Review of Community Services Board Child and Adolescent Services

Office of the Inspector General
For Mental Health, Mental Retardation
& Substance Abuse Services

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Section I

Office of the Inspector General

Review of Community Services Board
Child and Adolescent Services

Executive Summary

The Office of the Inspector General for Mental Health, Mental Retardation & Substance Abuse Services (OIG) has conducted a two-stage review of the mental health, intellectual disabilities, and substance abuse services for children, adolescents, and their families offered by Virginia's Community Services Boards. The goal of the review was to assess the range, nature, and other characteristics of Virginia's public community mental health, intellectual disabilities, and substance abuse services for children and adolescents.

This report is the second in a series of two on this subject. The first report, **OIG Report # 148-07 "Survey of Community Services Board Child and Adolescent Services,"** compiled and compared data on the development and current array of children's services from surveys that were completed by all 40 CSBs. It was published on the OIG website (www.oig.virginia.gov) on March 31, 2008.

The second stage of the review reported here consisted of site visits at 34 of the 40 CSBs and interviews with 520 persons who are affiliated with the CSA process in every county and city in Virginia. Site visits included interviews with staff and supervisors, review of records, and telephone interviews with parents or caregivers of children served by the CSBs.

Findings and Recommendations

A. Findings related to service availability

1. Families seeking services for children and adolescents with mental health service needs face enormous differences in service availability depending on where they live. Whether measured by expenditures, staffing, or percentage of child population served, the availability of mental health services for children and adolescents offered by CSBs varies widely among communities.

2. Few CSBs offer a large array of child and adolescent services with sufficient capacity to meet the needs of their community. Many CSBs have very limited services available to children. A few have virtually no service system designed especially for children.

3. Child and adolescent services at CSBs are mostly full to capacity, resulting in long waiting periods for new persons to access services. The average wait for all services, from all CSBs that reported was 26 days.

4. Representatives from stakeholder agencies express dissatisfaction with the levels of CSB service availability in their communities. Specific areas of concern include the following:
   - Wait time for access to services is too long.
   - The wide array of services that are needed to serve children is not available.
   - Services to children with substance abuse needs and autism spectrum disorders are inadequate.

5. Access to services for uninsured families and those that are not eligible for a dedicated source of funding for children and adolescents is extremely limited.

B. Findings related to service funding

1. Medicaid is the largest source of funding in CSB budgets for child and adolescent services. Statewide it composes 47.9% of funding for all three disabilities combined. For mental health services Medicaid makes up 54.1% across the state.

2. The majority of the CSBs that have developed more extensive systems of services for children have done so through the use of Medicaid, and not through special grants or CSA funding. The six highest per capita funded CSBs average 72% of their funding for mental health services from Medicaid. It is important to note however that 30% of the CSBs receive 10% or less of their funding for mental health services from Medicaid.

3. State general funds and local funding make up a comparatively small portion of total funds for child and adolescent services statewide. Total funding statewide includes 11.9% state funds and 17% local dollars for all three disabilities. For CSB mental health budgets, state funding is 10.7% and local funding is 12%.

4. CSA funds paid to CSBs for purchase of services make up a very small portion of CSB budgets for mental health services at only 8.6%. The budgets of 72% of the CSBs include less than 10% of their funding from CSA.

C. Findings related to service quality

1. Parents/caregivers of children receiving services at CSBs report very high levels of satisfaction with the CSB services their children are receiving.

2. Family level of involvement with CSB staff in the planning and provision of services is quite high. Families and stakeholders confirmed this involvement.

3. In the majority of cases reviewed, CSB involvement with and collaboration with other agencies was limited or did not occur.

4. Progress toward treatment goals is generally good for services provided by CSBs.

5. CSB assessments for co-occurring substance abuse needs in children receiving mental health services were not found to be comprehensive. When substance abuse was identified, treatment goals related to substance abuse were present in approximately half of the cases.

6. Few CSBs offer comprehensive, formal programs that have broad national recognition as "evidence-based practices" (EBP). Many CSBs, however, utilize elements and principles that are found in EBP literature.

7. Stakeholder ratings of multiple measures of overall CSB service quality were modestly positive (54.4% positive), but with dissatisfaction shown by a large minority of respondents (38.2% negative).

8. Access to services for parents and caregivers of children and coordination of children's services with services to parents is not adequate.

D. Findings related to CSA and interagency coordination

1. CSBs are not the provider of choice for community-based CSA-funded mental health services in many communities. Only just over half of stakeholder respondents say their CSBs fulfill this role.

2. CSA funds are only a minor source of support for children's services at CSBs. Average CSA funding for CSBs is only 6.8%. 42% of CSBs report receiving no CSA funding. The highest level of CSA funding for any CSB is 33%.

3. Many agency stakeholders say their CSBs do not adequately make clear what services they offer or who is eligible for services, and they express dissatisfaction with the limitations on service availability.

4. The leading factor CSBs cite that has helped them develop children's services is the support and cooperation of the local CSA CPMT and other community agencies to work together on meeting community needs.

5. Over half the CSBs (55%) say they have developed one or more specific services to help improve the provision of services offered to children in the CSA process. These services include intensive care coordination and utilization management.

E. Findings related to CSB workforce issues

1. CSBs have great difficulty recruiting and retaining qualified staff to provide children's services. They list it as the second highest factor that has hindered development of services.

2. CSBs have inadequate psychiatric time to meet the needs of the children in their communities. Only 12.5% of the CSBs report that they have adequate psychiatric resources. CSBs estimate that an additional 25 FTE psychiatrists are needed statewide. The average wait time to see a psychiatrist for children who are currently being served by CSBs is 37 days.

3. The leading suggestion from CSBs for what can be done at the state level to improve the development of children's services is the provision of training, especially on evidence-based, effective services to children and families. (Note: Respondents were asked to list factors other than simply "increase funding.")

4. CSB staff describes morale on their teams as very high.

F. Findings related to preventing out-of-community residential placements

1. Only partial agreement exists among CSBs and the agency stakeholder community about the services that are most needed to prevent out-of-community residential placements.

G. Overarching findings related to the development of CSB services

Three primary and interdependent factors were identified by the OIG as the leading determinates of whether or not CSBs have developed more comprehensive systems of services that meet the needs of families and stakeholder agencies:

1. The extent to which leadership has been exercised to place a priority on the development of children's services, to develop community and interagency relationships, to use creativity and skill in making use of funding from Medicaid, grants, and CSA. This leadership comes from CSB board members, executive director, leader of children's services, or some combination of these persons.
2. Limited availability of funding to provide services for uninsured families and children that do not qualify for CSA and other categorical programs for children.
3. Relatively limited use of CSBs by local communities to provide services that are reimbursed by CSA.

Recommendations

1. It is recommended that DMHMRSAS lead an interagency process to develop a comprehensive plan for the provision of publicly supported, community based mental health, intellectual disability and substance abuse services for children, adolescents and

their families. The objective of this plan will be to determine the base level of services that should be available in every community, clarifying the array of services and per capita capacity that will be needed. The plan should leverage all available sources of funds such as Medicaid, CSA, special grants to support services and then estimate the level of additional state funds needed to achieve a balanced, flexible funding base to address the needs of those families that are uninsured or not eligible for other dedicated sources of reimbursement. The planning process should include input from relevant state and local agencies and the private provider community. The target date for the completion of the plan would be no later than July 1, 2009. To assure that adequate staffing and planning expertise can be dedicated to the development of this plan, it is recommended that DMHMRSAS seek the assistance of experts with experience in planning for systems of MH/ID/SA services for children, adolescents and families to supplement departmental staffing.

It is further recommended that DMHMRSAS present the plan to the General Assembly clarifying the level of support that can be anticipated from non-state sources and identifying specific needs from state sources to enable responsible expansion of services in the first two years of implementing the plan.

It is further recommended that in subsequent legislative cycles DMHMRSAS provide a report to the General Assembly that claries progress achieved in expanding services for children, adolescents and children according to the plan, documents success in leveraging funds from non-state sources, and requests annual increases in state funds that will assure solid, responsible growth of a new system of services based on the comprehensive plan.

2. It is recommended that every CSB appoint a single person to lead services for children and adolescents.

3. It is recommended that DMHMRSAS provide leadership in determining the areas of training and staff development that are needed to increase consistency in the quality of services delivered by CSBs statewide to children and adolescents. It is further recommended that DMHMRSAS develop a plan for assuring that this training is made available to CSB staff.

4. It is recommended that the CSBs that have developed the more comprehensive systems of services for children and adolescents share information with other CSBs regarding the organizational, interagency collaboration, staffing, and funding factors that have enabled their success. DMHMRSAS and/or the Virginia Association for Community Services Boards could facilitate this educational effort.

5. It is recommended that CSBs evaluate their methods for assessing substance abuse to assure comprehensive evaluation of the need for substance abuse treatment, particularly when the identified problem is mental health or intellectual disability related.

Section II - Introduction

The Office of the Inspector General for Mental Health, Mental Retardation and Substance Abuse Services (OIG) conducted a review of services for children and adolescents provided by the 40 Community Services Boards (CSBs) during November 2007 through May 2008. The goal of the review was to assess the range, nature, and other characteristics of Virginia's public community mental health, intellectual disabilities[1], and substance abuse services for children and adolescents[2]. The review also assessed the views held toward these services by families that use these services and those of the stakeholder community – the partner agencies that join with the CSBs in the collaborative planning and service delivery process known as the Comprehensive Services Act for Children and At-Risk Youth (CSA).

The first phase of the OIG review was a 63-question survey that all 40 CSBs completed. These surveys described the children's services provided by each CSB in considerable detail, including staffing, budget, service levels, and other information. **OIG Report # 148-07 "Survey of Community Services Board Child and Adolescent Services"** compiled the data from the surveys and compared CSB services across many variables. It was published on the OIG website (www.oig.virginia.gov) on March 31, 2008.

The second phase of the review consisted of site visits at 34 of the 40 CSBs. The CSBs that were visited serve jurisdictions that contain 99% of the population of Virginia, and 94% of the age 0-17 population. Site visits included interviews with staff and supervisors, review of records, and telephone interviews with parents or caregivers of children served by the CSBs (the same children whose records were reviewed).

The third phase of the review was a survey of the approximately 1500 persons who are affiliated with the CSA process in every county and city in Virginia. These "stakeholders" include all representatives and alternates to CSA Community Policy and Management Teams (CPMT) and CSA Family Assessment and Planning Teams (FAPT) from departments of social services, health, juvenile justice, CSBs, public schools, private agencies, local government, and family members.

Input to the Review

The OIG sought input to the design of the review of CSB children's services from a wide variety of sources:

- Secretary of Health and Human Resources and staff
- Senate and House staff
- Virginia Commission on Youth staff
- Joint Legislative Audit and Review Committee (JLARC) staff

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[1] The OIG uses the term intellectual disabilities wherever possible, except in cases where the term mental retardation is used in formal titles or previously published items.
[2] Hereafter, only the term children will be used to refer to both children and adolescents.

- Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) leadership and children's services staff
- Office of Comprehensive Services for Youth and At-Risk Youth and Families (CSA) staff
- Supreme Court Commission on Mental Health Law Reform – Child and Adolescent Task Force
- Child and Family Behavioral Health Policy and Planning Committee
- Virginia Association of Community Services Boards (VACSB)
- Community services boards (CSB) children's services directors
- Families, interagency staff, and other attendees at Systems of Care Conference (September 16-17, 2007)
- Local CSA and Departments of Social Services (DSS) directors and staff.

Statements of Quality

A process of extensive review of literature on children's mental health, substance abuse, and intellectual disability services, along with the input process described above, led to the creation of 9 statements of quality by which the OIG assessed services in the review. The widely accepted "Systems of Care" model[3] offered a framework for many of the statements of quality, but the criteria selected were individually verified by the input received by the OIG and described in terms relevant to the service and funding structures of Virginia. The overall design of the review and the creation of all the questions included in the interviews, checklists, and questionnaires were based on these statements of quality:

1. The families and caregivers of children receiving services are the leading participants and determinants of service needs and plans, assisted by professionals.
2. Services are community-based and designed to help children stay in their own families, in their own communities to the greatest extent possible.
3. The services provided are individually matched and appropriate to the individual needs and desires of the child and family and are described in a comprehensive services plan that is updated and changed as a result of changes in circumstances and desires of the family.
4. Services are the least restrictive possible and are delivered in the most normative environment possible.
5. Services are holistic (encompassing a wide range of life needs in different environments) and long term in their scope, rather than problem or symptom focused and specific only to one environment, e.g., school.
6. Services address the needs of the family as a system, with family and adult services available in a convenient and responsive manner.

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[3] From Stroul, B & Friedman, R (1986). *A system of care for children and youth with severe emotional disturbances* (rev, ed., p. 17). Washington, D.C: Georgetown University Child Development Center, National Technical Assistance Center for Children's Mental Health.

7. Services are well coordinated and collaborative with other main service and support systems for children and families in the community.
8. Staff are well trained (including cultural competence) for state-of-the-art services for children and families, receive good clinical supervision and support, and evaluated according to best practices and measurable outcomes for the persons they serve.
9. The CSB gives children's services a high priority, is a good partner in the CSA process, and offers a comprehensive range of services that are accessible in a timely and smooth manner.

Section III – CSB Child and Adolescent Program Site Visit Inspections

Process of the Site Visits

The OIG visited 34 CSBs, omitting only the 6 CSBs that either did not identify specific children's services staff or reported extremely small children's services staffing levels in the OIG survey sent to all CSBs. The six CSBs that were omitted from the site visit phase of the review included Chesapeake, Dickenson County, Eastern Shore, Goochland-Powhatan, Portsmouth, and Southside. All 40 CSBs were included in phase 1 - the survey of all CSBs' services – and phase 3 – the stakeholder interviews.

The site visits were announced to the CSBs approximately 5 working days before the visits in order for the CSBs to arrange for the OIG inspectors to meet with all children's services supervisors and staff. Upon arrival at the CSB, the inspectors made a random selection of records from cases of children currently receiving services or recently closed. The number of cases selected ranged from 10 to 35, depending on the size of the CSB's services for children (measured by number of assigned staff). CSB staff had no involvement in the selection of cases to be reviewed. The record sample from all the CSBs totaled 469. Records were reviewed according to a specific checklist. All questionnaires and checklists used in the review are available in the appendix of the online version of this report at the OIG website. Names and phone numbers of parents or caretakers were collected, when available, from the records that were reviewed. Meetings were held with all supervisors and all staff who could be made available without severe disruption to ongoing service commitments. A total of 234 supervisors and 859 staff were interviewed. All interviews were conducted in groups, with participants completing confidential, self-administered, written questionnaires, followed by brief open discussions. Site visits took place between March 4, 2008 and April 3, 2008.

Family Interviews

OIG inspectors made phone calls to all of the parents or caregivers whose names and phone numbers were available in the records of the sample of 469 children's records reviewed in the site visits. Of the 469, some had no caregiver information in the record, many had wrong or discontinued numbers, many were unreachable although at least three attempts were made to reach them, and a few refused or were unable to complete the

interviews. Interviews were completed with 175 persons, or 37% of the record review sample.

Inspectors used a questionnaire that asked respondents to indicate their agreement or disagreement with 13 statements about the services their child is receiving, the child's progress, and their satisfaction with the services. A table showing all the statements and responses is shown below.

Family or Caregiver Survey	**Strongly Agree % (n)**	**Agree % (n)**	**Disagree % (n)**	**Strongly Disagree % (n)**	**Not Applicable % (n)**
CSB staff members treat my child with dignity and respect.	61.1% (107)	38.3% (67)	0% (0)	.6% (1)	0% (0)
CSB staff members speak to my child and me in a way we understand.	53.1% (93)	43.4% (76)	3.4% (6)	0% (0)	0% (0)
My child and I actively worked with the staff members to develop a treatment plan that accurately addresses my child's current problems, issues and/or behaviors.	39.7% (69)	48.9% (85)	5.7% (10)	2.9% (5)	2.9% (5)
The CSB staff members we work with understand our problems and ask my opinion about what kind of help we want and need.	40.0% (70)	53.1% (93)	4.6% (8)	1.7% (3)	.6% (1)
The CSB staff members we work with have the skills, knowledge and abilities to help my child.	42.9% (75)	53.1% (93)	3.4% (6)	.6% (1)	0% (0)
The CSB staff member answers or returns my calls in a reasonable time.	44.0% (77)	49.1% (86)	5.7% (10)	.6% (1)	.6% (1)
I am satisfied with the amount of time the staff member spends with my child.	40.0% (70)	51.4% (90)	6.3% (11)	1.1% (2)	1.1% (2)
My opinion (whether good or bad) regarding my child's treatment is important to the staff member and is heard.	43.4% (76)	49.1% (86)	4.6% (8)	2.3% (4)	.6% (1)
We are getting as much help as we need at this time for my child.	30.9% (54)	54.3% (95)	11.4% (20)	3.4% (6)	0% (0)
Our staff member is open and honest with us.	43.7% (76)	55.2% (96)	.6% (1)	.6% (1)	0% (0)
Overall, my child and/or family benefits from the services being provided.	40.6% (71)	52.6% (92)	5.7% (10)	1.1% (2)	0% (0)
Overall, I have noticed improvement in the issues and/or behaviors that brought my child into services.	28.6% (50)	56.0% (98)	9.1% (16)	5.1% (9)	1.1% (2)
Overall, I am satisfied with the services that my child is receiving.	40.0% (70)	56.0% (98)	1.7% (3)	1.7% (3)	.6% (1)

- The parents and caregivers who were interviewed expressed very high levels of satisfaction with the services their children are receiving. All statements received positive ratings (strong agreement or agreement) concerning families' satisfaction with the services their child is receiving.
- The statements with the highest levels of agreement ("strongly agree" or "agree") were:
  - 99.4% - "CSB staff members treat my child with dignity and respect."
  - 98.9% - "Our staff member is open and honest with us."
  - 96.5% - "CSB staff members speak to my child and me in a way we understand."
- The statements with the lowest level of agreement ("strongly disagree" or "disagree" were:
  - 84.6% - "Overall, I have noticed improvement in the issues and/or behaviors that brought my child into services."
  - 85.2% - "We are getting as much help as we need at this time for my child."
  - 88.6% - "My child and I actively worked with the staff members to develop a treatment plan that accurately addresses my child's current problems, issues and/or behaviors.

Record Reviews

A total of 469 clinical records of children currently receiving mental health services, or cases recently closed, were drawn at random by the OIG staff from rosters of clients. To enhance comparability across CSBs, cases were only drawn from the services that are most widely found in all CSBs, here listed in descending order of commonality (a full description of what services are provided by all CSBs is found in **OIG Report #148-07 Survey of Community Services Board Child and Adolescent Services** found at www.oig.virginia.gov):

- Case Management
- Outpatient Therapy
- Home Based Therapy
- School Based Day Treatment

OIG inspectors reviewed records using an 11-item checklist that assessed such things as family involvement in service planning, holistic approach to meeting child and family needs, interagency cooperation, levels and nature of case management activity, improvement of the child, screening and treatment for co-occurring substance abuse conditions, and the range of other services received by the child.

The distribution of the **types of services** reviewed is shown in the table below.

Service Type Reviewed	**% of the sample (n)**
Case Management	48.2% (223)
Outpatient Therapy	21.6% (100)
In-Home Therapy	17.9% (83)
Day Treatment	12.3% (57)

The **family situations** of the children were assessed and tabulated. The vast majority of children being served reside with one or more of their parents or other relatives (92.2%), with only 5.8% residing in foster families and 2.0% in other living arrangements such as group homes.

The degree to which treatment is planned with the **involvement or leadership of the family** is a key indicator of quality for child and family services. OIG inspectors reviewed treatment plans, progress notes, and treatment team documents to assess the degree of involvement of families in the need assessment and service planning process.

- Families are routinely involved in helping to plan their children's mental health services – 82.8% of records showed some degree of family involvement in developing the service plan.

Family Directed Treatment Planning	**% (n)**
There is little or no record of the family's involvement with the IFSP.	13.4% (63)
There is evidence that the CSB staff member elicited and received input from the family about the plan.	70.4% (330)
The plan expresses the family's goals, a family-focused plan, with the staff member in a support and resource role.	12.4% (58)
It is apparent to the OIG inspector that caregiver involvement is impractical, not possible, or clinically irrelevant or inadvisable.	3.2% (15)

A **holistic approach** to services was also assessed. Whether the child is treated as a whole person, in a family system, with school and community involvement and with a future to prepare for, rather than focusing on a set of symptoms or problem behaviors, were the markers for finding a holistic approach to treatment.

- In about a quarter of the records (24.1%) it was difficult to see the "whole child." The treatment was not judged to be holistic.
- Inspectors judged 13.4% of records to reflect comprehensive, holistic, multi-faceted assessments and approaches to service.
- The majority (62.3%) were somewhere between these two positions.

Interagency coordination and collaboration are essential to good service outcomes, as most of the children served are involved with multiple services agencies such as schools, social services, court services, and many others, and it is clearly in the interest of the child and the families for all these agencies to work together. In Virginia the CSA system mandates coordination and collaboration for many children.

Records were reviewed to assess these qualities. *Cooperation* was defined as communication and sharing of information and plans, as distinct from *collaboration*, which was seen as joint and complementary planning and activity, such as might occur in a carefully developed FAPT plan. The following table displays the results of the interagency coordination assessment:

Interagency-Intersystem Coordination	**% (n)**
The CSB service operates substantially alone. Minimal consultation or communication.	28.4% (133)
The CSB service operates cooperatively with a few relevant agencies (other CSB services, referral source, dialogue with schools), with appropriate communication and sharing of information, but the service is CSB driven and cooperation is secondary.	58.8% (276)
The CSB services are collaborative with other key agencies – planned and executed as a team, with harmonious and complementary parts and roles.	9.8% (46)
Interagency collaboration is not applicable to this service.	2.6% (12)

- In over a quarter of the cases (28.4%) there was very little or no evidence of interagency coordination in the record. In 58.8% of the cases the CSB service operated cooperatively with a few relevant agencies, but the service is CSB driven and cooperation is secondary. While this may be appropriate in some limited focus outpatient therapy services, which were deemed "not applicable" by OIG inspectors, it is difficult to imagine children with mental health problems not being involved with several service providers, with the attendant need for coordination.

- Only 9.8% of the records were judged to show true collaboration (as defined above) between the CSB and other agencies.

Case management is a central service for children and families in a comprehensive service system. All but two CSBs reported that they offer some degree of children's mental health case management.[4] The OIG has studied adult intellectual disabilities and mental health case management in two other statewide, systemic service reviews.[5] This review of children's services used substantially the same approach as in those reviews to assess the nature and levels of activity of case managers serving children. Of the 469 records that the OIG reviewed, 223 were reviewed with a focus on case management services.

Progress notes and service tickets or logs documenting services from the immediately preceding quarter were reviewed to assess the level of case management activity measured by face-to-face contacts and their location.

- Face-to-face contacts with the child averaged 4.1 for the quarter for all cases reviewed (223).
- All contacts with the family (face-to-face, telephone, email, etc.) averaged 6.8 over the quarter.
- The location of visits varied fairly evenly among sites:

Case Management –Location of Face to Face Contacts in Various Settings in the Last 3 months	**Mean (average)**
Out in the community	2.75
At the child's school	2.72
In a CSB office	2.52
In the child's residence	2.03

The type of activity that the case managers engaged in with or on behalf of their clients has been assessed in all OIG reviews of case management. The following table shows the number of times each of the listed types of activities was noted in all of the children's records over the preceding three months.

Evidence that the CSB Staff Member Engaged in the Following Activities in the Last Quarter	**% Indicating Yes (n)**
Supportive counseling/behavioral consult to family	41.2% (193)
Contact with other CSB services	36.7% (172)
Contact with schools	33.7% (158)
Advocacy for child	16.8% (79)

[4] OIG Report #148-07
[5] OIG Report # 128-06 (MH) and OIG Report #142-07 (MR)

Contact with other social services agencies	15.8% (74)
Arrangement of medical services	14.3% (67)
Contact with DSS	8.7% (41)
Contact with court services unit	5.8% (27)
Participation with FAPT process for child	5.8% (27)
Contact with CSB emergency services	2.3% (11)

The **degree of improvement** in the child's condition was also the subject of record reviews. Inspectors made an overall judgment of whether the condition or problems for which the child was referred were improved over the past year of service.

- Minimal or no progress or set backs were noted in 36.2% of the cases.
- Moderate, mixed, or partial achievement of goals was seen in 58.8% of the cases.
- Highly positive, consistent achievement or progress toward goals was seen in 3.4% of the cases.

Co-occurring conditions of substance abuse and mental health problems are known to be common, especially in older adolescents. As has been done in most OIG community and facility reviews, some effort was made to determine whether the possible substance abuse needs of children are assessed and treated in children's mental health services.

- In 76.1% of cases there was some evidence that substance abuse was assessed. However, many of these assessments were judged by OIG inspectors to be superficial - cursory completion of checklists.
- Of the total of 469 records, 44, or 9.4% had some indication of substance abuse in the record. Some of these were explicit and addressed in problem assessment, and some were evident to inspectors from referral or other information, but were not formally noted as problems in the record. The incidence of substance abuse reported in the records seemed lower than expected by the inspection teams. However, it is not possible to compare this observed presence of substance abuse to research-based estimated rates due to the fact that age of the child was not a measured variable in this review and incidence rates are known to vary by age.
- Of the 44 records in which OIG staff noted substance abuse issues, treatment goals for substance abuse were evident in 56.8% of cases, but in 43.4% of the cases where substance abuse was evidently a problem, no substance abuse treatment was noted in the record.

Records were also reviewed to assess what **other CSB services the child and family were receiving** or had received in the last year. The table below shows the frequency with which other CSB services were noted in the records.

All Services That the Record Shows the Child is Receiving From the CSB in the Last Year	**% (n)**
Case Management	70.6% (331)
Medication Management (psychiatry service)	63.8% (299)
Outpatient Therapy	46.7% (219)
In-Home Therapy (includes MST, FFT)	22.6% (106)
Day Treatment (school based)	22.0% (103)
Other (mentoring, mental health support services, professional family care, respite)	4.7% (22)

Staff interviews

CSBs were asked to invite all staff who work in children's services to meet with OIG inspectors, except for those staff who had extended travel or clinical or contractual obligations. 859 staff were interviewed at the 34 CSBs. Staff were interviewed in groups, during which they privately completed a confidential written interview, and then engaged in a brief group discussion with OIG staff.

The following chart shows a breakdown of how many staff, who were interviewed, work in the various services areas offered by the CSBs.

Types of Services Represented by Staff[6]	**% (n)**
Case Management	40.4% (347)
Outpatient Therapy	24.1% (207)
In-Home Therapy	15.1% (130)
Day Treatment	32.7% (281)
Other	12.8% (110)

[6] Respondents were able to choose more than one response.

- **Staff tenure** in their current jobs averaged 3.4 years and 7.4 years overall in other clinical services work with children, including their current jobs.

- **Case management caseloads.** Persons who are case managers or who had case management as part of their job responsibilities are the largest group of CSB staff working with children. Case managers were asked to estimate their current caseloads, adjusted for full time equivalence.

  - The average caseload (adjusted for part time staff to full time equivalence) is 21.4.

  - As was the case in other OIG reviews of case management, children's services case managers said they must spend a lot of time each week – average of 40% -on administrative duties characterized as "paperwork."

The degree to which need assessment and **service planning are driven by the client** is an important statement of quality in many types of services. It is no less so for children's mental health services, although parents, rather than children, make the major decisions about treatment. Many recent OIG reviews of different types of services have focused on this issue and contrasted what staff reported were their practices in this area and what OIG review of records showed. As shown in the section of this report on family interviews, parents or caregivers were relatively pleased with their level of input on this issue (see page 14). Similarly, in the section on record reviews, OIG review showed good family involvement (see page 16). The table below contrasts staff ratings of their own practices and OIG findings in the records.

Family Directed Treatment Planning: Comparison of Staff Interview and Record Review Data	**Staff Description of Practices % (n= persons)**	**OIG Evaluation of Sample of Records % (n=records)**
Staff develops the service plan and explains it to the family	11.9% (102)	13.4% (63)
CSB staff member elicited and received input from the family about the plan.	55.1% (473)	70.4% (330)
The plan expresses the family's goals, a family-focused plan, with the staff member in a support and resource role.	25.8% (222)	12.4% (58)
It is apparent to the OIG inspector that caregiver involvement is impractical, not possible, or clinically irrelevant or inadvisable.	NA	3.2% (15)

Staff were asked to state their agreement or disagreement with a variety of statements concerning their impressions of CSB children's services, using a 4-point Likert scale of Strongly Agree, Agree, Disagree, or Strongly Disagree. No options for "not applicable" or "do not know" were given; respondents were told to leave questions blank if they did not apply. An extract of staff questions and answers is shown in the

tables below. The full survey with all question and answers is found in the appendix of the online version of this report.

Questions Related to Service Quality and Priority Of Children's Services at CSBs	**SA % (n)**	**A % (n)**	**D %(n)**	**SD %(n)**
Most of the children I serve show improvement as a result of the services we provide.	23.4% (196)	70.6% (591)	5.4% (45)	.6% (5)
Our agency allows families (or surrogate families, if child is in placement) enough choice and self-determination in developing services for their children.	22.6% (192)	68.5% (581)	7.9% (67)	.9% (8)
Child services are a high priority of the leadership of my CSB.	39.0% (330)	48.4% (410)	10.6% (90)	2.0% (17)
My agency stresses and supports extensive interagency coordination and collaboration in my work with children.	44.9% (383)	49.2% (420)	5.2% (44)	.7% (6)
The children I work with have access to a psychiatrist when they need to, without undue waiting.	11.8% (98)	44.9% (374)	31.1% (259)	12.2% (102)
The families I serve can call me – or another member of my team or a supervisor covering for me – during evenings or weekends (not just call CSB's ES program).	22.3% (178)	26.7% (213)	33.5% (268)	17.5% (140)
Mental health and substance abuse services at my agency are well integrated – the children I serve receive substance abuse services without barriers or challenges.	12.6% (88)	50.9% (355)	30.4% (212)	6.0% (42)
Mental health and intellectual disabilities services at my agency are well integrated – the children I serve receive mental retardation services without barriers or challenges.	9.6% (63)	51.4% (338)	31.2% (205)	7.9% (52)
When children and families I serve experience psychiatric or behavioral crises, our agency provides timely, effective crisis intervention to keep the people we serve safe in our community.	34.7% (288)	53.9% (448)	9.3% (77)	2.2% (18)

- Areas of high agreement
    - CSBs' support for interagency coordination.
    - Improvement of children served (most responses were "agree" vs. "strongly agree", suggesting improvement may be limited, consistent with the severity of needs seen).
    - Involvement of parents (similar low levels of "strongly agree" – many staff comments expressed frustration that families were not as involved as staff hoped or thought they should be).

- Areas of lower agreement
    - Timely access to psychiatry services
    - Evening and weekend staff availability
    - Integration of substance abuse and intellectual disabilities services with mental health services.

Questions Related to Staff Training and Support	SA % (n)	A % (n)	D %(n)	SD %(n)
My agency has provided me with specific training regarding family-centered services within the past two years.	13.4% (112)	43.9% (366)	36.3% (302)	6.4% (53)
My agency has provided me with specific training regarding evidence based practices for children within the past two years.	12.1% (98)	45.1% (367)	35.2% (286)	7.6% (62)
I am well prepared by training or experience to deal with co-occurring mental health and substance abuse disorders among the children and families I serve.	15.6% (131)	45.8% (385)	33.7% (283)	4.9% (41)
I am well prepared by training or experience to deal with co-occurring mental health and mental retardation disorders among the children and families I serve.	10.1% (85)	38.1% (320)	40.1% (337)	11.7% (98)
I am well prepared by training and agency supports to relate to the cultural diversity of my clients (e.g., race, language, etc.).	24.7% (210)	57.1% (485)	15.8% (134)	2.5% (21)
I am well prepared by training and support from my agency to understand and work with the processes of the Comprehensive Services Act for At Risk Youth and Families (CSA).	17.2% (143)	47.7% (396)	30.0% (249)	5.1% (42)

- Generally, ratings for training and support are lower than for service quality measures.
- Lowest ratings are for mental retardation (51.8% disagree), evidence-based practice (42.8% disagree), substance abuse (38.6% disagree), and family-centered services (42.7% disagree).
- Just less that half of the staff indicate that they are not well prepared to work with those who have co-occurring mental health and substance problems and co-occurring mental health issues and mental retardation.

Questions Related to Staff Morale and Work Conditions	SA % (n)	A % (n)	D %(n)	SD %(n)
My children's services team has good morale.	34.6% (293)	47.5% (403)	14.0% (119)	3.9% (33)
I receive effective, quality clinical supervision.	36.2% (308)	43.8% (373)	15.5% (132)	4.6% (39)
My job is professionally stimulating and satisfying.	30.7% (262)	53.8% (459)	13.4% (114)	2.1% (18)
I feel safe working out in the community or in the homes of the people I serve.	21.3% (171)	63.2% (506)	13.1% (105)	2.4% (19)
The expectations placed on me by my agency are clear and consistent.	16.7% (143)	57.8% (494)	22.0% (188)	3.4% (29)

My caseload is too large for me to do all that I would like to do for the children I serve.	22.0% (186)	28.4% (240)	41.0% (346)	8.5% (72)
The paperwork I must maintain is a burden and it interferes with service provision.	28.8% (246)	38.6% (329)	30.9% (264)	1.6% (14)

- Morale is very positive (82.1% gave positive responses).

- Highest ratings went to staff feelings of safety working out in the community and in the homes of clients (84.5%) and their feelings that their jobs are professionally stimulating and satisfying (84.5%). The quality of clinical supervision also drew high marks (80%).

- Lower ratings went to caseload size (50.4% said that caseloads are too large) and paperwork concerns (67.6% said that paperwork interferes with service provision).

Questions Related to Interagency Coordination	SA % (n)	A % (n)	D %(n)	SD %(n)
My agency stresses and supports extensive interagency coordination and collaboration in my work with children.	44.9% (383)	49.2% (420)	5.2% (44)	.7% (6)
I am well prepared by training and support from my agency to understand and work with the processes of the Comprehensive Services Act for At Risk Youth and Families (CSA).	17.2% (143)	47.7% (396)	30.0% (249)	5.1% (42)
I provide regular reports about the services I provide to the referring, collaborating, and/or funding agency (e.g., DSS, CSA).	24.9% (202)	52.3% (424)	20.3% (165)	2.5% (20)
Other CSA partner agencies (DSS, schools, court services, etc.) are generally open to collaboration and coordination of services to the families I serve.	30.3% (256)	60.4% (510)	8.2% (69)	1.1% (9)
Staff at the other community agencies I work with have an accurate understanding about what the CSB can and cannot do.	6.3% (50)	50.4% (403)	38.0% (304)	5.4% (43)

- Three issues received the highest "disagree" ratings from staff:
  - Staff training and support for CSA roles (35.1% disagree)
  - Provision of regular reports to CSA referral sources (22.8%)
  - Other agencies have accurate understandings of what the CSB can and cannot do (43.4%)

Supervisors Interview

A total of 234 supervisors of children's services at CSBs were interviewed by OIG staff. Interviews were conducted in small groups, with the supervisors independently completing a confidential 15-question survey, followed by a short group discussion of issues.

Experience. CSB children's services supervisors average 6.4 years tenure in these roles, and 14.7 years overall of work with children.

Access in emergencies. When asked if families are able to reach CSB children's services providers when crises occur in the evenings, nights, or weekends, almost 70% said families must call the agency-wide CSB emergency services number. Smaller percentages noted that families can call their providers of home-based or therapeutic foster care services or that other staff, such as case managers, sometimes give families their home numbers.

Measurement of staff competency. Supervisors were asked, "What do you do to assess or measure competence in all the skills that direct services staff who work with children and families must have?" Answers detailed the conventional techniques of clinical and administrative supervision, quality analysis of records, staff training, assurance of degrees and experience before hiring, etc. Only 6.5% mentioned use of family feedback or interviews and just over 5% said they measured competency with objective methods.

Case management caseloads. Case management is the most widely available CSB service to children among CSBs. Supervisors were asked to estimate the current average caseload of their case managers, adjusted for full time equivalence. The statewide average of their responses was 30.3. When asked what they considered the ideal or target size for children's case management, the supervisor's average answer was 23.9. Overall, they estimated that an additional 109 case managers are needed statewide. In the staff interview, (p.21) the average of staff responses given to a question about caseload size was 21.4.

As was done with the overall Survey of CSB Child and Adolescent Services (OIG Report #148-07) and with the Stakeholders Interview phase of this review (see page 28), supervisors were asked, "What 2 or 3 services that are not now available in your community would do the most to prevent having to place children in residential programs outside your community?"

What 2 or 3 services that are not now available in your community would do the most to prevent having to place children in residential programs outside your community?	% of total comments
Increased use of in-home therapy, expanded models of services, eligible recipients	13.5%
24 hour crisis stabilization programs, local, family-based	11.2%
Increased availability of a range of local, community-based residential options such as foster care, professional parents.	9.9%
Respite care. Temporary respite from having the child in the home, to build parenting strengths, handle crises, etc.	9.5%

Expanded and more flexible funding for day treatment, especially school-based.	9.3%
Training and supports for families, especially on behavioral management techniques.	7.4%
Expanded outpatient mental health therapy services, evaluations, earlier interventions, more flexible funding	6.5%
Expanded substance abuse treatment services (intensive outpatient, detox, residential treatment)	4.2%
Increased availability of psychiatric and medication services	4.2%
Treatment of caregivers' mental health and substance abuse problems, family treatment	3.8%
After school and summer day treatment, and alternative day treatment for children suspended or expelled from school	3.6%
Other services under 3%: Mentoring, special child crisis intervention capabilities, expanded prevention and early intervention services, transition to adult services (MHSS), transportation, vocational preparation, cultural and linguistic capability, increased parental accountability.	<3%

Supervisors were also asked what had helped and what had hindered the development of child and adolescent services at their specific CSB.

What factors have been most helpful in developing services for children and families in your community?	**% of total comments**
Cooperation and partnership with stakeholders, CSA support, interagency support, creativity among community partners.	35.3%
Leadership shown by the CSB – some cite the director of child services, the executive director, and board.	17.9%
Community needs for services, expressed need from stakeholders, pressure from community to develop services, poverty.	7.8%
Talented, qualified, creative staff at CSB	7.1%
Grants from state, other sources	6%
Availability of Medicaid funding for children's services	4.3%

CSA funding to purchase services from the CSB	3.2%
Other factors noted less than 3% of total items: Non mandated money from GA, leadership from local government, input from families, partnering with universities, trainings provided to staff.	<3%

What factors have most hindered the development of services for children and families in your community?	**% of total comments**
Lack of flexible funding for children without Medicaid, CSA funding, or other insurance, Medicaid and/or CSA funding too restrictive, MDCD does not cover all needed services.	35.8%
Difficulty recruiting and retaining qualified staff (non-medical)	17.9%
Lack of cohesion and cooperation among agencies, CSA, and CSB, lack of local support, CSA preference for private providers, "turf issues"	13%
Transportation, large rural areas, families can't come in for services, home based services too expensive in rural areas.	11.1%
Lack of support from families, families do not seek/make use of services, need help themselves, do not cooperate	6.2%
Difficulty recruiting and retaining child psychiatrists	3.4%
Other factors noted less than 3% of total items: lack of priority for child services at CSB, lack of priority for child services at DMHMRSAS, state, agency structure limits child services, over-reliance on grants, fees, risky or unstable funding, loss of staff time due to administrative requirements, rigidity, lack of creativity.	<3%

Supervisors were asked, "What one or two changes do you think are most needed to improve child and family services in Virginia?" (Instructions asked them to extend their answers beyond "more money.")

"What one or two changes do you think are most needed to improve child and family services in Virginia?"	**% of total comments**
Expand types of eligible services and make funding more flexible, especially Medicaid, to meet needs of family members, non SED children, at risk children, prevention, non-mandated	30.1%

Increase community education, awareness, recognition of the need for children's services.	11.4%
DMHMRSAS, state increase priority for children's services, achieve parity with support for adult services	9.8%
DMHMRSAS provide training for staff at CSBs, especially on EBP	5.8%
Find and retain more staff and more qualified staff to work in children's mental health services,	5.8%
Provide accountability and supports for parent involvement in services for their children and themselves	5.8%
Assist communities with providing psychiatric services, work with universities	4.3%
Improve coordination among CSA partner agencies at state level as well as at local level	4%
Decrease paperwork requirements on CSB service providers	4%
Improve transportation or provide resources to counter effects of large geographic areas and/or traffic and families' lack of transportation, CSB expense of providing outreach services in these situations.	3.7%
Improve transition of children from schools to CSB-operated community services	3.1%
Other factors noted less than 3% of total items: create shared vision for system of care, create mandates for children's services at CSBs, mandate that the CSB be the provider of CSA services, improve monitoring of private providers, improve SA and MH cooperation at state and local level, more bilingual and culturally competent staff, vocational services.	<3%

Section IV – Stakeholders Survey

Process of Stakeholders Survey

The OIG developed a questionnaire that assessed impressions of CSB services held by staff from CSA partner agencies from each city and county in Virginia. The 26 question survey focused on:

- Views of CSB as a provider of MH, SA, and MR services to children
- Views of CSB as CSA partner

- Community service needs and gaps
- Priority services to reduce/prevent residential placements

Contact information was obtained for all members (and alternates) of the CPMTs and FAPTs in all of Virginia's cities and counties. Over 1500 persons received emailed invitations from the Inspector General to participate in a survey about CSB mental health, intellectual disabilities, and substance abuse services and the needs of each community. The invitation contained a link to the OIG website to access the survey online. The survey was anonymous and confidential. 520 persons responded to the invitation and completed the 26-question survey. A complete report of the results of the survey is found in the appendix of the online version of this report at the OIG website.

Respondents represented a wide range of community partners and CSA representatives.

Organization Represented	Response %	Response N
Department of Social Services	28.4	145
Public schools	15.1	77
Juvenile and Domestic Relations Court services unit	11.4	58
Health Department	6.7	34
Private provider	9.2	47
Family member	2.4	12
Local governmental official	6.7	34
Child advocacy organization	2.0	10
State agency	5.7	29
Other	12.5	64
Answered question		510
Skipped question		10

Stakeholders Interview

Respondents were asked to state their agreement or disagreement with a variety of statements concerning their impressions of CSB children's services, using a 5-point Likert scale of Strongly Agree, Agree, Disagree, Strongly Disagree, and Not Applicable/Don't Know. For the presentations below, responses are collapsed into Agree or Disagree. If the sum does not add to 100%, the balance is N/A.

A rating average is also computed for the responses for each question. Strongly Agree is rated 1, Agree is 2, Disagree is 3, and Strongly Disagree is 4. Thus the lower the mean or average of ratings, the more favorable is the judgment of stakeholders on that issue.

Responses have been grouped into three categories:

1. Impressions of the CSB as a mental health services provider for persons referred by stakeholders,
2. Impressions of the CSB as a provider of specialized services,

3. Impressions of the CSB as a services planning and collaboration partner in the CSA process.

1. Impressions of Stakeholders of the CSB's Provision of Mental Health Services to Children they have Referred	**Agree %**	**Disagree %**	**Rating Average** (Range – high of 1 to low of 5)
CSB services for children involve families in the assessment of needs and the development of treatment plans for their children when possible.	78.3	10.7	2.02
The CSB provides services to children and families that reflect Evidence Based Practices.	68.8	16.6	2.16
My local CSB has state-of- the-art knowledge and expertise about child and family mental health issues.	62.9	34.9	2.35
Overall, CSB mental health services for children have good treatment outcomes.	57.3	35.3	2.40
I am usually satisfied with the results when seeking services from the CSB for children with mental health needs.	60.7	37.4	2.42
The CSB keeps me informed about the progress of treatment for children that are referred to them by our agency.	48.0	37.0	2.47
My CSB is able to provide services not only those children and families who have Medicaid, FAMIS, or CSA funding, but also to those who do not have these resources.	54.5	30.2	2.48
I find that most of the children I see with mental health needs can be served by the CSB.	44.0	51.0	2.62
Access to CSB child mental health services is timely and efficient.	33.1	65.1	2.92
Average rating			**2.40**

- The highest level of stakeholder satisfaction with the CSB as a provider deals with the CSBs' efforts to involve families in the development of services for their children – a 2.02 average rating.

- The two statements with the lowest level of stakeholder satisfaction with the CSB as a provider concerns the CSBs' (1) "Access to CSB child mental health services is timely and efficient." – a 2.92 average rating and (2) "I find that most of the children I see with mental health needs can be served by the CSB." – a 2.62 average rating.

- These are the lowest ratings given to CSBs and are the only two ratings on the survey for which the percentage of negative rating is over 50%. These ratings reflect many written comments in the Stakeholders Survey that CSB waiting lists, due to limited service capacity, are a major problem in meeting the mental health needs of children and families. Comments relate to the reality or perception that many CSBs limit services to children with severe emotional disturbance and/or with Medicaid.

2. Impressions of Stakeholders of the CSB as a Provider of Specialized Services	**Agree %**	**Disagree %**	**Rating Average**
The CSB does a good job of meeting the needs of children with mental retardation.	54.9	27.9	2.33
When a child experiences a psychiatric or behavioral crisis, the CSB Emergency Services program is a responsive and effective means to keep the child and the community safe.	52.2	43.0	2.48
The CSB does a good job of meeting the needs of children with substance abuse problems.	38.6	46.3	2.59
The CSB does a good job of meeting the needs of children with autism and other developmental disorders.	39.6	42.6	2.62
Average rating			**2.51**

- The highest level of stakeholder satisfaction with the CSB as a provider of specialized services concerns the CSBs' efforts to serve children with intellectual disabilities – a 2.33 average rating.

- The lowest level of stakeholder satisfaction with the CSB as a provider of specialized services concerns the CSBs' efforts to serve children with autism and other developmental disorders – a 2.62 average rating. This is tied with "Most of the children I see with mental health needs can be served by the CSB" as the second lowest rating of all categories.

- N/A or Do Not Know ratings were higher for these items than for most, probably because fewer people have experience with these services for special populations.

- The relatively low rating for provision of substance abuse services is significant, as the CSB is the only provider of out patient substance abuse services for children without health insurance in many communities.

3. Impressions of Stakeholders of the CSB as a services planning and collaboration partner in the CSA process	Agree %	Disagree %	Rating Average
The CSB collaborates with my agency in jointly planning and providing services to individual children with mental health needs.	64.8	31.1	2.23
There is a common vision among local agencies about a systems of care model and serving kids in families, rather than in congregate care settings.	65.5	30.7	2.27
The CSB is open to criticism and input about its services from other agencies.	55.0	37.3	2.40
Staff at our agency understand the regulations and parameters that guide the CSBs role and services.	57.9	38.9	2.40
The CSB does a good job of explaining its strengths and limitations to our staff and the community of agencies with which I work.	52.9	43.1	2.43
Staff at the CSB understand the regulations and parameters that guide our agency's role and services.	55.2	39.4	2.44
The CSB is an effective partner with my agency and the CSA in increasing the availability of mental health services for children and families through grants, contracts, and other means.	53.4	41.2	2.45
The CSB is a vigorous and effective partner in our local CSA system.	62.6	35.0	2.47
My local CSB is usually the provider of choice for children who are served by our community's FAPT/CPMT processes.	54.2	49.4	2.57
Average rating			**2.41**

- The highest level of stakeholder satisfaction with the CSB as an interagency partner concerns shared understandings among local agencies about systems of care model – a 2.27 average rating.

- The lowest level of stakeholder satisfaction with the CSB as an interagency partner concerns whether the CSB is the provider of choice for FAPTs and CPMTs – a 2.57 average rating.

- Generally, the ratings are positive, all over 52% favorable.

Stakeholders Opinions of CSB Strengths

The 520 respondents to the Stakeholder Survey were asked the question, "What does the CSB do well?" about the CSB that serves their locality. While not everyone responded to this question, there were a total of 454 comments made by stakeholder respondents. OIG staff analyzed the text comments and categorized them into separate statements of

quality. The following table displays the frequency with which each statement was noted by respondents.

What does the CSB do very well?	Number of times the comment was noted	% of total comments
The CSB communicates, cooperates, and collaborates well with partner agencies in the community. Helps improve system of care.	67	14.8%
The CSB provides effective services for children. Many excellent services to meet community needs.	50	11.0%
The CSB is a leader and expert on mental health services for the community. Highly skilled clinical staff – knowledgeable, competent, qualified.	35	7.7%
The CSB does a good job of providing specialized services to children with developmental and intellectual disabilities, and with early intervention programs.	33	7.3%
The CSB provides services regardless of the family's ability to pay. Services targeted to indigent population. Good at finding funding, stretching funds, etc.	31	6.8%
The CSB is an active partner in the CSA process, good representation or facilitation of FAPT/CPMT activities.	31	6.8%
Substance abuse evaluations and treatment and prevention services are good, considered effective.	31	6.8%
Positive statements about working with CSB staff - work well with families, listen, have good rapport, accessible, easy to work with, informed, client-oriented, friendly.	22	4.8%
Case management services are valued.	19	4.2%
Other positive observations at 4% or less: emergency services, assessments/diagnoses, adult services, share resources/provide training, long term services, psychiatric/medication services, day treatment.		<4%
Negative observations. "Nothing," no progress in years, focus on adults, not timely in response, understaffed, not open to working with CSA, highly restrictive entry criteria,	23	5.1%

inconsistent.		
Not applicable, don't know, don't work with CSB.	13	2.9%

Stakeholders Opinions of CSB Weaknesses

The 520 respondents to the Stakeholder Survey were asked the question, "What is your biggest criticism of the CSB?" While not everyone responded to this question, there were a total of 454 comments made by stakeholder respondents (this is exactly the same number as positive comments, shown above).

What is your biggest criticism of the CSB?	Number of times the comment was noted	% of total comments
There is a waiting list for CSB services. Access/intake are slow, not client-friendly, services take a long time to start after first contact.	107	23.6%
The CSB does not offer the comprehensive range of services needed by children and families in our community (most responses noted that the CSB lacks funding to do so).	42	9.3%
The CSB is not collaborative with other agencies, poor communication, does not understand other agencies' roles.	36	7.9%
The CSB does not provide adequate substance abuse evaluation and treatment services for children and adolescents, SA services are of poor quality.	26	5.7%
The CSB is overly reliant on Medicaid. Eligibility for persons without insurance, Medicaid, or CSA funding is very limited; co-pays are excessive. Service eligibility is limited, excludes many referrals.	23	5.1%
CSBs are understaffed, staff stretched too thin to do well, too much paperwork.	21	4.6%
Criticism of staff qualifications, knowledge, supervision, reputation, energy, commitment.	20	4.4%
Emergency services are slow to respond, not helpful for children and families in crisis except for hospital screening.	20	4.4%

Other negative observations at less than 4% each: Over reliance on case management. High staff turnover, frequent change of worker assigned to families/agencies. Lack of outpatient counseling services and evaluations services for children. Limited access to psychiatry/medication services. Limited CSB services in certain communities or jurisdictions served by the CSB, e.g., smaller, rural counties in the CSB service area. Lack of Evidence Based Services, services not innovative. Inadequate services for children with intellectual disabilities. CSB services, eligibility, structure are not understood, frequently change. CSB is quick to close cases for non-compliance. Treatment for parents is separate from children, difficult to obtain. Poor executive leadership. Inconsistent participation in FAPT/CPMT. Inadequate services for children with autism/Asberger's. Limited services for adolescents with serious mental illnesses, poor transition to adult services.		<4%
No criticism, "none"	13	3.1%

Services Needed to Reduce Residential Placements

Stakeholders were asked, "What service that is not now available in our community, would do the most, if it were available, to help prevent out of community residential placements". There were a total of 489 responses to this question.

"What service that is not now available in our community, would do the most, if it were available, to help prevent out of community residential placements"	**Number of times the comment was noted**	**% of total comments**
More home-based intensive services to children and families, "wrap-around" services.	74	15.1%
Increased availability of substance abuse services for children – outpatient and intensive outpatient.	53	10.8%
More residential options in the local area, including group homes, therapeutic foster care, improved and expanded foster care, foster care for families, professional parents, sponsored placements.	41	8.4%
Increased availability of mental health outpatient and	37	7.6%

intensive outpatient services for children.		
Broader range and increased availability of assessment and evaluation services	35	7.2%
Educational, support, and treatment services for families. parents.	29	5.9%
Community-based treatment for sexually acting-out, behavior problem children	23	4.7%
Mentoring services – services that match a behavioral aide, coach, "buddy" with children receiving services.	21	4.3%
Respite services for children in crisis, parents needed break from care of children with difficulties	21	4.3%
Crisis intervention, crisis stabilization services, crisis supports in the home.	20	4.1%
Shorten the wait for services, improve access to services.	18	3.7%
Support and therapy groups for children, e.g., anger management.	16	3.3%
Increased access to psychiatric care.	16	3.3%
More day support/day treatment programs	15	3.1%
Other services listed less than 3% of the total listed: More case management, more service access for children without Medicaid or other funds, more services delivered in the schools, more team approach across agencies, additional services for children with autism, anti-gang services, improve overall service quality, sheltered employment and vocational opportunities, residential SA treatment, Spanish language services.		<3%

Section V – Findings and Recommendations

A. Findings related to service availability

1. Families seeking services for children and adolescents with mental health service needs face enormous differences in service availability depending on where they live. Whether measured by expenditures, staffing, or percentage of child population served, the availability of mental health services for children and

adolescents offered by CSBs varies widely among communities. Across the 40 CSBs:

- Per capita funds budgeted for services ranges from a high of $258.36 to a low of $0.96 per child. Highest is 300 times the lowest.
- Staff to community population ratios range from the richest staffing at 1 staff member to 237 child population to the leanest staffing at 1 staff member to 15,380 population. Richest is 40 times the leanest.
- Service penetration rate in the community ranges from a high of 1.21% of the population of children and adolescents in the community to a low of 0.38% of the population. Highest penetration rate is 15 times the lowest.

2. Few CSBs offer a large array of child and adolescent services with sufficient capacity to meet the needs of their community. Many CSBs have very limited services available to children. A few have virtually no service system designed especially for children.
   - Analysis of service availability data provided by CSBs[7] showed no CSB offers all 48 of the services listed in the survey and only one CSBs offer a complete array of 12 *key* services, and many offer only a few.[8]
     - The average number of services offered by all CSBs is 7.6 (of 12 key services). The range is from 4 services to 12.
     - 12 CSBs (30%) of CSBs offer only 6 or fewer services.
     - 6 CSBs (15%) of CSBs offer 10 or more services.
     - Only one (Hampton-Newport News CSB) offers all 12.

   - A further analysis was conducted to assess the availability of 5 highly specialized, high impact services that are considered (by stakeholders, CSB staff, OIG) to offer the most promise to serve children with severe needs and help prevent residential placement. These services are specialized children's emergency services, crisis stabilization, home-based therapy, school-based day treatment, local residential services.
     - Only 2 CSBs (5%) offer all 5 intensive services.
     - The average number of intensive services offered by all CSBs is 1.7, with a range from 0 to 5.
     - 7 (17.5%) CSBs offer none. 11 (27.5%) offer only one of the intensive services.

3. Child and adolescent services at CSBs are mostly full to capacity, resulting in long waiting periods for new persons to access services. The average wait for all services, from all CSBs that reported was 26 days.

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[7] Data on service availability was provided to the OIG for publication in **OIG Report # 148-07 "Survey of Community Services Board Child and Adolescent Services,"** published on the OIG website (www.oig.virginia.gov) on March 31, 2008. This data was combined and selected from 48 separate services to a core group of 12 services for this analysis. The 12 key services are the following: specialized children's emergency services, crisis stabilization, evaluations for CSA services, psychiatric/medication, office-based MH therapy, office-based SA therapy, MH, MR, and SA case management, home-based therapy, school-based day treatment, local residential services.

[8] A table showing the availability of the key services by CSB is found on page 44 of this report.

- The average wait for outpatient services is 30.0 days.
- The average wait for psychiatry services is 31.2 days.
- The average wait for intensive home based services is 21.3 days.
- The average wait for case management services is 20.7 days.

4. Representatives from stakeholder agencies express dissatisfaction with the levels of CSB service availability in their communities. Specific areas of concern include the following:
   - Wait time for access to services is too long.
   - The wide array of services that are needed to serve children is not available.
   - Services to children with substance abuse needs and autism spectrum disorders are inadequate.

5. Access to services for uninsured families and those that are not eligible for a dedicated source of funding for children and adolescents is extremely limited.

B. Findings related to service funding

1. Medicaid is the largest source of funding in CSB budgets for child and adolescent services. Statewide it composes 47.9% of funding for all three disabilities combined. For mental health services Medicaid makes up 54.1% across the state.

2. The majority of the CSBs that have developed more extensive systems of services for children have done so through the use of Medicaid, and not through special grants or CSA funding. The six highest per capita funded CSBs average 72% of their funding for mental health services from Medicaid. It is important to note however that 30% of the CSBs receive 10% or less of their funding for mental health services from Medicaid.

3. State general funds and local funding make up a comparatively small portion of total funds for child and adolescent services statewide. Total funding statewide includes 11.9% state funds and 17% local dollars for all three disabilities. For CSB mental health budgets, state funding is 10.7% and local funding is 12%.

4. CSA funds paid to CSBs for purchase of services make up a very small portion of CSB budgets for mental health services at only 8.6%. The budgets of 72% of the CSBs include less than 10% of their funding from CSA.

C. Findings related to service quality

1. Parents/caregivers of children receiving services at CSBs report very high levels of satisfaction with the CSB services their children are receiving.
   - All interview questions received a majority positive response from families.
   - Ratings ranged from 84.6% positive responses to 99.4%.

2. Family level of involvement with CSB staff in the planning and provision of services is quite high. Families and stakeholders confirmed this involvement.

- 88.6% of family members said they were involved with the development of their child's treatment plan.
- 78.3% of agency stakeholders agreed that CSBs involve families in the planning and provision of services.
- OIG review of records showed good to excellent parental involvement in 82.8% of cases.

3. In the majority of cases reviewed, CSB involvement with and collaboration with other agencies was limited or did not occur.
   - 28.4% of records reviewed show very little or no interagency cooperation or communication.
   - 58.8% of records showed some cooperation, but not active collaboration.
   - Only 9.8% showed true "system of care" collaborative approaches with community partners.

4. Progress toward treatment goals is generally good for services provided by CSBs.
   - OIG review of records showed improvement and progress toward goals in 62.2% of cases reviewed.
   - 84.6% of family members said improvement occurred in the issues that brought the child into services.
   - 57.3% of agency stakeholders said there have been good treatment outcomes in children served by the CSB.

5. CSB assessments for co-occurring substance abuse needs in children receiving mental health services were not found to be comprehensive. When substance abuse was identified, treatment goals related to substance abuse were present in approximately half of the cases.

6. Few CSBs offer comprehensive, formal programs that have broad national recognition as "evidence-based practices" (EBP). Many CSBs, however, utilize elements and principles that are found in EBP literature.

7. Stakeholder ratings of multiple measures of overall CSB service quality were modestly positive (54.4% positive), but with dissatisfaction shown by a large minority of respondents (38.2% negative).

8. Access to services for parents and caregivers of children and coordination of children's services with services to parents is not adequate.

D. Findings related to CSA and interagency coordination

1. CSBs are not the provider of choice for community-based CSA-funded mental health services in many communities. Only just over half of stakeholder respondents say their CSBs fulfill this role.

2. CSA funds are only a minor source of support for children’s services at CSBs. Average CSA funding for CSBs is only 6.8%. 42% of CSBs report receiving no CSA funding. The highest level of CSA funding for any CSB is 33%.

3. Many agency stakeholders say their CSBs do not adequately make clear what services they offer or who is eligible for services, and they express dissatisfaction with the limitations on service availability.

4. The leading factor CSBs cite that has helped them develop children’s services is the support and cooperation of the local CSA CPMT and other community agencies to work together on meeting community needs.

5. Over half the CSBs (55%) say they have developed one or more specific services to help improve the provision of services offered to children in the CSA process. These services include intensive care coordination and utilization management.

E. Findings related to CSB workforce issues

1. CSBs have great difficulty recruiting and retaining qualified staff to provide children’s services. They list it as the second highest factor that has hindered development of services.

2. CSBs have inadequate psychiatric time to meet the needs of the children in their communities. Only 12.5% of the CSBs report that they have adequate psychiatric resources. CSBs estimate that an additional 25 FTE psychiatrists are needed statewide. The average wait time to see a psychiatrist for children who are currently being served by CSBs is 37 days.

3. The leading suggestion from CSBs for what can be done at the state level to improve the development of children’s services is the provision of training, especially on evidence-based, effective services to children and families. (Note: Respondents were asked to list factors other than simply “increase funding.”)

4. CSB staff describes morale on their teams as very high.

F. Findings related to preventing out-of-community residential placements

1. Only partial agreement exists among CSBs and the agency stakeholder community about the services that are most needed to prevent out-of-community residential placements.
    - CSBs rated crisis stabilization programs, community-based residential alternatives such as improved foster care, and school-based therapeutic day treatment as the top three needed services.
    - Agency stakeholders rated community-based residential alternatives, increased and improved home-based services, and increased and improved substance abuse treatment as their top three.

G. Overarching findings related to the development of CSB services

Three primary and interdependent factors were identified by the OIG as the leading determinates of whether or not CSBs have developed more comprehensive systems of services that meet the needs of families and stakeholder agencies:

1. The extent to which leadership has been exercised to place a priority on the development of children's services, to develop community and interagency relationships, to use creativity and skill in making use of funding from Medicaid, grants, and CSA. This leadership comes from CSB board members, executive director, leader of children's services, or some combination of these persons.
2. Limited availability of funding to provide services for uninsured families and children that do not qualify for CSA and other categorical programs for children.
3. Relatively limited use of CSBs by local communities to provide services that are reimbursed by CSA.

Recommendations

1. It is recommended that DMHMRSAS lead an interagency process to develop a comprehensive plan for the provision of publicly supported, community based mental health, intellectual disability and substance abuse services for children, adolescents and their families. The objective of this plan will be to determine the base level of services that should be available in every community, clarifying the array of services and per capita capacity that will be needed. The plan should leverage all available sources of funds such as Medicaid, CSA, special grants to support services and then estimate the level of additional state funds needed to achieve a balanced, flexible funding base to address the needs of those families that are uninsured or not eligible for other dedicated sources of reimbursement. The planning process should include input from relevant state and local agencies and the private provider community. The target date for the completion of the plan would be no later than July 1, 2009. To assure that adequate staffing and planning expertise can be dedicated to the development of this plan, it is recommended that DMHMRSAS seek the assistance of experts with experience in planning for systems of MH/ID/SA services for children, adolescents and families to supplement departmental staffing.

It is further recommended that DMHMRSAS present the plan to the General Assembly clarifying the level of support that can be anticipated from non-state sources and identifying specific needs from state sources to enable responsible expansion of services in the first two years of implementing the plan.

It is further recommended that in subsequent legislative cycles DMHMRSAS provide a report to the General Assembly that claries progress achieved in expanding services for children, adolescents and children according to the plan, documents success in leveraging funds from non-state sources, and requests annual increases in state funds that will assure solid, responsible growth of a new system of services based on the comprehensive plan.

2. It is recommended that every CSB appoint a single person to lead services for children and adolescents.

3. It is recommended that DMHMRSAS provide leadership in determining the areas of training and staff development that are needed to increase consistency in the quality of services delivered by CSBs statewide to children and adolescents. It is further recommended that DMHMRSAS develop a plan for assuring that this training is made available to CSB staff.

4. It is recommended that the CSBs that have developed the more comprehensive systems of services for children and adolescents share information with other CSBs regarding the organizational, interagency collaboration, staffing, and funding factors that have enabled their success. DMHMRSAS and/or the Virginia Association for Community Services Boards could facilitate this educational effort.

5. It is recommended that CSBs evaluate their methods for assessing substance abuse to assure comprehensive evaluation of the need for substance abuse treatment, particularly when the identified problem is mental health or intellectual disability related.

DMHMRSAS Response:

I am writing to thank you for sending me the final Office of the Inspector General Report "Review of Community Services Board Child and Adolescent Services." I appreciate the broad scope of the report and the work you and the staff of the Office of the Inspector General have done over the past year. I will be discussing the findings and recommendations of the report with other DMHMRSAS leadership in the coming weeks.

Of particular interest is how our agency can work in partnership with the community services boards and their interagency teams to utilize the findings related to service availability, funding, and interagency coordination to improve and build the service array for children with behavioral health problems. Your inventory of service availability documents the wide diversity in the level of community services, noting some communities with strong systems, and others with very limited services.

The report is timely in that it coincides with, and its findings are consistent with, many efforts at the state and local level to make improvements to the child serving system, including the First Lady's For Keeps Initiative, the Virginia Council on Reform, and legislation passed in the 2008 General Assembly session affecting the Virginia Comprehensive Services Act and the Community Services Boards. The development of a wide array of community-based services is critical to the success of these efforts. The information in your report will be a most useful tool in planning for these system changes. Once again, I thank you and your staff for this very important work.

James S. Reinhard, M.D.
Commissioner, DMHMRSAS

CSB	ES Child (Spec)*	Crisis Stab*	CSA Evals	MH Psych.	Office Based MH Therapy	Office Based SA TX	MH Case Mgmt	MR Case Mgmt	SA Case Mgmt	Home-Based Therapy*	School Based Day Tx*	Residential Services*	Number of MH Services Available	Number of Intensive Services*
Alexandria		1	1	1	1	1	1	1	1	1			9	2
Alleghany Highlands				1	1	1	1	1	1	1			7	1
Arlington	1	1	1	1	1	1	1	1	1				9	2
Blue Ridge	1		1	1	1	1	1	1	1	1	1		10	3
Central VA	1	1		1	1	1	1	1	1	1	1	1	11	5
Chesapeake				1	1	1	1	1	1				6	0
Chesterfield				1	1	1	1	1	1	1	1		8	2
Colonial				1	1	1	1	1	1	1			7	1
Crossroads				1	1	1	1	1	1				6	0
Cumberland Mt.				1	1	1	1	1		1			6	1
Danville-Pitts		1		1	1	1	1	1	1	1			8	2
Dickenson			1	1	1	1	1		1				6	0
District 19				1	1	1	1	1			1		6	1
Eastern Shore	1	1		1	1	1	1						6	2
Fairfax-Fall Church		1		1	1	1	1	1				1	7	2
Goochland Pow				1	1	1		1					4	0
Hampton NN	1	1	1	1	1	1	1	1	1	1	1	1	12	5
Hanover	1		1	1	1	1	1	1	1	1	1		10	3
Harrisonburg-Rock				1	1	1	1	1					5	0
Henrico				1	1	1	1	1	1	1			7	1
Highlands				1	1	1	1	1		1			6	1
Loudoun			1	1	1	1	1	1	1	1			8	1
Middle-Penn NN	1	1	1	1	1	1	1	1		1			9	3
Mt. Rogers			1	1	1	1	1	1		1	1		8	2
New River Valley	1	1	1	1	1	1	1	1	1		1		10	3
Norfolk					1	1	1	1					4	0
Northwestern				1	1	1	1	1	1	1	1		8	2
Piedmont			1	1	1	1	1	1	1	1	1		9	2
Planning District 1	1	1	1	1	1	1	1	1	1	1		1	11	4
Portsmouth				1	1	1	1	1	1	1			7	1
Prince William			1	1	1	1	1	1	1	1	1		9	2
Rapp-Area			1	1	1	1	1	1	1	1	1		9	2
Rapp-Rapidan			1	1	1	1	1	1	1				7	0
Region Ten				1	1	1	1	1		1	1		7	2
Richmond		1	1	1			1	1	1	1	1	1	9	4
Rockbridge Area			1	1	1	1	1	1		1	1		8	2
Southside				1	1	1	1	1		1			6	1
Valley				1	1	1	1	1		1	1		7	2
Virginia Beach			1	1	1	1	1	1	1		1		8	1
Western Tidewater				1			1	1	1		1		5	1
Total	9	11	18	39	38	38	39	38	26	26	18	5		

Table title: **Children's Service Availability by CSB (January 2008)**

* Intensive services include (B) Emerg. Services (Designated Children's Service), (C) Crisis Stab., (K) Home-Based Therapy, (L) School-Based Day Treatment, (M) Residential Services

Section VI.

Appendix

Record Review Instrument:

Office of the Inspector General
CSB Child and Adolescent Services Record Review

CSB [ ][ ][ ] Name of Child ____________ OIG Reviewer ____________ Date [ ][ ]-[ ][ ]-[ ][ ]

Service Type Reviewed: ○ Case Management ○ Outpatient Therapy ○ In-Home Therapy ○ Day Treatment

1. Child is:
   - ○ living with natural parents, one parent, relative(s), or adoptive parents
   - ○ living in placement with foster or other surrogate parents
   - ○ other ____________

2. Family-Directed Treatment Planning (review last year)

Review the assessment, annual and quarterly treatment plans, and progress notes for evidence of family involvement in assessing the problems and developing and adjusting the treatment plan. For older adolescents when appropriate, the child's involvement may be stressed more. Treat foster family as family if there is no contact allowed with natural parents.	*Pick one only*
There is little or no record of the family's involvement with the ISP. The assessment and the plan are based on the clinician's or referring agency's view of needs. Family preferences, goals, strengths, and solutions do not strongly influence the plan and if present at all, are an add-on. Focus on family deficits not strengths.	○
There is evidence that the CSB staff member elicited and received input from the family about the plan. The plan shows effort to obtain or include input by the family. There is some statement of family's preferences, goals, strengths, and solutions. Family present at meeting, signs treatment plan. Plan is a shared effort between staff and family.	○
The plan expresses the family's goals, a family-focused plan, with the staff member in a support and resource role. Caregivers are actively involved in the child's treatment. The plans express the family's wishes and preferences and aims at family-strengthening solutions.	○
It is apparent to the OIG inspector that caregiver involvement is impractical, not possible, or clinically irrelevant or inadvisable. Equivalent to "not applicable." Parent behavior makes involvement impossible. CPS referral.	○

3. Holistic Approach - focus on the whole child, in his or her environment (review last year)

Is there evidence of a holistic approach to treatment? Is the child seen as a whole person, in family, school, and community environments, with an overall goal of achieving stability and success in the community, avoiding residential placement, and building life strengths in all areas (behavioral, school, social, family strengthening, health, social network, etc.)	*Pick one only*
Clinical focus is primarily on symptoms and behaviors with little attention to a comprehensive view of the child as a whole person (with health, school, social, family needs and issues). Assessment is piecemeal and symptom-focused, rather than child and family-focused. The goals are for specific behavior change, rather than strength-building for success in the community. A "band aid" approach. A comprehensive assessment tool may be incomplete or partially complete.	○
Clinical focus, assessments, treatment planning, and interventions are more comprehensive than above, but less comprehensive than below. A partially filled-in picture of a whole child and relevant family, school, and community systems is evident, but assessments and interventions are not comprehensive, multi-faceted, and systemic. Some team input.	○
Clinical focus includes a comprehensive, holistic, multi-faceted assessment of the child, with symptoms or behaviors seen in a context of a whole person, who is in family, school, and community systems. Assessments, clinical interventions and goals address health, family, social, and school needs and capabilities. Team input to assessment/plan. A "whole child" approach.	○

4. Interagency - Intersystem Coordination (review last year)

Is there evidence of a coordinated approach to treatment, with consultation, input, involvement, and coordination with family, extended family, referring agency, relevant agencies and systems in the child's life? Include schools, Departments of Social Services, court services units, healthcare, social or recreational organizations, etc.	*Pick one only*
The CSB service operates substantially alone. Minimal consultation or communication. Little to no evidence of collaboration or connection to other services. Focus is on the CSB worker and the child, parents.	○
The CSB service operates *cooperatively* with a few relevant agencies (other CSB services, referral source, dialogue with schools), with appropriate communication and sharing of information, but the service is CSB driven and cooperation is secondary. FAPT process, with some cooperative planning, but still segmented responsibility among agencies.	○
The CSB services are *collaborative* with other key agencies - planned and executed as a team, with harmonious and complementary parts and roles. Frequent, open communication, joint planning, joint or closely collaborated action.	○
Interagency collaboration is not applicable to this service.	○

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Family Agency Contact Interview:

Office of the Inspector General
CSB Adult Child and Adolescent Services Review

Family and Agency Contact Interview

Date ☐☐-☐☐-☐☐ CSB ☐☐☐ Child ________________

1. Family Contact? ☐ Name ________________ Phone Number ____________

2. Agency Contact? ☐ Name ________________ Phone Number ____________

3. Agency Represented:

○ DSS ○ Schools ○ J & D Court ○ Health ○ Other________

4. **Family or Caregiver Survey**. Indicate respondent's choice by using this scale:
SA= Strongly Agree; A= Agree; D= Disagree; SD= Strongly Disagree; NA= Not Applicable, Not Experienced.
Fill in the bubble of the choice that most closely represents your view.

	SA	A	D	SD	NA
4a. CSB staff members treat my child with dignity and respect.	○	○	○	○	○
4b. CSB staff members speak to my child and me in a way we understand.	○	○	○	○	○
4c. My child and I actively worked with the staff members to develop a treatment plan that accurately addresses my child's current problems, issues and/or behaviors.	○	○	○	○	○
4d. The CSB staff members we work with understand our problems and ask my opinion about what kind of help we want and need.	○	○	○	○	○
4e. The CSB staff member we work with has the skills, knowledge and abilities to help my child.	○	○	○	○	○
4f. The CSB staff member answers or returns my calls in a reasonable time.	○	○	○	○	○
4g. I am satisfied with the amount of time the staff member spends with my child.	○	○	○	○	○
4h. My opinion (whether good or bad) regarding my child's treatment is important to the staff member and is heard.	○	○	○	○	○
4i. We are getting as much help as we need at this time for my child.	○	○	○	○	○
4j. Our staff member is open and honest with us.	○	○	○	○	○
4k. Overall, my child and/or family benefits from the services being provided.	○	○	○	○	○
4l. Overall, I have noticed improvement in the issues and/or behaviors that brought my child into services.	○	○	○	○	○
4m. Overall, I am satisfied with the services that my child is receiving.	○	○	○	○	○

5. **Agency Contact Survey**. Indicate respondent's choice by using this scale:
SA= Strongly Agree; A= Agree; D= Disagree; SD= Strongly Disagree; NA= Not Applicable, Not Experienced.
Fill in the bubble of the choice that most closely represents your view.

	SA	A	D	SD	NA
5a. CSB staff members treat the children they work with with dignity and respect.	○	○	○	○	○
5b. CSB staff members speak to children and family members in a way they understand.	○	○	○	○	○
5c. The CSB staff member involves caregivers in the development of a treatment plan that accurately addresses the child's current problems, issues and/or behaviors.	○	○	○	○	○
5d. The CSB staff member involves me as a collaborating agency in the development of a treatment plan that accurately addresses the child's current problems, issues and/or behaviors.	○	○	○	○	○
5e. The CSB staff member keeps me informed about treatment progress with the child.	○	○	○	○	○

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Staff Interview:

36972

Office of the Inspector General
CSB Adult Child and Adolescent Services Review
Staff Interview

Date [ ][ ]-[ ][ ][ ]-[ ][ ]   CSB [ ][ ][ ]

1. The service in which you work:

○ Case Management ○ Outpatient Therapy ○ In-Home Therapy ○ Day Treatment ○ Other ______________

2. How long have you been employed in your current job, serving essentially same caseload? [ ][ ] years [ ][ ] months

3. How much experience have you had, including this job, in a clinical position with children? [ ][ ] years [ ][ ] months

For case management only:

4. How many children are in your current caseload? [ ][ ][ ] What percentage of a FT position do you spend in CM activities? [ ][ ] %

5. Estimate the percentage of your time each week that is taken up by documentation requirements (paperwork)? [ ][ ] %

Indicate your agreement with the following statements. If a statement is not applicable, leave it blank: SA= Strongly agree; A= Agree; D= Disagree; SD= Strongly disagree.	SA	A	D	SD
My agency stresses and supports extensive interagency coordination and collaboration in my work with children.	○	○	○	○
My agency provides the training I need to be as effective in my job as possible.	○	○	○	○
The expectations placed on me by my agency are clear and consistent.	○	○	○	○
Child services are a high priority of the leadership of my CSB.	○	○	○	○
My caseload is too large for me to do all that I would like to do for the children I serve.	○	○	○	○
The paperwork I must maintain is a burden and it interferes with service provision.	○	○	○	○
Our agency allows families (or surrogate families, if child is in placement) enough choice and self-determination in developing services for their children.	○	○	○	○
My agency has provided me with specific training regarding family-centered services within the past two years.	○	○	○	○
My agency has provided me with specific training regarding Evidence Based Practices for children within the past two years.	○	○	○	○
I am well prepared by training or experience to deal with co-occurring *mental health* and *substance abuse disorders* among the children and families I serve.	○	○	○	○
I am well prepared by training or experience to deal with co-occurring *mental health* and *mental retardation disorders* among the children and families I serve.	○	○	○	○
I am well prepared by training and agency supports to relate to the cultural diversity of my clients (e.g., race, language, etc.)	○	○	○	○
I am well prepared by training and support from my agency to understand and work with the processes of the Comprehensive Services Act for At Risk Youth and Families (CSA).	○	○	○	○
I provide regular reports about the services I provide to the referring, collaborating, and/or funding agency (e.g., DSS, CSA).	○	○	○	○
Other CSA partner agencies (DSS, schools, court services, etc.) are generally open to collaboration and coordination of services to the families I serve.	○	○	○	○
My children's services team has good morale.	○	○	○	○
I receive effective, quality clinical supervision.	○	○	○	○
My job is professionally stimulating and satisfying.	○	○	○	○
I feel safe working out in the community or in the homes of the people I serve.	○	○	○	○

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Stakeholder Interview:

Office of the Inspector General
CSB Adult Child and Adolescent Services Review
Stakeholders Interview

Date [ ][ ]-[ ][ ]-[ ][ ]   CSB [ ][ ][ ]

1. Type of Stakeholder:

O FAPT member O CPMT member O CSA Coordinator O Family Member O Other ________________

2. Agency Represented:

O DSS O Schools O J&D Court O Health O Other________________

3. **Stakeholders survey**. Please use this scale to record your agreement with the following statements:
SA= Strongly Agree; A= Agree; D= Disagree; SD= Strongly Disagree; NA= Not Applicable, not experienced.
Fill in the circle of the choice that most clearly represents your view.

Please respond to the following statements with your degree of agreement.	SA	A	D	SD	NA
a. I am usually satisfied with the results when seeking services from the CSB for children with mental health needs.	O	O	O	O	O
b. My local CSB has state-of-the-art knowledge and expertise about child and family mental health issues.	O	O	O	O	O
c. My local CSB is usually the provider of choice for children who are served by our community's FAPT/CPMT processes.	O	O	O	O	O
d. The CSB collaborates with my agency in jointly planning and providing services to individual children with mental health needs.	O	O	O	O	O
e. The CSB is open to criticism and input about its services from other agencies.	O	O	O	O	O
f. The CSB is a vigorous and effective partner in our local CSA system.	O	O	O	O	O
g. The CSB keeps me informed about the progress of treatment for children that are referred to them by our agency.	O	O	O	O	O
h. Staff at our agency understand the regulations and parameters that guide the CSBs role and services.	O	O	O	O	O
i. Staff at the CSB understand the regulations and parameters that guide our agency's role and services.	O	O	O	O	O
j. The CSB is an effective partner with my agency and the CSA in increasing the availability of mental health services for children and families through grants, contracts, and other means.	O	O	O	O	O
k. CSB services for children involve families in the assessment of needs and the development of treatment plans for their chidren when possible.	O	O	O	O	O
l. The CSB provides services to children and families that reflect Evidence Based Practices.	O	O	O	O	O
m. Overall, CSB mental health services for children have good treatment outcomes.	O	O	O	O	O
n. Access to CSB child mental health services is timely and efficient.	O	O	O	O	O
o. There is a common vision among local agencies about a systems of care model and serving kids in families, rather than in congregate care settings.	O	O	O	O	O
p. The CSB does a good job of explaining its strengths and limitations to our staff and the community of agencies with which I work.	O	O	O	O	O

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Supervisor Interview:

Office of the Inspector General
CSB Child and Adolescent Services Review
Supervisor Interview

CSB: ______________________________*Date:*________________________

1. How long have you been in a position that supervises child and adolescent services at this CSB? _______years
2. How many years of service have you had overall in your career, as a provider or supervisor of clinical service for children and adolescents, including your current job? ______ years
3. What do you do to assure or increase family involvement and family-centered services in your programs?
4. What do you do to assure interagency coordination and collaboration in the provision of your services to children and families?
5. What provision is made for families to reach their case manager, clinician, or other staff that they know and work with when crises occur on evenings or weekends, or staff vacations – or do calls only go to the CSB's emergency services team?
6. What do you do to assess or measure competence in all the skills that direct services staff who work with children and families must have?
7. What do you do to assist children and their families about transitioning from special education or CSA services into mental health, mental retardation, or substance abuse services at your agency?
8. What do you do to measure the quality and customer satisfaction of the child and family services you provide?
9. For your child case management staff, what is the average caseload now? ____What should be the target caseload size for a full time child case manager in Virginia? _____ How many more child case managers do you estimate your CSB needs to adequately meet needs? ____
10. What do you do to prepare child case managers for the roles of program evaluator, service monitor, and advocate – skills they are not likely to have learned in academic training or other jobs.
11. What 2 or 3 services that are not now available in your community would do the most to prevent having to place children in residential programs outside your community?
12. What factors have been most helpful in developing services for children and families in your community?
13. What factors have most hindered the development of services for children and families in your community?
14. For children's SA or MR services supervisors (circle which one you are):
Assess the CSB's support and priority for developing these services and any special reasons why they have or have not developed.
15. What one or two changes do you think are most needed to improve child and family services in Virginia (try to extend your answers beyond "more money")?