychiatric care in the individual's own residence.

Virginia lacks adequate behavioral health services infrastructure to meet the current needs of older adults. Specialized crisis response, intervention, and ongoing treatment services and supports for older individuals with behavioral health disorders are not widely or routinely available. The provision of those specialized services is complicated by the lack of providers trained to serve older individuals with mental health or substance use disorders. To provide innovative direct care services for older adults in their home communities with the goal of reducing the need for psychiatric hospitalization provide specialized services, the Department and CSBs have worked together and with other stakeholders to implement regional model programs in Northern Virginia and Eastern Virginia.

Although the Department continues to work closely with health and long-term care partners to strengthen the availability of services and supports for older adults with mental health or substance use disorders, access to needed behavioral health services continues to be limited.

As these populations continue to grow, Virginia will experience increased demand for access to specialized service and supports that help to prevent them from experiencing crises.

Criminal Justice Interface

Diversion of Individuals from the Criminal Justice System: According to the *Virginia Compensation Board Mental Illness in Jails Report (2012),* of the 26,669 inmates in 62 of 64 local and regional jails surveyed in July 2012, a total of 6,322 had been diagnosed with or were suspected of having a mental illness. Of these 6,322 inmates, almost half had a serious mental disorder. These individuals were almost evenly divided between pretrial and post-conviction status. Virginia has made advances in its behavioral health/criminal justice collaboration in several important areas over the past three years. These include:

- *Cross Systems Mapping (XCM),* which brings community criminal justice and behavioral health representatives together to "map" individuals' step-by-step experience across the behavioral health and criminal justice systems, identify gaps in services, look for diversion or system improvement opportunities, and create a local action plan for appropriate interventions that prevent or reduce an individual's involvement in the criminal justice system and promote access community services and supports. To date, approximately 1,400 criminal justice and behavioral health stakeholders representing 97 localities have participated in 48 mapping workshops. These workshops have directly led to the growth of Crisis Intervention Team programs and increase the number of criminal justice and behavioral health collaborations across Virginia.
- *Crisis Intervention Teams (CIT*), which provide a 40 hour training program for law officers and others to improve their ability to respond safely and effectively to persons with mental illness, reduce the use of force and restraint, and divert persons from arrest and link them to mental health services whenever possible. Since 2008, the number of CIT programs has increased from 22 to 33 and over 5,700 police, sheriffs' deputies, jail corrections officers, first responders (e.g., emergency medical, fire, and rescue), and

mental health personnel have participated in CIT training. Currently, 85 percent of Virginia's population lives in areas with CIT programs.

- *Police Reception/Drop Off Centers*, which provide drop off capability for law enforcement through therapeutic (non-criminal justice setting) secure assessment centers. As part of CIT, ten CSBs have "drop-off" sites to reduce time spent by officers on mental health-related calls (five of these programs provide 24/7 access). The centers allow individual who otherwise might have been arrested to be appropriately referred to community treatment or medically admitted. The 2014 General Assembly provided funds to establish three additional centers.
- *Jail diversion and jail treatment programs* in 10 CSBs, which include CIT programs, post-booking jail diversion, limited jail based treatment and community competency restoration, jail discharge planning, and services and supports for individuals re-entering the community from jails and prisons.

Prisoner Reentry: As the Virginia prison population has grown older and become more diverse, an increasing number of Department of Corrections (DOC) inmates who are being released from correctional centers have special needs that require community supports upon release. The majority of these individuals need nursing or assisted living placements. Others have behavioral health needs. Seamlessly meeting the needs of these individuals can pose significant challenges to DOC and community corrections staff, local social services departments and community services boards, and local public and private service providers.

The Prisoner and Juvenile Reentry Council was established through Executive Order 11 (2010) and continued by Executive Order 48 (2012), to develop collaborative strategies to strengthen Virginia's prisoner reentry program for the estimated 10,000 to 12,000 adults and 500 juveniles who are projected to be released from incarceration and returned to communities each year. Reentry is the process of leaving a prison, correctional center or jail and returning to the community. To ensure that offenders have been adequately prepared for reentry and reduce potential re-incarceration, offenders must be equipped to find employment, have access to treatment for behavioral health issues, and be reintegrated into stable home environments. This requires collaboration among state and local criminal justice and service agencies, courts, families, and other community supports. The Council established an aggressive agenda of 60 recommendations to strengthen public safety, reduce recidivism, and improve collaboration among local and state agencies. Implementation of these recommendations by appropriate agencies and partners is being monitored and ongoing collaboration and partnerships encouraged among local agencies, services providers, and other community organizations to successfully promote and support the Council's recommendations.

There are relatively few releases that present major challenges to the community, but when they do occur, the challenges are significant. There is no single "profile" of offenders with a combination and complexity of needs that limit options. To address the increasing challenges associated with the release of special needs inmates from DOC facilities, the DOC formed an interagency task force that included the Department. The task force reviewed recent difficult cases, which revealed the following active variables:

1. Age of the offender;
2. Lack of cooperating family;
3. Medical needs;
4. Mental health needs;
5. Violent or sex crimes;
6. Behavior problems while at DOC;
7. Not eligible for parole or probation supervision;
8. Incompetent to give consent;
9. Problems, delays, or barriers to receiving benefits (SSI/SSDI/Medicaid); and

10. Inadequate notice to community providers such as local social services departments or CSBs.

The committee met until December 2012 and developed a Pre-Release Protocol for DOC for inmates with special needs and a blueprint for community use in planning for special needs inmates. It also recommended that DOC restore funding for DOC to purchase services for released inmates, increase the number of positions in DSS regional offices to process and case manage releases, establish a process and provide funding to obtain guardianship when needed, and ask the Joint Legislative Audit and Review Commission (JLARC) to study impact of release of aging and special needs inmates and recommend program improvements.

Goal, Objectives, and Implementation Action Steps

Goal: Enhance statewide consistency, availability, and accessibility of recovery-oriented behavioral health services and supports across Virginia.

Objectives and Implementation Action Steps

1. Implement a recovery-oriented system of behavioral health services and supports.

a. Develop a Recovery Oriented System of Care (ROSC) values template that can be used to direct financial, clinical, and administrative decisions going forward.

b. Provide training and support to behavioral health services providers to integrate recovery values, principles, concepts, and language in services system policies, processes, and structures.

c. Expand opportunities for individuals and their families to participate as partners in all aspects of service planning, delivery, and evaluation.

d. Engage and collaborate with policy-makers, funders, and other stakeholders (social services, schools, medical community, corrections, and employers) in developing and supporting recovery-focused communities.

e. Develop a ROSC Strategic Plan for Virginia with statewide and regional recovery-oriented goals and action steps to implement a recovery-oriented system of care in Virginia's behavioral health services system.

f. Continue the BRSS TCS process to bring peers, advocates, families, providers, state agencies and other stakeholders together to monitor and report on progress in achieving a recovery-oriented system of care.

2. Increase the statewide availability of behavioral health emergency response and crisis prevention and diversion services capacity.

a. Expand support for an adequate and more consistent continuum of emergency and crisis response services to include local purchase of inpatient hospitalization beds, crisis intervention teams and similar criminal justice behavioral health interventions, therapeutic drop-off centers for law enforcement, and psychiatric evaluations and medication administration within 24 hours.

b. Participate on and provide support to the Task Force on Improving Mental Health Services and Crisis Response.

c. Implement SAMHSA Practice *Guidelines: Core Elements for Response to Mental Health Crisis* systemwide through training and educational events on practices in crisis stabilization, including the use of the practice guidelines.

d. Expand the use of psychiatric advance directives as part of routine care in CSBs and state hospitals through training and support to CSBs and hospitals that are AD "adopters;" training and certification of AD facilitators; and development and maintenance of AD technical assistance resources such as the toolkit and website.

3. Increase the statewide availability of behavioral health services capacity.

a. Expand support for an adequate and more consistent array of mental health services to include intensive case management, outpatient counseling, mental health services (in-home daily support of individuals), psychiatric services and medication management, PACT (Program of Assertive Community Treatment), peer support, and wrap-around services.
b. Implement the behavioral health recommendations of the Governor's School and Campus Safety Initiative.
c. Continue to plan and implement cross-agency suicide prevention initiatives across the Commonwealth.

4. Expand the capability of Virginia's behavioral health services system to recognize and address the growing services and supports needs among veterans.

a. Participate with DVS in the implementation of the Virginia Wounded Warrior Program.
b. 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.
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.

5. Develop a comprehensive, community-based continuum of specialized behavioral health services for older adults in Virginia.

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 potential financial resources for the development of person-centered, family-focused, community-based services for older adults that reflect best practices.

6. Strengthen the Commonwealth's capacity to safely and effectively intervene to prevent or reduce the involvement of individuals with mental health and substance use disorders in the criminal justice system.

a. Expand support for crisis intervention teams and similar criminal justice behavioral health interventions, including therapeutic law enforcement assessment/ drop-off centers.
b. Continue 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. Support local law enforcement interventions to prevent individuals who are in crisis from involvement in the criminal justice system by providing Crisis Intervention Team (CIT) training, promoting CIT program development and outcomes measurement, and establishing police reception and drop-off centers.
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. Provide training on civil commitment, competency restoration, and other behavioral health topics to court personnel (judiciary, prosecutors, defense bar and other attorneys, clerks and bailiffs), probation and parole, community corrections, jail and other corrections staff, and emergency services workers.

7. Strengthen the Commonwealth's capacity to address the behavioral health needs of offenders who are released from DOC facilities

a. Support efforts of the DOC to identify special needs offenders and involve community agencies in pre-release planning to include the initiation of necessary paperwork for SSI, Medicaid, or other benefits prior to release.

b. Monitor implementation of the Pre-Release Protocol for DOC for inmates with special needs.

c. Work with DOC and community agencies to implement the blueprint created for community use in planning for special needs inmates.

B. Child and Adolescent Mental Health Services

Comprehensive Service Array

Children with mental health or substance use problems and their families often face a complex, multi-faceted, and rapidly evolving array of public and private providers. Effective collaboration among Virginia child-serving agencies is essential because it strongly influences the success of services interventions. These include CSBs, social services, juvenile justice, schools, and an extensive array of privately operated children's services that have developed over the past few years with public Medicaid and Comprehensive Services Act (CSA) funds.

Through a variety of children's services system transformation efforts, Virginia child serving agencies have defined the vision and goals of an expanded and effective system of care for children and their families. The system of care philosophy, which calls for a coordinated interagency network of services and supports that has the child and family at the center of all planning and care coordination, has been widely endorsed at the national level and in Virginia. The system of care philosophy stresses that the best place for children to grow and develop in a healthy manner is their own family homes – or as close to their own family homes as possible. It recognizes that while some residential and inpatient services may always be needed, if a wide array of less intensive family and community-based services were commonly available, the need for residential and inpatient care could be reduced.

In 2011, the Department developed a successful SAMHSA Systems of Care Expansion Planning Grant to support training and technical assistance activities advancing the systems of care philosophy on a statewide basis and in selected communities. Colonial Behavioral Health, Fairfax-Falls Church CSB, Rappahannock Area CSB, and Valley CSB received scholarship assistance to participate in Systems of Care Training Institutes and to visit a "best practice" site. The $500,000 planning grant officially ended in September 2012 but a no-cost extension was received to continue training activities for the balance of FY 2013.

Virginia's behavioral health services system for children faces a number of challenges, the most significant of which is that children and families are faced with inadequate and inconsistent access to a comprehensive array of services and supports that include 30 services in the following categories:

- Assessment and Evaluation;
- Outpatient or Office Based Services;
- Case Management and Intensive Care Coordination;
- Home and Community-Based Services;
- Intensive Community Supports;
- Community Crisis Response Services;
- Residential; and
- Inpatient Services.

This comprehensive service array to support a child-centered, family-focused system of care is not consistently available in all areas of the state and even when services are available, there is not sufficient capacity. The lack of community-based services has caused an over-reliance on inpatient and residential treatment services for children. While inpatient care is an essential component of the comprehensive service array, its restrictiveness and cost necessitate using it only when there is no other appropriate alternative. A quality clinical assessment, including those provided as part of the Virginia Independent Clinical Assessment Program (VICAP), is an important tool to assure that children get the appropriate community services at the right time to meet their unique service needs.

Because rapid widespread development of the full service array is not realistic, the Department's final report to the General Assembly, a Plan for Community-Based Children's Behavioral Health Services – Final Report *(*Item 304 M 2011), identifies the following base services as immediate priorities for community services capacity investment.

- Crisis Response Services, including crisis stabilization, emergency assessments by prescreeners with child-specific training, emergency respite, in-home crisis stabilization, and mobile child crisis response;
- Case Management and Intensive Care Coordination; and
- Child Psychiatry Services.

To address needs identified in the Plan, the General Assembly provided $1.5 million in FY 2013 and $3.65 million in FY 2014 for regional programs to provide children's Crisis Response and Child Psychiatry Services in all five health planning regions. Regional programs funded in FY2013 include:

- *Region I* – Central Virginia CSB for mobile crisis outreach, regional consultation and training to all other CSBs in the regional and child psychiatry available via face-to-face and telepsychiatry services across the region.
- *Region III* – Mount Rogers CSB to add child-specific crisis counselors in three CSBs and to improve access to psychiatry services using telepsychiatry and consultation to pediatricians in this rural, medically underserved area.
- *Region IV* – Richmond Behavioral Health Authority for a six bed crisis stabilization service, mobile crisis outreach and child psychiatry available via face-to-face and telepsychiatry services across the region.

Regional programs funded in FY 2014 include:

- *Region II* – Arlington CSB to lead the regional program with crisis stabilization beds at Leland House and Grafton, mobile crisis services headquartered in Arlington and Chantilly (western Fairfax) and administratively managed by the Arlington CSB, and child psychiatry available via face-to-face and telepsychiatry services across the region.
- *Region V* – Virginia Beach to lead the regional program with crisis stabilization beds at Bon Secours Maryview Medical Center, mobile crisis teams in four CSBs and child psychiatry available via face-to-face and telepsychiatry services across the region.

Building on the Planning Grant, Virginia has received a four-year System of Care Implementation Grant to further advance system of care principles in Virginia communities. This grant is supporting a Wraparound Center of Excellence that is providing training to Intensive Care Coordinators with the assistance of the University of Maryland Center for Innovation and Implementation; a competitive opportunity for local providers to receive mini-grants to enhance their local system of care; and a youth component added to the federal block grant-funded Virginia Family Network at NAMI that is doing outreach and education for youth affected by behavioral health problems. A Youth Coordinator hired at Virginia Family Network in January 2013 with grant funds is expanding the scope of family support activities, including family education workshops and family forum leadership/network training events.

A statewide children's behavioral health workforce development initiative is being implemented in collaboration with Virginia colleges and universities other child-serving agencies to enhance public and private provider expertise in implementing the system of care philosophy and providing crisis response and other services that reduce reliance on more restrictive and costly care. This initiative includes development of a Workforce Development Plan, collaboration with the Office of Comprehensive Services Training Committee, and provision of various systems training in areas such as trauma-informed care and education and support events for families.

Infant and Toddler Early Intervention Services (Part C)

In Virginia, infant and toddler early intervention is delivered through a comprehensive, coordinated, interagency, and multidisciplinary services system that is regulated by Part C of the Individuals with Disabilities Education Act (IDEA). Infant and toddler services are supports are 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. They 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. Part C of IDEA has strictly prescribed requirements, similar to mandates associated with public school special education services.

Infant and toddler services include an array of family-centered, community-based services and supports provided to children who are from 0-3 years of age. Infant and Toddler Intervention includes assistive technology; audiology; family training, consultation, and home visits; health services; medical services (for diagnosis and evaluation); nursing services; nutrition services; occupational therapy; physical therapy; psychology services; service coordination; social work services; special instruction; speech-language pathology; transportation services; and vision services.

The Part C program mandates services to children birth through age three who have a developmental delay, or a diagnosed physical or mental condition that is likely to result in a developmental delay. While state and federal grant funding has remained relatively flat, Virginia's local lead agencies have continued to serve higher numbers of children. In FY 2012 Virginia served 15,626 infants and toddlers with disabilities, a 52 percent increase since FY 2007. This combination of flat funding and increased demand resulted in an increasing inability of some local systems to meet required service delivery standards. In state FY 2013, a number of the 40 local lead agencies struggled with compliance by having a waiting list or putting limits on the number of services allowed. If services are not in compliance with federal requirements, families may pursue a specified dispute resolution process to require provision of these entitled services.

Recognizing this shortfall and continued increases in enrollment demand, the 2013 General Assembly allocated an additional $8.25 million in state general funds for Part C early intervention services. Of this, $2.25 million will be allocated in FY 2013 to the 26 local lead agencies that had experienced funding shortfalls and, $6 million will be distributed in FY 2014 to each local system by an allocation formula. These funds will help local systems comply with federal regulations; however, it will not completely eliminate shortfalls. As a result, the Department is working with the local lead agencies to develop fiscal management resources and training to assure that all insurance payments are maximized and working with individual lead agencies on their utilization of available funds. The Department also is consulting with national experts on best practices.

Goal, Objectives, and Implementation Action Steps

Goal: Enhance access to the full comprehensive array of services and supports for children and adolescents across the Commonwealth.

Objectives and Implementation Action Steps

1. ***Increase the statewide availability of a consistent array of child and adolescent behavioral health services as the goal and standard in every community.***
   a. Expand the array and capacity of children's behavioral health services to assure a consistent level of base services statewide.
   b. Support training efforts across child-serving systems to increase consistency in public and private providers' knowledge and skills and support implementation of a comprehensive service array in a manner consistent with best practice standards.
   c. Provide continuing education that supports clinical licensing requirements.
   d. Implement new service initiatives that include child psychiatry through face-to-face telepsychiatry and consultation to pediatric and primary care providers.
   e. Enhance linkages with partner agencies to fill gaps and build community capacity for children and youth who need behavioral health services and supports.
2. ***Provide services and supports that meet the developmental needs of infants and toddlers and comply with federal Part C requirements.***
   a. Expand the Part C early intervention services.
   b. Work with local lead agencies to develop fiscal resources and maximize insurance payments.
   c. Provide individual consultation with local agencies on utilizing available funds.
   d. Consult with national experts on Part C best practices.
   e. Adopt comprehensive regulations for the Virginia early intervention program.

C. Substance Abuse Services

Substance Abuse Treatment Services

Untreated substance use disorders costs Virginia millions of dollars in cost-shifting to the criminal justice system, the health care system, and lost productivity, not to mention the human suffering and effects on family and friends. Based on 2010 and 2011 National Surveys of Drug Use and Health (NSDUH) estimates, 23.21 percent of Virginians over 12 engage in binge drinking (5 or more drinks on one occasion), and 8.2 percent meet clinical requirements for abuse or dependence of either alcohol or illicit drugs.

Substance misuse and addiction commonly lead to crimes and criminalization of addiction – 70 percent of Virginias' incarcerated populations have substance abuse issues that, if not addressed, considerably increase the risk of recidivism. Governor McDonnell's Virginia Prisoner and Juvenile Re-entry Council has recommended adoption of evidence-based treatment models at prisons and jails, and in the community, with improved coordination and continuity for the 13,000 inmates who return to Virginia communities each year.

Co-occurring substance use and mental health disorders are characterized by the simultaneous presence of two independent medical disorders – psychiatric disorders and alcohol or other drug use disorders - that can occur at any age. Co-occurring mental health and substance use disorders are common: 35 percent of people with serious mental illness use alcohol or other drugs in a way that compromises stable recovery, and 19 percent of persons with alcohol abuse or dependence meet criteria for a mental illness. The Department has adopted the *Comprehensive, Continuous, and Integrated System of Care (CCISC)* model at all levels of the services system. CCISC incorporates the principles of integrated system planning, a welcoming environment, uniform dual diagnosis program capability, universal practice guidelines, dual competence, concurrent treatment, and continuity of relationships with clinicians. (Minkoff, 1989, 1991, 2000, 2001)

In October 2011 the Department completed an interagency plan, developed in collaboration with the Departments of Corrections, Criminal Justice Services, Health, Health Professions, Juvenile

Justice, Medical Assistance Services, Rehabilitative Services, and Social Services, Creating Opportunities for People in Need of Substance Abuse Services, An Interagency Approach to Strategic Resource Development, to improve access to substance abuse services for Virginians. This process also included input from private and public providers, advocates, and people in recovery. The plan recognizes that access to a consistent array of services such as case management medication assisted treatment, and various levels of residential treatment is inconsistent across the state and proposed a multi-year investment plan to address these and other service gaps. It also includes a number of multi-agency strategies to provide recovery-oriented services and supports, including expanding employment and safe, sober, and affordable housing options that promote productive, law-abiding, sober lifestyles.

The most recent (2011) Virginia Medical Examiner's Report indicated a record number of deaths from drugs and poisonings, following a national trend in which the number of deaths from drug overdoses exceeds the number of traffic fatalities. That year, 818 individuals died as a result of drugs or poisoning. Of these, 79 percent (394) were accidental and 62 percent were attributed to four drugs commonly used to control pain (fentanyl, hydrocodone, methadone, and oxycodone). Oxycodone caused the most deaths (163), with 40 percent occurring in the western part of Virginia. In late 2012, Virginia was selected in a competitive process to participate in a national policy project sponsored by the National Governors' Association to reduce prescription drug abuse. This project involved the Department, Department of Health Professions (DHP), and State Police and is focusing on enforcement, monitoring, disposal, and training and education. The final report has been submitted to the Governor.

The 2013 General Assembly passed legislation to prevent deaths from opioid overdose by permitting individuals who have been trained to nasally administer naloxone (Narcon®), which stops the action of the opioid on the central nervous system. This legislation requires the Department, the Department of Health (VDH), and DHP to establish pilot projects that allow prescribers to write prescriptions for this drug for a trained lay person to administer to any person who is overdosing. The pilot projects will be in Southwest Virginia and metropolitan Richmond and project results will be reported to the General Assembly in 2015.

Substance Abuse Prevention Priorities

Prevention is aimed at substantially reducing the incidence of alcohol, tobacco, and other drug use and abuse with a focus on enhancing protective factors and reducing risk factors. 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. Risk factors may be biological, psychological, social, or environmental and can be present in individuals, families, schools, and the community. For example, children who experience a higher number of risk factors, such as poor school achievement, parents with poor family management skills, and neighborhoods where drug use is tolerated, are more likely to experiment and use alcohol, tobacco, or other drugs.

The Department oversees and supports substance abuse prevention services delivered through CSBs that are funded with Substance Abuse Prevention and Treatment Block Grant (SAPT) funds. The Department also supports a community-based process involving human service providers, schools, law enforcement organizations, faith and business communities, and parents and youth who participate in prevention planning coalitions. In a survey conducted for the 2014-2020 Comprehensive State Plan, CSBs reported that prevention coalitions identified elementary school students; middle school students; and parents and families as priority populations targeted for focused prevention efforts and availability of tobacco, alcohol, drugs, and other substances; family management problems; friends who engage in the problem behavior; and early initiation of problem behavior as the most significant risk factors.

The Department also participates with 12 other state agencies on Virginia's Office of Substance Abuse Prevention Collaborative (VOSAP) to plan and direct statewide prevention initiatives.

VOSAP members and other stakeholders serve on the advisory committee for a five year SAMHSA Strategic Prevention Framework State Prevention Grant to address motor vehicle crashes involving alcohol impaired drivers ages 15-24. Through 13 jurisdictional-level sub-awards, year-long community-based, data-driven needs assessment and strategic plans have been completed. Evidence-based programs and practices are now being implemented in 11 of those jurisdictions to reduce the number of alcohol-involved motor vehicle crashes with drivers who are 15-24 years old. Program and epidemiological evaluations of this project are on-going.

An amendment to the federal Alcohol, Drug Abuse, and Mental Health Administration Reorganization Act requires states to conduct annual inspections of randomly selected tobacco retail outlets to determine the likelihood that underage youth can purchase tobacco products. As a condition for receipt of federal SAPT treatment and prevention funds (approximately $40 million), a state's noncompliance rate must not exceed 20 percent. Virginia's noncompliance rate for the federal fiscal year 2013 was 13.5 percent.

Goal, Objectives, and Implementation Action Steps

Goal: Increase the statewide availability of substance abuse services.

Objectives and Implementation Action Steps

1. ***Enhance access to a consistent array of substance abuse treatment services across Virginia.***
   a. Increase access to an adequate and more consistent array of substance abuse services, including case management, intensive outpatient services, medication assisted treatment, detoxification beds, and residential treatment for pregnant women and women with dependent children.
   b. Reduce wait times to access treatment services.
   c. Enhance uniform screening and assessment of co-occurring mental health and substance use disorders.
   d. Develop capacity to serve adolescents with substance use and co-occurring mental health disorders.
   e. Expand substance abuse peer recovery programs that provide group support, housing and employment assistance, day activity, and links to community resources.
   f. Provide structured, safe, sober living environments for adults who are actively engaged in treatment as a step down from detoxification or residential services.
   g. Expand Project Link, which provides intensive, coordinated interagency care for pregnant and post-partum women who are using drugs.
2. ***Foster interagency partnerships to provide services to individuals with substance use disorders.***
   a. Expand access to identification and intervention for offenders with substance use disorders in community correctional settings.
   b. Participate with the DHP and State Police in the National Governor' Association policy project to reduce the abuse of prescription drugs.
   c. Implement two pilot projects with VDH and DHP to permit individuals who have been trained to recognize overdose to nasally administer naloxone to person who is overdosing.
   d. Create a multi-agency work force development capacity focusing on the treatment of substance use disorders.
   e. Expand DRS substance abuse employment counselors in CSBs.
   f. Support DOC efforts to provide services to offenders with substance use disorders.
   g. Support the establishment and implementation of drug courts across Virginia.

3. Reduce the incidence of alcohol, tobacco, and other drug use and abuse among Virginia youth and adults.

a. Build and sustain collaborative relationships at the state level and support community-based prevention planning coalitions at the local level to implement strategies that reduce exposure to risk and enhance protective factors.

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 educate youth about the harmful effects of tobacco use and support tobacco specific prevention strategies and activities.

D. Peer Services and Peer Provided Recovery Supports

Peer support is recognized as an important factor in the recovery process for many individuals with mental health or substance use disorders. At the federal level, SAMHSA has identified recovery support as a priority strategic initiative in *"Leading Change: A Plan for SAMHSA's Role and Actions 2011-2014."* The recovery support initiative promotes peer support and the social inclusion of individuals with or in recovery from mental and substance use disorders in the community. SAMHSA includes recovery support as an expectation for receipt of state mental health and substance abuse block grants.

The federal Centers for Medicare and Medicaid Services (CMS) has approved the use of Medicaid funding for Peer Recovery Supports services and has recognized these services as an important component in a state's delivery of effective treatment. The Department and DMAS are exploring the addition of peer support as a distinct service in the state Medicaid plan and are working together to develop provider competency requirements for a new peer support service.

The Department continues to lay the groundwork for a new Office of Peer Services and Recovery Supports in the central office and an advisory committee with a balanced representation from mental health and substance peer programs, advocacy groups, and individuals who have received public and private behavioral health services. Together, the office and advisory committee would develop and expand systemic and service level understanding of and capacity for peer-to-peer services and recovery supports by promoting inclusion of individuals and families with lived experiences in the work of Department and its community partners; collaboration among traditional services providers and the peer community, and implementation of peer run and recovery-based programs throughout Virginia.

Virginia uses federal, state, and local funding to support direct services provided to individuals by individuals who have themselves experienced mental health or substance use disorders, i.e., by peers. Peer-provided and peer-run services and supports are delivered through CSBs, state hospitals, and by peer-operated programs. These activities sustain the important ongoing partnership between the peer community and traditional treatment providers. They create empowering experiences for peers and are intended to reduce stigma and foster a more welcoming and responsive system of care. The Department contracts with the following peer-run service organizations.

Organization	Description
Center for Recovery and Wellness	This program provides recovery oriented training, socialization, and peer support services in Lynchburg and surrounding counties.
Depression and Bi-Polar Support Alliance	This program provides support groups using the Pathways to Recovery Program model and an annual retreat to participants in Northern Virginia.
Friends4 Recovery Whole Health Center	This bi-lingual English and Spanish program provides peer support services and wellness training in the Richmond area.
Laurie Mitchell Employment Center	This program offers peer-provided employment training and supports, computer classes, resume writing, interview training, and social activities to participants in Northern Virginia.

Organization	Description
Middle Peninsula/Northern Neck Consumer Operated Program	This program provides peer support and wellness programs in the Middle Peninsula/Northern Neck service area.
On Our Own of Roanoke Valley	This program provides peer support services, veteran's outreach, Wellness Recovery Plan (WRAP) facilitation, and wellness groups.
On Our Own of Charlottesville	This program provides co-occurring support, psycho-social programs, WRAP facilitation, wellness groups, and peer-provided outreach to homeless persons.
PD 19/House of Job/Voices Against Crack	This program uses recovery coaches and is working in Petersburg and surrounding communities to establish recovery housing.
Region Ten CSB	This program uses recovery coaches and is working with individuals receiving services in the Charlottesville area to develop Recovery Action Plans. (RAP)
SpiritWorks/Colonial CSB	This program provides local peer support services in Williamsburg and surrounding communities, works with individuals receiving services to develop RAPs, and provides technical assistance to peer-run programs.
The Coalfields Coalition	The coalition provides peer support services, using RAP, and works closely with the regional substance abuse services coalition in Southwest Virginia. (Cumberland Mountain, PD 1 and Dickenson County CSBs).
WeCare, Inc./Piedmont CSB	This program provides peer support services to individuals with a serious mental illness and substance abuse issues in the Martinsville area.

The Department contracts with the Mental Health America of Virginia (MHAV), National Alliance on Mental Illness (NAMI) Virginia, Substance Abuse Addiction and Recovery Alliance (SAARA), and Virginia Organization of Consumers Asserting Leadership (VOCAL) to provide support and training to individuals receiving services and family education about mental health or substance use disorders and their treatment. MHAV provides *Consumer Empowerment Leadership Training* (CELT) and *Wellness Advocacy and Leadership Through Technology* (WALTT). NAMI Virginia's individual and family education programs include *In Our Own Voice*, *Peer to Peer*, *Family to Family*, and *The Basics*. VOCAL provides technical assistance to peer-run programs, trains WRAP facilitators, and supports a statewide peer network and an annual conference for individuals receiving services.

Goal, Objectives, and Implementation Action Steps

Goal: Increase use of peers in direct service roles and expand recovery support services across the Commonwealth.

Objectives and Implementation Action Steps

1. Increase opportunities for individual and family involvement in planning, evaluating, and delivering behavioral health and developmental services.

a. Continue to fund and support Virginia's statewide network of peer organizations and family alliances.

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. Support CSB and state facility 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 the quantity and quality of peer support services providers.

a. Continue to fund and support development and expansion of a wide range of peer services and peer provided recovery supports delivered through CSBs, state hospitals, and peer-operated programs.

b. Provide ongoing education and support to public and private behavioral health providers aimed at increasing their use of peer support specialists and promoting effective collaborations with independent peer programs.
c. Work with DMAS to establish Peer Support Services as a Covered State Medical Assistance Plan rehabilitation service and to adopt regulations that include a peer support services definition, program and provider requirements, and adequate reimbursement rates.
d. Implement a peer support specialist certification program contingent on resource availability.

3. Establish an Office of Peer Services and Recovery Supports in the Department's central office.

a. Establish a peer advisory council to provide ongoing interface with the peer community.
b. Begin Office of Peer Services and Recovery Supports operations contingent on resource availability.

E. State Hospital Effectiveness and Efficiency

Annual Consultative Audits of State Mental Health Facility Operations

The roles of state hospitals and community inpatient providers of psychiatric services have continued to evolve as Virginia works to implement state policies promoting community-based care. Because their services are generally provided in very structured and secure treatment environments, state hospitals are challenged to promote recovery-oriented and person-centered treatment that help individuals improve their health and wellness, learn to live self-directed lives, and reach their full potential. State hospitals have made significant progress in changing their cultures to support recovery, self-determination, empowerment, and person-centered planning.

To improve state hospital service delivery and standardize hospital procedures, as appropriate, the Department has implemented annual consultative audits (ACAs) that use a peer-review process involving teams of colleagues from other state hospitals, individuals receiving services, and central office staff. Teams review and provide feedback on facility operations and compliance with oversight and accreditation requirements and offer consultative suggestions to improve service delivery. The initial round of ACAs resulted in a concerted focus on completely revamping the assessment and treatment planning process approach and documents to make it uniform across all hospitals. This involved training conducted at all facilities and preparations for implementing standardized treatment planning module in the Department's new electronic health record system The second round of ACAs, completed in early 2013, included instrument and process improvements recommended by first-year ACA participants and a new consumer peer review component.

Access to and discharge of individuals from state hospitals and publically-funded care provided by private psychiatric hospitals is now managed by regional consortia of CSBs and other stakeholders in the jurisdictions served by the state hospitals. Active regional management is challenged by the continuing loss of private psychiatric beds and by regional differences in needs, resources, and service availability.

State hospitals have around 3,500 admissions and 3,600 discharges annually. Some persons who are determined by their treatment teams to be clinically ready for discharge face barriers to discharge because community supports and housing arrangements that meet their specific needs are not available. On average, between 140 and 150 individuals are waiting for discharge because they have extraordinary barriers and of these, one-third are civil patients with special needs, one-third are geriatric patients who need nursing home placements, and one-third are forensic patients who are committed as not guilty by reason of insanity and whose services need court approval.

Demand Pressures on State Hospital Bed Capacity

The following facility populations are placing significant demands on state facility bed use.

Forensic Services: State hospitals provide:

- Inpatient evaluation and restoration of competency to stand trial for jail inmates;
- Inpatient treatment of unrestorably incompetent defendants (URIST);
- Emergency inpatient psychiatric treatment of jail inmates;
- Evaluation and treatment of Not Guilty by Reason of Insanity (NGRI) acquittees; and
- Inpatient evaluation of sanity at the time of offense.

In FY 2013 there were 930 new adult forensic admissions to state hospitals and 455 forensic patients that carried over from FY 2012. In 2002, an estimated 26 percent of available state hospital beds (469 of 1,803 beds) were occupied by forensic patients. In FY 2013, forensic patients consumed 180,606 bed days, or 33 percent of all available bed days (based on hospitals' operating capacities). The discharge length of stay (LOS) for all forensic patients discharged in FY 2013 was 369 days. The discharge LOS for civil patients was 123 days.

Adults with a forensic status receive services on state hospital civil units as well as at the maximum security and intermediate security units at Central State Hospital and minimum security units at Western and Eastern State Hospitals. In FY 2013, 34 percent of adult civil beds were occupied by adults with a forensic status, up from 20 percent in FY 2006. The result is fewer state hospital beds for civil patients such as individuals on temporary detention orders and more restricted access for forensic referrals.

During the past five years, the Department has made significant progress in reducing state hospital waiting lists for jail inmate admissions. This waitlist has declined from 111 in July 2007 to an average of 43 in late 2012. By March 2013, the number of the waitlist averaged 15. The Department also has reduced the NGRI waitlist (transfers from CSH to ESH) from 16 individuals awaiting transfer to ESH (average 50 day wait time) in August 2011 and 12 individuals in September 2012 (average 195 wait time) to 1 individual awaiting transfer to ESH (67 day wait). This reduction is due to ESH's aggressive utilization management and conversion of a geriatric unit to house low-risk (of violence and escape) NGRI patients.

Although the Code expresses a preference for outpatient competency evaluations and outpatient competence restoration whenever possible, many persons who could be served on an outpatient basis are instead referred to state hospitals. To safely divert forensic admissions to state hospitals, the Department provided outpatient competency restoration in all seven regions and allocated $144,000 in ongoing funds to CSBs to provide adult outpatient competency restoration services in either the community or jail. In FY 2013, the Department reimbursed CSBs for providing competency restoration services on an outpatient basis (either in the individual's home, the CSB clinic, or in a local/regional jail) for 116 individuals. Additional development of community-focused forensic services, including outpatient and jail-based evaluations, restoration of competency, and treatment for persons found NGRI, is necessary to offset the increasing demand for state hospital beds by individuals with a forensic status.

Geriatric Services: Virginia serves many older adults with psychiatric needs in its state hospital geriatric centers (representing 18 percent of total hospital bed days in FY 2013) rather than in the community. This rate is exceeded by only four other states, in large part because the Commonwealth lacks adequate community infrastructure that provides specialized programs and providers trained to address the specific needs of older individuals with mental health or substance use disorders.

Although some older adults living in nursing facilities are receiving case management and other specialized services through OBRA-87 funding, long-term care facilities that lack access to psychiatric care have difficulty managing behavioral challenges of residents with behavioral

health disorders. This inability to manage behavior problems can translate into injuries to the individual or other residents and to caregivers. At times, long term care facilities respond to behavior problems with an over reliance on medications or by transferring those individuals to community hospitals or to state hospital geriatric centers.

State hospital geriatric centers are working with nursing facilities across Virginia to encourage and support the transition of individuals residing in the centers to the community. 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 individuals, some of them have been integrated into community settings.

Over the years, the percentage of individuals admitted to state geriatric centers under TDOs 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 for patients over 65 years of age. Because community hospitals often experienced placement issues that resulted in stays beyond 14 days, many were reluctant to accept these individuals. Community hospitals and the state geriatric centers are working closely with the Regional Utilization Management Committees to coordinate and manage transfers from community hospitals to the centers. 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.

Goal, Objectives, and Implementation Action Steps

Goal: Increase the effectiveness and efficiency of state hospital services.

Objectives and Implementation Action Steps

1. ***Provide high quality state hospital services that efficiently and appropriately meet the needs of individuals receiving services.***
   a. Maintain sufficient numbers of trained state hospital staff to provide quality services and assure the safety of individuals receiving services.
   b. Incorporate peer supports and active treatment that includes wellness recovery planning and educational, career development, and job training programs.
   c. Implement wellness programs designed to lower obesity, hypertension, diabetes, and heart disease and facilitate exercise and other healthy lifestyle choices.
   d. Reduce state hospital bed utilization through aggressive monitoring of service plans and discharge efforts such as targeted discharge assistance that reduce lengths of stay and enable individuals to be integrated more quickly into the community.
   e. Continue work with the regions to implement best practices for regional management of inpatient resources.
   f. Support OIG efforts to monitor state hospital progress in improving quality of care.
2. ***Improve state hospital service delivery and standardize hospital procedures as appropriate.***
   a. Conduct Annual Consultation Audits (ACAs) in each state hospital each year.
   b. Utilized peer consultative feedback to enhance treatment effectiveness and efficiency and standardize hospital procedures as appropriate.
3. ***Reduce or divert forensic admissions from state hospitals and increase conditional releases and discharges to the community.***
   a. Expand provision of outpatient forensic evaluations that safely and appropriately divert individuals from inpatient pretrial evaluation and treatment.
   b. Expand outpatient restoration services that use a structured treatment protocol to assure that defendants receive appropriate active treatment to restore competency in jails and community settings.

c. Continue to improve NGRI acquittee flow-through by:
   - Supporting development of community alternatives that provide a higher level of support and services, thereby decreasing the need for prolonged hospitalization;
   - Placing NGRI acquittees into the least restrictive settings necessary as quickly as possible;
   - Providing enhanced access to expert consultation to help services providers address treatment-recalcitrant individuals; and
   - Creating transitional housing opportunities for NGRI acquittees.

d. Provide training and resources on forensic issues to the Virginia legal community by:
   - Increasing opportunities to share training developed for courts and attorneys;
   - Supporting pre-trial evaluator and adult outpatient competency restoration training; and
   - Integrating forensic issues into all Cross-Systems Mapping events.

e. Improve the Department's Forensic Information System (FIMS).

4. Reduce or divert older adult admissions from state hospitals and increase discharges to the community.

a. Support development of community best practice alternatives to intensive services, including geriatric intensive treatment teams, crisis stabilization and respite care, and CSB supported assisted-living housing.

b. Examine opportunities for public and private development of specialized community-based services for individuals receiving services in state hospital settings.

c. Provide training to long-term care facilities, primary care providers, and family caregivers on dealing with older adults with behavioral or mental health issues.

d. Provide behavioral health supports to traditional nursing that allow residents to remain in their current settings.

e. Participate in cross-agency initiatives such as PACE and "Money Follows the Person" that keep older adults with behavioral issues out of institutions.

DEVELOPMENTAL SERVICES AND SUPPORTS

A. Developmental Services Community Capacity Development

Department of Justice (DOJ) Settlement Agreement Focus on Community Integration, Self-Determination, and Quality Services

In August 2008, the U.S. Department of Justice (DOJ) initiated an investigation of the Central Virginia Training Center (CVTC) pursuant to the Civil Rights of Institutionalized Persons Act (CRIPA). In April 2010, DOJ notified the Commonwealth that it was expanding its investigation to focus on Virginia's compliance with the Americans with Disabilities Act (ADA) and the U.S. Supreme Court Olmstead ruling. The Olmstead decision requires that individuals be served in the most integrated settings appropriate to meet their needs consistent with their choice. In February 2011, DOJ submitted a findings letter concluding that the Commonwealth had failed to provide services to individuals with intellectual and developmental disabilities in the most integrated setting appropriate to their needs. Instead, Virginia had relied heavily on institutional settings, at significant financial costs to the Commonwealth. In March 2011, upon advice and counsel from the Office of the Attorney General, Virginia entered into negotiations with DOJ in an effort to reach a settlement without subjecting the Commonwealth to an extremely costly and lengthy court battle with the federal government. On January 26, 2012, Virginia and DOJ reached a Settlement Agreement that resolved DOJ's investigation of Virginia's training centers and community programs and the state's compliance with the ADA and Olmstead with respect to individuals with intellectual and developmental disabilities. The Full Settlement Agreement

(United States v. Commonwealth of Virginia, Civil Action No. 3:12 CV 059) was approved by the United States District Court for the Eastern District of Virginia on August 23, 2012.

The Settlement Agreement affirms the Commonwealth's intention to move rapidly toward a community-based system of supports provided in the most integrated setting appropriate to the specific needs of individuals with intellectual or developmental disabilities (ID/DD) and includes a commitment that Virginia's developmental services system be reformed to achieve the goals of community integration, self-determination, and quality services. The Agreement:

Expands Community-Based Services

- Significantly increases the number of new intellectual disability (ID) and developmental disability (DD) waiver slots over 10 years to transition individuals currently living in training centers to community services and provide for continued growth of slots for individuals in the community who are on the waiting list for waiver slots.

Supports Quality Community-Based Services

- Strengthens quality and risk management systems for community services.
- Expands the role of licensing specialists and case management services responsibilities.

Transitions Individuals Currently Residing in Training Centers to the Community

- Helps guide and support individuals moving from training centers to new homes by creating teams to facilitate communication and planning with individuals and families, and to resolve any problems delaying discharges.
- Requires active participation by CSBs in discharge planning and transition from training centers, including pre-move and post-move monitoring processes.
- Requires Virginia to provide a plan and timeframes to cease residential operations at four of the five state training centers by 2020.

The Agreement's target population is individuals with an intellectual or developmental disability who meet any of the following additional criteria: (1) currently reside at any training center, (2) meet the criteria for the ID or DD waiver wait lists, or (3) currently reside in a nursing home or intermediate care facility (ICF).

Compliance with the Settlement Agreement requires unprecedented expansion of developmental services and supports that keep individuals in their home communities and enable training center residents to move to integrated community settings. This expansion must include new and enhanced waiver slots to address extensive medical and behavioral challenges and provide residential services in homes with four or fewer beds, crisis prevention and stabilization services, and individual and family supports. Also required are community support services that keep families intact and reduce the need for costly out-of-home placements. Access to these critical supports requires partnerships at the state and local levels with housing agencies to access rental assistance and employment services organizations to create employment opportunities that emphasize integrated supported and competitive employment.

The Department and its partner agencies have undertaken a comprehensive effort involving 18 project teams comprised of developmental services providers and stakeholders to comply with Settlement Agreement requirements and milestones.

● Additional Waiver Slots ● New Medicaid Waivers ● Individual & Family Support ● Crisis Intervention & Prevention ● Employment First ● Independent Housing	● Discharge Planning & Integration ● Quality Improvement & Data Analysis ● Case Management ● Case Manager Training ● Provider Risk Management ● Incident Reporting	● Mortality Review ● Licensing ● Quality Service Reviews (QSRs) ● Facilities Closures ● Provider Training ● Regional Community Support Centers Coordination

Each team's work is contributing to the Commonwealth's transition to a community-based developmental services system with sufficient quality services and supports.

New Medicaid ID and DD Waiver Slots and Waivers

Virginia's initial Medicaid Waiver for Home and Community-Based Services for individuals with intellectual disability (ID waiver) and the Medicaid State Plan Option were developed in 1991. Waiver services include crisis stabilization and crisis supervision, personal emergency response system; day support, prevocational services, supported employment, in-home residential support services, residential support services, therapeutic consultation, personal assistance, companion services, assistive technology, environmental modifications, respite services, skilled nursing, and transition services. A Day Support (DS) waiver was established in 2006 to offer day support, prevocational, and supported employment services to individuals on the ID Waiver urgent and non-urgent waiting lists.

The Individuals and Families with Developmental Disabilities Supports Waiver (IFDDS or DD) Waiver was established in 2000 and contains in-home residential support, day support, skilled nursing, crisis services, respite, personal attendant care, and supported employment. Even as the additional waiver slots were funded by the General Assembly, waiting lists for slots continued to grow. The settlement agreement requires that Virginia create 4,170 waiver slots for the target population by June 30, 2021, according to the following timetable:

ID Waiver Slots for Individuals:							
State FY	In Training Centers	On the Urgent Wait List	On the DD Wait List	State FY	In Training Centers	On the Urgent Wait List	On the DD Wait List
2012[1]	60	275	150	2017	90	300	25
2013	160	225*	25**	2018	90	325	25
2014	160	225*	25**	2019	35	325	25
2015	90	250*	25**	2020	35	355	50
2016	85	275	25	2021	0	360	75
				Total	**805**	**2,915**	**450**

[1] These FY2012 slots have already been funded and assigned to individuals.

*25 slots each year are prioritized for individuals less than 22 years who reside in nursing homes or large ICFs.

**15 slots each year are prioritized for individuals less than 22 years who reside in homes or large ICFs.

Over the 2012-2014 biennium, the General Assembly has provided 450 ID waiver slots and 130 DD waiver slots in addition to the slots required by the settlement agreement. Even with recent growth in the number of waiver recipients, wait lists for waiver services are growing. In September 2013, 3,758 individuals were on the ID urgent and 2,755 on the non-urgent wait lists and 1,305 individuals were on the DD wait list.

Community developmental services providers are serving proportionately greater numbers of individuals with significant and complex needs that require specialized services and supports. The current ID waiver does not provide the level of supports and reimbursement rates for targeted services that would make it a truly effective alternative for individuals who need high intensity services. Recognizing this, the 2013 General Assembly included $7.8 million for "exceptional" ID waiver rates for congregate residential support services for individuals who meet specific criteria and need more intensive medical or behavioral supports in order to live successfully in the community. This rate will add an additional 25 percent to the usual reimbursement for congregate residential support services for qualifying individuals.

The Commonwealth must evaluate methods to assure that its waiver programs are sustainable and address extensive medical and behavioral needs of individuals receiving services, promote services with the highest social value (e.g., group and individual supported employment

options), and expand the array of the most person-centered outcomes (e.g., residential supports to include smaller more integrated environments. The Department and DMAS are studying possible improvements for waiver changes over the next two years to move toward needs-based waivers (not ID/DD based) and to recommend rate changes to serve individuals with the most complex needs and align incentives for more integrated environments.

The Department assumed responsibilities for the day-to-day operations of the DD Waiver on November 12, 2013 and has contracted with the Human Services Research Institute to evaluate the Commonwealth's current service delivery system for individuals with intellectual and developmental disabilities and to make recommendations to move the system to a more person-focused needs-based system of supports. The findings from this study, which will be concluded in late summer of 2014, will likely include recommendations and strategies for enhancements, restructuring, and systems changes that will affect the three current waivers for persons with intellectual or developmental disability.

Crisis Intervention and Prevention

In 2011, the Department elected to implement the nationally recognized Systemic Therapeutic Assessment Respite and Treatment (START) model to provide crisis services to adults with intellectual disability and co-occurring mental health issues or behavioral problems. To comply with the terms of the Settlement Agreement, approved after initial program start-up began, coverage was expanded to the adult DD population in June 2012. The goal of the START program is to maintain individuals in their home and prevent crises when possible by providing in-home supports and out of home crisis stabilization services when they are needed. In addition to these services, the program provides cross-system crisis intervention and intervention planning; maintains linkages and agreements with existing providers; and provides support, clinical training, technical assistance, and follow-up consultation to community partners, including emergency services personnel. To support implementation of START, the Department received $5 million in FY 2012. Additional funds approved by the General Assembly brought the total funding for adult mobile crisis teams to $11.6 million on July 1, 2013.

Virginia is in the first full year of implementation of this statewide crisis response system. Three therapeutic respite homes opened by February 2013 and the remaining two homes are scheduled to come on line in the near future. In addition, mobile supports provided by all teams in all five regions were fully operational by May 2013, with the goal of 24/7 availability within one hour (urban) and two hours (rural) by FY 2014. Medicaid reimbursement is being pursued for all covered services.

With full mobilization of mobile supports, the START program is now providing 24 hour/7 day support to individuals in crisis in each region, with the goal of responding on-site to crises within one hour in urban regions and two hours in rural areas by June 30, 2014. During FY 2013, 479 individuals had been referred to the START program for assessment and support.

The 2013 General Assembly also appropriated $1.25 M for mobile crisis, in-home, and psychiatric services for children with intellectual or developmental disabilities. At least one regional children's crisis program is expected to be implemented in FY 2014.

During the late summer of 2013, the Department convened a workgroup to evaluate the current capacity of the Commonwealth to meet the needs of children/youth and adults with ID/DD who experience behavioral and/or psychiatric crises. The workgroup is meeting with the START programs to identify gaps in the current system and methods to address these gaps. Among the areas being addressed are plans to add crisis intervention services for children/youth with ID/DD, crisis intervention services either on-site or in-home for individuals who exhibit extreme behaviors, and an enhancement to current START mobile crisis teams. These plans will be put in place beginning in December 2013/January 2014 and phased in throughout FY 2014.

Individual and Family Support Program

The Department has established an Individual and Family Support (IFSP) to provide individuals with intellectual disabilities or developmental disabilities access to person- and family-centered resources, supports, services and other assistance that will enable eligible individuals to continue to live at home. The basic tenets of this program, which is available to individuals who are on the ID or DD waiting list and their families, are to keep families together until the individual with a disability chooses to live independently by:

- Enhancing a family's ability to meet the many needs of the family member with ID/DD;
- Helping to relieve the stress of care giving so individuals can continue to reside at home;
- Improving the quality of supports to families while minimizing the need and cost of out-of home placement;
- Allowing families to participate in recreational and social activities; and
- Making a positive difference in the life of the person with a disability as well as the lives of all family members.

The IFSP can provide up to $3,000 annually to pay for a wide array of usually short-term resources, supports, services and other assistance, including:

- Professionally provided services and supports, such as respite, behavioral consultation, and behavior management;
- Transportation services;
- Assistive technology and home modifications, goods, or products that directly support the individual;
- Temporary rental assistance or deposits;
- Fees for summer camp and other recreation services;
- Temporary assistance with utilities or deposits;
- Dental or medical expenses of the individual;
- Family education, information, and training;
- Peer mentoring and family-to-family supports; and/or
- Other direct support services as approved by the Department.

To qualify for the program, the individual must have a demonstrated need for the requested services, supports, or other assistance. IFSP emergency regulations were effective through January 15, 2014, when permanent regulations become effective. In FY 2013, the program exceeded its goal and provided support to 825 individuals and families. In FY 2014; over 1,500 applications were received and 800 were approved by November 25, 2013.

Regional Community Supports Transition Plan

The capacity of the services system to provide medical, dental, and behavioral supports in the community as close to individuals' homes as possible also needs to be strengthened. For individuals with intellectual disability, challenging or difficult-to-manage behaviors can adversely affect their abilities and opportunities to participate fully in any aspect of community life and may pose a threat of serious harm to themselves or others. Without appropriate community-based interventions, these individuals may be at increased risk for psychiatric hospitalization because they require specialized supports in a secure environment or placement in a state training center or community ICF/ID facility.

The Department is developing a plan and timeframes with community and facility stakeholders to transition the Regional Community Support Centers (RCSCs), now located at the training centers, to community-based Developmental Disabilities Regional Health Supports Networks (RHSNs). This plan will identify current service availability and unmet health supports needs and will make recommendations on how to uniquely support this community-based supports

model in each region. The team also will identify budgetary requirements and legislative changes that would be needed to successfully implement these networks.

Provider Training and Development

Transformation to a community-focused system of developmental services and supports will continue to cause dramatic increases in the number of licensed providers of community developmental services. This increase in new providers and emerging evidence-based practices will require additional quality assurance and management oversight. The Department must strengthen its quality management and administrative capacity to provide oversight, training, and technical support necessary to ensure provider compliance with regulations and standards of quality. Quality varies greatly among providers of Medicaid Waiver services and many providers are not aware of best practices. State and partner agency training resources are limited generally, including Department central office training and technical support capacity for new providers and to improve staff competencies across the spectrum of support service delivery.

The Department is developing and will provide a statewide core competency-based training curriculum for all staff that provides services under the settlement agreement. This curriculum is intended to ensure that all providers and staff provide sufficient habilitation to teach individuals skills and competencies that increase self-sufficiency and independence. Curriculum content will include person-centered practices, community integration and self-determination awareness, and required elements of service training. The program will include adequate coaching and supervision of staff trainees.

The Department also is working to strengthen service provider staff training and monitoring systems to support the health and wellness of individuals with the most complex needs. This includes a clinical consultation team for community providers and adding requirements to the existing monitoring process that staff periodically demonstrate the competencies needed to fulfill their role in maintaining the health of the specific individuals they support.

Goal, Objectives, and Implementation Action Steps

Goal: Transform to a community-based system that will enable individuals who need developmental services and supports to live a life that is fully integrated in the community.

Objectives and Implementation Action Steps

1. Build community developmental services and supports capacity.

a. Develop community-based developmental services and supports pursuant to implementing agreed-upon plans with the U.S. Department of Justice.

b. Collaborate with DMAS to expand waiver capacity, modify existing or create new waivers, and address waiver rate structures.

c. Provide 24/7 support to individuals in crisis and their families through regional mobile support teams that provide in-home supports, crisis services, and proactive planning to avoid crises.

d. Develop a plan to provide crisis services to individuals under 18 with intellectual or developmental disabilities.

e. Assist individuals on the ID or DD waiver wait lists and their families to access resources, supports, services, and other assistance through the Individual and Family Support Program.

f. Develop community respite alternatives to training centers.

g. Develop specialized medical, dental, behavioral, and other clinical services in the community and expand access to non-specialized community practitioners.

h. Expand family supports and other initiatives that allow individuals to have control over how their service dollars are spent.

2. Improve the quality and effectiveness of developmental services.

a. Establish and implement a statewide core competency training curriculum for all staff providing services to individuals in the settlement agreement target population.

b. Provide clinical consultation to community providers.

c. Revise existing monitoring process to require that staff periodically demonstrate the competencies needed to fulfill their role in maintaining the health of the specific individuals they support.

B. Training Center Discharge Planning and Community Integration

Transition of Training Center Residents to Community Services

A critical part of the comprehensive effort to comply with settlement agreement milestones is the safe and successful transition of individuals currently residing at a training center to the most integrated community settings. Training centers are implementing a standardized discharge process developed in 2011. This process uses personal support teams that work with CSB case managers to provide individuals and their authorized representative with specific options for types of community placements, services, and supports based on the individual's needs and desires. To accomplish this, efforts are underway to educate training center staff about community living options and community services and supports to propose appropriate options to individuals. Discharge plans to transition into the most integrated setting consistent with each individual's informed choice and support needs are in place for all individuals residing at training centers and per- and post- move monitoring processes are in place.

Transitions of long-term training center residents to the community totaled 101 in FY 2012, 155 in 2013; and 40 in FY 2014 (through September 25, 2013). An additional 322 families are currently actively discussing discharge. For individuals discharged in FY 2013, the majority (97) chose group homes, followed by intermediate care facilities (25), sponsored residential (19), nursing facilities (12), and family homes (2). Four individuals returned to a training center.

During this transition, proportionately greater numbers of individuals continuing to be served in training centers will have significant or complex needs or will experience serious medical conditions requiring specialized services and supports. These include pervasive physical disabilities or medical conditions such as scoliosis, gastrointestinal problems, either hearing or visual deficit, or both, or neurological conditions in addition to an intellectual disability. A number will be non-ambulatory (requiring specialized wheelchairs) or will need significant staff assistance to walk. Increasingly, individuals receiving services in training center will have at least one psychiatric diagnosis or significant behavioral challenges. Training centers must maintain sufficient numbers of trained professional, direct care, ancillary, and support staff in order to provide quality supports and services that address the needs of individuals who continue to receive services at the centers.

To assure the successful transition of individuals to appropriate community settings, training centers have redoubled their efforts to prepare center residents to live successfully in the community. ARs are participating in the move process to assure that the essential supports needed to support individual in the community are included in discharge plans. Discharge plans and transition plans are being developed and modified based on the needs of the individuals and their ARs. Centers are performing intensive pre-move and transition activities, participating in the resolution of barriers to discharge, and performing post-move monitoring. These activities are helping individuals living in training centers and those who support them identify and make informed choices regarding specific supports and services necessary to live successfully in the most integrated setting possible.

Training Center Closure Plan

In order to financially support implementation of the settlement agreement, Virginia plans to downsize one and close four state training centers over the next eight years, using the following closure schedule: FY 2014 – Southside Virginia Training Center (SVTC); FY 2015 – Northern Virginia Training Center (NVTC); FY 2018 – Southwestern Virginia Training Center (SWVTC); and FY 2020 – Central Virginia Training Center (CVTC). This schedule considers a number of factors, including locations where the highest numbers of individuals or their families have expressed a desire to move, community readiness and capacity to serve individuals with extensive and complex needs, and training center campus infrastructure age and condition.

During the transition process, maintaining adequate training center staffing is essential to assure provision of services and supports that prepare individuals for successful discharge and maintain a safe environment for individuals receiving supports and services. Workforce training, recruitment, retention, and placement activities to maintain balanced staffing and appropriate competency levels will be a particular challenge at those centers scheduled for closure. As the number of beds decline and buildings are closed, training centers must reconfigure remaining units to maintain appropriate staffing coverage and operational efficiency. Approximately 3,000 employees at the four training centers would be affected by closures. Prior to the scheduled closure, employees will receive:

- Information about future employment options and programs to improve employability (e.g., skill-development, assessment and skills inventories, and career counseling)
- On-site workforce development resource center assistance and resources
- On-site linkages with and placement assistance from other state agencies, other state facilities, CSBs, and private providers
- Virginia Retirement system counseling and assistance.

In addition, the Department has established a progressive retention plan that pays bonuses at the end of each quarter to employees who meet all specified performance criteria. Bonuses are progressive to retain adequate staff and assure the continued presence of employees with skills that are critical to center operations. This plan is currently in place at SVTC and will be implemented at other training centers as their closure dates near. The Department also will be working with the General Assembly to determine the best course of action for the training center campuses when they become available.

Annual Consultative Audits

To improve service delivery and standardize procedures, as appropriate, the Department will expand annual consultative audits (ACAs) to training centers in FY 2014. ACAs use a peer-review process involving teams of colleagues from other training centers and central office staff. Teams review and provide feedback on facility operations and compliance with oversight and accreditation requirements and offer ideas and tools to improve service delivery.

Goal, Objectives, and Implementation Action Steps

Goal: Assure the safe and successful transition of individuals currently residing at a training center to the most integrated community settings appropriate to their needs and desires.

Objectives and Implementation Action Steps

1. Implement discharge planning and community transition protocols.

a. Ensure that personal support teams, in collaboration with CSB case managers, provide individuals and their authorized representatives with specific options for types of community placements, services, and supports based on individuals' needs and desires.

b. Ensure that training center staff is educated about community services and supports to propose appropriate options to individuals.

c. Work with CSBs and community providers to resolve barriers to discharge.

d. Implement pre-and post-move monitoring processes.

e. Track outcomes of individuals discharged from training centers.

2. Implement the training center closure plan.

a. Implement the plan to close Southside Virginia Training Center and provide workforce development and outplacement services to affected staff.
   - Provide employee forums and on-site guidance about employment opportunities and career building at the training center workforce development resource center.
   - Implement programs to improve employability such as skill-building workshops, skills inventory assessments, resume assistance, career counseling, and job fairs with CSBs and private providers.
   - Arrange on-site placement assistance from other state agencies, state facilities, and public and private providers.
   - Arrange for Virginia Retirement System assistance with counseling and completion of needed information.
   - Assist employees learn how to become private providers themselves.

b. Implement a progressive retention bonus plan to help retain viable working staff as training centers completely close.

c. Continue to reduce bed utilization at the remaining training centers through aggressive monitoring of service plans and discharge efforts that enable individuals to be integrated more quickly into the community.

3. Provide high quality state training center services that efficiently and appropriately meet the needs of individuals receiving services.

a. Maintain sufficient numbers of trained staff in each training center to provide quality services that are appropriate to the populations served and assure the safety of individuals receiving services.

b. Maintain compliance with federal Centers for Medicare and Medicaid Services expectations and improve the quality and effectiveness of developmental services through training, technical assistance, monitoring of service outcomes, and oversight of program performance.

c. Support the efforts of the OIG to monitor the progress of training centers in improving quality of care.

4. Improve training center service delivery and standardize center procedures as appropriate.

a. Conduct Annual Consultation Audits (ACAs) in each state training each year.

b. Systemically address issues identified in ACA reviews.

c. Support use by individual state hospitals of ACA survey results to improve its treatment effectiveness and efficiency.

CIVIL COMMITMENT OF SEXUALLY VIOLENT PREDATORS

Virginia legislation creating a civil commitment program for sexually violent predators (SVPs) established a system of cooperative activity involving the Department of Corrections (DOC), which screens all SVP eligible inmates approaching completion of sentence for an SVP qualifying crime; the Department, which provides a highly structured and intensively supervised SVP conditional release program in the community and operates a secure SVP facility; and the Office of the Attorney General, which handles the legal aspects of civilly committing these individuals.

Historically, when individuals are civilly committed as SVPs, approximately 20 percent have been placed directly in the community SVP conditional release program where they are

intensively monitored by probation officers under a memorandum of understanding between the Department and the DOC. The remaining individuals have been placed in the Virginia Center for Behavioral Rehabilitation (VCBR). VCBR is a secure 450 facility that provides evaluation and rehabilitation services to individuals found by the court to meet the statutory criterion of SVP and committed to the Department for inpatient treatment. Although the facility is a high security institution that requires some visible security features such as perimeter fencing, VCBR is operated as a rehabilitation facility similar to the state hospitals. Virginia is one of 20 states that operate inpatient SVP programs. All are similar except Texas, Arizona, and Pennsylvania, which have different types of commitment.

VCBR serves convicted sex offenders who are civilly committed to the Department at the end of their confinement in the DOC 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. Rehabilitation involves multiple, daily group sessions, individual behavioral therapy, vocational training, work therapy, and other 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.

The VCBR treatment program continues to evolve to provide evidence-based sex offender treatment intended to reduce the risk that SVPs will reoffend so they can be safely managed in the community once conditionally released. Treatment at VCBR is offered in three phases:

- *Phase I:* focuses on control over sexual behavior and aggression and accountability for offense (37 percent of residents);
- *Phase II:* focuses on developing insight into risk factors and introducing positive goals for lifestyle change (53 percent of residents); and
- *Phase III:* focuses on transition back to the community (11 percent of residents).

Only two percent of eligible residents have refused to consent to treatment, which is the lowest refusal rate among the 20 SVP programs nationwide. Working with the Department's Office of SVP Services during the past two years, VCBR has increased its pre-release support for residents becoming eligible for SVP conditional release. To track this process, in 2012 the Office revised and expanded its ability to capture, store, and retrieve resident data.

VCBR established a vocational training program in January 2011 and its work program began in February 2012. Previously, no residents were in vocational training or working. The VCBR work program currently has 124 residents working in the program's 135 jobs. In May 2013, 73 percent of resident workers were employed in food services, housekeeping, grounds maintenance, and as recreation and education aides. Residents who are active participants in treatment and who are making progress toward completing the program and transitioning to conditional release have the opportunity to gain work experience, earn a small income, and make an important contribution to overall program effectiveness.

VCBR participated in the first annual consultative audit of the center's programs in November 2012. The results of this audit documented the positive changes in facility operations and treatment begun by VCBR leadership in 2010. VCBR also created a comprehensive evaluation tool for administrative operations and functions, security, and treatment criteria for consideration of alternative VCBR operational arrangements.

VCBR was originally designed and funded to reflect a system based on four SVP predicate crimes, with a projected commitment rate of about two individuals per month. However, 2006 Code changes increased the number of predicate crimes from 4 to 28. This and a change in the screening tool resulted in an increase in the numbers who are eligible for SVP commitment. In June 2010, the VCBR census reached 200 residents. In response, the General Assembly directed the Department to implement a plan to double bunk up to 150 additional VCBR residents in the current facility, increasing capacity from 300 to 400 beds. As of June 2013, 34 rooms were double-bunked. The VCBR census is projected to increase to 386 by the end of FY 2013, 434 by FY 2015, and 528 by FY 2017. The 2013 Appropriation Act includes language authorizing the Department to use existing resources to initiate preplanning to expand SVP bed capacity.

VCBR is continuing its partnerships with the Office of the Attorney General and with Probation and Parole offices to support and expand the safe and appropriate use of SVP conditional release. These partnerships have resulted in improved approaches to developing conditional release plans, minimized interagency conflicts, and helped VCBR census management by preventing more individuals' conditional release revocations to the center.

To increase the use of conditional release VCBR has created a position to assist with developing SVP conditional release plans and has started pre-release groups to help residents develop viable home plans. The center has increased its use of regional visits to initiate contacts with supervising probation offices and to secure housing and work opportunities. VCBR discharged six residents in 2010 and 27 residents in 2012. All had completed the program. At the present rate of discharge, VCBR should discharge 30 residents during 2013.

Goal, Objective, and Implementation Action Steps

Goal: Address SVP service capacity issues in order to appropriately access and safely operate the Virginia Center for Behavioral Rehabilitation and provide SVP rehabilitation services.

Objective and Implementation Action Steps:

1. Provide evidence-based sex offender treatment, employment, and vocational training in a safe and secure setting. Meet the needs for additional bed and treatment space at VCBR.

a. Implement a three-phased program evidence-based sex offender treatment intended to reduce the risk that SVPs will reoffend.

b. Provide opportunities for VCBR residents to gain work experience.

c. Reconfigure center services and security to serve up to 150 additional individuals at VCBR.

2. Increase the safe and appropriate use of conditional release of eligible residents.

a. Maintain partnerships with the Office of the Attorney General and with Probation and Parole offices to support and expand SVP conditional release.

b. Continue to develop and implement SVP conditional release plans.

c. Monitor VCBR resident progress toward transitioning to conditional release.

VII. DEPARTMENT INITIATIVES

INFORMATION TECHNOLOGY SOLUTIONS

Two new external requirements have dramatically increased the scope and complexity of the Department's information services and technology (IS&T) work and capacity.

First is the requirement to align with and support the strategic plan of the Health and Human Resources Secretariat. This includes two specific modernizations:

- Implementation of an Electronic Health Record System (EHRS) that meets federal Meaningful Use (MU) requirements in 14 state facilities operated by the Department.
- Conformance to and use of modern computing technologies being implemented in the electronic Health and Human Resources (eHHR) program via a collaboration between HHR, DMV, and VITA.

The second external requirement is to support implementation of the U.S. Department of Justice (DOJ) settlement agreement entered into between the Commonwealth of Virginia (COV) and DOJ in January 2012. This agreement is being implemented by the Department via a suite of 19 business transformation projects, several of which require new information technology systems and support. Foremost among these systems are:

- Development and use of a data warehouse to support increased quality management and oversight processes;
- Upgrades to or replacement of the computerized system(s) for licensing and management of provider services; and
- Development and deployment of computerized systems for management of discharges from state training centers.

These HHR and DOJ business drivers present an environment demanding rapid coordinated change navigated and measured by information, and analysis. Both have created increased demands on IS&T work regarding the pace, quality, and capabilities for information technology systems development, deployment, and adoption.

State Facility Electronic Health Record Implementation

In 2009, Congress passed the *American Recovery and Reinvestment Act (ARRA)*. This broad legislation addresses a realm of healthcare modernization issues, one of which is the requirement for health care providers to implement an EHRS to manage and document patient care. Financial incentives are available from ARRA for compliance and financial penalties are imposed by the U.S. Centers for Medicaid and Medicare Services (CMS) for non-compliance.

The Department began planning for implementation of an EHRS in FY 2011. Funding support for implementation was secured in the 2012-2014 biennium budget and a Request for Proposals was developed in collaboration with VITA's Supply Chain Management in FY 2012. An EHRS procurement award to Siemens Medical Solutions USA, Inc. was executed in December 2012. A three year implementation of the Department's EHRS, subsequently named OneMind, began in January 2013.

During year one (calendar year 2013), OneMind is being installed, configured, and deployed for use by three pilot hospitals (Western State Hospital, Eastern State Hospital, and Southwest Virginia Mental Health Institute). Limited use of OneMind began at the three pilot hospitals in June 2013 to meet the federal timeline requirements associated with available MU financial incentives.

During year two of the implementation (calendar year 2014) 11 state facilities will begin using OneMind. This second wave implementation will be structured to maximize available MU incentives, minimize adverse Medicare payment adjustments, leverage staff resources at co-

located facilities, and minimize the ongoing need for operation and maintenance of ancillary systems in service at the remaining hospitals. During year three (calendar 2015) 14 state hospitals will migrate their billing and reimbursement business processes to OneMind. In conjunction with the DOJ settlement agreement, two training centers are scheduled to close prior to the completion of the OneMind implementation project, and thus are not scheduled for OneMind deployment.

Implementation of OneMind will result in improved care coordination and communications for individuals receiving services in state facilities. Specific care improvement goals encompass:

- Reduction of near-miss and adverse events through improved communications, information sharing, and real-time alerts and notifications;
- Improved patient and population health outcomes through system-wide adherence to clinical best practices, increased transparency, and exchange of clinical information;
- Improved efficiency and empowered, informed, and engaged healthcare delivery staff through automated collection and use of patient care data; and
- Reduced risk and cost of patient care and hospital certification requirements through replacement of multiple disparate locally developed healthcare data tracking systems by a federally certified EHRS.

eHHR Alignment and Adoption

The Department currently supports over two dozen shared application systems through its IS&T function and several *hundred* siloed applications developed by central office business units and state facilities. Essentially none of these systems use current generation computing technologies that enable information sharing and efficient use of information technology resources.

The eHHR Program is establishing a modern Information technology computing infrastructure that supports automation of business processes, sharing of data, and re-use of information technology assets. Components of this infrastructure are operational today and new services and functionality will become available over the course of the next few years.

A material multi-year upgrade of the Department's IS&T function is underway to align all new application system development/maintenance and acquisition/deployment with the eHHR strategy. Through this upgrade Department applications and data will become more standardized and accessible within the Department, across HHR Secretariat agencies, and ultimately across COV Secretariats. This upgrade includes adoption of modern and efficient software development tools and methods, adoption of best practice project management methods and tools, compliance with COV/VITA infrastructure and security requirements, and efficient information technology processes for day-to-day operations and support of production application systems.

Department Data Warehouse/Business Intelligence Initiative

Data is a unifying asset applicable to all Department (and COV) business units. Although initiated and driven by the DOJ program, the need for data warehouse and business intelligence (DWBI) capabilities is intrinsic to all Department business objectives.

In FY 2013 the Department, with support from CapTech Consulting, performed an analysis of organizational data maturity and developed a white paper, DBHDS Data Strategy Final, to navigate the agency's evolution from its current state of data management and utilization to a desired future state. Using an industry benchmark for this assessment, the Department is embarking on a project to evolve its DWBI maturity from Level 1 (*Non-existent*) to Level 4 (*Repeatable*) through a two year DWBI project.

The outcome of this project will accomplish development and ongoing maintenance of a DBHDS technical architecture/infrastructure that supports data collection, maintenance, analysis, and

reporting. This cohesive architecture will accommodate data derived from the Department's existing siloed applications as well as future shared technologies and data resultant from eHHR and EHRS. Moreover, the DWBI project will support easier exchange of agency data with non-Department entities such as its service delivery partners and other COV agencies. Current processes requiring either highly technical software development work or laborious manual effort for compilation and correlation of data from different sources for reporting purposes will be replaced by business unit processes using self-service tools accessing business-unit governed data sources and computation methods.

The DWBI project participated in and is completely aligned with the COV Enterprise Information Architecture strategy and requirement that was recently developed and published by VITA in response to state legislation that became effective on July 1, 2013.

Goal, Objective, and Implementation Action Steps

Goal: Improve the Department's capability to develop, deploy, and adopt information technology systems solutions that support service delivery and improve business processes.

Objective and Implementation Action Steps

1. ***Successfully implement OneMind, the Department's electronic health record system in all facilities operated by the Department.***
   a. Complete the implementation of all Siemens Soarian clinical modules at all facilities operated by the Department.
   b. Achieve and attest to CMS Meaningful Use requirements at six hospitals (WSH, ESH, SWVMHI, CAT, PGH, and HDMC).
   c. Maximize available federal financial incentive payments, minimize potential Medicare reimbursement penalties, and support OneMind implementation expense recovery.
   d. Complete the implementation of the Siemens Soarian care delivery services billing reimbursement module by December 2015.
   e. Eliminate redundant data processing systems and reporting applications in the Department's central office and in individual facilities while maintaining ability to produce required analyses and reports.
   f. Streamline, automate and standardize clinical and financial business processes in the Department's central office and at individual facilities.
   g. Provide OneMind end-users with first-line Help Desk support.
   f. Provide infrastructure support to improve care delivery, quality of care, and improve consumer and population outcomes.
2. ***Align Department information services and technology with eHHR program objectives and services.***
   a. Implement ITIL-based best practices for Production Support and Service Desk support of computer and application systems.
   b. Implement appropriate software acquisition, development, and implementation methods for information and application systems required by business units.
   c. Align Department projects with VITA Production Management and Development (PMD) oversight processes, applicable VITA security and architecture standards, and use of evolving eHHR program services.
3. ***Establish enterprise data warehouse and business intelligence capabilities capable to meet the present needs of the organization and able to evolve as future requirements change.***
   a. Establish data warehouse prerequisites including development of a marketing plan, project charter, detailed project plan, and a governance board mission statement.

b. Acquire hardware and software for all environments to ensure the technical environments are available and identify and acquire a business sponsor and project personnel.
c. Create a governance board to oversee evolution of the future data ecosystem.
d. Establish a standard architecture and data integration framework for all future development, to include standards, a data management framework, and reporting structure and layout.
e. Remove local-office focused reporting databases to the extent possible to normalize data and business logic in one organization-wide easily accessible source.
f. Create the master data management system to link individuals from different systems together by creating mapping structures and a front-end for mapping, importing and mapping individuals from different sources together, and training the data steward on governance.
g. Build an analytic data warehouse prototype that populates the staging and data warehouse structures and the self-service business intelligence area, and designs and provides initial reports to business users.
h. Build the data warehouse that includes phased implementation of the subject areas needed to satisfy the DOJ settlement and quality management requirements (e.g., services, housing, employment, facilities, criminal justice, and providers).
i. Provide training and implement self-service business intelligence and reporting solutions for end-users.

WORKFORCE DEVELOPMENT AND CULTURAL AND LINGUISTIC COMPETENCY

Workforce Development

State facilities operate 24 hours a day, seven days a week and depend on a cadre of skilled and dedicated salaried and wage employees in a wide variety of classifications. Most provide direct care or support facility infrastructure. Facilities experience a number of human resource challenges, including workforce aging, increased cultural diversity, and health care professional shortages. Competition among providers and the difficult nature of the work makes it hard to attract psychiatrists, occupational and physical therapists, nurses, pharmacists, and direct care staff. Vacancy and turnover rates in general are likely to worsen, exacerbating staffing shortages and overtime demand.

- The state hospital workforce includes 3,981 classified plus 770 wage and contract employees whose average age is just over 47 years old and average work tenure is 11.5 years. The direct care separation rate is almost 24 percent. In the next five years, 21.3 percent will be eligible to retire with unreduced benefits.
- The state training center workforce 3,333 classified plus 318 wage and contract employees whose average age is just over 47 years old and average work tenure is almost 14 years. The direct care separation rate is 24.4 percent. In the next five years, almost 27 percent will be eligible to retire with unreduced benefits.
- VCBR has 424 salaried employees plus 26 wage and contract employees whose average age is just over 39 years old and average work tenure is just over five years. The separation rate is 37.1 percent for direct care positions and 18.8 percent for security positions, due in large part to the difficult nature of the work with this challenging population and existing facility capacity issues. In the next five years, almost seven percent will be eligible to retire with unreduced benefits.

The Department's central office has 271 classified plus 28 wage and contract employees whose average age is almost 52 years old and average work tenure is 15.2 years. In the next five years, almost 39 percent of central office staff, many of in supervisory or management roles, will be eligible to retire with unreduced benefits.

The loss of experienced well-trained staff across many occupational groups puts state facilities in jeopardy of losing an adequate workforce and requires significant recruitment and succession planning and training to transfer responsibilities from retiring to new employees. Career progression and pathways that support employee advancement through successively higher levels of competencies will be increasingly important. The Department has developed SystemLEAD, a long-term leadership development initiative designed to give participants broad exposure to the competencies necessary for leadership in the services system. SystemLEAD will be piloted with staff in the central office, one state hospital and training center, and in partnership with neighboring CSBs. Its curriculum will focus on leadership competencies, including knowledge, skills, abilities, and behaviors that staff who aspire to leadership roles in the service system must possess and includes an individualized assessment and development plan, training and group projects, coaching and mentoring, special work assignments, and cross training opportunities. SystemLEAD goals are to:

- Prepare well-qualified internal candidates to assume key leadership positions;
- Retain superior performers who will not leave their organizations or the services system because of lack of opportunity or lack of development; and
- Reduce turnover rates among high-performing participating employees.

The first phase of the program, which includes creating the core and site committees and communicating the initiative to the workforce, is set to begin in late 2013 or early 2014.

Cultural and Linguistic Competency (CLC)

Racially, ethnically, and linguistically diverse populations in Virginia have increased significantly over the past ten years. The 2010 Census data reflects this increasing diversity.

- More than 1.5 million Virginia residents reported themselves to be black or African American, accounting for nearly 20 percent of the total population. This segment remains the largest minority group in Virginia.
- Just over 630,000 residents or 7.9 percent of the Virginia population reported themselves to be Hispanic. This is a 92 percent increase since 2000. Half of this segment is made up of individuals under age 19.
- Almost 440,000 Virginia residents or 5.5 percent of the Virginia population are Asian. This is a 69 percent increase since 2000.
- More than 233,000 Virginia residents, or 2.9 percent of the population, reported that they belong to two or more of the six race categories counted in the census: white; black or African-American; American Indian and Alaska native; Asian; Native Hawaiian and other Pacific Islander; or some other race.

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. In 2010, 41.6 percent of all Virginia households (both natives and the foreign born) had limited linguistic competence in English (Migration Policy Institute, Virginia Table 1, Change in the Limited English Proficient Population of Virginia, 2990-2010). In these households, all persons age 14 and over were linguistically isolated, with 22.4 percent speaking Spanish, 22.1 percent speaking Asian or Pacific Island languages, 8.5 percent speaking other Indo-European languages, and 13 percent speaking other languages (U.S. Census Bureau, 2010 American Fact Finder Summary Table 1 S1602).

Additionally, communication barriers associated with hearing loss can seriously impede access to behavioral health and developmental services and require specialized services and accommodations for these individuals. The Department supports specialized regional consultation and direct services to individuals who are deaf, hard-of-hearing, late deafened, or deafblind. The Statewide Cultural and Linguistic Competence Steering Committee will create a

subcommittee to focus on increasing services system capacity to effectively service this population, including:

- Evaluating services provided through the regional deaf services coordinator programs and identifying areas where specialized services and accommodations such as direct clinical services in American Sign Language and service coordination are not available;
- Evaluating the ongoing training needs of state facility staff;
- Exploring the feasibility of establishing a contract for American Sign Language remote video-interpreting that could be accessed 24/7 by state facilities; and
- Recommending service improvements and long term funding needs to sustain existing regional programs and establish regional programs in areas that are not covered.

The Department's *Plan for Cultural and Linguistic Competency in Behavioral Health and Developmental Services 2013-2014* includes the following vision for culturally competent care.

- Care that is given with understanding of and respect for the individual's health-related beliefs and cultural values;
- Staff that respect health related beliefs, interpersonal styles, and attitudes and behaviors of the individuals, families, and communities they serve; and
- Administrative, management, and clinical operations that result in a workforce that is culturally and linguistically competent and a system that provides the highest quality of care to all communities.

To effectively leverage limited resources, the Department's Office of Cultural and Linguistic Competency will develop specific goals and activities for the following 2013-2014 focus areas:

- Language Services Planning at the Secretariat and Local Level;
- Workforce Diversity and Inclusion (Recruitment, Retention, and Succession);
- CLC Response Development; and
- Organizational CLC Training and Consultation.

Goal, Objectives, and Implementation Action Steps

Goal: Assure that Virginia's behavioral health and developmental services workforce has the leadership, clinical, and direct support skills and expertise to provide needed services and supports.

Objectives and Implementation Action Steps

1. Increase the skills and productivity of behavioral health and developmental services system professional, paraprofessional, direct care, and administrative staff.

a. Enhance public-academic partnerships with Virginia universities, colleges, community colleges, and other learning organizations to expand the pipeline and skill levels of hard-to-fill professional and direct care positions.

b. Promote opportunities for distance learning for existing staff and public-academic partnerships that support on-site training of graduate, undergraduate, and medical students at state facilities and CSBs.

c. Implement recruitment and retention strategies to maintain sufficient numbers of well-qualified and highly trained staff in state facilities and the central office.

d. Implement state facility and central office career progression and pathways that support employee advancement through successively higher levels of competencies.

e. Implement comprehensive workforce and succession planning and systematic training and workforce development strategies in state facilities and the central office to transfer responsibilities from retiring employees to new employees.

f. Provide training and cross-training programs designed to develop state facility and central office employees technical or clinical expertise and new skill sets in areas such

as communications and new technologies and to improve analytic skills, problem-solving capabilities and other competencies.

2. ***Increase the capacity of the behavioral and developmental services system to provide culturally and linguistically appropriate services and supports to diverse populations***.
   a. Expand and improve the quality of language-accessible behavioral health and developmental services.
      - Provide alternative methods to train and consult on language planning and services.
      - Identify opportunities to engage organizations in language audits.
      - Develop a mechanism (process) for annual review of CSB preferred language data.
      - Partner with the U.S. Department of Health and Human Services Office of Civil Rights to provide daylong technical training in six areas of the state.
      - Provide six Qualified Bilingual Staff Interpreter Training Programs in five areas of the state to leverage bilingual resources existing in organizations.
   b. Increase the number of services system organizations that develop diversity and inclusion (D&I) initiatives to increase cultural and linguistic competencies of providers.
      - Encourage organizations to develop human resources policy on CLC competencies and language proficiency.
      - Create promotional material related to the strategic benefits of D&I in behavioral health and developmental services system organizations.
      - Develop D&I training to share with interested parties in the services system.
      - Identify measures for evaluating D&I training.
   c. Increase the number of services system organizations who are beginning or advancing organizational cultural competency planning.
      - Identify methods to train leaders and middle managers on CLC and CLC planning and offer CLS train-the-training to services system training and development staff.
      - Create a speakers bureau listing to expand the pool of training and consultation resources available across the Commonwealth.
      - Provide regional training events on CLC in children's mental health systems of care.
   d. Increase the number of activities and resources that engage communities and allow providers to advance culturally and linguistically appropriate behavioral health and developmental services in the Commonwealth.
      - Develop companion material to be included with DOJ settlement guidance for community-based care.
      - Continue to sponsor the National Minority Mental Health Awareness Month Media Contest.
      - Develop Standardized CLAS training materials for use by behavioral health and developmental services trainers reflecting basic CLAS concepts and the revised standards and expectations.
      - Publish planning documents related to access and outcomes for refugees seeking mental health services in the Commonwealth.
      - Develop resource materials for CLS in health reform for services system providers.
      - Continue to support the Annual Building Bridges Conference for addressing developmental disabilities in racially, ethnically, and linguistically diverse communities.

STATE FACILITY CAPITAL INFRASTRUCTURE AND ENERGY EFFICIENCIES

State facilities operated by the Department include 333 buildings containing about 5.8 million square feet of space on 12 campuses. The average age of operational buildings averages 53 years. Inadequate maintenance and renovation funding has left many buildings in generally poor condition, requiring major building systems replacements, such as: fire alarm and fire sprinkler systems, emergency egress, security and plumbing. Also, many buildings are inefficient to operate and require major renovations to meet current life safety standards and

requirements. Department capital improvement priorities include roof, utilities, HVAC, and environmental hazard abatement projects to keep operational buildings in use, and a phased program of facility replacements which replaces large, multi-building hospital campuses with improved physical environments on a smaller campus which safely and efficiently address the program needs of individuals receiving services (see Appendix G).

The replacement ESH adult and geriatric treatment centers are now complete. The construction of a 246 bed replacement at WSH is scheduled for completion in 2013. The down-sized facility at SEVTC has replaced 20 old cottages with 15 new 5-bedroom homes which are energy and operational efficient. Major renovations are nearly complete at CVTC to enhance client safety and improve energy efficiency. Also, the Department has implemented a computerized maintenance management system which monitors both energy consumption and maintenance activity at each facility. The Department continues to explore strategies to reduce state facility energy consumption, increase efficiency, and reduce costs, including:

- Energy Performance Contracts to modernize aging state facility energy delivery systems and has reduce energy consumption and operating costs;
- Smaller high-efficiency boilers located nearer the load served to eliminate distribution system losses;
- Conversion to renewable energy sources such as ground-source heat pumps and a biomass boiler that can burn several low-cost fuels such as native warm season grasses and wood waste products.
- Laundry energy improvements and consolidation of facility laundries;
- Centralization of cooking facilities; and
- Building area reductions to achieve greater energy efficiency and design that meets the U.S. Green Building Council's LEED® criteria for SILVER.

To assist in financially supporting implementation of the DOJ settlement agreement, Virginia plans to close four of the five training centers, starting with SVTC by FY 2014. Closure of the next three centers will be phased-in through FY 2020. As training centers close, every effort will be made to sell the properties at market value in order to make resources available for services growth in the community.

Goal, Objective, and Implementation Action Steps

Goal: Provide state facility infrastructure that efficiently and appropriately meets the needs of individuals receiving services.

Objective and Implementation Action Steps:

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.

a. Continue to update state facility master plans to appropriately address the programming needs of individuals receiving services.

b. Complete state facility replacements and major renovations.

c. Continue to work with state facilities to identify and implement initiatives that generate energy efficiencies.

d. Implement state facility projects necessary to keep operational buildings in use, including roof, utility, HVAC, and environmental hazard abatement.

e. Implement closure plans that maintain existing property while expending minimum funds.

f. Actively participate and assist in the sale of surplus real estate property and make funds available for the revolving trust fund.

VIII. RESOURCE REQUIREMENTS

The following capacity development priorities respond to critical issues facing Virginia's behavioral health and developmental services system. Implementation of these capacity development priorities is contingent on resource availability.

Behavioral Health Services Investment Priorities

- Expand statewide mental health services capacity to fill identified services gaps, including individual and group psychotherapy, family counseling, supportive counseling, psychiatry and medication services for older teens and young adults during the difficult period of transition from school to adulthood; Programs of Assertive Community Treatment (PACT) teams in communities that now lack this essential intensive service; therapeutic assessment centers (drop-off centers); early intervention services (Part C); discharge assistance for individuals receiving services in state hospitals whose discharges have been delayed due to extraordinary barriers; permanent supportive housing assistance; extended care for individuals under a temporary detention order; and enhanced forensic-related evaluation rates.
- Expand statewide substance abuse intensive outpatient treatment, including earlier access to assessment and intensive outpatient services within the Systems of Care framework for youth with substance abuse and co-occurring disorders; rehabilitation and employment capacity to help persons in recovery from alcohol and drug addiction find and keep jobs; and community-based residential medical detoxification.
- Expand peer support recovery services for persons with mental health, substance use, or co-occurring disorders to include peer support groups; education in illness and wellness management; job-readiness training; coaching and mentoring; assistance with social services and entitlements; drop-in and socialization opportunities, and residential supports.
- Cover increased WSH operating costs incurred when new facility opened in October 2013, including increased IT requirements and VITA charges, security, and operations and increased CCCA security and IT costs associated with WSH's move to a new building.
- Offset lost Medicaid revenues associated with the diminishing geriatric population at ESH with state general funds.

Developmental Services Investment Priorities

- Collaborate with the Department of Medical Assistance Services (DMAS) to expand waiver capacity, modify existing or create new waivers, and address waiver rate structures.
- Expand developmental services capacity to implement the settlement agreement with the U.S. Department of Justice (DOJ). This includes family supports, rental subsidies, crisis stabilization, and quality management and independent review.
- Establish community-based regional Developmental Disability Health Supports Network clinical teams to provide or facilitate access to local professionals providing medical, dental, and other clinical services; behavioral and other supports; and specialized equipment.
- Provide housing bridge funds to support transition of individuals residing at NVTC to the most integrated community setting of their choice by offsetting the gap between their monthly Social Security income and the projected fair market cost of housing in the region.

Civil Commitment of Sexually Violent Predators Investment Priority

- Cover conditional release services and supervision at the point that an individual's probation obligation by the Department of Corrections (DOC) ends.

Systemwide Investment Priorities

- Support ongoing operation of the Department's electronic health record system (EHRS).
- Upgrade regional IT security staffing and processes to meet federal and state requirements.
- Support Department's interface with the state's new financial information system.

IX. CONCLUSION

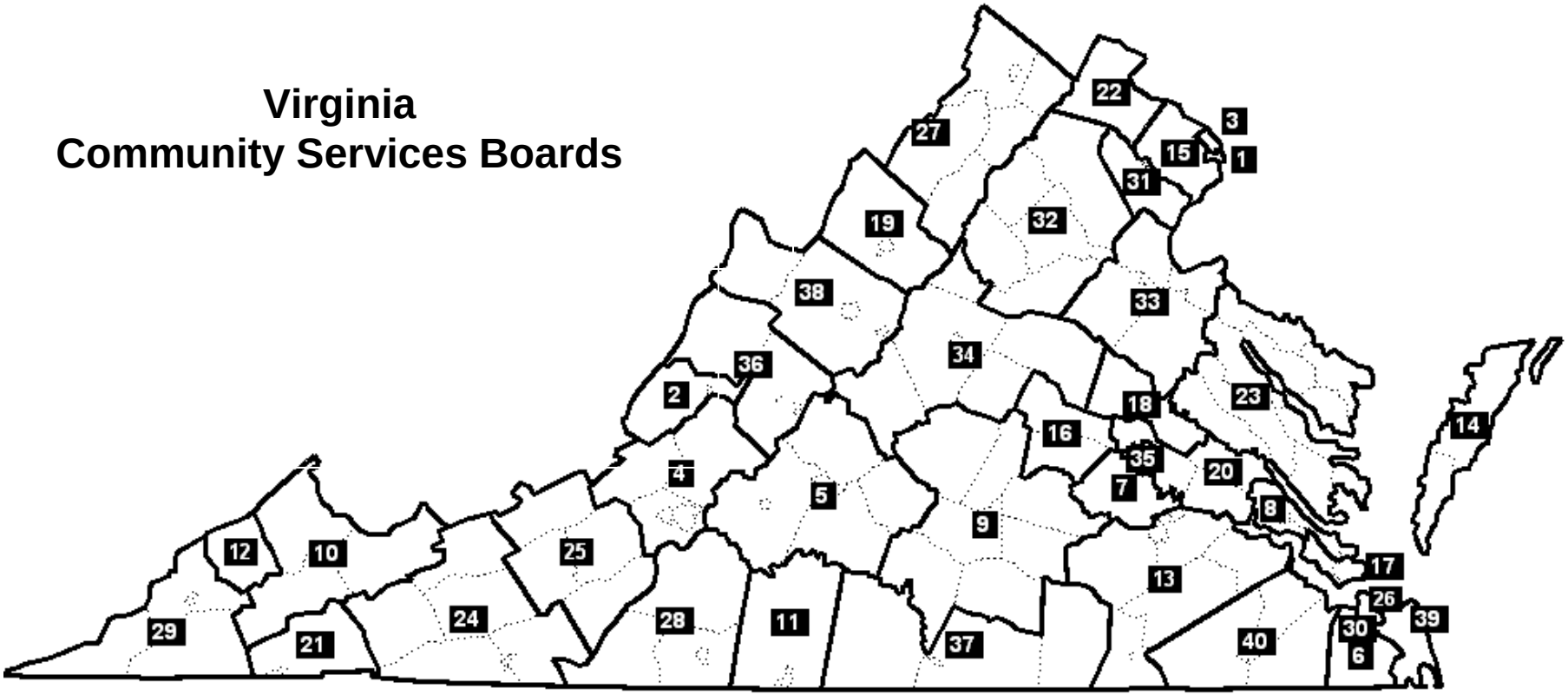
This document responds to the requirement in §37.2-315 of the *Code of Virginia* for a six-year Comprehensive State Plan for mental health, mental retardation, and substance abuse services that identifies the services and supports needs of individuals receiving behavioral health and developmental services in Virginia and proposes objectives and action steps to address these needs.

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. They also will enhance the ability of the services system to perform its core functions in a manner that is effective, efficient, and responsive to the needs of individuals receiving services and their families.

The Department's executive leadership will continue to monitor implementation of the Creating Opportunities strategic initiatives and major agency activities identified in the *Comprehensive State Plan 2014-2020*. Successful implementation of these strategic initiatives will continue Virginia's progress in advancing a community-focused system of recovery-oriented and person-centered services and supports that promote the highest possible level of participation by individuals receiving behavioral health or developmental services in all aspects of community life including work, school, family, and other meaningful relationships.

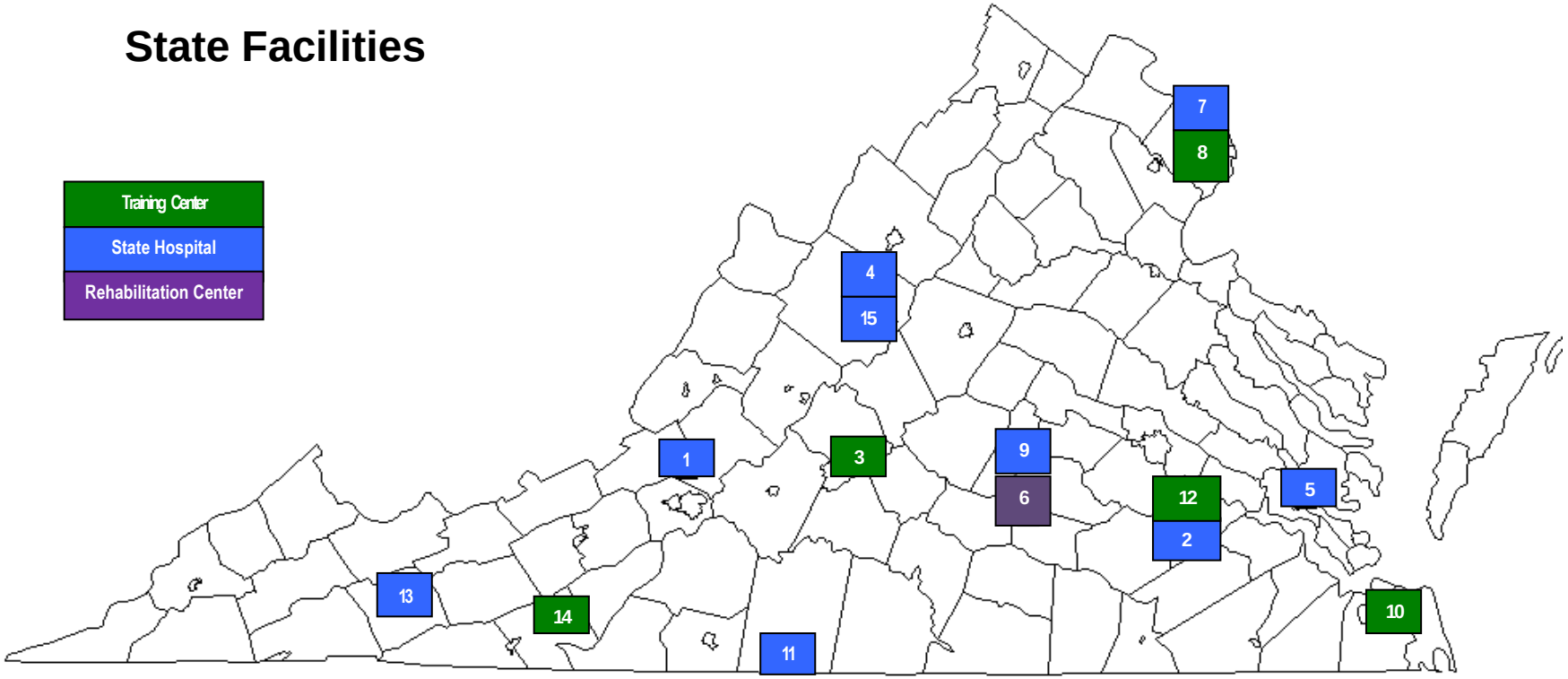
Appendix A

Maps of Community Services Board Service Areas and State Facility Locations



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	Horizon	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 Facilities



	Facility	Location		Facility	Location
1	Catawba Hospital	Catawba	9	Piedmont Geriatric Hospital	Burkeville
2	Central State Hospital	Petersburg	10	Southeastern VA Training Center	Chesapeake
3	Central VA Training Center	Madison Heights	11	Southern VA MH Institute	Danville
4	CCCA	Staunton	12	Southside VA Training Center	Petersburg
5	Eastern State Hospital	Williamsburg	13	Southwestern VA MH Institute	Marion
6	Virginia Center for Behavioral Rehabilitation	Burkeville	14	Southwestern VA Training Center	Hillsville
7	Northern VA MH Institute	Falls Church	15	Western State Hospital	Staunton
8	Northern VA Training Center	Fairfax			

Appendix B
Descriptions of Populations Served

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.

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 age17, 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 disorders, 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 or Other Developmental Disability

Intellectual disability 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. Intellectual disability is a life-long disability; however, with appropriate personalized supports over a sustained period, the life functioning of individuals generally will improve.

Developmental disabilities are a diverse group of severe chronic conditions that are due to mental or physical impairment, or both, are manifested before a person reaches age 22, and usually last throughout a person's lifetime. People with developmental disabilities may 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 services or supports.

Individuals Who Have a Substance Use Disorder

According to the Diagnostic and Statistical Manual (DSM IV-TR), 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." There are two levels of substance use disorders: substance dependence and substance abuse. The DSM-IV-TR provides criteria for each level.

- Criteria for a diagnosis of substance dependence focuses "impairment or distress… manifested by three (or more) [symptoms] in a twelve month period" to include:
  1. Tolerance (needing more of the substance to achieve the desired level of intoxication or effect, or experiencing a diminished effect using the same amount of the substance);
  2. Withdrawal (marked by a physical syndrome related to the specific substance, or taking the substance to avoid withdrawal symptoms);
  3. Taking larger amounts or taking the substance over longer periods than intended (e.g., not being able to limit the number of alcoholic beverages consumed at a given event);
  4. Persistent desire combined with unsuccessful efforts to reduce use of the substance;
  5. Expending large amounts of time obtaining the substance use the substance or recover from its effects, to the point where the individual's life becomes focused on the substance;

6. Engagement in important social, occupational or recreational activities are reduced due to substance use; and
7. Continued use despite knowledge that the substance use is causing a persistent physical or psychological problem (e.g., persistent drinking in spite of knowing that an ulcer is made worse by alcohol consumption).

- Criteria for substance abuse focuses on “a maladaptive pattern of substance use leading to clinically significant impairment or distress,” indicated by at least one of the following within a twelve month period:
  1. Failure to fulfill major role obligations at work, school or home (e.g., repeated absences at work related to substance use; expulsion from school; neglect of children or household duties);
  2. Recurrent use of the substance in situations which are physically hazardous (e.g., driving while intoxicated);
  3. Recurrent arrests related to substance use (e.g., arrests for disorderly conduct after consuming alcohol); and
  4. Continued use of the substance despite persistent or recurrent social problems related to use of the substance (e.g., physical fights while intoxicated; arguing with significant others about the consequences of intoxication).

An individual’s symptoms related to a specific substance can never have met the criteria for substance dependence.

Appendix C
Community Services Board Services Utilization

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 individuals 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: Individuals Served by CSBs[1]

FY	Mental Health Services (MH)		Developmental Services (DEV)		Substance Abuse Services (SA)		Services Available 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
2009	104,831	165,066	27,172	35,350	40,723	52,104	80,225	91,452	252,951	343,972
2010	108,158	171,506	19,374	25,909	38,661	51,204	85,158	103,041	251,351	351,660
2011	107,892	174,183	20,387	26,912	36,769	48,964	86,881	97,776	251,929	353,814
2012	113,552	181,410	20,562	27,161	36,743	49,090	112,916	127,780	283,773	385,441
2013	112,121	180,176	20,248	26,399	34,382	46,632	126,035	130,152	292,786	383,359

NOTES:

1 Unduplicated counts of individuals 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 individuals receiving services in a program (mental health, developmental, or substance abuse services) area, regardless of how many services they received. If an individual with a dual diagnosis (e.g., mental illness and substance use disorder) received services in both program areas, he would be counted twice.

3 Duplicated (**Dupl.**) numbers of individuals are the total numbers of individuals receiving each category or subcategory of core services. Thus, if an individual 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 individuals served for each program area.

With the implementation in FY 2004 of the Community Consumer Submission (software that extracts data on each individual receiving services from CSB information systems and transmits encrypted data to the Department) a totally unduplicated count of

individuals 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 individuals 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 2010, 56,689 individuals received services in more than one program area

Table 2: Unduplicated Count of Individuals Receiving CSB Services					
FY	**Number**	**FY**	**Number**	**FY**	**Number**
2004	167,096	2008	190,125	2012	216,951
2005	174,183	2009	198,271	2013	213,902
2006	176,276	2019	194,662		
2007	185,287	2011	196,951		

Table 3: FY 2013 Community Services Board Static Capacities by Core Service				
Services Available at Admission to a Program Area	**MH Services**	**DEV Services**	**SA Services**	**Grand TOTAL**
Adult Psychiatric or Substance Abuse Inpatient	40 beds		5 bed	45 beds
Community-Based SA Medical Detox Inpatient			4beds	4 beds
Total Local Inpatient Services Beds	40 beds		9 beds	49 beds
Day Treatment/Partial Hospitalization	2,855 slots		120 slots	2,975 slots
Ambulatory Crisis Stabilization Services	76 slots			76 slots
Rehabilitation/Habilitation	2,595 slots	2,233 slots		4,828 slots
Sheltered Employment	51 slots	643 slots		694 slots
Day Support Group Supported Employment	34 slots	591 slots		625 slots
Transitional/Supported Employment FTEs	19 FTEs	68 FTEs		87 FTEs
Highly Intensive Residential Services	48 beds	208 beds	103 beds	359 beds
Residential Crisis Stabilization Services	157 beds	20 Beds	7 beds	184 beds
Intensive Residential Services	214 beds	868 beds	620 beds	1,702 beds
Supervised Residential Services	683 beds	392 beds	89 beds	864 beds
Supportive Residential Services FTEs	549 FTEs	235 FTEs	4 FTEs	788 FTEs

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 2013 Unduplicated Numbers of Individuals Receiving CSB Services by Age						
Age	**MH Services**	**DEV Services**	**SA Services**	**Emergency Svs.**	**Ancillary Services**	**Total**
0-2	649	1,011	47	550	77	**2,190**
3-12	17,970	2,254	102	14,008	2,890	**28,556**
13-17	14,069	1,329	2,667	12,909	6,589	**26,962**
18-22	7,269	2,340	4,053	6,943	6,614	**19,713**
23-59	62,961	11,729	26,667	31,441	36,227	**120,548**
60-64	4,481	770	584	989	2,031	**6,931**
65-74	3,659	638	237	696	2,098	**6,063**
75+	1,057	176	23	185	1,706	**2,851**
Unknown	6	1	2	14	68	**88**
Total	**112,121**	**20,248**	**34,382**	**67,735**	**58,300**	**213,902**

Appendix D
State Hospital and Training Center Utilization

Individuals Served in State Hospitals, Average Daily Census, Admissions, and Separations -- FY 2013

MH Facility	# Individuals Served	Average Daily Census	# Admissions	# Separations
Eastern State Hospital	495	258	242	256
Western State Hospital	683	214	530	539
Central State Hospital	669	204	514	534
Southwestern VA MHI	699	149	720	714
Northern VA MHI	697	116	693	692
Southern VA MHI	290	65	261	270
Commonwealth Center for Children and Adolescents	595	32	691	698
Catawba Hospital	297	92	249	249
Piedmont Geriatric Hospital	157	102	59	53
Total*	**4,408**	**1,233**	**3,959**	**4,005**

Individuals Served by Hiram Davis Medical Center, ADC, Admissions, and Separations -- FY2013

	# Individuals Served	Average Daily Census	# Admissions	# Separations
Hiram Davis Medical Center	118	57	79	69

Individuals Served by Virginia Center for Behavioral Rehabilitation, ADC, Admissions, and Separations -- FY2013

	# Individuals Served	Average Daily Census	# Admissions	# Separations
VCBR	344	296	48	31

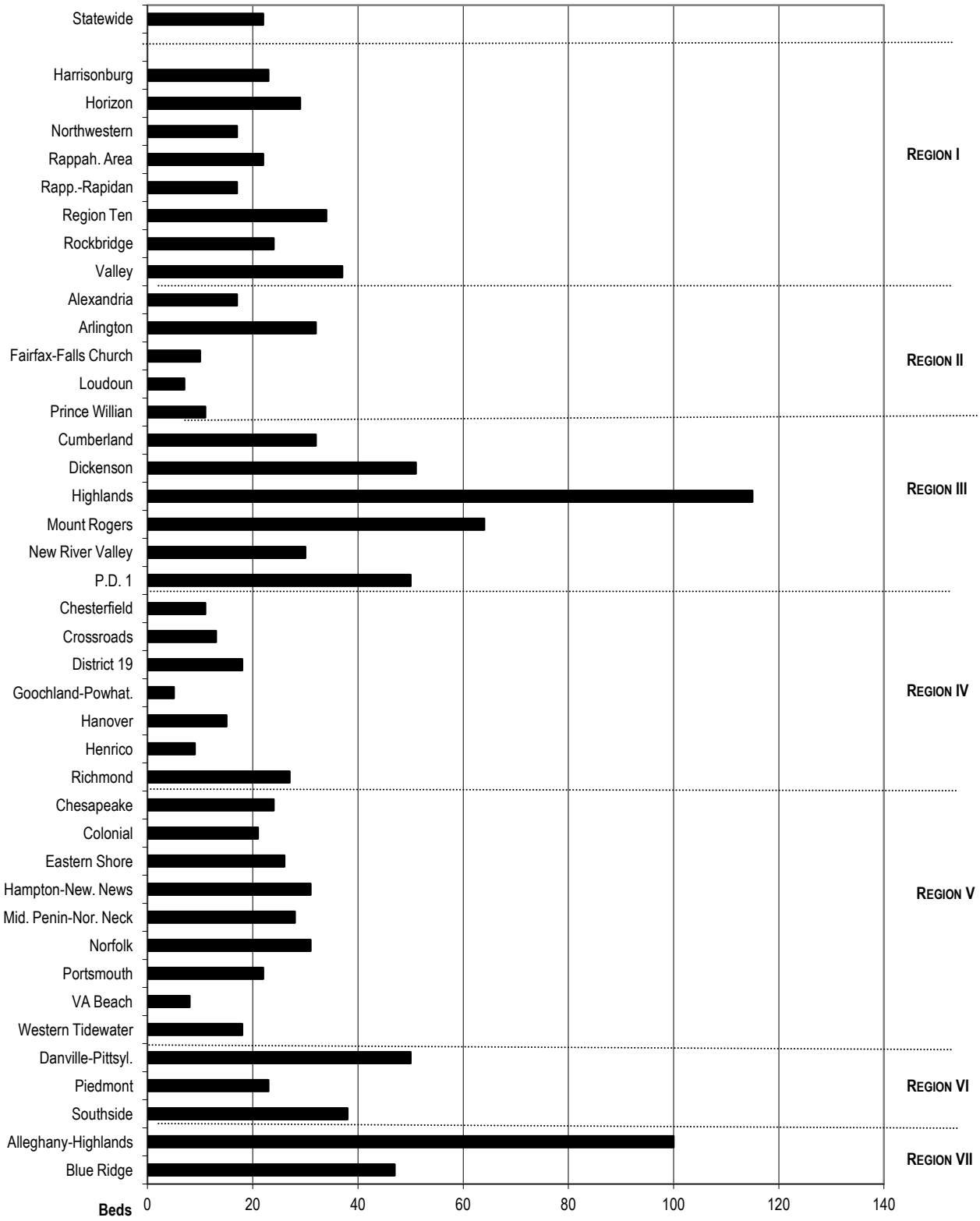
Individuals Served in Training Centers, ADC, Admissions, and Separations - FY2013

Training Center	# Individuals Served	Average Daily Census	# Admissions				# Separations			
			Emerg.	Respite	LT Adm.	TOTAL	Emerg.	Respite	LT Resid.	TOTAL
CVTC	345	314	1	5	1	7	1	5	40	46
NVTC	153	142	0	0	0	0	0	0	18	18
SEVTC	108	92	4	0	0	4	4	0	20	24
SVTC	196	156	2	2	1	5	2	3	83	88
SWVTC	184	163	5	13	1	19	5	11	20	36
Total	**986**	**868**	**13**	**20**	**3**	**35**	**12**	**19**	**181**	**212**

Source: DBHDS AVATAR Information System
*Unduplicated count (unique individuals) by state facility type

TOTAL UNDUPLICATED COUNT OF INDIVIDUALS SERVED ACROSS ALL STATE FACILITIES: 5,772

Adult Civil State Hospital Bed Utilization by CSB and Region FY 2013
Beds Per 10,000 SMI Population Prevalence

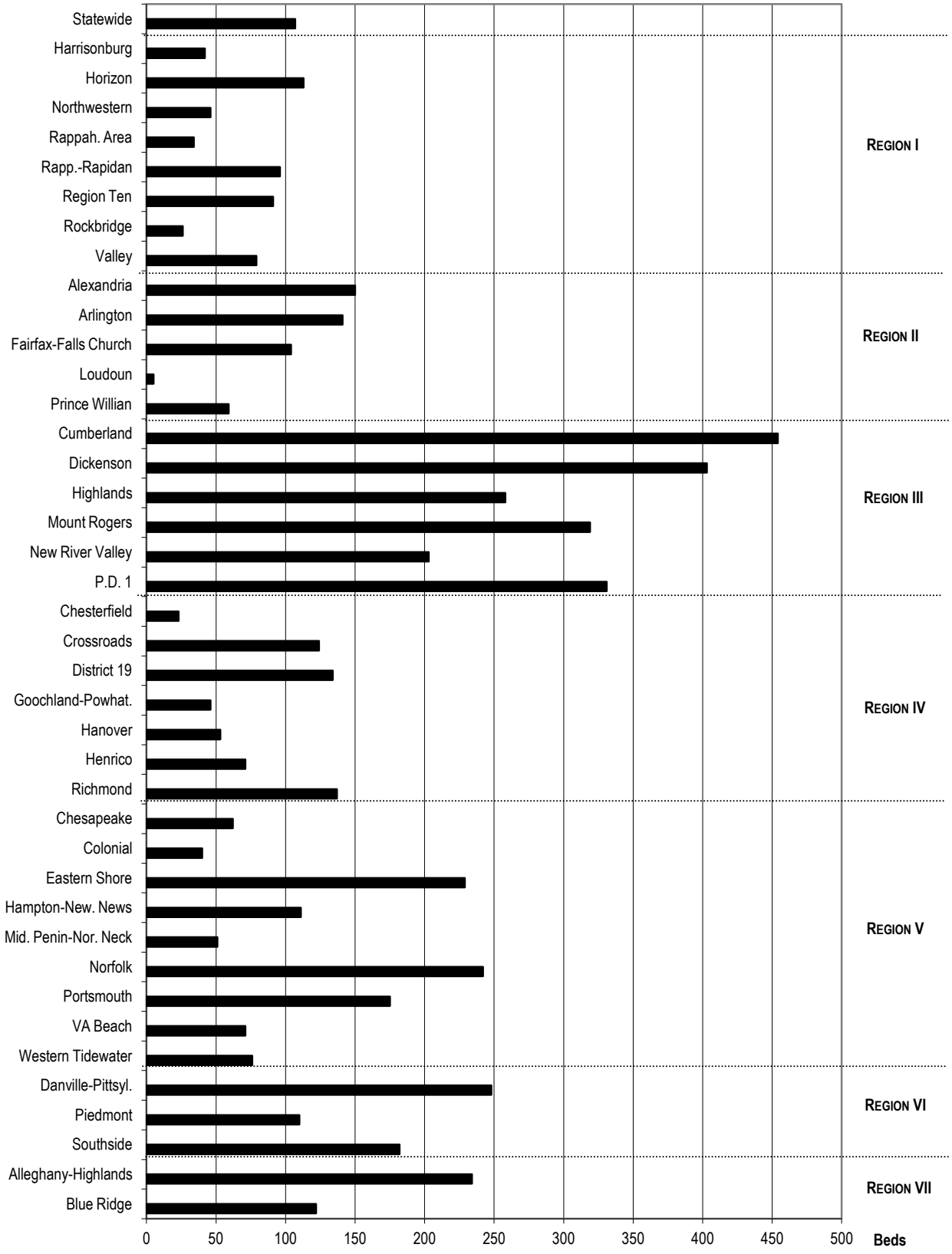


Adult Civil State Hospital Facility Utilization by CSB and Region -- FY2013

	CSB	All Bed Days FY 2013	SMI Prevalence	FY 2013 Bed Days Per 10 K SMI Prevalence	FY 2013 Beds Per 100 K Prevalence Population
I	Harrisonburg-Rockingham	4,622	5,532	8,355	23
	Central Virginia	11,477	10,942	10,489	29
	Northwestern	5,861	9,414	6,226	17
	Rappahannock Area	11,096	13,592	8,164	22
	Rappahannock-Rapidan	4,374	6,972	6,274	17
	Region Ten	12,834	10,284	12,480	34
	Rockbridge Area	1,617	1,822	8,875	24
	Valley	6,970	5,184	13,445	37
II	Alexandria	4,009	6,501	6,167	17
	Arlington	11,530	9,999	11,531	32
	Fairfax-Falls Church	16,640	47,553	3,499	10
	Loudoun County	3,409	12,780	2,667	7
	Prince William County	7,430	18,881	3,935	11
III	Cumberland Mountain	4,840	4,204	11,513	32
	Dickenson County	1,262	673	18,752	51
	Highlands	13,320	3,170	42,019	115
	Mount Rogers	12,156	5,175	23,490	64
	New River Valley	8,827	7,999	11,035	30
	Planning District 1	7,360	4,029	18,268	50
IV	Chesterfield	5,222	13,120	3,980	11
	Crossroads	2,139	4,496	4,758	13
	District 19	4,809	7,334	6,557	18
	Goochland-Powhatan	366	2,120	1,726	5
	Hanover County	2,345	4,155	5,644	15
	Henrico Area	4,650	14,136	3,289	9
	Richmond BHA	8,917	9,161	9,734	27
V	Chesapeake	8,114	9,275	8,748	24
	Colonial	5,164	6,874	7,512	21
	Eastern Shore	1,848	1,949	9,482	26
	Hampton-Newport News	15,138	13,181	11,485	31
	Middle Pen.-Northern Neck	6,187	6,146	10,067	28
	Norfolk	11,859	10,522	11,271	31
	Portsmouth	3,183	3,968	8,022	22
	Virginia Beach	5,439	18,545	2,933	8
	Western Tidewater	4,071	6,072	6,705	18
VI	Danville-Pittsylvania	8,308	4,515	18,401	50
	Piedmont	5,124	6,111	8,385	23
	Southside	5,047	3,653	13,816	38
VII	Alleghany Highlands	3,430	943	36,373	100
	Blue Ridge	18,498	10,790	17,144	47
	VIRGINIA STATEWIDE	**279,492**	**341,773**	**8,178**	**22**

Source: DBHDS AVATAR and Weldon Cooper Center for Public Service Age & Sex estimates for 2012
Note: Excludes HRMC, VCBR, and CCCA and 97 bed days with no CSB association

Training Center Bed Utilization by Individuals by CSB and Region FY 2013
Beds Per 10,000 ID Population Prevalence



State Training Center Utilization by CSB and Region -- FY 2013

	CSB	All Bed Days FY 2013	ID Prevalence	FY 2013 Bed Days Per 10 K ID Prevalence	FY 2013 Beds Per 100 K Population
I	Harrisonburg-Rockingham	1,871	1,213	15,425	42
	Horizon	9,993	2,417	41,345	113
	Northwestern	3,587	2,129	16,848	46
	Rappahannock Area	3,994	3,184	12,544	34
	Rappahannock-Rapidan	5,574	1,595	34,947	96
	Region Ten	7,463	2,257	33,066	91
	Rockbridge Area	365	390	9,359	26
	Valley	3,281	1,144	28,680	79
II	Alexandria	7,420	1,354	54,801	150
	Arlington	10,681	2,081	51,326	141
	Fairfax-Falls Church	41,063	10,785	38,074	104
	Loudoun County	549	3,096	1,773	5
	Prince William County	9,590	4,479	21,411	59
III	Cumberland Mountain	15,216	919	165,571	454
	Dickenson County	2,190	149	146,980	403
	Highlands	6,532	693	94,257	258
	Mount Rogers	13,248	1,138	116,415	319
	New River Valley	12,655	1,708	74,093	203
	Planning District 1	10,658	883	120,702	331
IV	Chesterfield	2,577	3,047	8,457	23
	Crossroads	4,460	983	45,371	124
	District 19	7,934	1,627	48,765	134
	Goochland-Powhatan	787	473	16,638	46
	Hanover County	1,840	958	19,207	53
	Henrico Area	8,295	3,201	25,914	71
	Richmond BHA	9,783	1,963	49,837	137
V	Chesapeake	4,885	2,142	22,806	62
	Colonial	2,247	1,543	14,563	40
	Eastern Shore	3,574	428	83,505	229
	Hampton-Newport News	11,941	2,955	40,409	111
	Middle Pen.-Northern Neck	2,483	1,342	18,502	51
	Norfolk	20,218	2,286	88,443	242
	Portsmouth	5,684	892	63,722	175
	Virginia Beach	10,856	4,175	26,002	71
	Western Tidewater	3,844	1,386	27,734	76
VI	Danville-Pittsylvania	9,050	1,000	90,500	248
	Piedmont	5,059	1,342	37,697	103
	Southside	5,337	805	66,298	182
VII	Alleghany Highlands	1,787	209	85,502	234
	Blue Ridge	10,696	2,393	44,697	122
	VIRGINIA STATEWIDE	**299,267**	**76,763**	**38,986**	**107**

Source: DBHDS AVATAR and Weldon Cooper Center for Public Service Age & Sex estimates for 2012
Note: Excludes 881 bed days with no CSB association

Numbers Served by Age - FY 2013

Age	State Hospitals	Training Centers	Hiram Davis	VSBR	Total
0-17	604	3	0	0	**611**
18-22	339	13	1	1	**350**
23-59	2,802	730	79	321	**3,865**
60-64	219	122	11	20	**363**
65-74	287	97	11	13	**401**
75+	164	30	16	1	**202**
Total	**4,415**	**995**	**118**	**356**	**5,792**

Numbers Served in State Facilities by Gender - FY 2013

Gender	State Hospitals	Training Centers	Hiram Davis	VCBR	Total
Male	2,728	579	68	356	**3,670**
Female	1,687	416	50		**2,122**
Total	**4,415**	**995**	**118**	**356**	**5,792**

State Hospital and Training Center Numbers of Admissions, Separations, and Average Daily Census FY 1976 to FY 2013

	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	1,275
FY 2010	4,809	4,856	1,355	100	194	1,196
FY 2011	4,366	4,421	1,319	111	193	1,106
FY 2012	4,330	4,369	1,271	78	205	1,013
FY 2013	3,959	4,005	1,233	35***	212****	868

* Excludes Hiram Davis Medical Center and the Virginia Center for Behavioral Rehabilitation. State MH 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.

*** Of the 35 admissions, 20 were for respite services, 12 were emergency admissions, and 3 were long-term admissions.

****Of the 212 discharges, 181 had been long-term admissions

Appendix E
Prevalence Estimates by CSB

Estimated Prevalence of Serious Mental Illness by CSB and Region

	CSB	Population Age18+ (2012 Population)	Est. Population with SMI (5.4%)	Lower Limit of SMI 95% Confidence Interval (3.7%)	Upper Limit of SMI 95% Confidence Interval (7.1%)
I	Harrisonburg-Rockingham	102,451	5,532	3,791	7,274
	Horizon	202,635	10,942	7,497	14,387
	Northwestern	174,339	9,414	6,451	12,378
	Rappahannock Area	251,705	13,592	9,313	17,871
	Rappahannock-Rapidan	129,109	6,972	4,777	9,167
	Region Ten	190,446	10,284	7,047	13,522
	Rockbridge Area	33,748	1,822	1,249	2,396
	Valley	95,996	5,184	3,552	6,816
II	Alexandria	120,398	6,501	4,455	8,548
	Arlington	185,165	9,999	6,851	13,147
	Fairfax-Falls Church	880,619	47,553	32,583	62,524
	Loudoun County	236,670	12,780	8,757	16,804
	Prince William County	349,656	18,881	12,937	24,826
III	Cumberland Mountain	77,844	4,204	2,880	5,527
	Dickenson County	12,457	673	461	884
	Highlands	58,708	3,170	2,172	4,168
	Mount Rogers	95,825	5,175	3,546	6,804
	New River Valley	148,130	7,999	5,481	10,517
	Planning District 1	74,610	4,029	2,761	5,297
IV	Chesterfield	242,965	13,120	8,990	17,251
	Crossroads	83,258	4,496	3,081	5,911
	District 19	135,807	7,334	5,025	9,642
	Goochland-Powhatan	39,268	2,120	1,453	2,788
	Hanover County	76,945	4,155	2,847	5,463
	Henrico Area	261,781	14,136	9,686	18,586
	Richmond BHA	169,639	9,161	6,277	12,044
V	Chesapeake	171,758	9,275	6,355	12,195
	Colonial	127,292	6,874	4,710	9,038
	Eastern Shore	36,088	1,949	1,335	2,562
	Hampton-Newport News	244,088	13,181	9,031	17,330
	Middle Pen.-Northern Neck	113,822	6,146	4,211	8,081
	Norfolk	194,848	10,522	7,209	13,834
	Portsmouth	73,490	3,968	2,719	5,218
	Virginia Beach	343,423	18,545	12,707	24,383
	Western Tidewater	112,443	6,072	4,160	7,983
VI	Danville-Pittsylvania	83,611	4,515	3,094	5,936
	Piedmont	113,166	6,111	4,187	8,035
	Southside	67,652	3,653	2,503	4,803
VII	Alleghany Highlands	17,462	943	646	1,240
	Blue Ridge	199,813	10,790	7,393	14,187
	TOTAL	**6,329,130**	**341,773**	**234,178**	**449,368**

Source for population counts: Weldon Cooper Center for Public Service Age & Sex estimates for 2012
Methodology Source: NRI/SDICC report for CMHS. September 2012

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

CSB		Population Age 9 through 17 (2011 Estimate)	Est. SED, Level of Functioning Score = 50		Est. SED, Level of Functioning Score = 60	
			Lower	Upper	Lower	Upper
I	Harrisonburg-Rockingham	20,817	1,041	1,457	1,874	2,290
	Horizon	39,040	1,952	2,733	3,514	4,294
	Northwestern	36,683	1,834	2,568	3,301	4,035
	Rappahannock Area	63,793	3,190	4,465	5,741	7,017
	Rappahannock-Rapidan	28,793	1,440	2,015	2,591	3,167
	Region Ten	35,585	1,779	2,491	3,203	3,914
	Rockbridge Area	5,679	284	398	511	625
	Valley	17,639	882	1,235	1,588	1,940
II	Alexandria	14,397	720	1,008	1,296	1,584
	Arlington	22,285	1,114	1,560	2,006	2,451
	Fairfax-Falls Church	189,258	9,463	13,248	17,033	20,818
	Loudoun County	69,171	3,459	4,842	6,225	7,609
	Prince William County	93,492	4,675	6,544	8,414	10,284
III	Cumberland Mountain	13,339	667	934	1,200	1,467
	Dickenson County	2,284	114	160	206	251
	Highlands	10,297	515	721	927	1,133
	Mount Rogers	17,053	853	1,194	1,535	1,876
	New River Valley	25,583	1,279	1,791	2,302	2,814
	Planning District 1	13,137	657	920	1,182	1,445
IV	Chesterfield	59,210	2,960	4,145	5,329	6,513
	Crossroads	15,069	753	1,055	1,356	1,658
	District 19	25,859	1,293	1,810	2,327	2,844
	Goochland-Powhatan	7,624	381	534	686	839
	Hanover County	17,949	897	1,256	1,615	1,974
	Henrico Area	55,431	2,772	3,880	4,989	6,097
	Richmond BHA	28,013	1,401	1,961	2,521	3,081
V	Chesapeake	40,296	2,015	2,821	3,627	4,433
	Colonial	26,589	1,329	1,861	2,393	2,925
	Eastern Shore	6,406	320	448	577	705
	Hampton-Newport News	50,901	2,545	3,563	4,581	5,599
	Middle Pen.-Northern Neck	19,289	964	1,350	1,736	2,122
	Norfolk	35,196	1,760	2,464	3,168	3,872
	Portsmouth	15,169	758	1,062	1,365	1,669
	Virginia Beach	71,079	3,554	4,975	6,397	7,819
	Western Tidewater	24,887	1,244	1,742	2,240	2,738
VI	Danville-Pittsylvania	15,698	785	1,099	1,413	1,727
	Piedmont	20,181	1,009	1,413	1,816	2,220
	Southside	12,253	613	858	1,103	1,348
VII	Alleghany Highlands	3,230	162	226	291	355
	Blue Ridge	37,933	1,897	2,655	3,414	4,173
	TOTAL	**1,306,580**	**65,329**	**91,461**	**117,592**	**143,724**

Source for population counts: Weldon Cooper Center for Public Service Age & Sex estimates for 2012
Methodology Source: NRI/SDICC report for CMHS. September 2012 (LOF 50, 5% &7% LOF 60, 9% & 11%)

Estimated Prevalence of Intellectual and Related Developmental Disabilities by CSB and Region

	CSB	Population Age 0-3 (2011 Estimate)	Estimated # Part C Eligible Infants/Toddlers 38%	Population Age 6+ (2011 Estimate)	Estimated # With ID 1%	General Population	Estimated # With DD 1.8%
I	Harrisonburg-Rockingham	4,231	1,608	121,321	1,213	128,372	2,311
	Horizon	8,169	3,104	241,727	2,417	255,342	4,596
	Northwestern	7,916	3,008	212,876	2,129	226,069	4,069
	Rappahannock Area	13,426	5,102	318,439	3,184	340,815	6,135
	Rappahannock-Rapidan	5,933	2,254	159,467	1,595	169,355	3,048
	Region Ten	8,105	3,080	225,693	2,257	239,202	4,306
	Rockbridge Area	1,032	392	39,031	390	40,751	734
	Valley	3,899	1,482	114,432	1,144	120,931	2,177
II	Alexandria	6,559	2,492	135,362	1,354	146,294	2,633
	Arlington	7,781	2,957	208,077	2,081	221,045	3,979
	Fairfax-Falls Church	46,064	17,504	1,078,519	10,785	1,155,292	20,795
	Loudoun County	16,383	6,226	309,593	3,096	336,898	6,064
	Prince William County	23,296	8,852	447,866	4,479	486,692	8,760
III	Cumberland Mountain	2,822	1,072	91,869	919	96,572	1,738
	Dickenson County	499	190	14,858	149	15,690	282
	Highlands	2,134	811	69,295	693	72,852	1,311
	Mount Rogers	3,517	1,336	113,788	1,138	119,649	2,154
	New River Valley	4,910	1,866	170,750	1,708	178,933	3,221
	Planning District 1	2,960	1,125	88,308	883	93,241	1,678
IV	Chesterfield	11,518	4,377	304,659	3,047	323,856	5,829
	Crossroads	3,253	1,236	98,334	983	103,756	1,868
	District 19	6,289	2,390	162,660	1,627	173,142	3,117
	Goochland-Powhatan	1,297	493	47,308	473	49,470	890
	Hanover County	2,939	1,117	95,769	958	100,668	1,812
	Henrico Area	12,719	4,833	320,060	3,201	341,258	6,143
	Richmond BHA	8,382	3,185	196,339	1,963	210,309	3,786
V	Chesapeake	8,545	3,247	214,176	2,142	228,417	4,112
	Colonial	4,821	1,832	154,342	1,543	162,377	2,923
	Eastern Shore	1,674	636	42,777	428	45,567	820
	Hampton-Newport News	13,216	5,022	295,535	2,955	317,562	5,716
	Middle Pen.-Northern Neck	4,087	1,553	134,206	1,342	141,017	2,538
	Norfolk	10,309	3,917	228,601	2,286	245,782	4,424
	Portsmouth	4,373	1,662	89,182	892	96,470	1,736
	Virginia Beach	17,740	6,741	417,455	4,175	447,021	8,046
	Western Tidewater	5,335	2,027	138,625	1,386	147,517	2,655
VI	Danville-Pittsylvania	3,458	1,314	100,040	1,000	105,803	1,904
	Piedmont	4,440	1,687	134,164	1,342	141,564	2,548
	Southside	2,442	928	80,538	805	84,608	1,523
VII	Alleghany Highlands	653	248	20,913	209	22,001	396
	Blue Ridge	8,638	3,282	239,311	2,393	253,707	4,567
	TOTAL	**305,761**	**116,189**	**7,676,265**	**76,763**	**8,185,867**	**147,346**

Source for population counts: Weldon Cooper Center for Public Service Age & Sex estimates for 2012

Estimated Prevalence of Drug and Alcohol Dependence by CSB and Region

	CSB	Population 12+ (2011 estimate)	Estimated Drug Dependence 1.77%	Estimated Alcohol Dependence 3.04%	Total Estimated # Drug/Alcohol Dependence*
I	Harrisonburg-Rockingham	219,931	3,893	6,686	5,311
	Horizon	110,419	1,954	3,357	10,579
	Northwestern	190,945	3,380	5,805	9,184
	Rappahannock Area	280,900	4,972	8,539	13,511
	Rappahannock-Rapidan	142,242	2,518	4,324	6,842
	Region Ten	205,405	3,636	6,244	9,880
	Rockbridge Area	36,093	639	1,097	1,736
	Valley	103,929	1,840	3,159	4,999
II	Alexandria	125,845	2,227	3,826	6,053
	Arlington	193,701	3,428	5,888	9,317
	Fairfax-Falls Church	963,677	17,057	29,296	46,353
	Loudoun County	265,313	4,696	8,066	12,762
	Prince William County	389,783	6,899	11,849	18,749
III	Cumberland Mountain	83,958	1,486	2,552	4,038
	Dickenson County	13,471	238	410	648
	Highlands	63,282	1,120	1,924	3,044
	Mount Rogers	103,666	1,835	3,151	4,986
	New River Valley	157,812	2,793	4,797	7,591
	Planning District 1	80,631	1,427	2,451	3,878
IV	Chesterfield	270,257	4,784	8,216	12,999
	Crossroads	89,873	1,591	2,732	4,323
	District 19	147,308	2,607	4,478	7,086
	Goochland-Powhatan	42,988	761	1,307	2,068
	Hanover County	85,463	1,513	2,598	4,111
	Henrico Area	286,473	5,071	8,709	13,779
	Richmond BHA	180,107	3,188	5,475	8,663
V	Chesapeake	190,391	3,370	5,788	9,158
	Colonial	139,399	2,467	4,238	6,705
	Eastern Shore	38,853	688	1,181	1,869
	Hampton-Newport News	265,597	4,701	8,074	12,775
	Middle Pen.-Northern Neck	122,888	2,175	3,736	5,911
	Norfolk	207,919	3,680	6,321	10,001
	Portsmouth	79,730	1,411	2,424	3,835
	Virginia Beach	374,981	6,637	11,399	18,037
	Western Tidewater	123,543	2,187	3,756	5,942
VI	Danville-Pittsylvania	90,687	1,605	2,757	4,362
	Piedmont	122,316	2,165	3,718	5,883
	Southside	73,344	1,298	2,230	3,528
VII	Alleghany Highlands	19,047	337	579	916
	Blue Ridge	216,810	3,838	6,591	10,429
	TOTAL	**6,898,965**	**122,112**	**209,729**	**331,840**

Source for population counts: Weldon Cooper Center for Public Service Age & Sex estimates for 2012

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

Appendix F
Individuals on Waiting Lists for Services by CSB

Adults on CSB Mental Health Services Waiting Lists -- January - April 2013

	CSB	Adult SMI Prevalence*	Unduplicated # of Adults Served (FY 2013)			On CSB Waiting Lists		Total on CSB Waiting List
			# Served	# SMI	% with SMI	Receiving CSB Svs	Not Receiving CSB Svs	
I	Harrisonburg-Rockingham	5,532	2,351	1,374	58%	39	10	49
	Horizon	10,942	1,356	603	44%	53	0	53
	Northwestern	9,414	2,080	1,313	63%	24	48	72
	Rappahannock Area	13,592	1,803	852	47%	25	8	33
	Rappahannock-Rapidan	6,972	2,253	1,224	54%	142	2	144
	Region Ten	10,284	2,174	1,668	77%	14	47	61
	Rockbridge	1,822	750	316	42%	0	0	0
	Valley	5,184	1,780	611	34%	0	0	0
II	Alexandria	6,501	1,549	1,051	68%	85	48	133
	Arlington	9,999	2,301	1,540	67%	31	2	33
	Fairfax-Falls Church	47,553	5,107	2,149	42%	258	7	265
	Loudoun	12,780	3,010	2,239	74%	19	0	19
	Prince William	18,881	3,815	2,360	62%	226	16	242
III	Cumberland Mountain	4,204	1,570	868	55%	298	0	298
	Dickenson County	673	934	512	55%	0	0	0
	Highlands	3,170	2,095	1,212	58%	13	0	13
	Mount Rogers	5,175	2,175	1,450	67%	355	0	355
	New River Valley	7,999	1,763	1,297	74%	20	6	26
	P.D. 1	4,029	713	443	62%	12	0	12
IV	Chesterfield	13,120	1,983	724	37%	14	16	30
	Crossroads	4,496	1,221	956	78%	37	30	67
	District 19	7,334	5,321	3,834	72%	0	16	16
	Goochland-Powhatan	2,120	629	480	76%	0	4	4
	Hanover	4,155	1,819	1,265	70%	50	0	50
	Henrico	14,136	1,398	707	51%	96	11	107
	Richmond BHA	9,161	2,525	2,017	80%	202	40	242
V	Chesapeake	9,275	2,357	1,180	50%	31	0	31
	Colonial	6,874	2,015	1,310	65%	69	2	71
	Eastern Shore	1,949	308	149	48%	0	2	2
	Hampton-Newport News	13,181	1,555	758	49%	8	0	8
	Middle Pen.-Northern Neck	6,146	2,299	1,524	66%	162	38	200
	Norfolk	10,522	2,440	1,507	62%	87	14	101
	Portsmouth	3,968	2,173	1,535	71%	0	51	51
	Virginia Beach	18,545	3,676	2,322	63%	137	34	171
	Western Tidewater	6,072	881	753	85%	43	0	43
VI	Danville-Pittsylvania	4,515	681	518	76%	33	48	81
	Piedmont	6,111	1,404	1,032	74%	26	58	84
	Southside	3,653	1,584	933	59%	6	14	20
VII	Alleghany Highlands	943	630	402	64%	19	0	19
	Blue Ridge	10,790	2,949	2,483	84%	12	0	12
	TOTAL	**341,773**	**77,076**	**49,471**	64%	2,646	572	3,218

*Source for CSB prevalence is statewide estimate that 5.4 percent of adults have a SMI & Weldon Cooper Center for Public Service 2012 Age & Sex estimates

Children and Adolescents on CSB Mental Health Services Waiting Lists – January - April 2013

CSB		SED Prevalence with extreme impairment*	Unduplicated # of Children/ Adolescents Served (FY 2013)			# on CSB Waiting Lists		Total on CSB Waiting List
			# Served	# SED	% with SED	Receiving CSB Svs	Not Receiving CSB Svs	
I	Harrisonburg-Rockingham	1,041	1,337	908	68%	0	0	0
	Horizon	1,952	267	113	42%	104	0	104
	Northwestern	1,834	1,151	742	64%	9	0	9
	Rappahannock Area	3,190	561	416	74%	13	3	16
	Rappahannock-Rapidan	1,440	1,068	567	53%	18	3	21
	Region Ten	1,779	1,182	943	80%	0	0	0
	Rockbridge	284	193	155	80%	0	0	0
	Valley	882	617	196	32%	0	0	0
II	Alexandria	720	372	307	83%	14	26	40
	Arlington	1,114	550	332	60%	2	15	17
	Fairfax-Falls Church	9,463	2,290	1,860	81%	37	24	61
	Loudoun	3,459	1,647	1,304	79%	0	0	0
	Prince William	4,675	1,938	1,242	64%	21	48	69
III	Cumberland Mountain	667	500	424	85%	82	0	82
	Dickenson County	114	340	226	66%	0	0	0
	Highlands	515	1,097	625	57%	36	0	36
	Mount Rogers	853	455	252	55%	211	0	211
	New River Valley	1,279	573	376	66%	68	18	86
	P.D. 1	657	13	7	54%	0	0	0
IV	Chesterfield	2,960	768	341	44%	44	31	75
	Crossroads	753	840	736	88%	14	4	18
	District 19	1,293	1,551	915	59%	0	0	0
	Goochland-Powhatan	381	243	208	86%	1	6	7
	Hanover	897	889	526	59%	4	0	4
	Henrico	2,772	368	208	57%	45	2	47
	Richmond BHA	1,401	883	694	79%	4	0	4
V	Chesapeake	2,015	554	334	60%	0	0	0
	Colonial	1,329	679	349	51%	0	0	0
	Eastern Shore	320	67	32	48%	0	50	50
	Hampton-Newport News	2,545	643	444	69%	0	0	0
	Middle Pen.-Northern Neck	964	2,613	1,819	70%	111	40	151
	Norfolk	1,760	947	592	63%	8	0	8
	Portsmouth	758	422	244	58%	0	0	0
	Virginia Beach	3,554	575	376	65%	15	34	49
	Western Tidewater	1,244	484	382	79%	0	0	0
VI	Danville-Pittsylvania	785	197	81	41%	6	21	27
	Piedmont	1,009	437	351	80%	16	19	35
	Southside	613	559	402	72%	0	27	27
VII	Alleghany Highlands	162	143	72	50%	12	2	14
	Blue Ridge	1,897	2,675	1,948	73%	0	0	0
	TOTAL	**65,329**	**31,351**	**22,049**	70%	**895**	**373**	**1,268**

*Source for CSB prevalence is statewide mean for children with LOF score of 50 & Weldon Cooper Center for Public Service 2012 Age & Sex estimates

Individuals on CSB Developmental Services Waiting Lists – January - April 2013

	CSB	ID Prevalence Age 6 +	Unduplicated # Served (FY 2013)	Numbers with Identified Service Needs								
				# Not on IDOLS Waiting Lists				# on IDOLS Waiting List		Total Identified as Needing Services		
				Receiving CSB Services		Not Receiving CSB Services						
				Adult	C/A	Adult	C/A	Adult	C/A	Adult	C/A	Total
I	Harrisonburg-Rockingham	1,213	210	11	1	0	0	26	60	37	61	98
	Horizon	2,417	372	4	0	0	0	78	116	82	116	198
	Northwestern	2,129	322					87	74	87	74	161
	Rappahannock Area	3,184	354	22	7	0	0	116	242	138	249	387
	Rappahannock-Rapidan	1,595	488	11	2	0	0	56	88	67	90	157
	Region Ten	2,257	963	5	1	3	0	47	69	55	70	125
	Rockbridge	390	135			0		9	20	9	20	29
	Valley	1,144	424					53	60	53	60	113
II	Alexandria	1,354	139	2	2	3	0	8	43	13	45	58
	Arlington	2,081	334	19	13	8	1	35	48	62	62	124
	Fairfax-Falls Church	10,785	1,117	372	26	17	36	356	596	418	658	1,076
	Loudoun	3,096	728	60	14	9	4	62	142	131	160	291
	Prince William	4,479	801	26	8	27	15	121	113	174	136	310
III	Cumberland Mountain	919	521					22	51	22	51	73
	Dickenson County	149	139					1	0	1	0	1
	Highlands	693	351	0	0	0	1	31	61	31	62	93
	Mount Rogers	1,138	517	60	53	0	0	22	114	82	167	249
	New River Valley	1,708	568					54	128	54	128	182
	P.D. 1	883	284		0	0	0	15	32	15	32	47
IV	Chesterfield	3,047	164	186	64	0	0	163	347	349	411	760
	Crossroads	983	359					35	42	35	42	77
	District 19	1,627	1,644	26	0	0	4	41	28	67	32	99
	Goochland-Powhatan	473	315					12	28	12	28	40
	Hanover	958	1,348	7	13	0	0	46	69	53	82	135
	Henrico	3,201	282	117	21	0	1	166	194	283	216	499
	Richmond Behavioral	1,963	632	27	8	0	3	121	188	148	199	347
V	Chesapeake	2,142	1,326	3	0	1	0	103	62	107	62	169
	Colonial	1,543	242					50	56	50	56	106
	Eastern Shore	428	98					5	4	5	4	9
	Hampton-Newport News	2,955	263					141	150	141	150	291
	Middle Pen.-Northern Neck	1,342	684	0	34	0	8	36	24	36	66	102
	Norfolk	2,286	422					152	123	152	123	275
	Portsmouth	892	631					24	13	24	13	37
	Virginia Beach	4,175	1,020	4	0	0	0	161	185	165	185	350
	Western Tidewater	1,386	530	26	4	0	0	71	43	97	47	144
VI	Danville-Pittsylvania	1,000	32	3	1	1	0	89	72	93	73	166
	Piedmont	1,342	342	0	1	13	1	56	41	69	43	112
	Southside	805	239					15	12	15	12	27
VII	Alleghany Highlands	209	80					4	11	4	11	15
	Blue Ridge	2,393	828	1	0	0	0	110	124	111	124	235
	TOTAL	**76,763**	**20,248**	**992**	**273**	**82**	**74**	**2800**	**3873**	**3,874**	**4,220**	**8,094**

Source for population counts: Weldon Cooper Center for Public Service Age & Sex estimates for 2012
Individuals on the IDOLS Wait List as of May 1, 2013.

Adults and Adolescents on CSB Substance Abuse Services Waiting Lists – January - April 2013

	CSB	Drug & Alcohol Dependence Prevalence	Unduplicated # Served (FY 2013)	# on CSB Waiting Lists				Totals on CSB Adult and Adolescent Waiting Lists		
				Receiving CSB Services		Not Receiving Some CSB Services				
				Adult	Adol.	Adult	Adol.	Adult	Adolescent	Total
I	Harrisonburg-Rockingham	5,953	334	19	0	11	0	30	0	30
	Horizon	10,579	819	0	0	0	0	0	0	0
	Northwestern	10,348	879	4	0	7	0	11	0	11
	Rappahannock Area	14,878	799	2	1	0	0	2	1	3
	Rappahannock-Rapidan	7,688	1,337	9	1	1	0	10	1	11
	Region Ten	11,139	1,293	0	0	0	0	0	0	0
	Rockbridge	1,987	142	0	0	0	0	0	0	0
	Valley	5,725	926	0	0	0	0	0	0	0
II	Alexandria	6,699	717	5	0	41	4	46	4	50
	Arlington	10,106	1,037	0	0	0	4	0	4	4
	Fairfax-Falls Church	51,538	2,121	70	7	104	2	174	9	183
	Loudoun	13,512	694	11	8	3	1	14	9	23
	Prince William	20,084	2,007	8	1	3	7	11	8	19
III	Cumberland Mountain	4,704	476	17	0	0	0	17	0	17
	Dickenson County	755	274	6	0	0	0	6	0	6
	Highlands	3,477	546	0	0	0	0	0	0	0
	Mount Rogers	5,775	1,239	12	4	4	0	12	4	16
	New River Valley	8,669	626	8	1	5	1	13	2	15
	P.D. 1	4,496	563	47	0	2	0	49	0	49
IV	Chesterfield	14,513	860	115	19	66	0	181	19	200
	Crossroads	5,000	1,517	1	0	0	0	1	0	1
	District 19	8,187	2,969	0	0	0	0	0	0	0
	Goochland-Powhatan	2,369	259	0	0	2	1	2	1	3
	Hanover	4,643	1,749	13	1	0	0	13	1	14
	Henrico	15,407	946	48	1	2	1	50	2	52
	Richmond Behavioral	9,762	1,029	34	0	62	7	96	7	103
V	Chesapeake	10,214	1,454	3	0	0	0	3	0	3
	Colonial	7,501	476	0	0	0	0	0	0	0
	Eastern Shore	2,160	106	0	0	0	0	0	0	0
	Hampton-Newport News	14,726	472	0	0	0	0	0	0	0
	Middle Pen.-Northern Neck	6,781	804	6	0	3	0	9	0	9
	Norfolk	11,403	620	15	0	20	0	35	0	35
	Portsmouth	4,395	1,198	0	0	60	0	60	0	60
	Virginia Beach	20,280	501	24	1	11	0	35	1	36
	Western Tidewater	6,791	330	0	0	0	0	0	0	0
VI	Danville-Pittsylvania	5,046	234	11	0	9	1	20	1	21
	Piedmont	6,799	862	2	1	25	1	27	2	29
	Southside	4,132	211	2	0	1	0	3	0	3
VII	Alleghany Highlands	1,059	171	6	5	1	2	7	7	14
	Blue Ridge	11,931	785	9	0	75	0	84	0	84
	TOTAL	**331,840**	**34,382**	**507**	**51**	**514**	**32**	**1021**	**83**	**1,104**

Source for population counts: Weldon Cooper Center for Public Service Age & Sex estimates for 2012 & NSDUH 2011 prevalence

Appendix G
Proposed State Facility Capital Projects Priority Listing 2014 – 2020

Project Title	Project Type	Total Project Cost
Repair/replace boilers, heat distribution and HVAC Systems, Phase 6	Improvements-Infrastructure Repairs	$ 18,743,000
Replace facility roofs and building envelopes	Improvements-Infrastructure Repairs	$ 10,172,000
Replace Central State Hospital	New Construction	$ 137,100,000
Jefferson Building Improvements	Improvements-Other	$ 978,000
Repair/replace campus infrastructures	Improvements-Infrastructure Repairs	$ 2,641,500
Expand Western State Hospital	New Construction	$ 17,132,000
Abate environmental hazards	Improvements-Environmental	$ 3,160,800
Expand Sexually Violent Predator facility	New Construction	$ 91,537,000
System food service transformation	Improvements-Other	$ 11,537,500
Six Year Capital Resource Requirements Total		**$ 293,001,800**

Appendix H
Glossary of Services and Services System Terms and Acronyms

Acronym/Term	Name
AA	Alcoholics Anonymous
AAIDD	American Association on Intellectual and Developmental Disabilities
ABS	Adaptive Behavior Scale (ID)
ACA	Annual Consultative Audit (DBHDS)
ACF	Administration on Children and Families (U.S.)
ACS	American Community Survey
ACT	Assertive Community Treatment
AD	Advance Directive
ADA	Americans with Disabilities Act (U.S.) or Assistant Director Administrative (DBHDS facility position)
ADC	Average Daily Census
ADD	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
AMA	Against Medical Advice or American Medical Association
ANLOL	"A New Lease on Life" integrated primary care and behavioral health care initiative (Virginia)
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
ARRA	American Recovery and Reinvestment Act (U.S.)
ASD	Autism Spectrum Disorder
ASAM	American Society of Addiction Medicine
ASFA	Adoption and Safe Families Act of 1997 (U.S.)
ASI	Addiction Severity Index
ASIST	Applied Suicide Prevention Skills Training Program
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 (Virginia)
BHS	Behavioral Health Services
BHDA	Behavioral Health Services Administrator (Virginia Medical managed care program)
BRSS TCS	Bringing Recovery Supports to Scale Technical Assistance Center Strategy
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)
CBT	Cognitive Behavioral Therapy
CCCA	Commonwealth Center for Children and Adolescents (DBHDS facility located in Staunton)
CCD	Consortium for Citizens with Disabilities
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 critical incidents information system)
CIT	Crisis Intervention Team or Community Integration Manager (DBHDS)
CLC	Cultural and Linguistic Competency
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 (Virginia)
COBRA	Comprehensive Omnibus Budget Reconciliation Act (also OBRA)
CODIE	Central Office Data and Information Exchange (DBHDS intranet)
COPN	Certificate of Public Need
COSIG	Co-Occurring State Incentive Grant
COY	Commission on Youth (Virginia)
COV	Commonwealth of Virginia
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 (Virginia)
CSH	Central State Hospital (DBHDS facility located in Dinwiddie)
CSP	Community Support Program
CSS	Community Support System
CTI	Critical Time Intervention
CVTC	Central Virginia Training Center (DBHDS facility located near Lynchburg)
CWIC	Community Work Incentives Coordinator
D&I	Diversity and Inclusion
DAD Project	Discharge Assistance and Diversion Project (Northern Virginia)
DAP	Discharge Assistance Project
DARS	Department for Aging and Rehabilitative Services (formerly Department of Rehabilitative Services) (Virginia)
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)

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)
dLCV	disAbility Law Center of Virginia (formerly the Virginia Office for Protection and Advocacy)
DMAS	Department of Medical Assistance Services (Virginia)
DMC	Data Management Committee of the VACSB
DOC	Department of Corrections (Virginia)
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
DS	Day Support Medicaid Waiver (Virginia)
DSP	Direct Support Professional
DSM-IV	Diagnostic and Statistical Manual (Mental Disorders), Fourth Edition
DV	Developmental Services
DVH	Department for the Visually Handicapped (Virginia)
DVS	Department of Veterans Services (Virginia)
DWBI	Data Warehouse and Business Intelligence
EBP	Evidence-Based Practice
ECA	Epidemiologic Catchment Area
ECO	Emergency Custody Order (Virginia)
ED Forum	Executive Directors Forum of the VACSB (Virginia)
EHRS	Electronic Health Record System
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)
ESO	Employment Services Organization
FAMIS	Family Access to Medical Insurance Security (Virginia)
FAPT	Family Assessment and Planning Team (Virginia)
FAS	Fetal Alcohol Syndrome
FFP	Federal Financial Participation (Medicaid)
FFS	Fee-for-Service
FHA	Federal Housing Administration (U.S.)
FIMS	Forensic Information System (DBHDS application)
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)
FPL	Federal Poverty Line
FSO	Facility Security Officer (DBHDS)
FTE	Full Time Equivalent
FY	Fiscal Year -State (SFY)-July 1 to June 30; Federal (FFY) - October 1 to September 30
GA	General Assembly (Virginia)
GAF	Global Assessment of Functioning
HCBS	Home and Community-Based Services Medicaid Waiver
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
HDMC	Hiram W. Davis Medical Center (DBHDS facility located in Dinwiddie)
HTF	Virginia Housing Trust Fund
I&R	Information and Referral
IAPSRS	International Association of Psychosocial Rehabilitation Services
ICD	International Classification of Diseases
ICF	Intermediate Care Facility (CMS)
ICF/ID	Intermediate Care Facility for Individuals with Intellectual Disability (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.)
IDOLS	Intellectual Disability On-Line System (Virginia ID waiver database)
ID waiver	Medicaid Home and Community-Based Waive, formerly the MR waiver (CMS)
IFDDS	Individuals and Families Developmental Disabilities Services or DD Medicaid Waiver (Virginia)
IFSP	Individual and Family Support Program (DBHDS)
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)
IS&T	Information Services and Technology
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)
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)

LIHTC	Low Income Housing Tax Credit
LIPOS	Local Inpatient Purchase of Services
LOF	Level of Functioning
LOS	Length of Stay
LSC	Life Safety Code
LTC	Long Term Care
LTESS	Long-term Employment Support Services
MCH	Maternal and Child Health
MCO	Managed Care Organization
Medicaid DSA	Medicaid Disproportionate Share Adjustments
Medicaid DSH	Medicaid Disproportionate Share Hospital
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 (Virginia)
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)
MIRC	Medicaid Innovation and Reform Commission (Virginia)
MITA	Medicaid Information Technology Architecture
MMIS	Medicaid Management Information System (Virginia)
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
MU	Meaningful Use
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
NADDDS	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
NIAAA	National Institute on Alcohol and Alcohol Abuse (U.S.)
NIATx	Network to Improve Addiction Treatment
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)
NSDUH	National Household Survey on Drug Use and Health
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)
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 (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.)
OneMind	DBHDS EHRS
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 Practice or Planning
PD	Planning District (Virginia)
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.)
PMD	Production Management and Development
PMPM	Per Member Per Month
POIS	Purchase of Individualized Services
POS	Purchase of Services
PPAC	Prevention and Promotion Advisory Council
PPACA	Patient Protection and Affordable Care Act (U.S.)

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
QA	Quality Assurance
QI	Quality Improvement
QMHP	Qualified Mental Health Professional
QMRP	Qualified Mental Retardation Professional
QSR	Quality Service Review
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
RHSN	Regional Health Supports Network
RM	Risk Management
ROSC	Recovery Orients System of Care (evidence-based change process)
ROSI	Recovery-Oriented System Indicator survey
RPP	Regional Planning Partnership
RQC	Regional Quality Council (DBHDS)
RST	Regional Support Team (DBHDS)
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)
SGF	State General Funds
SHRC	State Human Rights Committee
SILC	State Independent Living Council
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
SOAR	SSI Outreach and Recovery evidence based practice
SPF-SIG	Strategic Prevention Framework State Prevention Grant
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
START	Systemic Therapeutic Assessment Respite and Treatment
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)
SystemLEAD	DBHDS Long-Term Leadership Development Initiative
TAC	Technical Assistance Collaborative
TACIDD	The Advisory Consortium on Intellectual and Developmental Disabilities
TANF	Temporary Assistance for Needy Families (federal block grant)
TBI	Traumatic Brain Injury
TC	Training Center (state ICF of individuals with intellectual disability)
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
URIST	Unrestorably Incompetent to Stand Trial
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
VACIL	Virginia Centers for Independent Living
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
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)
VCHA	Virginia Community Healthcare Association
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
VHIT	Virginia Health Information Technology
VHDA	Virginia Housing Development Authority (Virginia)
VHRI	Virginia Health Reform Initiative
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
VOSAP	Virginia Office for Substance Abuse Prevention (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
VWWP	Virginia Wounded Warriors Program
WALTT	Wellness Advocacy and Leadership Through Technology
WIB	Workforce Investment Board
WRAP	Wellness Recovery Action Plan
WSH	Western State Hospital (DBHDS facility located in Staunton)
XSM	Cross Systems Mapping

Appendix I

Comprehensive State Plan 2014-2020 Reference Documents

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