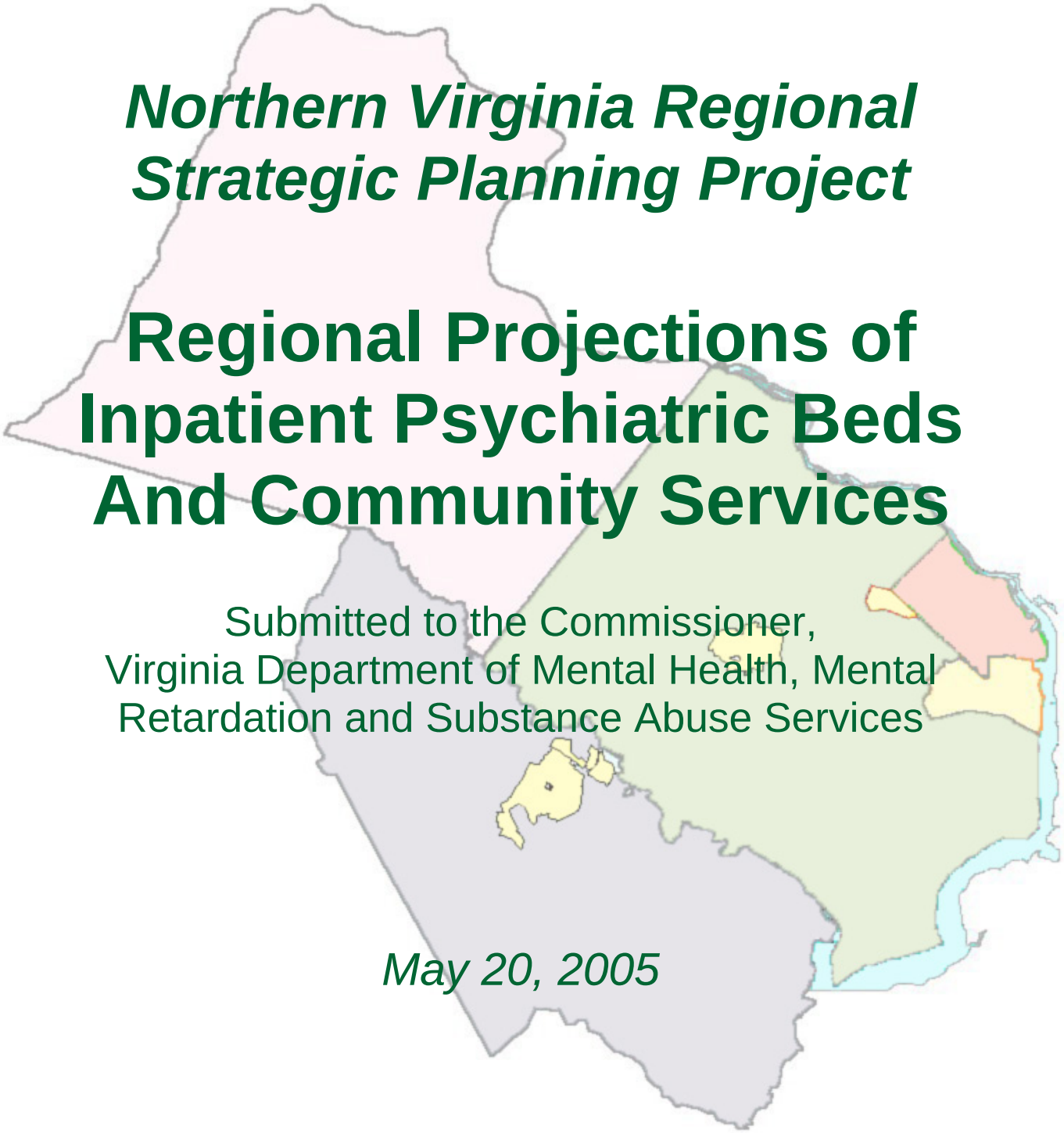


*Northern Virginia Regional Strategic Planning Project*

# Regional Projections of Inpatient Psychiatric Beds And Community Services

Submitted to the Commissioner,
Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services

*May 20, 2005*

**OUR VISION FOR MENTAL HEALTH SERVICES:**

Development of a cost-effective, comprehensive, culturally competent array of recovery oriented, consumer choice driven integrated services that are flexible and accessible to consumers and oriented toward proactive care, maintaining stability, and maximizing independence and community integration. Education must be intensified to combat and overcome discrimination historically associated with mental illness.

The Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) tasked the state facilities and community services boards with describing the future need for psychiatric beds and community alternatives to offset the number of public psychiatric beds. With its rapidly growing population, Northern Virginia is challenged to predict an ever-increasing need for psychiatric inpatient beds as well as create diversion and discharge programs to reduce the number of admissions to and length of stay in psychiatric hospitals.

Data gleaned from a variety of sources suggests that population will grow by 26.7% by 2020, adding over a half million people to this Northern Virginia area. As shown in Appendix A, all age groups are expected to increase:

- children and adolescents to increase by 127,500 (23.7%)
- adults by 312,000 (23.2%)
- older adults, ages 65 – 84, by 99,800 (68.3%)
- elderly persons, 85 years and older, by almost 7,000 (40.3%).

Past regional planning efforts focused primarily on adult mental health services. In addition to continuing its focus of adult services, the Mental Health Work Group (MHWG) broadened its scope in order to examine service delivery issues for children/adolescents, older adults, and persons with co-occurring mental illness and substance abuse. The result of this expansion is a better understanding of the different needs of each population and the recognition of commonalities among the service recommendations.

Of particular concern to the planning group is the most appropriate use of all state operated or funded psychiatric inpatient beds and in particular those beds at the Northern Virginia Mental Health Institute (NVMHI). In addition to providing services to persons who need intensive and intermediate psychiatric inpatient care, NVMHI currently serves adults who could conceivably receive services in the community for acute hospitalization or rehabilitation services. As a result of several meetings with representatives from the private psychiatric hospitals, an agreement was reached that the private hospitals would strive to take 95% of the TDOs (temporary detention orders) and the community services boards will attempt to increase crisis care and rehabilitation services. If these efforts are successful, almost the entire capacity of the NVMHI will be used for persons who need intensive or intermediate care.

Attempting to adhere to the principle that, whenever possible, persons should be served in their own communities, the work groups reviewed the places where people receive mental health services. Clearly, many people – children and adolescents, adults in need of forensic services, adults who have been adjudicated NGRI (Not Guilty by Reason of Insanity), and older adults -- leave Northern Virginia to receive inpatient psychiatric services. This trend is especially troublesome for young people and for older adults – both groups are dependent upon family and

other support systems to facilitate recovery. Although most children receive inpatient care locally, a small number of youth are sent to Commonwealth Center for Children and Adolescents in Staunton and sometimes out of state for inpatient services and a much larger number are sent outside their community in order to receive intensive residential services.

Many older adults also leave the area to receive inpatient services at the Eastern State Hospital (ESH) in Williamsburg. With relatively few local options, older adults who need acute or more extensive care travel to ESH, the state hospital that provides Intermediate Care Facility services for Northern Virginia and other parts of the state. A preferred treatment option for older adults is to keep people in place and to bring services to them. With this is mind, the Older Adults Work Group developed an innovative model for serving people in Northern Virginia and recommends that a state funded unit be available in this area.

The Steering Committee recognizes in this planning exercise that new or expanded community alternatives are needed to keep pace with the demand for inpatient service. However, they are also concerned about structural issues that may negatively impact services, including:

- the need for regular inflationary adjustments to state funding and reimbursement rates
- the lack of affordable housing in Northern Virginia
- the need for affordable medical care by all segments of the population
- proposed closings of military facilities in some parts of Northern Virginia and increases in primarily civilian personnel at other local bases
- inadequate road system and poor mass transit, resulting in especially heavy, slow and extended rush hour traffic and lengthy travel times at virtually any time of the day.

This report is produced to respond to the DMHMRSAS' request for strategic planning data for the next three biennia. Northern Virginia is providing additional information of service needs and strategies through 2020. The format for this report is built around worksheets that DMHMRSAS provided to capture the psychiatric inpatient and community service needs for children/adolescent, adults (including those with co-occurring disorders and in need of forensic services) and older adults. Each section of this report contains an introduction, a list of community services to offset the need for inpatient psychiatric beds and the completed DMHMRSAS forms relating bed needs and community services for each of three biennia (2006-2008, 2008-2010, 2010-2012) as well as forms for 2012-2020.

## Adult Inpatient and Community Services

This year the Adult Mental Health Work Group (MHWG) focused on the appropriate uses of Northern Virginia Mental Health Institute (NVMHI). The MHWG is concerned that:

- NVMHI routinely operates at 98% occupancy and often cannot accommodate patients who need inpatient psychiatric services because all the beds are full.
- About 25% of the patients at NVMHI could be served outside a hospital if alternative services were available.
- Substantial numbers of patients are sent out of area for psychiatric hospitalization.
- Rapid population growth in Northern Virginia will add to the demand for psychiatric beds.
- Increasing numbers of people must rely on the public sector for mental health services because they do not have health insurance coverage.
-

In planning for the future use of inpatient psychiatric beds, the MHWG articulated two principals:

1. Whenever possible, people should receive services in their own communities.
2. Additional community resources could offset the need for additional psychiatric beds.

The MHWG identified four levels of inpatient care (acute, intensive, intermediate and rehabilitation) currently provided at NVMHI. The Work Group suggests that

- NVMHI emphasize providing intensive and intermediate care
- the private hospitals provide the bulk of acute care, especially TDOs (temporary detention orders), a position with which the Private Psychiatric Hospital Work Group agrees
- the community services boards provide acute care in the form of crisis care beds and rehabilitation services.

The impact of this recommendation is shown in Appendix B and reflected in the service recommendations for both inpatient and community services.

The MHWG continued to place special emphasis on services for forensic patients at NVMHI and Western State Hospital (WSH). At any given time this year, about 30 patients in NGRI (Not Guilty by Reason of Insanity) status are at NVMHI, occupying almost a quarter of the NVMHI bed capacity. Only about half of these NGRI patients have earned unescorted community privileges that enable them to focus primarily on community reintegration. The other NGRI patients are at a privilege level that does not allow independent community reintegration activities. The amount of time a patient takes to move through the NGRI gradual release process varies but typically exceeds one year and may take several years. After considerable deliberation, the MHWG is recommending that those NGRI patients who do not yet have unescorted community privileges be transferred to a step-down facility or other inpatient program that would be designed to address the unique treatment needs of this group. At this level of privilege, the focus of a specialized program for NGRI patients should include recovery, vocational skill development, substance abuse treatment and relapse prevention. While this

facility should be located in Northern Virginia, the MHWG recognizes that an interim step may involve a facility outside the region.

Other forensic patients are also of concern because an increasing number of them are being transferred from local jails this year to WSH, where they receive treatment for mental illness or evaluation for competency to stand trial. Not only are an increasing number being transferred but lengths of stay are longer than they were last year. While mental health services are established in some local jails, some inmates have severe mental illness that is best treated in a psychiatric hospital. Recognizing the impact on psychiatric inpatient bed usage, the MHWG identified several strategies to improve forensic services. These are listed in Appendix C.

Working in conjunction with the MHWG, the Co-occurring Disorders (MH/SA) Work Group (CODWG) developed a continuum of services for persons with co-occurring disorders and defined which of these services could potentially reduce the use of psychiatric hospital beds. A list of recommended services may be found in Appendix D.

The following information pertains to psychiatric inpatient bed needs and community alternatives to hospitalization and reflects the recommendations of the work groups dealing with adult mental health services. The data show that 266 inpatient psychiatric beds will be needed for public sector consumers by 2020. The MHWH identified the need for three types of inpatient beds and one secure residential treatment program:

- beds at NVMHI and WSH or other state hospitals
- private sector beds purchased by the CSBs, i.e., DAD funds, for commitments and treatment
- secure private sector beds used for TDOs
- secure residential treatment program for people on NGRI status.

The following information pertains to psychiatric inpatient bed needs and community alternatives to hospitalization. It includes a list of proposed community services to offset the need for inpatient psychiatric beds; a summary of the impact of the proposed community services on the need for inpatient beds; and the work sheets that are required by DMHMRSAS.

## Community Services to Offset Need for Adult Inpatient Psychiatric Hospital Beds

| 2006-2008 | 2008-2010 | 2010-2012 | 2012-2020 |
|---|---|---|---|
| ICRT+<br>▪ Capacity to meet very high intensity behavioral needs<br>▪ Capacity to attend to higher than average medical needs<br>▪ "hospital without walls"<br>▪ **Offset** 1:1 | ICRT+<br>▪ Capacity to meet very high intensity behavioral needs<br>▪ Capacity to attend to higher than average medical needs<br>▪ "hospital without walls"<br>▪ **Offset** 1:1 | ICRT+<br>▪ Capacity to meet very high intensity behavioral needs<br>▪ Capacity to attend to higher than average medical needs<br>▪ "hospital without walls"<br>▪ **Offset** 1:1 | |
| 24/7 Non-transitional Housing<br>▪ ALOS greater than 18 months, may be permanent<br>▪ Resident attends day program off-site<br>▪ **Offset** 30:1 for every 30 residents, offset I hospital bed) | 24/7 Non-transitional Housing<br>▪ LOS greater than 18 months, may be permanent<br>▪ Resident attends day program off-site<br>▪ **Offset** 30:1 for every 30 residents, offset I hospital bed) | | |
| 24/7 Transitional Housing<br>▪ ALOS about 18 months, then step-down<br>▪ **Offset** 52:1 for every 52 residents, offset I hospital bed) | ▪ | | 24/7 Transitional Housing<br>▪ ALOS about 18 months, then step-down<br>▪ **Offset** 52:1 for every 52 residents, offset I hospital bed) |
| ICT/PACT<br>▪ With housing<br>▪ **Offset:** 10.5 (for every 10.5 consumers in PACT, offset 1 hospital bed) | ICT/PACT<br>▪ With housing<br>▪ **Offset:** 10.5: 1 (for every 10.5 consumers in PACT, offset 1 hospital bed) | ICT/PACT<br>▪ With housing<br>▪ 10.5 consumers in PACT, offset 1 hospital bed) | ICT/PACT<br>▪ With housing<br>▪ **Offset:** 10.5: 1 (for every 10.,5 consumers in PACT, offset 1 hospital bed) |

| 2006-2008 | 2008-2010 | 2010-2012 | 2012-2020 |
|---|---|---|---|
| ALF<br>▪ Assisted living<br>▪ 24/7 staffing<br>▪ Meals served<br>▪ Assistance with ADLs though short of nursing home level of care<br>▪ Similar to Tall Oaks, Cardinal House, Sunrise<br>▪ **Offset:** 15:1 (for every 15 residents in an ALF, offset 1 hospital bed) | ▪ | | ALF<br>▪ Assisted living<br>▪ 24/7 staffing<br>▪ Meals served<br>▪ Assistance with ADLs though short of nursing home level of care<br>▪ Similar to Tall Oaks, Cardinal House, Sunrise<br>▪ **Offset:** 15:1 (for every 15 residents in an ALF, offset 1 hospital bed) |
| Nursing Home<br>▪ Ability to handle aggressive behavior<br>▪ Some adult patients may have early dementia<br>▪ **Offset:** 17:1 (for every 17 nursing home residents, offset 1 hospital bed) | | | |
| | | Crisis Care<br>▪ Stabilization<br>▪ TDOs<br>▪ 23 hour detention<br>▪ Respite<br>▪ **Offset**: 1.25:1 (for every 1.25 residents, offset one hospital bed) | |
| Crisis Stabilization and Social Detox<br>▪ Will use 3-5 days on average | | | |
| MH/SA Residential Treatment<br>▪ 6 month program<br>▪ Similar to Cornerstones in Fairfax<br>▪ **Offset:** 12:1 (for every 12 residents, offset 1 hospital bed) | MH/SA Residential Treatment<br>▪ 6 month program<br>▪ Similar to Cornerstones in Fairfax<br>▪ **Offset:** 12:1 (for every 12 residents, offset 1 hospital bed) | MH/SA Residential Treatment<br>▪ 6 month program<br>▪ Similar to Cornerstones in Fairfax<br>▪ **Offset:** 12:1 (for every 12 residents, offset 1 hospital bed) | MH/SA Residential Treatment<br>▪ 6 month program<br>▪ Similar to Cornerstones in Fairfax<br>▪ **Offset:** 12:1 (for every 12 residents, offset 1 hospital bed) |

| 2006-2008 | 2008-2010 | 2010-2012 | 2012-2020 |
|---|---|---|---|
| 24/7 MH/SA Transitional Housing<br>▪ ALOS about 18 months, then step-down<br>▪ **Offset** 52:1 for every 52 residents, offset I hospital bed) | 24/7 MH/SA Transitional Housing<br>▪ ALOS about 18 months, then step-down<br>▪ **Offset** 52:1 for every 52 residents, offset I hospital bed) | 24/7 MH/SA Transitional Housing<br>▪ ALOS about 18 months, then step-down<br>▪ **Offset** 52:1 for every 52 residents, offset I hospital bed) | 24/7 MH/SA Transitional Housing<br>▪ ALOS about 18 months, then step-down<br>▪ **Offset** 52:1 for every 52 residents, offset I hospital bed) |
| NGRI to State Program Outside Region<br>▪ Move NGRI patients who have no unescorted community privileges to step-down facility out of region until regional setting is established | | | |

## Summary: Inpatient Psychiatric Bed Needs With and Without Additional Community Adults Services

| | 2006-2008 | 2008-2010 | 2010-2012 | 2012-2020 |
|---|---|---|---|---|
| Number of Inpatient Beds Needed without Additional Community Services | 231 | 240 | 245 | 266 |
| Number of Inpatient Beds Needed without Additional Community Services - cumulative impact | 196<br>(NVMHI: 129<br>Other State: 29<br>Private: 16<br>Undesignated: 22) | 196<br>(NVMHI: 129<br>Other State: 31<br>Private: 17<br>Undesignated: 19) | 191<br>(NVMHI: 129<br>Other State: 31<br>Private: 14<br>Undesignated: 17) | 199<br>(NVMHI: 129<br>Other State: 34<br>Private: 18<br>Undesignated: 18) |

REVISED WORKSHEET: MH INPATIENT BEDS NEEDED BY THE REGION

REGION: _____II_____ DATE (CIRCLE): 2006-08

ADULTS

ASSUME NO MAJOR CHANGES IN THE REGION'S COMMUNITY SERVICES CAPACITY

| Future Inpatient Psychiatric Beds Needed by Service Type or Category | Number of Beds Needed |
|---|---|
| Acute Stabilization | |
| Intensive Care | |
| Intermediate Care | |
| Rehabilitation | |
| Total Number of Beds Needed According to Levels of Inpatient Service (This number should include all the psychiatric beds that are needed.) | 231 (85% occupancy) |
| Future Inpatient Psychiatric Beds Needed by Type of Legal Status | Number of Beds Needed |
| TDO* (all ages) | |
| Commitment and Court-Mandated Admission (CMA)* | |
| NGRI | |
| Other Forensic (e.g., Jail TDO, Emergency Treatment, Evaluation, and Restoration) | |
| Total Number of Beds Needed According to Legal Status (This number should be equal to or less than the number listed above, i.e., all the psychiatric beds that are projected as needed by the Region.) | To be provided |

ASSUME CREATION OR EXPANSION OF CERTAIN SPECIFIED COMMUNITY SERVICES

| Future Inpatient Psychiatric Beds Needed by Service Type or Category | Number of Beds Needed |
|---|---|
| Acute Stabilization | NVMHI: 6; Private 16 (+15 in reserve for TDOs) |
| Intensive Care | NVMHI: 54; WSH or other state hospital: 29 |
| Intermediate Care | NVMHI: 54 |
| Rehabilitation | NVMHI: 15 |
| Undesignated (NGRI in new NV facility or elsewhere in state) | TBD: 16 |
| Undesignated | TBD: 6 |
| Total Number of Beds Needed According to Levels of Inpatient Service | 196 |
| Future Inpatient Psychiatric Beds Needed by Type of Legal Status | Number of Beds Needed |
| TDO* | |
| Commitment and Court-Mandated Admission (CMA)* | |
| NGRI | 16 |
| Other Forensic (e.g., Jail TDO, Emergency Treatment, Evaluation, and Restoration) | 29 |
| Total Number of Beds Needed According to Legal Status (This number should be equal to or less than the number listed above.) | |

If the Following Additional Community Service Capacity Was in Place in the Region:

| *Services Needed* | *Preferred Location(s)* Identify the CSB area(s), if possible, or if this would be a regional service | *Capacity Needed* |
|---|---|---|
| ICRT+ | Regional | 6 beds |
| 24/7 Non-transitional Housing | TBD | 16 beds |
| 24/7 Transitional Housing | TBD | 14beds |
| PACT/ICT with Housing | CSBs | 2 teams |
| ALF | Regional | 10 beds |
| Nursing Home | TBD | 12 beds |
| Crisis Stabilization and Social Detox | TBD | 28 beds |
| MH/SA Residential Treatment | Regional | 10 beds |
| 24/7 MH/SA Transitional Residential | Regional | 8 beds |
| NGRI to an alternative secure space until a NV facility is built | TBD | 16 beds |

REVISED WORKSHEET: MH INPATIENT BEDS NEEDED BY THE REGION

REGION: _____II_____ DATE (CIRCLE): 2008-10

COMPLETE SEPARATELY FOR EACH POPULATION GROUP: CIRCLE THE APPLICABLE GROUP:

ADULTS

ASSUME NO MAJOR CHANGES IN THE REGION'S COMMUNITY SERVICES CAPACITY

| Future Inpatient Psychiatric Beds Needed by Service Type or Category | Number of Beds Needed |
|---|---|
| Acute Stabilization | |
| Intensive Care | |
| Intermediate Care | |
| Rehabilitation | |
| Total Number of Beds Needed According to Levels of Inpatient Service (This number should include all the psychiatric beds that are needed.) | 240 (85% occupancy) |
| **Future Inpatient Psychiatric Beds Needed by Type of Legal Status** | **Number of Beds Needed** |
| TDO* | |
| Commitment and Court-Mandated Admission (CMA)* | |
| NGRI | |
| Other Forensic (e.g., Jail TDO, Emergency Treatment, Evaluation, and Restoration) | |
| Total Number of Beds Needed According to Legal Status (This number should be equal to or less than the number listed above, i.e., all the psychiatric beds that are projected as needed by the Region.) | To be provided |

ASSUME CREATION OR EXPANSION OF CERTAIN SPECIFIED COMMUNITY SERVICES

| Future Inpatient Psychiatric Beds Needed by Service Type or Category | Number of Beds Needed |
|---|---|
| Acute Stabilization | NVMHI: 6; Private 17 (+15 in reserve for TDOs) |
| Intensive Care | NVMHI: 54; WSH or other state hospital : 31 |
| Intermediate Care | NVMHI: 54 |
| Rehabilitation | NVMHI: 15 |
| Undesignated (NGRI in new secure NV facility or elsewhere in state) | TBD: 17 |
| Undesignated | TBD: 2 - 37 |
| Total Number of Beds Needed According to Levels of Inpatient Service | 231 |
| Total Number of Beds Needed According to Levels of Inpatient Service if community services requested for 2006-2008 are funded | 196 |
| **Future Inpatient Psychiatric Beds Needed by Type of Legal Status** | **Number of Beds Needed** |
| TDO* | |
| Commitment and Court-Mandated Admission (CMA)* | |
| NGRI | 17 |
| Other Forensic (e.g., Jail TDO, Emergency Treatment, Evaluation, and Restoration) | 31 |
| Total Number of Beds Needed According to Legal Status (This number should be equal to or less than the number listed above.) | |

If the Following Additional Community Service Capacity Was in Place in the Region:

| *Services Needed* | *Preferred Location(s)* Identify the CSB area(s), if possible, or if this would be a regional service | *Capacity Needed* |
|---|---|---|
| MH/SA Residential Treatment | Regional | 10 beds |
| 24/7 MH/SA Transitional Residential | Regional | 16 beds |
| 24/7 Supported Non-transitional Group Home | Regional | 6 beds |
| ICRT+ | Regional | 6 beds |
| PACT/ICT with housing | CSBs | 1 team |

* If a Region cannot separate its projected number of needed TDO and Commitment/CMA beds, it should indicate this in a footnote and insert a combined TDO and Commitment/CMA bed number in the TDO bed need row.

REVISED WORKSHEET: MH INPATIENT BEDS NEEDED BY THE REGION

REGION: _____II_____ DATE (CIRCLE): 2010-12

COMPLETE SEPARATELY FOR EACH POPULATION GROUP: CIRCLE THE APPLICABLE GROUP:

ADULTS

ASSUME NO MAJOR CHANGES IN THE REGION'S COMMUNITY SERVICES CAPACITY

| Future Inpatient Psychiatric Beds Needed by Service Type or Category | Number of Beds Needed |
|---|---|
| Acute Stabilization | |
| Intensive Care | |
| Intermediate Care | |
| Rehabilitation | |
| Total Number of Beds Needed According to Levels of Inpatient Service (This number should include all the psychiatric beds that are needed.) | 245 (85% occupancy) |
| **Future Inpatient Psychiatric Beds Needed by Type of Legal Status** | **Number of Beds Needed** |
| TDO* | |
| Commitment and Court-Mandated Admission (CMA)* | |
| NGRI | |
| Other Forensic (e.g., Jail TDO, Emergency Treatment, Evaluation, and Restoration) | |
| Total Number of Beds Needed According to Legal Status (This number should be equal to or less than the number listed above, i.e., all the psychiatric beds that are projected as needed by the Region.) | To be provided |

ASSUME CREATION OR EXPANSION OF CERTAIN SPECIFIED COMMUNITY SERVICES

| Future Inpatient Psychiatric Beds Needed by Service Type or Category | Number of Beds Needed |
|---|---|
| Acute Stabilization | NVMHI: 6; Private 14 (+15 reserve for TDOs) |
| Intensive Care | NVMHI: 54; WSH or other state hospital: 31 |
| Intermediate Care | NVMHI: 54 |
| Rehabilitation | NVMHI: 15 |
| Undesignated (NGRI in new secure NV facility or elsewhere in state) | TBD: 17 |
| Total Number of Beds Needed According to Levels of Inpatient Service if 2010-2012 request is Funded | 235 |
| Total Number of Beds Needed According to Levels of Inpatient Service if community services requested for2006-2008, 2008-2010 and 2010-2012 requests are funded | 191 |
| **Future Inpatient Psychiatric Beds Needed by Type of Legal Status** | **Number of Beds Needed** |
| TDO* | |
| Commitment and Court-Mandated Admission (CMA)* | |
| NGRI | 17 |
| Other Forensic (e.g., Jail TDO, Emergency Treatment, Evaluation, and Restoration) | 31 |
| Total Number of Beds Needed According to Legal Status (This number should be equal to or less than the number listed above.) | |

If the Following Additional Community Service Capacity Was in Place in the Region:

| *Services Needed* | *Preferred Location(s)* Identify the CSB area(s), if possible, or if this would be a regional service | *Capacity Needed* |
|---|---|---|
| ICRT+ | TBD | 6 beds |
| MH/SA Residential Treatment | Regional | 10 beds |
| 24/7 MH/SA Transitional Residential | Regional | 16 beds |
| Crisis Care | TBD | 8 beds |
| PACT/ICT with housing | CSB | 1 team |

REVISED WORKSHEET: MH INPATIENT BEDS NEEDED BY THE REGION

REGION: _____II_____ DATE (CIRCLE): 2012-20

COMPLETE SEPARATELY FOR EACH POPULATION GROUP: CIRCLE THE APPLICABLE GROUP:

ADULTS

ASSUME NO MAJOR CHANGES IN THE REGION'S COMMUNITY SERVICES CAPACITY

| Future Inpatient Psychiatric Beds Needed by Service Type or Category | Number of Beds Needed |
|---|---|
| Acute Stabilization | |
| Intensive Care | |
| Intermediate Care | |
| Rehabilitation | |
| Total Number of Beds Needed According to Levels of Inpatient Service (This number should include all the psychiatric beds that are needed.) | 266 (85% occupancy) |
| **Future Inpatient Psychiatric Beds Needed by Type of Legal Status** | **Number of Beds Needed** |
| TDO* | |
| Commitment and Court-Mandated Admission (CMA)* | |
| NGRI | |
| Other Forensic (e.g., Jail TDO, Emergency Treatment, Evaluation, and Restoration) | |
| Total Number of Beds Needed According to Legal Status (This number should be equal to or less than the number listed above, i.e., all the psychiatric beds that are projected as needed by the Region.) | To be provided |

ASSUME CREATION OR EXPANSION OF CERTAIN SPECIFIED COMMUNITY SERVICES

| Future Inpatient Psychiatric Beds Needed by Service Type or Category | Number of Beds Needed |
|---|---|
| Acute Stabilization | NVMHI: 6; Private 18 (+10 in reserve for TDOs) |
| Intensive Care | NVMHI: 54; WSH or other state hospital: 34 |
| Intermediate Care | NVMHI: 54 |
| Rehabilitation | NVMHI: 15 |
| Undesignated (NGRI in new secure NV facility or elsewhere in state) | TBD: 18 |
| Total Number of Beds Needed According to Levels of Inpatient Service if 2012-2020 request is Funded | 253 |
| Total Number of Beds Needed According to Levels of Inpatient Service if community services requested for2006-2008, 2008-2010 and 2010-2012 requests are funded | 199 |
| **Future Inpatient Psychiatric Beds Needed by Type of Legal Status** | **Number of Beds Needed** |
| TDO* | |
| Commitment and Court-Mandated Admission (CMA)* | |
| NGRI | 18 |
| Other Forensic (e.g., Jail TDO, Emergency Treatment, Evaluation, and Restoration) | 34 |
| Total Number of Beds Needed According to Legal Status (This number should be equal to or less than the number listed above.) | |

If the Following Additional Community Service Capacity Was in Place in the Region:

| *Services Needed* | *Preferred Location(s)* Identify the CSB area(s), if possible, or if this would be a regional service | *Capacity Needed* |
|---|---|---|
| MH/SA Residential Treatment | Regional | 8 beds |
| 24/7 MH/SA Transitional Residential | Regional | 16 beds |
| 24/7 Transitional Group Home | TBD | 8 beds |
| PACT/ICT with housing | CSBs | 2 teams |
| ALF | Regional | 16 beds |

* If a Region cannot separate its projected number of needed TDO and Commitment/CMA beds, it should indicate this in a footnote and insert a combined TDO and Commitment/CMA bed number in the TDO bed need row.

## Older Adult Inpatient and Community Services

The Older Adult Mental Health Work Group (OAMHWG), in collaboration with the existing provider network for housing and services for persons over 65 years of age, structured their work this year in order to

- document the uniqueness of services for older adults (those persons 65 years of age and older)
- describe the lack of state-funded inpatient hospital services for older adults in Northern Virginia
- approximate the unmet need for inpatient services
- develop a model for improved service delivery
- modify the level of inpatient service definitions to apply to older adults.

Among its first tasks, the OAMHWH made several observations that help clarify the circumstances in which regional services for older adults are provided. These observations include:

- Most older adults who have mental illness do not have dementia or Alzheimer's disease.
- The vast majority of older adults receives their mental health care from the private sector and will continue to do so.
- DMHMRSAS has always served older adults with mental health needs for whom the private sector resources are insufficient. In the past, older adults were served in much greater numbers than they are now.
- Many older adults who need CSB services are already known to CSB adult MH or MR services.
- CSBs do not directly operate any facilities for older adults and do not control admissions to private facilities.
- Less than 5% of older adults with medical or psychiatric problems live in nursing homes
- Many older adults with mental illness also have medical problems requiring specialized diagnostic and treatment services.
- CSBs provide no specialized prescreening for older adults in order to increase diversion from psych hospitals.
- Acute care for older adults is about 60 days, compared to 6 days for adults

Among their many activities, the OAMHWG developed surveys to elicit information about the mental health needs of older adults and the availability or lack of services for this group. They obtained information from representatives of the Adult Day Health Services, Adult Protective Services and Community Services Boards in Alexandria, Arlington, Fairfax-Falls Church, Loudoun and Prince William. Please refer to Figure 1 for the results of these surveys.

Figure 1. Survey Results

## But Services Are Not Available for Everyone in Northern Virginia

**CSB:**
Number of Older Adults
Needing MH Services: 679
Number of Older Adults
Receiving MH Services: 632
Number Needing but Not
Getting Psychiatric
Hospitalization: 11

**Adult Day Health Centers:**
Number of Older Adults
Needing MH Services: 105
Number of Older Adults
Receiving MH Services: 46
Number Needing but Not
Getting Psychiatric
Hospitalization: 6

**Adult Protective Services:**
Number of Older Adults
Receiving APS Services: 813
Number of Older Adults
Receiving MH Services: 191
Number Needing but Not
Getting Psychiatric
Hospitalization: 137

Source: Limited survey conducted in February 2005. Reflects activity for FY2004. Some service delivery and need numbers are estimates.

In addition, they collected data pertaining to inpatient usage at Eastern State Hospital (ESH) in Williamsburg. They noted that ESH offers services at an Intermediate Care Facility (ICF) but not acute care. While some patients benefit from the longer ICF stay, others would be better served within an acute care setting, even though stabilization may take several weeks. They documented that of the 36 Northern Virginians were hospitalized at ESH in FY 2004, 78% needed only short-term, acute care, which is 30 – 60 days for older adults.

Lastly, the OAMHWG modified the levels of inpatient service definitions so that they apply more appropriately to older adults. Please see these revisions in Appendix E.

Key to the work of the OAMHWG is the service model (Figure 2). The model is described as follows:

> The Older Adult Network of Housing and Services (yellow) depicts the various places Older Adults might live in the community, and the services that are available to them to support their living as independently as possible. These services are available from both public and private agencies. With few exceptions (Birmingham Green, Lincolnia to a limited extent), the public sector has no control over admissions to these housing options and services. Massive deinstitutionalization from the State psychiatric hospitals in the past two decades coupled with more restrictive screening measures for admission to the State psychiatric hospitals has resulted in eroded trust between the community network and the State system. Transitions between the hospitals and community network as a result have become much more difficult, and utilizing these resources for both front door diversion and back door discharge from the hospital has become extremely challenging. The proposed model seeks to address this erosion of trust between the State services and the community network by proactively responding to crises as they arise and assisting the network in managing consumers where they are, and if this is not possible,

assisting the network with transitions between hospitals, housing alternatives and other community supportive services. It is the belief of the Older Adults Workgroup that with this model fewer consumers will require State hospital services, quality of care will be improved, and those who are hospitalized will have a shorter stay.

The chart depicts new services proposed in blue. Central to the collaboration effort will be an ICT/PACT-like team (Intensive Community Treatment/Program for Assertive Community Treatment) which will have staff trained and experienced in working with older adults. This service will be responsible for doing all pre-commitment screenings for persons over 65. This team will also provide a very intensive outreach treatment service which will seek to stabilize consumers in their current environment. This would include both direct treatment and education/consultations to others involved in the consumers' care. By becoming very familiar with all the resources in the network and being responsive to them when they have a crisis, this team will facilitate accessing services both at front door and back door through relationships built on trust.

In order to support the network and to keep people out of psychiatric hospital beds, additional new programs would be:

Psychosocial Day Treatment: To provide long-term day treatment and programming for older mentally ill consumers. This would assist with both diversion and discharge.

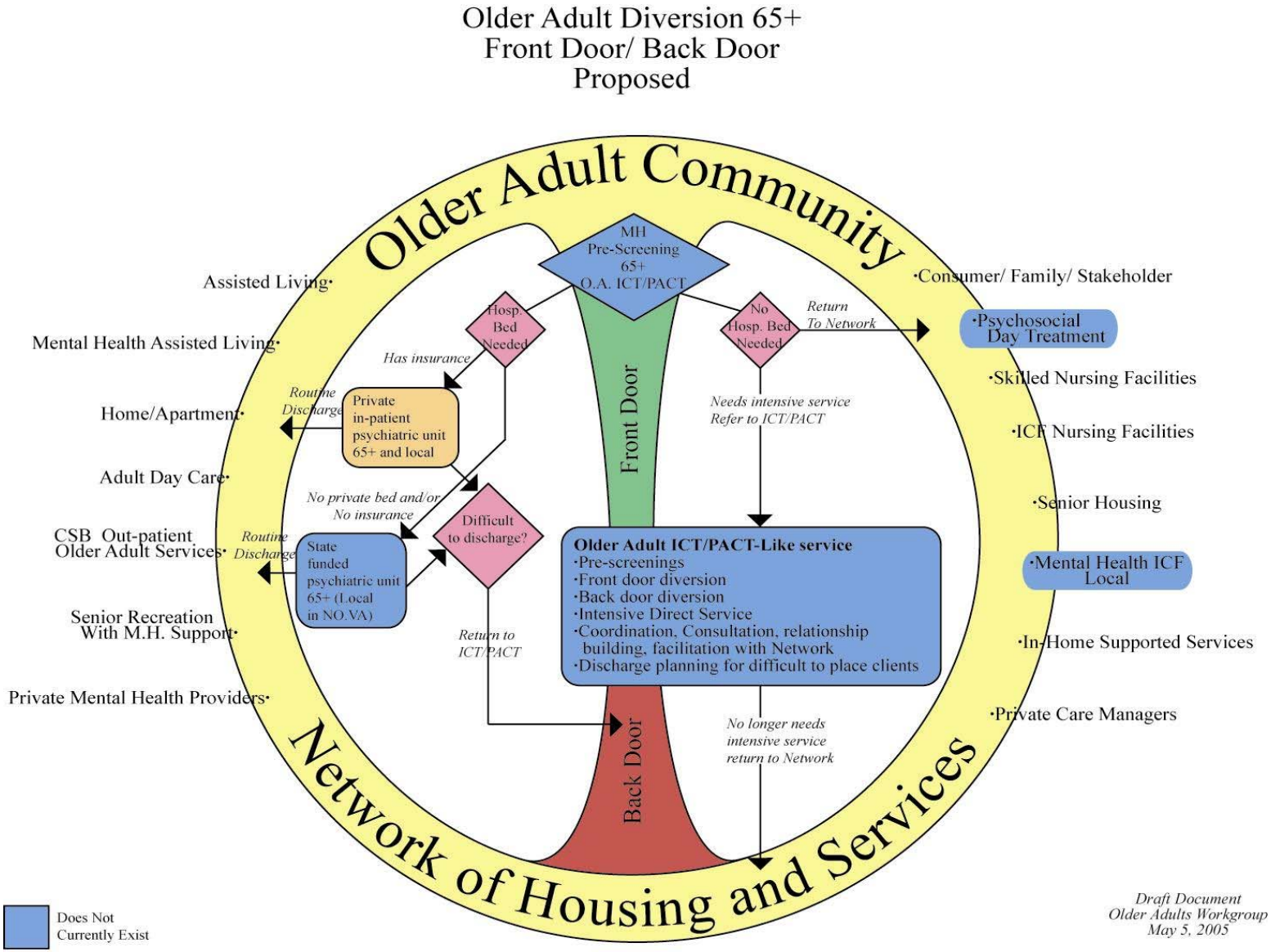
Mental Health ICF**:** To provide ICF level of care for consumers with mental illness currently hospitalized at Eastern State Hospital long term care units who do not require acute treatment but do require a higher level of behavior management and mental health treatment than traditional nursing homes provide. This would facilitate diversion and discharge.

State funded inpatient beds for persons over 65: This would take the place of Eastern State Psychiatric Hospital Geriatric units. Despite anticipating lower bed day usage because of the proposed added services, the proposed system would only work if there are State funded psychiatric beds to provide the safety net when all other options fail. Locating these beds in our community would greatly enhance the Older Adult Pact-like service's ability to assist with discharge planning and placement and would keep Northern Virginia's frailest consumers and family visitors from having to travel 3 hours away to Williamsburg.

The chart itself describes how consumers will be channeled based on the decisions made at the three decision points (colored in fuchsia). The Pact-like team will provide services where there are crises or discharge difficulties. It is not intended to take the place of existing services or processes for routine consumer activities. It will, however, replace emergency services as the prescreener for older adult clients.

The information that follows Figure 2 pertains to psychiatric inpatient bed needs and community alternatives to hospitalization. It includes a list of proposed community services to offset the need for inpatient psychiatric beds; a summary of the impact of the proposed community services on the need for inpatient beds; and the work sheets that are required by DMHMRSAS.

**Figure 2. Diversion for Older Adults**



## Community Services to Offset Need for Older Adult Hospital Beds

| 2006-2008 | 2008-2010 | 2010-2012 | 2012-2020 |
|---|---|---|---|
| ICT/PACT-like Service<br>▪ Regional Hub with Satellites<br>▪ Prescreening for consumers prior to hospital admission with focus on diverting consumer to community service<br>▪ Intensive outreach treatment service<br>▪ Direct treatment<br>▪ Education/consultation with others involved in consumer's care<br>▪ **Offset** 10:1 | ICT/PACT-like Service<br>▪ Regional Hub with Satellites<br>▪ Prescreening for consumers prior to hospital admission with focus on diverting consumer to community service<br>▪ Intensive outreach treatment service<br>▪ Direct treatment<br>▪ Education/consultation with others involved in consumer's care<br>▪ **Offset** 10:1 | | ICT/PACT-like Service<br>▪ Regional Hub with Satellites<br>▪ Prescreening for consumers prior to hospital admission with focus on diverting consumer to community service<br>▪ Intensive outreach treatment service<br>▪ Direct treatment<br>▪ Education/consultation with others involved in consumer's care<br>▪ **Offset** 10:1 |
| Psychosocial Day Treatment<br>▪ 1 pilot program<br>▪ 15 slots each<br>▪ Divert participants from inpatient service | Psychosocial Day Treatment<br>▪ 4 programs<br>▪ 15 slots each<br>▪ Divert participants from inpatient service | | Psychosocial Day Treatment<br>▪ 3 programs<br>▪ 15 slots each<br>▪ Divert participants from inpatient service |
| Mental Health ICF<br>▪ Local facility in Northern Virginia<br>▪ Diversion from ESH and private hospitals<br>▪ **Offset** 1:1 | | | |
| State-Funded Local Inpatient Psychiatric Beds for Older Adults<br>▪ Create a state-funded hospital unit in Northern Virginia to eliminate the need for patients to go to ESH in Williamsburg<br>▪ **Offset:** 1:1 | | | State-Funded Local Inpatient Psychiatric Beds for Older Adults<br>▪ Create a state-funded hospital unit in Northern Virginia to eliminate the need for patients to go to ESH in Williamsburg<br>▪ **Offset:** 1:1 |

**Summary: Inpatient Psychiatric Bed Needs With and Without Additional Community Older Adult Services**

| | 2006-2008 | 2008-2010 | 2010-2012 | 2012-2020 |
|---|---|---|---|---|
| Number of Inpatient Beds Needed without Additional Community Services | 74 | 80 | 85 | 109 |
| Number of Inpatient Beds Needed without Additional Community Services - cumulative impact | 7 | 2 | 7 | 0 |

REVISED WORKSHEET: MH INPATIENT BEDS NEEDED BY THE REGION

REGION: _____II_____ DATE (CIRCLE): 2006-08

OLDER ADULTS

ASSUME NO MAJOR CHANGES IN THE REGION'S COMMUNITY SERVICES CAPACITY

| Future Inpatient Psychiatric Beds Needed by Service Type or Category | Number of Beds Needed |
|---|---|
| Acute Stabilization | |
| Intensive Care | |
| Intermediate Care | |
| Rehabilitation | |
| Total Number of Beds Needed According to Levels of Inpatient Service (This number should include all the psychiatric beds that are needed.) | 39 (according to ESH census)<br>74 (ESH census + survey results) |
| Future Inpatient Psychiatric Beds Needed by Type of Legal Status | Number of Beds Needed |
| TDO* (all ages) | |
| Commitment and Court-Mandated Admission (CMA)* | |
| NGRI | |
| Other Forensic (e.g., Jail TDO, Emergency Treatment, Evaluation, and Restoration) | |
| Total Number of Beds Needed According to Legal Status (This number should be equal to or less than the number listed above, i.e., all the psychiatric beds that are projected as needed by the Region.) | |

ASSUME CREATION OR EXPANSION OF CERTAIN SPECIFIED COMMUNITY SERVICES

| Future Inpatient Psychiatric Beds Needed by Service Type or Category | Number of Beds Needed |
|---|---|
| Acute Stabilization | |
| Intensive Care | |
| Intermediate Care | |
| Rehabilitation | |
| Total Number of Beds Needed According to Levels of Inpatient Service | 7 |
| Future Inpatient Psychiatric Beds Needed by Type of Legal Status | Number of Beds Needed |
| TDO* | |
| Commitment and Court-Mandated Admission (CMA)* | |
| NGRI | |
| Other Forensic (e.g., Jail TDO, Emergency Treatment, Evaluation, and Restoration) | |
| Total Number of Beds Needed According to Legal Status (This number should be equal to or less than the number listed above.) | |

If the Following Additional Community Service Capacity Was in Place in the Region:

| *Services Needed* | *Preferred Location(s)*<br>Identify the CSB area(s), if possible, or if this would be a regional service | *Capacity Needed* |
|---|---|---|
| ICT/PACT-like Regional Hub with Satellites | Regional | 1 team |
| Mental Health ICF – local | Regional | 30 beds |
| State-funded Local Inpatient Psychiatric Beds for Older Adults | Regional | 30 beds |
| Psychosocial Day Treatment | CSB (one) | 15 slots |

REVISED WORKSHEET: MH INPATIENT BEDS NEEDED BY THE REGION

REGION: _____II_____ DATE (CIRCLE): 2008-10

COMPLETE SEPARATELY FOR EACH POPULATION GROUP: CIRCLE THE APPLICABLE GROUP:

OLDER ADULTS

ASSUME NO MAJOR CHANGES IN THE REGION'S COMMUNITY SERVICES CAPACITY

| Future Inpatient Psychiatric Beds Needed by Service Type or Category | Number of Beds Needed |
|---|---|
| Acute Stabilization | |
| Intensive Care | |
| Intermediate Care | |
| Rehabilitation | |
| Total Number of Beds Needed According to Levels of Inpatient Service (This number should include all the psychiatric beds that are needed.) | 38 (according to ESH census)<br>80 (ESH census + survey results) |
| **Future Inpatient Psychiatric Beds Needed by Type of Legal Status** | **Number of Beds Needed** |
| TDO* | |
| Commitment and Court-Mandated Admission (CMA)* | |
| NGRI | |
| Other Forensic (e.g., Jail TDO, Emergency Treatment, Evaluation, and Restoration) | |
| Total Number of Beds Needed According to Legal Status (This number should be equal to or less than the number listed above, i.e., all the psychiatric beds that are projected as needed by the Region.) | |

ASSUME CREATION OR EXPANSION OF CERTAIN SPECIFIED COMMUNITY SERVICES

| Future Inpatient Psychiatric Beds Needed by Service Type or Category | Number of Beds Needed |
|---|---|
| Acute Stabilization | |
| Intensive Care | |
| Intermediate Care | |
| Rehabilitation | |
| Total Number of Beds Needed According to Levels of Inpatient Service | 69 |
| Total Number of Beds Needed According to Levels of Inpatient Service if community services requested for 2006-2008 are funded | 2 |
| **Future Inpatient Psychiatric Beds Needed by Type of Legal Status** | **Number of Beds Needed** |
| TDO* | |
| Commitment and Court-Mandated Admission (CMA)* | |
| NGRI | |
| Other Forensic (e.g., Jail TDO, Emergency Treatment, Evaluation, and Restoration) | |
| Total Number of Beds Needed According to Legal Status (This number should be equal to or less than the number listed above.) | |

If the Following Additional Community Service Capacity Was in Place in the Region:

| *Services Needed* | *Preferred Location(s)*<br>Identify the CSB area(s), if possible, or if this would be a regional service | *Capacity Needed* |
|---|---|---|
| ICT/PACT-like Regional Hub with Satellites | Regional | 1 team |
| Psychosocial Day Treatment | CSB (four) | 60 slots |

* If a Region cannot separate its projected number of needed TDO and Commitment/CMA beds, it should indicate this in a footnote and insert a combined TDO and Commitment/CMA bed number in the TDO bed need row.

REVISED WORKSHEET: MH INPATIENT BEDS NEEDED BY THE REGION

REGION: _____II_____ DATE (CIRCLE): 2010-12

COMPLETE SEPARATELY FOR EACH POPULATION GROUP: CIRCLE THE APPLICABLE GROUP:

OLDER ADULTS

ASSUME NO MAJOR CHANGES IN THE REGION'S COMMUNITY SERVICES CAPACITY

| Future Inpatient Psychiatric Beds Needed by Service Type or Category | Number of Beds Needed |
|---|---|
| Acute Stabilization | |
| Intensive Care | |
| Intermediate Care | |
| Rehabilitation | |
| Total Number of Beds Needed According to Levels of Inpatient Service (This number should include all the psychiatric beds that are needed.) | 41 (according to ESH census)<br>85 (ESH census + survey results) |
| **Future Inpatient Psychiatric Beds Needed by Type of Legal Status** | **Number of Beds Needed** |
| TDO* | |
| Commitment and Court-Mandated Admission (CMA)* | |
| NGRI | |
| Other Forensic (e.g., Jail TDO, Emergency Treatment, Evaluation, and Restoration) | |
| Total Number of Beds Needed According to Legal Status (This number should be equal to or less than the number listed above, i.e., all the psychiatric beds that are projected as needed by the Region.) | |

ASSUME CREATION OR EXPANSION OF CERTAIN SPECIFIED COMMUNITY SERVICES

| Future Inpatient Psychiatric Beds Needed by Service Type or Category | Number of Beds Needed |
|---|---|
| Acute Stabilization | |
| Intensive Care | |
| Intermediate Care | |
| Rehabilitation | |
| Total Number of Beds Needed According to Levels of Inpatient Service if 2010-2012 request is Funded | 85 |
| Total Number of Beds Needed According to Levels of Inpatient Service if community services requested for2006-2008, 2008-2010 and 2010-2012 requests are funded | 7 |
| **Future Inpatient Psychiatric Beds Needed by Type of Legal Status** | **Number of Beds Needed** |
| TDO* | |
| Commitment and Court-Mandated Admission (CMA)* | |
| NGRI | |
| Other Forensic (e.g., Jail TDO, Emergency Treatment, Evaluation, and Restoration) | |
| Total Number of Beds Needed According to Legal Status (This number should be equal to or less than the number listed above.) | |

If the Following Additional Community Service Capacity Was in Place in the Region:

| *Services Needed* | *Preferred Location(s)*<br>Identify the CSB area(s), if possible, or if this would be a regional service | *Capacity Needed* |
|---|---|---|
| NA | | |

* If a Region cannot separate its projected number of needed TDO and Commitment/CMA beds, it should indicate this in a footnote and insert a combined TDO and Commitment/CMA bed number in the TDO bed need row.

REVISED WORKSHEET: MH INPATIENT BEDS NEEDED BY THE REGION

REGION: _____II_____ DATE (CIRCLE): 2012-20

COMPLETE SEPARATELY FOR EACH POPULATION GROUP: CIRCLE THE APPLICABLE GROUP:

OLDER ADULTS

ASSUME NO MAJOR CHANGES IN THE REGION'S COMMUNITY SERVICES CAPACITY

| Future Inpatient Psychiatric Beds Needed by Service Type or Category | Number of Beds Needed |
|---|---|
| Acute Stabilization | |
| Intensive Care | |
| Intermediate Care | |
| Rehabilitation | |
| Total Number of Beds Needed According to Levels of Inpatient Service (This number should include all the psychiatric beds that are needed.) | 52 (according to ESH census)<br>109 (ESH census + survey results) |
| **Future Inpatient Psychiatric Beds Needed by Type of Legal Status** | **Number of Beds Needed** |
| TDO* | |
| Commitment and Court-Mandated Admission (CMA)* | |
| NGRI | |
| Other Forensic (e.g., Jail TDO, Emergency Treatment, Evaluation, and Restoration) | |
| Total Number of Beds Needed According to Legal Status (This number should be equal to or less than the number listed above, i.e., all the psychiatric beds that are projected as needed by the Region.) | |

ASSUME CREATION OR EXPANSION OF CERTAIN SPECIFIED COMMUNITY SERVICES

| Future Inpatient Psychiatric Beds Needed by Service Type or Category | Number of Beds Needed |
|---|---|
| Acute Stabilization | |
| Intensive Care | |
| Intermediate Care | |
| Rehabilitation | |
| Total Number of Beds Needed According to Levels of Inpatient Service if 2012-2020 request is Funded | 70 |
| Total Number of Beds Needed According to Levels of Inpatient Service if community services requested for2006-2008, 2008-2010 and 2010-2012 requests are funded | 0 |
| **Future Inpatient Psychiatric Beds Needed by Type of Legal Status** | **Number of Beds Needed** |
| TDO* | |
| Commitment and Court-Mandated Admission (CMA)* | |
| NGRI | |
| Other Forensic (e.g., Jail TDO, Emergency Treatment, Evaluation, and Restoration) | |
| Total Number of Beds Needed According to Legal Status (This number should be equal to or less than the number listed above.) | |

If the Following Additional Community Service Capacity Was in Place in the Region:

| *Services Needed* | *Preferred Location(s)*<br>Identify the CSB area(s), if possible, or if this would be a regional service | *Capacity Needed* |
|---|---|---|
| ICT/PACT-like Regional Hub with Satellites | Regional | 1 team |
| Psychosocial Day Treatment | CSB (three) | 45 slots |
| State-funded Local Inpatient Psychiatric Beds for Older Adults | Regional | 30 beds |

* If a Region cannot separate its projected number of needed TDO and Commitment/CMA beds, it should indicate this in a footnote and insert a combined TDO and Commitment/CMA bed number in the TDO bed need row.

## Children/Adolescent Inpatient and Community Services

The Children and Adolescent Work Group (CAWG) is built upon an existing committee comprised of CSA (Comprehensive Services Act for Children) coordinators, CSB Youth and Family directors and private providers. Although they had several other important issues requiring their attention, they agreed to address the psychiatric bed issue, as well.

Their first task was to adjust the level of service definitions so that they apply to children and adolescents (Appendix F). The Work Group then inventoried the psychiatric hospitals that they use for children and adolescents and observed that most hospitalizations occur at private, not public, hospitals and that most of those private hospitalizations are at one local hospital. For youth, psychiatric hospitalization is a last resort and used as a temporary measure, until other residential treatment or community service is arranged.

The CAWG also identified critical service gaps that include:

- While preventive services for children at-risk of hospitalization are available, the funding for these services is limited and frequently unavailable. This funding gap often results in the use of more intensive services due to the availability of funding. These services also function as step-down services to facilitate a child's transition back to the community. When the transitional supports are not available, children are at greater risk of returning to an out-of-home placement.
- Crisis stabilization (non-medical acute residential) is not available for most children. Less intensive than hospitalization, crisis stabilization would allow diversion of a significant proportion of children back to community-based services vs. longer residential stays.
- Because long-term treatment for complex psychiatric needs does not exist in Northern Virginia, children needing this service have been placed out of the state. As of the fourth quarter of FY2004, Northern Virginia sent 103 children out-of-state for residential treatment at an estimated cost of $8.5 million dollars for the year.
- Specific populations without placement options in Northern Virginia include: sexually reactive/abusive youth, dually diagnosed MH/SA and psychiatric placement of pregnant teens.
- Long-term (rehabilitative) residential services are available but are funded only for children in foster care or those children whose IEP (individual education plan) specifies these services as needed for their education. Other children who need these services are limited to seeking funding through Medicaid (for as long as their stay is deemed "medically necessary").

The following information pertains to psychiatric inpatient bed needs and community alternatives to hospitalization. It includes a list of proposed community services to offset the need for inpatient psychiatric bed; a summary of the impact of the proposed community services on the need for inpatient beds; and the work sheets that are required by DMHMRSAS. In addition, a discussion of the need for youth sexual offender services, a priority issue with the group, is included as Appendix G.

## Community Services to Offset Need for Children/Adolescent Hospital Beds

| 2006-2008 | 2008-2010 | 2010-2012 | 2012-2020 |
|---|---|---|---|
| Youth Crisis Care:<br>▪ Acute psychiatric care in Fairfax and Arlington<br>▪ **Offset** .75 beds for each bed | ▪<br>Youth Crisis Care:<br>▪ Acute psychiatric care in Fairfax and Arlington<br>▪ **Offset** .75 beds for each bed<br>▪ | | |
| Transfer Adolescents with Mental Retardation from CCCA to a State Training Center<br>▪ Transfer to behavioral unit at a sate training center<br>▪ **Offset** (estimate one bed gained at CCCA) | Prescreening Prior to CCCA Admission for Evaluation<br>▪ Prescreening not currently<br>▪ Anticipate prescreening may result in diversion from hospital to alternative service<br>▪ **Offset** (estimate one bed gained at CCCA) | Health Family Intervention<br>▪ Prevention service<br>▪ Evidence-based practice<br>▪ Long-term outcome | Health Family Intervention<br>▪ Prevention service<br>▪ Evidence-based practice<br>▪ Long-term outcome |
| Sexual Offender Intensive Residential Program – Primary Treatment Services<br>▪ 12 beds | Health Family Intervention<br>▪ Prevention service<br>▪ Evidence-based practice<br>Long-term outcome | | |
| Sexual Offender Intensive Residential Program – Step-down Services<br>▪ 12 beds | | | |
| Support for Non-Mandated Youth Who Are Not Eligible for CSA funding | | | |

**Summary: Inpatient Psychiatric Bed Needs With and Without Additional Community Children and Adolescent Services**

| | 2006-2008 | 2008-2010 | 2010-2012 | 2012-2020 |
|---|---|---|---|---|
| Number of Inpatient Beds Needed without Additional Community Services (all payment sources) | 56 | 59 | 60 | 66 |
| Number of Inpatient Beds Needed without Additional Community Services - cumulative impact (all payment sources) | 43 | 36 | 37 | 43 |

REVISED WORKSHEET: MH INPATIENT BEDS NEEDED BY THE REGION

REGION: _____II_____ DATE (CIRCLE): 2006-08

CHILDREN/ADOLESCENTS

ASSUME NO MAJOR CHANGES IN THE REGION'S COMMUNITY SERVICES CAPACITY

| Future Inpatient Psychiatric Beds Needed by Service Type or Category | Number of Beds Needed |
|---|---|
| Acute Stabilization | |
| Intensive Care | |
| Intermediate Care | |
| Rehabilitation | |
| Total Number of Beds Needed According to Levels of Inpatient Service (This number should include all the psychiatric beds that are needed.) | 56 beds (CCCA: 8; Private48 for all payment sources) |
| Future Inpatient Psychiatric Beds Needed by Type of Legal Status | Number of Beds Needed |
| TDO* | |
| Commitment and Court-Mandated Admission (CMA)* | |
| NGRI | |
| Other Forensic (e.g., Jail TDO, Emergency Treatment, Evaluation, and Restoration) | |
| Total Number of Beds Needed According to Legal Status (This number should be equal to or less than the number listed above, i.e., all the psychiatric beds that are projected as needed by the Region.) | |

ASSUME CREATION OR EXPANSION OF CERTAIN SPECIFIED COMMUNITY SERVICES

| Future Inpatient Psychiatric Beds Needed by Service Type or Category | Number of Beds Needed |
|---|---|
| Acute Stabilization | |
| Intensive Care | |
| Intermediate Care | |
| Rehabilitation | |
| Total Number of Beds Needed According to Levels of Inpatient Service | 43 |
| Future Inpatient Psychiatric Beds Needed by Type of Legal Status | Number of Beds Needed |
| TDO* | |
| Commitment and Court-Mandated Admission (CMA)* | |
| NGRI | |
| Other Forensic (e.g., Jail TDO, Emergency Treatment, Evaluation, and Restoration) | |
| Total Number of Beds Needed According to Legal Status (This number should be equal to or less than the number listed above.) | |

If the Following Additional Community Service Capacity Was in Place in the Region:

| *Services Needed* | *Preferred Location(s)* Identify the CSB area(s), if possible, or if this would be a regional service | *Capacity Needed* |
|---|---|---|
| Youth Crisis Care | Fairfax-Falls Church, Arlington, | 16beds |
| Transfer Adolescents with Mental Retardation from CCCA to State Training Center | Behavioral Unit at State Training Center | 1 bed |
| Sexual Offender Treatment – Primary Treatment Services | Regional | 12 beds |
| Sexual Offender Treatment – Step-down Services | Regional | 12 beds |
| Support for Non-Mandated Youth Who Are Not Eligible for CSA Funding | Regional | |

REVISED WORKSHEET: MH INPATIENT BEDS NEEDED BY THE REGION

REGION: _____II_____ DATE (CIRCLE): 2008-10

COMPLETE SEPARATELY FOR EACH POPULATION GROUP: CIRCLE THE APPLICABLE GROUP:

CHILDREN/ADOLESCENTS

ASSUME NO MAJOR CHANGES IN THE REGION'S COMMUNITY SERVICES CAPACITY

| Future Inpatient Psychiatric Beds Needed by Service Type or Category | Number of Beds Needed |
|---|---|
| Acute Stabilization | |
| Intensive Care | |
| Intermediate Care | |
| Rehabilitation | |
| Total Number of Beds Needed According to Levels of Inpatient Service (This number should include all the psychiatric beds that are needed.) | 59 beds (State: 9; Private: 50 for all payment sources) |
| **Future Inpatient Psychiatric Beds Needed by Type of Legal Status** | **Number of Beds Needed** |
| TDO* | |
| Commitment and Court-Mandated Admission (CMA)* | |
| NGRI | |
| Other Forensic (e.g., Jail TDO, Emergency Treatment, Evaluation, and Restoration) | |
| Total Number of Beds Needed According to Legal Status (This number should be equal to or less than the number listed above, i.e., all the psychiatric beds that are projected as needed by the Region.) | |

ASSUME CREATION OR EXPANSION OF CERTAIN SPECIFIED COMMUNITY SERVICES

| Future Inpatient Psychiatric Beds Needed by Service Type or Category | Number of Beds Needed |
|---|---|
| Acute Stabilization | |
| Intensive Care | |
| Intermediate Care | |
| Rehabilitation | |
| Total Number of Beds Needed According to Levels of Inpatient Service | 49 |
| Total Number of Beds Needed According to Levels of Inpatient Service if community services requested for 2006-2008 are funded | 36 |
| **Future Inpatient Psychiatric Beds Needed by Type of Legal Status** | **Number of Beds Needed** |
| TDO* | |
| Commitment and Court-Mandated Admission (CMA)* | |
| NGRI | |
| Other Forensic (e.g., Jail TDO, Emergency Treatment, Evaluation, and Restoration) | |
| Total Number of Beds Needed According to Legal Status (This number should be equal to or less than the number listed above.) | |

If the Following Additional Community Service Capacity Was in Place in the Region:

| *Services Needed* | *Preferred Location(s)* Identify the CSB area(s), if possible, or if this would be a regional service | *Capacity Needed* |
|---|---|---|
| Prescreening Prior to Sending Adolescent to CCCA for 10 day evaluation | CCCA | 1 beds |
| Youth Crisis Care | Alexandria, Loudoun, Prince William | 12 beds |
| Healthy Family Intervention | | |

* If a Region cannot separate its projected number of needed TDO and Commitment/CMA beds, it should indicate this in a footnote and insert a combined TDO and Commitment/CMA bed number in the TDO bed need row.

REVISED WORKSHEET: MH INPATIENT BEDS NEEDED BY THE REGION

REGION: _____II_____ DATE (CIRCLE): 2010-12

COMPLETE SEPARATELY FOR EACH POPULATION GROUP: CIRCLE THE APPLICABLE GROUP:

CHILDREN/ADOLESCENTS

ASSUME NO MAJOR CHANGES IN THE REGION'S COMMUNITY SERVICES CAPACITY

| Future Inpatient Psychiatric Beds Needed by Service Type or Category | Number of Beds Needed |
|---|---|
| Acute Stabilization | |
| Intensive Care | |
| Intermediate Care | |
| Rehabilitation | |
| Total Number of Beds Needed According to Levels of Inpatient Service (This number should include all the psychiatric beds that are needed.) | 60 beds (State: 9; Private: 51) |
| **Future Inpatient Psychiatric Beds Needed by Type of Legal Status** | **Number of Beds Needed** |
| TDO* | |
| Commitment and Court-Mandated Admission (CMA)* | |
| NGRI | |
| Other Forensic (e.g., Jail TDO, Emergency Treatment, Evaluation, and Restoration) | |
| Total Number of Beds Needed According to Legal Status (This number should be equal to or less than the number listed above, i.e., all the psychiatric beds that are projected as needed by the Region.) | |

ASSUME CREATION OR EXPANSION OF CERTAIN SPECIFIED COMMUNITY SERVICES

| Future Inpatient Psychiatric Beds Needed by Service Type or Category | Number of Beds Needed |
|---|---|
| Acute Stabilization | |
| Intensive Care | |
| Intermediate Care | |
| Rehabilitation | |
| Total Number of Beds Needed According to Levels of Inpatient Service if 2010-2012 request is Funded | 60 |
| Total Number of Beds Needed According to Levels of Inpatient Service if community services requested for2006-2008, 2008-2010 and 2010-2012 requests are funded | 37 |
| **Future Inpatient Psychiatric Beds Needed by Type of Legal Status** | **Number of Beds Needed** |
| TDO* | |
| Commitment and Court-Mandated Admission (CMA)* | |
| NGRI | |
| Other Forensic (e.g., Jail TDO, Emergency Treatment, Evaluation, and Restoration) | |
| Total Number of Beds Needed According to Legal Status (This number should be equal to or less than the number listed above.) | |

If the Following Additional Community Service Capacity Was in Place in the Region:

| *Services Needed* | *Preferred Location(s)* Identify the CSB area(s), if possible, or if this would be a regional service | *Capacity Needed* |
|---|---|---|
| Healthy Family Intervention | | |

* If a Region cannot separate its projected number of needed TDO and Commitment/CMA beds, it should indicate this in a footnote and insert a combined TDO and Commitment/CMA bed number in the TDO bed need row.

REVISED WORKSHEET: MH INPATIENT BEDS NEEDED BY THE REGION

REGION: _____II_____ DATE (CIRCLE): 2012-20

COMPLETE SEPARATELY FOR EACH POPULATION GROUP: CIRCLE THE APPLICABLE GROUP:

CHILDREN/ADOLESCENTS

ASSUME NO MAJOR CHANGES IN THE REGION'S COMMUNITY SERVICES CAPACITY

| Future Inpatient Psychiatric Beds Needed by Service Type or Category | Number of Beds Needed |
|---|---|
| Acute Stabilization | |
| Intensive Care | |
| Intermediate Care | |
| Rehabilitation | |
| Total Number of Beds Needed According to Levels of Inpatient Service (This number should include all the psychiatric beds that are needed.) | 66 beds (State: 10; Private: 56 |
| **Future Inpatient Psychiatric Beds Needed by Type of Legal Status** | **Number of Beds Needed** |
| TDO* | |
| Commitment and Court-Mandated Admission (CMA)* | |
| NGRI | |
| Other Forensic (e.g., Jail TDO, Emergency Treatment, Evaluation, and Restoration) | |
| Total Number of Beds Needed According to Legal Status (This number should be equal to or less than the number listed above, i.e., all the psychiatric beds that are projected as needed by the Region.) | |

ASSUME CREATION OR EXPANSION OF CERTAIN SPECIFIED COMMUNITY SERVICES

| Future Inpatient Psychiatric Beds Needed by Service Type or Category | Number of Beds Needed |
|---|---|
| Acute Stabilization | |
| Intensive Care | |
| Intermediate Care | |
| Rehabilitation | |
| Total Number of Beds Needed According to Levels of Inpatient Service if 2012-2020 request is Funded | 66 |
| Total Number of Beds Needed According to Levels of Inpatient Service if community services requested for2006-2008, 2008-2010 and 2010-2012 requests are funded | 43 |
| **Future Inpatient Psychiatric Beds Needed by Type of Legal Status** | **Number of Beds Needed** |
| TDO* | |
| Commitment and Court-Mandated Admission (CMA)* | |
| NGRI | |
| Other Forensic (e.g., Jail TDO, Emergency Treatment, Evaluation, and Restoration) | |
| Total Number of Beds Needed According to Legal Status (This number should be equal to or less than the number listed above.) | |

If the Following Additional Community Service Capacity Was in Place in the Region:

| *Services Needed* | *Preferred Location(s)* Identify the CSB area(s), if possible, or if this would be a regional service | *Capacity Needed* |
|---|---|---|
| Healthy Family Intervention | | |

* If a Region cannot separate its projected number of needed TDO and Commitment/CMA beds, it should indicate this in a footnote and insert a combined TDO and Commitment/CMA bed number in the TDO bed need row.

## Appendix A. Northern Virginia Population Growth, Estimates for 2000-2020

| | 2000 | | 2005 | | 2006-2008 | | 2008-2010 | | 2010-2012 | | 2012-2020 | | Increase 2005-2020 | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Number | Percentage | Number | Percentage | Number | Percentage | Number | Percentage | Number | Percentage | Number | Percentage | Number | Percentage |
| 0-18 years | 487,007 | | 538,674 | | 572,657 | | 591,811 | | 606,049 | | 666,248 | | 127,574 | |
| Growth Rate | | | | | | 1.0630 | | 1.0334 | | 1.0240 | | 1.0993 | | 1.2368 |
| | | | | | | 6.30% | | 3.34% | | 2.40% | | 9.93% | | 23.68% |
| 19-64 years | 1,196,747 | | 1,343,315 | | 1,439,850 | | 1,495,092 | | 1,528,026 | | 1,655,322 | | 312,007 | |
| Growth Rate | | | | | | 1.0719 | | 1.0384 | | 1.0220 | | 1.0833 | | 1.2323 |
| | | | | | | 7.19% | | 3.84% | | 2.20% | | 8.33% | | 23.23% |
| 65+ years | 135,683 | | 163,096 | | 183,287 | | 197,079 | | 211,527 | | 269,775 | | 106,679 | |
| Growth Rate | | | | | | 1.1238 | | 1.0752 | | 1.0733 | | 1.2754 | | 1.6541 |
| | | | | | | 12.38% | | 7.52% | | 7.33% | | 27.54% | | 65.41% |

## Appendix B. Proposed Service Arrangements for Adults in Northern Virginia, 2004-2020

| | 2004/2005 Base | | 2006-2008 | | 2008-2010 | | 2010-2012 | | 2012-2020 | |
|---|---|---|---|---|---|---|---|---|---|---|
| | **State Beds** | **Local Hosp.** | **State Beds** | **Local Hosp.** | **State Beds** | **Local Hosp.** | **State Beds** | **Local Hosp.** | **State Beds** | **Local Hosp.** |
| Acute Stabilization (TDO+Acute Care) | 3.8% NVMHI | 22.9% Total Usage | 5% NVMHI | 100% public purchase | 5.0% NVMHI | 100% public purchase | 5.0% NVMHI | 100% public pur-chase | 5.0% NVMHI | 100% public purchase |
| Intensive Care | 13.8% NVMHI | 23.9% Total Usage | 42% NVMHI | | 42% NVMHI | | 42% NVMHI | | 42% NVMHI | |
| Intermediate Care | 36.9% NVMHI | 29.3% Total Usage | 42% NVMHI | | 42% NVMHI | | 42% NVMHI | | 42% NVMHI | |
| Rehabilitation | 45.4% NVMHI | 23.9% Total Usage | 11% NVMHI | | 11% NVMHI | | 11% NVMHI | | 11% NVMHI | |
| Proposed NVMHI Beds | 129 | | 129 | | 129 | | 129 | | 129 | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| Growth Rates | | | 1.0718 | | 1.0384 | | 1.022 | | 1.0833 | |
| | | | 7.18% | | 3.84% | | 2.20% | | 8.33% | |

## Appendix C. Recommendations for Forensic Services

**Assumption:** It is preferable that patients be treated in their own community.

**Related Factors**:
- Attorneys may advise offender to plead NGRI without fully understanding the consequences of this decision.
- Linkages between CSH and NVMHI should be explored, especially as to the timing of transferring patients to NVMHI. Some NGRI patients are transferred to NVMHI years before they will be eligible for community passes.
- Forensic charges are sometimes related to homelessness.
- Virginia has a risk-adverse posture which may preclude some community services.

| | |
|---|---|
| **NGRI – Inpatient**<br>• LOS at NVMHI is extensive.<br>• Need statewide specialized inpatient treatment unit focused on :<br>o Community Re-entry<br>o Substance abuse services and Relapse Prevention<br>o Pre-vocational and vocational services<br>• Expand NVMHI or other facility? | **NGRI – Community**<br>• Use of crisis care facility for 48 hour passes<br>• Gradual integration into home community<br>• 24/7 residential placement<br>• Need adequate resources<br>o Work Adjustment Training (pre-vocational, vocational, supported employment)<br>o Club houses<br>o Full continuum of services<br>• Co-occurring disorders specialty services |
| **Forensics – Inpatient**<br>• Specialized contract services<br>• Adequately resourced<br>• Unit in local community for a subset of forensic clients<br>• Can't use WSH unless increase beds | **Forensics – Community**<br>• Jail or relevant community services<br>• Circuit riders for evaluations (new funds needed)<br>• Look at LOS<br>• Limitations of what can be done in jail, e.g., medications<br>• Need jail diversion<br>• Where is the most ethically and clinically-efficient place to do evaluations?<br>• MH courts<br>• Look closer at client data<br>• Endorse concept of minimum MH services in jail<br>• Co-occurring disorders specialty services |

**Appendix D. Services for Persons with Co-Occurring Disorders**

## Persons with Co-occurring Disorders (MH/SA) Should Be Treated In NV with a Full Continuum of Care

*All Services Specializing in Co-Occurring Disorders*

**Inpatient**

- **Establish Co-Occurring Disorders Unit**
  - **Contract w/ existing facility**
  - **Build new facility**
  - **Have NVMHI Unit w/ specialized services**
- **Specialized Services:**
  - **Co-Occurring Disorders (COD) groups**
  - **Relapse prevention**
  - **Vocational services**
  - **Discharge planning, incl. readiness steps, e.g., 24 hr or 48 hr passes**
  - **Linkage w/ self-help groups**

**Community**

- **Up to 23 hr bed social detox stabilization**
- **Crisis Detox facility (contract, build)**
  - **Also used for 24 or 48 hr passes**
- **Increase COD bed capacity in existing programs**
- **Local 24/7 residential facility**
- **Modified therapeutic community**
- **Halfway house**
- **Intensive and clinical case management services**
- **COD Outpatient and Medication Services**
- **MH/SA services in jail**
- **Jail diversion**
- **Specialty courts**
- **COD staff training: all staff COD capable; some staff COD enahnced**

## Appendix E. Service Definitions for Older Adults

| *LEVEL I: Acute Stabilization/Level 2 Intensive Care for Older Adults* | | |
|---|---|---|
| Need Indicator | Interventions | Expected Outcomes |
| High Acuity<br><br>High Complexity<br>• Substance-induced symptomatology<br>• Situational crises resulting from psychosocial stressors<br>• Situational difficulties resulting from Axis II symptomatology<br>• Not taking prescribed medication or in need of medication adjustment (with history of good response to medication<br>• Unsafe behaviors requiring intervention<br>• Current lack of willingness or ability to participate in treatment<br>• First episode of acute psychiatric illness with Axis I diagnosis or psychotic symptoms and aggressive behaviors induced by a neurological/medical condition requiring psychotropic medication and behavioral interventions to stabilize. Typically presented in an older patient. | Acute Stabilization requires a multidisciplinary treatment model and a higher staff to patient ratio than intermediate care or rehabilitation services. Interventions are focused around resolution of psychiatric crisis and rapid return to the community. Interventions are focused around resolution of psychiatric crisis, assessment of clients' psychiatric as well as neurological and medical conditions, stabilization of dangerous and aggressive behaviors and return to the community or transfer or discharge to a lower level of care. Although they will vary depending upon the individual and the nature of the presenting problem, interventions typically involve:<br>• Increased level of observation<br>• Highly structured treatment milieu<br>• Risk assessment<br>• Frequent, ongoing clinical assessment<br>• Patient and family education and involvement<br>• Cultural/interpretive services<br>• Acute crisis counseling<br>• Detoxification management<br>• Medication stabilization<br>• Medication education<br>• Potential need for physical interventions to manage self-injurious or aggressive behaviors<br>• Medical management, including potential for emergency medication<br>• Immediate, aggressive discharge planning<br>• Consultation and collaboration with other specialists including, but not limited to, neurologists and internal medicine specialists. | • 2-3 weeks Rapid stabilization of symptoms<br>• Resolution of risk/safety issues<br>• Effective continuity of care plan<br>• Linkages with substance abuse services<br>• Timely communication and appointments with community providers<br>• Discharge plan considers all safety and functioning level needs of client. |

| *LEVEL II: Intensive Care (Combine with Level 1) for Older Adults* | | |
|---|---|---|
| Need Indicator | Interventions | Expected Outcomes |
| High Complexity<br><br>High Acuity<br>• Unsafe behaviors requiring intervention<br>• Current lack of willingness or ability to participate in treatment | Intensive Care necessitates an interdisciplinary treatment model to fully address complexity of presenting problems, and interventions require a higher staff to patient ratio than intermediate care or rehabilitation services. Interventions are focused around resolution of more long-term, persistent or recurrent psychiatric difficulties and return to the community with the expectation of improved community tenure. Treatment may be characterized by:<br>• Possible increased level of observation<br>• Structured treatment milieu<br>• On-going risk assessment<br>• Frequent, ongoing clinical assessment<br>• Legal authorization of treatment<br>• Flexible assessment and treatment approaches<br>• Highly individualized services<br>• Modalities which encourage motivation and engagement in treatment<br>• Patient and family education and involvement<br>• Cultural/interpretive services<br>• Group and individual treatment modalities<br>• Behavioral assessment and intervention services<br>• Primary care services to address medical co-morbidity<br>• Stabilization & on-going management of medical issues<br>• Medication education<br>• Medication management<br>• Potential need for physical intervention<br>• Potential need for emergency medication<br>• Individualized, creative, and flexible discharge planning<br>• Supported transition to community services | • Length of stay 30 days or less<br>• Stabilization of symptoms<br>• Resolution of risk issues<br>• Effective continuity of care plan<br>• Highly individualized discharge plan, including co-morbidity issues addressed<br>• Linkages with community substance abuse services<br>• Linkages with Primary Care service in community<br>• Timely communication/ appointments with community providers<br>• Beginning readiness to explore relapse prevention and recovery |

| *LEVEL III: Intermediate Care for Older Adults* | | |
|---|---|---|
| Need Indicator | Interventions | Expected Outcomes |
| High Complexity<br>Variable Acuity<br>• Residential instability<br>• Sustained imminence of risk to self or others<br>• Challenging behaviors with complex etiologies<br>• Inconsistent self-management of symptoms or need for changes in relapse prevention plan | Intermediate Care: An interdisciplinary treatment model is required to address complexity found at this level of care. Staffing levels that are lower than acute or intensive care levels of care, but which have flexibility to address variable acuity, are required for this level of care. Treatment is focused on resolution of identified barriers to recovery and identification of placement and services supportive of a successful transition to, and tenure in, the community. Interventions may include:<br>• Variable levels of observation<br>• Structured treatment milieu<br>• On-going risk assessment<br>• Possible legal authorization of treatment<br>• Modalities which encourage motivation and engagement in treatment<br>• Individual Psychotherapy<br>• Patient and family involvement and education<br>• Cultural and interpretive services<br>• Psychosocial Rehabilitation programming<br>• Vocational Rehabilitation services<br>• Skill building<br>• Behavioral assessment and intervention services<br>• Substance abuse programming, services, and referrals<br>• Forensic services<br>• Co-morbidity/ Primary care services<br>• Complex medication management<br>• Potential need for physical intervention<br>• Potential for emergency medication<br>• Extensive residential planning<br>• Creative discharge planning, including consideration of step down or wrap around services<br>• Supported transition to community services<br>• Individualized Integration of Recovery-informed Interventions | • Length of stay greater than 30 days<br>• Stabilization of symptoms to support recovery and relapse prevention<br>• Attainment of functional skills required for goal achievement and recovery<br>• Progression through NGRI privileging process<br>• Linkages with outpatient substance abuse and primary care services<br>• Successful transition to community-based living situation |

| *LEVEL IV: Rehabilitation Services for Older Adults* | | |
|---|---|---|
| Need Indicator | Interventions | Expected Outcomes |
| High Complexity<br><br>Low Acuity<br>• Active co-morbid medical complications<br>• Lack of confidence in ability to recover<br>• Lack of clarity around recovery goals<br>• Continued and unstable episodes of aggression to self or others preventing discharge to a nursing home, ALF or community<br>- | Rehabilitation Services: A multi-disciplinary treatment model with a lower staff to patient ratio and more independent involvement in treatment and recovery is characteristic of this level of care. Focus of treatment is on solidification of adaptive skills, independent management of chronic symptomatology, and development of community supports and a network of services to support enduring success following discharge. Interventions at this level of care typically include:<br>• Motivational/engagement modalities<br>• Integration of recovery-informed interventions<br>• Patient and family education and involvement<br>• Individual Psychotherapy<br>• Cultural/Interpretive services<br>• Psychosocial Rehabilitation programming<br>• Vocational rehabilitation services<br>• Transportation skill building/services<br>• Forensic services<br>• Substance abuse programming/referrals<br>• Emphasis on independent medication management (vs. medication education)<br>• Medical illness management/primary care services<br>• Discharge planning<br>• Extensive residential planning<br>• Community reintegration<br>• Supportive transition services<br>• Provision of personal care | • Length of stay greater than 30 days<br>• Maintenance of symptoms at baseline<br>• Acquisition of adaptive skills and improvements in adaptive functioning<br>• Identification and clarification of recovery goals<br>• Increased self confidence and hope<br>• Progression through NGRI privileging process<br>• Maintenance of medical/physical health<br>• Successful transition to residential placement<br>• Some may require permanent placement in a State run psychiatrically oriented long-term care facility much like the current ESH Geriatric Program |

## Appendix F. Level of Service Definitions for Children and Adolescents

| | Level I<br>ACUTE | Level II<br>INTENSIVE | Level III<br>INTERMEDIATE-LONG TERM HOSPITALIZATION | Level IV<br>RESIDENTIAL |
|---|---|---|---|---|
| Private Hospitals<br>Acute Stabilization<br>TDO<br>Commitment | ✔ | May provide but not publicly funded. May be funded though private pay, CSA. | May provide but not publicly funded. May be funded through private pay, CSA. | |
| CCCA<br>Acute Stabilization<br>TDO<br>Commitment<br>Intensive Care<br>Intermediate Care<br>Forensics (10 day evaluations | ✔ | ✔ | ✔ | |
| Community<br>Acute Stabilization<br>Rehab | ✔ | | | ✔ |

| *LEVEL I: Acute Stabilization for Children and Adolescents* | | |
|---|---|---|
| Need Indicator | Interventions | Expected Outcomes |
| • Substance-induced symptomatology<br>• Situational crises resulting from psychosocial stressors<br>• Situational difficulties resulting from Axis II symptomatology<br>• Not taking prescribed medication or in need of medication adjustment (with history of good response to medication | Acute Stabilization requires a multidisciplinary treatment model and a higher staff to patient ratio than intermediate care or rehabilitation services. Interventions are focused around resolution of psychiatric crisis and rapid return to the community. Although they will vary depending upon the individual and the nature of the presenting problem, interventions typically involve:<br>• Possible Increased level of observation<br>• Structured treatment milieu<br>• Risk assessment<br>• Legal authorization for treatment<br>• Frequent, ongoing clinical assessment<br>• Forensic services<br>• Patient and family education and involvement<br>• Cultural/interpretive services<br>• Acute crisis counseling<br>• Detoxification management<br>• Medication stabilization<br>• Medication education<br>• Potential need for physical interventions to manage self-injurious or aggressive behaviors<br>• Medical management, including potential for emergency medication<br>• Immediate, aggressive discharge planning | • Short length of stay (2-5 days)<br>• RAPID STABILIZATION OF SYMPTOMS<br>• Resolution of risk/safety issues<br>• Effective continuity of care plan<br>• Linkages with substance abuse services and other primary core services in community<br>• Timely communication and appointments with community providers |

| *LEVEL II: Intensive Care for Children and Adolescents* | | |
|---|---|---|
| Need Indicator | Interventions | Expected Outcomes |
| • Unsafe behaviors requiring intervention<br>• Current lack of willingness or ability to participate in treatment | Intensive Care necessitates an interdisciplinary treatment model to fully address complexity of presenting problems, and interventions require a higher staff to patient ratio than intermediate care or rehabilitation services. Interventions are focused around resolution of more long-term, persistent or recurrent psychiatric difficulties and return to the community with the expectation of improved community tenure. Treatment may be characterized by:<br>• Increased level of observation<br>• Highly Structured treatment milieu<br>• On-going risk assessment<br>• Frequent, ongoing clinical assessment<br>• Legal authorization of treatment<br>• Flexible assessment and treatment approaches<br>• Highly individualized services<br>• Modalities which encourage motivation and engagement in treatment<br>• Patient and family education and involvement<br>• Cultural/interpretive services<br>• Individual, Family and Group treatment modalities<br>• Acute Crisis Counseling<br>• Detox Management<br>• Educational Services<br>• Behavioral assessment and intervention services<br>• Primary care services to address medical co-morbidity<br>• Stabilization & on-going management of medical issues<br>• Medication Stabilization<br>• Medication education<br>• Medication management including need for emergency medication<br>• Potential need for physical intervention to manage self injury/aggressive behavior<br>• Potential need for emergency medication<br>• Forensic Services<br>• Individualized, creative, and flexible discharge planning<br>• Supported transition to community services | • Length of stay 30 days or less<br>• Stabilization of symptoms<br>• Resolution of risk issues<br>• Effective continuity of care plan<br>• Highly individualized discharge plan, including co-morbidity issues addressed<br>• Linkages with community substance abuse services<br>• Linkages with Primary Care service in community<br>• Timely communication/ appointments with community providers<br>• Beginning readiness to explore relapse prevention and recovery |

| *LEVEL III: Intermediate Care/Long Term Hospitalization for Children and Adolescents* | | |
|---|---|---|
| Need Indicator | Interventions | Expected Outcomes |
| • Residential instability<br>• Sustained imminence of risk to self or others<br>• Challenging behaviors with complex etiologies<br>• Inconsistent self-management of symptoms or need for changes in relapse prevention plan | Intermediate Care: An interdisciplinary treatment model is required to address complexity found at this level of care. Staffing levels that are lower than acute or intensive care levels of care, but which have flexibility to address variable acuity, are required for this level of care. Treatment is focused on resolution of identified barriers to recovery and identification of placement and services supportive of a successful transition to, and tenure in, the community. Interventions may include:<br>• Variable levels of observation<br>• Structured treatment milieu<br>• On-going risk assessment<br>• Legal authorization of treatment<br>• Modalities which encourage motivation and engagement in treatment<br>• Individual, family and group treatment modalities<br>• Patient and family involvement and education<br>• Cultural and interpretive services<br>• Psychosocial Rehabilitation programming<br>• Vocational Rehabilitation services<br>• Skill building<br>• Behavioral assessment and intervention services<br>• Substance abuse programming, services, and referrals<br>• Forensic services<br>• Co-morbidity/ Primary care services<br>• Complex medication management<br>• Potential need for physical intervention<br>• Potential for emergency medication<br>• Extensive residential planning<br>• Creative discharge planning, including consideration of step down or wrap around services<br>• Supported transition to community services<br>• Individual and Family integration around recovery principals | • Length of stay greater than 30 days<br>• Stabilization of symptoms to support recovery and relapse prevention<br>• Attainment of functional skills required for goal achievement and recovery<br>• Progression through NGRI privileging process<br>• Linkages with outpatient substance abuse and primary care services<br>• Successful transition to community |

| *LEVEL IV: Residential Services for Children and Adolescents* | | |
|---|---|---|
| Need Indicator | Interventions | Expected Outcomes |
| • Active co-morbid psychiatric and environmental complications<br>• Lack of confidence in ability to recover with family support needed<br>• Lack of clarity around recovery goals | Residential Services: Long term structured setting where the youth is placed outside his/her residence. Interventions are provided by a multi-disciplinary treatment team with the goal of learning and incorporating adaptive functioning skills, independent management of chronic symptomatology, and development of family and community supports through a network of wraparound supports to ensure ongoing success following completion of the program. Interventions at this level of care typically include:<br>• Motivational/engagement modalities<br>• Integration of recovery-informed interventions<br>• Patient and family education and involvement<br>• Individual, Family and group treatment modalities<br>• Educational Services<br>• Psychosocial Rehabilitation programming<br>• Transportation skill building/services<br>• Forensic services<br>• Substance abuse programming/referrals<br>• Emphasis on independent/family medication management and support<br>• Medical illness management/primary care services<br>• Discharge planning<br>• Discharge and step down service planning<br>• Community reintegration<br>• Supportive transition services | • Length of stay greater than 30 days<br>• Maintenance of symptoms at baseline<br>• Acquisition of adaptive skills and improvements in adaptive functioning<br>• Identification and clarification of recovery goals<br>• Increased self confidence and hope<br>• Academic achievement<br>• Maintenance of medical/physical health<br>• Successful transition back to the family/guardian in the community |

## Appendix G. Youth Sexual Offender Report (to be included in final version)

### Northern Virginia Regional Gaps and Barriers in Services for Sexually Abusive Youth

This workgroup examined the existing continuum of services within and outside the Northern Virginia region. To determine the need for services a survey was conducted across the region of the number of youth being served during 2003 for sexually abusive behaviors. Those known to the CSA system accounted for 111, 74 of whom were receiving residential services outside of the Northern Virginia region. It is estimated that a similar number of children were receiving predominantly outpatient services within the region for comparable issues (but outside of the awareness of the CSA system.)

Appropriate treatment settings more intensive than outpatient are not available in the Northern Virginia region. Such services would allow youth to remain in, or transition back to, a less restrictive setting. The costs of placing children in more restrictive residential settings are not limited to the greater financial impact, but include a reduction in treatment efficacy resulting from the family's inability to more fully participate in the treatment process. Recommendations are on page 43.

**Continuum of Care was defined in 4 major categories:**

**I CASE ASSESSMENT**

Components:

- Assessment (Risk and Psychosexual Assessment)
- Determining needs
- Determining services
- Legal/Court status

Barrier: Staff is legally prevented from sharing information, (i.e. assessment data prior to adjudication due to the individual rights of those charged.)

Gap: A secure assessment center would allow the time to do a comprehensive assessment of risk and plan for the most appropriate level of treatment services.

**II SERVICE DELIVERY**

Child/Youth's Treatment: Any of the following might be the most appropriate placement either initially or during a step-down process.

- Out-patient services with qualified staff;
- Home-based treatment with qualified staff;
- Local out-of-home placement (with qualified staff);
- Treatment foster care (availability of trained/experienced foster parents);
- Group home;
- Local secure residential facility.

Family/Victim Treatment/Services: Families and victims should be assisted in addressing the impact and implications of the abuses committed. This is absolutely necessary if reunification is to occur, and is strongly recommended otherwise. Victims must often be encouraged to obtain help.

- Therapeutic out-patient services;
- Local vs. distant residential services;
- Respite services;
- Out-patient and support services for the victim.

Barriers:
Awareness and practice of best practices
Limited cultural competence in assessment, treatment and other services
Location of residential facilities with qualified staff

Gaps:
Availability and training of therapeutic foster parents and local group homes

Coordinated services to families while their child is in residential facility (primarily due to distant location of residential facilities)
Family therapy, education, and victim treatment does not occur consistently due to lack of follow-through by family or by case managers
Treatment for out-of-family victim – including follow through by case manager
Case managers are not trained in best practices and community containment model

## III SERVICES FROM STEP-DOWN TO CLOSURE

Elements:

- Coordinated discharge/transition planning;
- Less restrictive setting;
- Out-patient and/or home-based treatments;
- Family reunification;
- Stabilization of family;
- Case closure, and
- Post-case assessment/follow-up.

Gaps
Group Homes
Therapeutic Foster Care
Out-patient therapy
Educational environment

## IV POST TREATMENT SERVICES

After Care:

- 6 – 12 month follow up care is needed and not routinely provided.
- Assess the offender and the family – treatment/support needs to be determined based on risk
- Refer to ongoing support services (sexually abusive youth, victim, siblings and family)

Gaps
Relapse prevention groups
Support groups (for sexually abusive youth, victim, siblings and family)

Barrier
No leverage with clients to encourage their follow-through
Cost of treatment

## V. RECOMMENDATIONS ON MAJOR GAPS IN THE CONTINUUM OF CARE:

#1 Recommendation: Develop options for secure assessment center, potentially using detention center space.
follow direction of Regional CPMT towards implementing service. Development of a secure assessment facility in northern Virginia. (high priority) A secure short-term assessment facility would allow the time necessary to determine the most appropriate placement for each youth. Currently, youth whose risk for re-offending cannot be assessed fully are frequently sent to a more restrictive treatment setting to err on the side of safety for the victim(s) and the community.
Time Frames:

- 6 months (by the September 2005 meeting of the Regional CPMTs.) Workgroup to identify options for consideration
- July 2006. Workgroup to

#2 Recommendation: Develop services with existing providers (through contract and/or RFP processes) with consideration to provision of self-contained or public-school based educational services.

Develop in-region out-of-home placements: Including therapeutic foster homes and group homes. (short-term goal) Youth who must be out of their own home either during an assessment (in a non-secure setting) or for a treatment episode (primary or step-down treatment) currently typically must leave the Northern Virginia area to obtain these services. This prohibits family involvement and complicates transitioning back to their home community. There is also great difficulty obtaining educational services in public school settings for these children.

Time Frames:

- 6 months (for September 2005 meeting of the Regional CPMTs.) Workgroup to identify providers interested in developing facilities in Northern Virginia and make recommendations for contracting.
- Service implementation time frame to be determined based on decisions made by the Regional CPMT (i.e. regarding availability of potential providers and their ability to begin operations.)

#3 Recommendation: Identification of existing qualified assessment, outpatient, home-based, and aftercare providers; and implementation **of standards and trainings recommended in the following two sections.**

Enhanced services to family members (including victim, siblings and other identified family members.) (short-term goal) The services to family members and victims (when not family members) are not consistently provided. This is less of an issue of service availability, than it is of case management and best practices. Family members and victims should be actively encouraged and supported to obtain an evaluation and any subsequent treatment services based on their needs.

Time frames:

- June 2005. Arrange and conduct a regional forum of public and private agencies involved in the management of sexually abusive youth. Insure that participants would support regional efforts around training and service development and solicit additional ideas and recommendations.
- November 2005. Regional Training Team to arrange and provide "Sexually Abusive Youth Overview Training" for identified representatives from all involved jurisdictions.

#4 Recommendation: Identification of regional representatives to coordinate with an ongoing Metropolitan Council of Governments (COG) workgroup, also working on these issues, to identify providers and/or develop services.

Sexually abusive youth residential treatment facility in Northern Virginia. (long-term goal) Through coordinated efforts with representatives of Maryland and Washington, D.C. determination of potential sites and providers of residential treatment services for sexually abusive youth to be determined.

Time frames:

- Sept 2005. Workgroup to report back to Regional CPMT on structure and progress of group exploring residential treatment options with the Metropolitan Council of Government workgroup.
-

## Northern Virginia Regional Standards for Treatment and Management of Sexually Abusive Youth

### I. Goal and Purpose of Standards:

To maintain a comprehensive high quality continuum of services provided by a treatment team which is most effective at providing appropriate outcomes for sexually abusive youth and ensures consistency in quality of services across the region.

### II. Principles

1. Community safety takes precedence over the treatment of the youth, however, treatment and management of sexually abusive youth should be provided in the most appropriate, least restrictive, environment.

2. Management of sexually abusive behavior is a lifelong task, and the goal of an integrated multi-modal treatment program is to minimize the risk of re-offending. The process will involve multiple stages of treatment with planning based on assessment of risk, treatment and supervision needs.

3. The best outcomes occur when youth have access to an informed, cooperative and supportive social network which is closely linked to and collaborates with their treatment team (including group, individual, and family therapists, case workers, school, court case managers, family members and other community supports).

4. Accountability and responsibility are major components, and objectives of all treatment modalities.

5. Court involvement is a necessary component of effective treatment and management to ensure cooperation and follow through.

6. Staff at all levels requires ongoing training in current research and best practices related to sexual offender treatment.

7. Minimum steps that must be taken as part of treatment include:
   a) confronting the sex abuser's denial;
   b) acknowledging culpability for their sexual problem;
   c) identifying and describing the pattern of their problematic behaviors;
   d) decreasing and developing control of deviant sexual arousal;
   e) facilitating the development of non-deviant sexual interests;
   f) understanding and articulating how their sexual behaviors had met sexual or non-sexual needs;
   g) understanding and articulating their cycle of offending;
   h) developing social and/or sexual skills as alternatives to their sexual or aggressive actions;
   i) demonstrating victim awareness
   j) clarifying cognitive distortions
   k) teaching the juvenile to recognize the internal and external antecedents of sexual offending behavior with appropriate intervention strategies;
   l) safety planning and relapse prevention; and
   m) assess and address the needs of all family members in the home.

8. Professionals conducting evaluations or providing treatment of sexually abusive youth must be well versed in working with this population. Towards this end they shall be Certified Sexual Offender Treatment Providers (CSOTP) and shall conduct services in accordance with the Practice Standards and Guidelines of the Association for the Treatment of Sexual Abusers.

9. Victims of sexual abuse should be assessed and referred to, or provided, treatment as deemed necessary. Treatment for victims should be coordinated with the sexual offenders' treatment when both are from the same family.

10. Treatment providers, case workers and evaluators should be culturally competent in working with the youth and family.

## III. Standards for Sexual Offender Assessments

1. At the end of the assessment process, the assessing professional should be prepared to address the following issues and to provide guidance to other professionals, the juvenile court and community agencies:
   - The risk of repeating the sexually aggressive behavior;
   - The treatment needs of the individual and his family;
   - The appropriateness of removing the sexual abuser from his family;
   - The appropriate treatment program for the abuser, e.g. a community outpatient treatment program or a more restrictive environment, such as a detention center, residential program, or inpatient unit.

2. Clinical assessments for sexually abusive youth are to address each of the following issues:

- Degree of cooperation.
- Honesty and forthrightness of the abuser.
- Degree of acceptance of responsibility for sexual offenses.
- Degree of remorse and regret.
- Relationship between the abuser and the victim.
- Age difference between the abuser and the victim.
- Characteristics of the sexual aggressive behavior.
- Frequency and duration of the sexual aggressive behavior.
- Precipitating factors that led to the sexual offense.
- Premeditated or impulsive.
- Characteristics of the victim that attracted the offender.
- Nature and extent of the coercive behaviors.
- Behaviors prior to, during and post sexual offense.
- Affect states prior to, during and post sexual offenses.
- Verbal interchange with the victim.
- Attempts to avoid detection.
- Understanding of the effects of his sexual behavior on the victim.
- Insight into the wrongfulness of his sexual behavior.
- Understanding of the consequences of his behavior.

3. All evaluations should include summaries of the following:

   a) *The Sexual-Aggressive History*. The assessment should obtain the juvenile's sexual history and assesses their sexual knowledge and education, sexual development, and sexual experiences. Inquiries are directed to learn what the juvenile knows about gender differences, sexual intercourse, and preferred patterns of sexual behaviors. It is necessary to discriminate between compulsive sexual behaviors and paraphilic compulsive sexual behaviors. Is there a history of arrests, convictions, incarcerations, use of weapons or cruelty to animals?

   b) *Developmental and Psychosocial History*. Other areas of the assessment process are those associated with a comprehensive developmental history, i.e., the nature of the pregnancy, perinatal history, developmental milestones, family relationships, early identificatory models, capacity for relationships, peer relationships and social skills.

   c) *Medical and Psychiatric History*. It is important to obtain a comprehensive medical and psychiatric history with specific attention to psychopathology, substance abuse and psychiatric co-morbidity.

   d) *School History*. A specific area of concern is the evaluation of intellectual capacities, and academic performance. Fifty to eighty percent of juvenile sexual abusers have learning problems, repeated a grade in school, and/or have been in classes for the learning disabled.

   e) *Mental Status Examination*. A comprehensive mental status examination is carried out to assess the presence of psychopathology, personality disturbances, organicity, and substance abuse and to acquire an understanding of adaptive, coping, and defensive strategies. Suicidal content and risk should be assessed specifically. Cognitive and personality disturbances should be assessed with evaluation tools (WAIS or Millon) if outside of normal limits.

   f) *Standardized Risk Assessment (J-SOAP II).* All youth over 11 years old should be evaluated on the J-SOAP II to augment the overall risk assessment.

   g) *Polygraph.* All youth who are over 12 years of age shall be administered a sexual history (full disclosure) polygraph examination as part of the overall Sexual Offender Evaluation. Polygraph examinations shall be conducted in accord with the ATSA standards by a qualified examiner.

4. In the final stages of the evaluation, it is useful to discuss the possible treatment alternatives with the patient and appropriate family members. Explain to the family members what their participation in the treatment program will involve.

## IV. Standards for Interventions/Treatment

1. Therapists providing individual, family or group therapy to sexually abusive youth or their families must be Certified as Sexual Offender Treatment Providers (CSOTP).

2. Supportive treatment providers (home-based workers, group co-therapists, psychiatric technicians, etc) must receive ongoing direct supervision by a CSOTP, and should possess:
   - a combination of education, training, and/or experience in providing specialized clinical evaluation and treatment;
   - an understanding of theories regarding sexual deviance, and of the community containment model;
   - access to additional resources and supervision and awareness of limitations;
   - ability to clearly state a method and rationale for the process utilized in evaluation and treatment;
   - an ability to respond to individual and cultural needs;
   - knowledge of laws, policies, and ethical concerns relating to confidentiality, reporting, risk management, client participation and confrontation;
   - knowledge of court systems, legal parameters, and therapeutic/legal interfacing and a general knowledge of the justice system.

3. Treatment providers shall develop and implement a written treatment plan based on the results of the most recent evaluation. Treatment plans shall be shared with all other treatment providers and collateral case managers.

4. Service planning must incorporate the stages that each client must go through, the tasks that they must accomplish, and address the transitions which will occur in response to the client's progress.

5. Treatment for youth over twelve shall include maintenance or monitoring polygraph evaluations every six to twelve months administered in accordance with ATSA standards.

6. Treatment should include face-to-face individual, family and group therapies. Clients must be assessed for group therapy readiness, but group therapy should be the predominant modality.

7. With anti-social youth who are not appropriate for group sessions, intensive community-based treatment models which emphasize ecological changes (i.e. Multi-Systemic Therapy or Wraparound Service Planning) should be considered and employed when feasible.

8. Group therapy should focus on cognitive and behavioral skill (not insight).

9. For those clients who persist in completely denying their sexual behaviors, therapists shall evaluate viability of treatment and end therapeutic work when no further benefit is likely.

10. Treatment must address deviant sexual arousal as part of the treatment process. Consider use of medications or aversive conditioning to facilitate control of high levels of deviant sexual arousal or high risks of offending for those clients without the ability to gain control through arousal conditioning procedures, or when behavioral approaches are not effective.

11. When working with special populations (e.g. mentally retarded), treatment providers need to address any special populations with whom they are unfamiliar working through added supports.

12. Intervention should include educating families regarding:
    - recognition of warning signs or risk indicators;
    - emotional/physical safety of potential victims;
    - notification;
    - advocating removal of offender rather than victim;
    - inappropriateness of reunification for clients who fully deny their culpability, or those who are non-compliant with treatment, at high risk of deviant sexual arousal, or at moderate to high risk of re-offending;

- insuring that appropriate safety plans are developed and implemented from the beginning of the treatment process, and are adapted and maintained through the visitation and reunification processes.

13. Decisions about reunification with the family or returning home should be discussed in a collaborative treatment staffing with parents or guardians of the victim (if they are a family member) and all other collaterals. Ensure victim input.

14. Youth in residential settings must be evaluated for risk of exploitative behaviors or victimization with roommates, and provided individual rooms when indicated.

15. Violations of treatment rules must be addressed through plans formulated within the full service team that includes expectations, consequences and remedial efforts.

**V. Standards for Case Management**

1. Team members who assume lead case management responsibility should complete the overview and case management training modules provided through the regional training group and obtain ongoing training on a regular basis.

2. Collaboration and unrestricted communication are vital to successful community-based treatment for sex offenders. Case managers shall ensure that ongoing communication around treatment and supervision for offenders is effective and comprehensive.

3. Whenever there are new or heightened concerns of risk; unanticipated treatment interruptions; violations of treatment rules or court orders; the information should be shared with the full treatment team.

4. A comprehensive Case Treatment/Supervision Plan shall be developed and maintained by the primary case manager (to be determined by the team), incorporating evaluation data; utilizing a collaborative approach involving an open, strategic method of information gathering; and providing a clear outline of expectations of all involved agencies and parties.

5. The lead agency case manager should make certain that the Case Treatment/Supervision Plan includes the following:
    - full use and understanding of all assessment, risk, and treatment tools in developing the Case Treatment/Supervision Plan;
    - explanation of the sexual abuser's responsibilities while under community supervision to ensure expectations of all agencies are clear and effective;
    - input from the offender and all concerned agencies, significant others and interested parties;
    - biographical data, type of sex abuse and/or offense, level of risk (as determined by risk assessment tools):
    - risk assessment based on dynamic (variable) risk or acute (imminent) risk;
    - specific provision for victim protection;
    - special conditions of supervision;
    - how and when abuser is to fulfill responsibilities;
    - information regarding the role of the supervisory agency and how supervision will be structured.

6. Abuser and all interested parties should sign and date the Case Treatment/ Supervision Plan in order to ensure understanding and commitment to the contents.

7. Regular (initially, at least quarterly) case management team reviews should occur and address a) compliance or lack of compliance; b) progress or lack of progress; and c) any changes to the Case Treatment/Supervision Plan. The primary case manager shall act as catalyst and coordinator for these meetings and guarantee inclusion of all interested agencies/individuals in the case. When there is a lack of progress, the lead case manager should ensure that the Case Treatment/Supervision Plan is modified and that community safety is addressed.

8. A Consent for Exchange of Information should be signed to ensure free and open communication between county agencies, probation/parole, the court system, treatment providers and others as deemed appropriate.

9. All team members should work with the lead agency case manager to ensure that the abuser is expected to comply with the following during treatment and aftercare:
    - The abuser is attending and actively involved in an approved community-based offender program;
    - place of residence and employment are appropriate;
    - activities are well monitored, documented and appropriate;
    - the abuser has access to, and assistance in developing, support networks that have a positive influence, are aware of the abuser's criminal history, are supportive of the Case Treatment/Supervision Plan and can recognize risk factors.

## VI. Recommendations

That each participating CPMT endorse the preceding *Northern Virginia Regional Standards for Treatment and Management of Sexually Abusive Youth*, and encourage all participating agencies (public and private) to strive towards achieving these standards to the extent possible.

## VII. Bibliography and Credits


Association for the Treatment of Sexual Abusers (2001). Practice Standards and Guidelines.

Center For Sex Offender Management (1999). Understanding Juvenile Sexual Offending Behavior: Emerging Research, Treatment Approaches and Management Practices.

Center For Sex Offender Management (2000).Community Supervision of the Sex Offender: An Overview of Current and Promising Practices.

Wolf, Steven C. (1995). Best Practice Standards and Protocols for Working with Sexually Aggressive Children and Youth. Draft guidelines from the author.


## NORTHERN VIRGINIA REGIONAL SEXUALLY ABUSIVE YOUTH TRAINING OUTLINE

The regional workgroup on training identified several levels of training based on the level of contact and responsibility assumed by the individuals being trained.

- The Overview Training is designed for those case workers, attorneys, police, CASA, judges and others who would have any involvement with sexually abusive youth.
- The Specialized Case Management Training would target case managers identified to work with sexually abusive youth and/or those who would assume lead case management responsibility for a sexually abusive youth.
- In-service Trainings would vary in level of expertise targeted and would be open to any workers interested.

I. **Sexually Abusive Youth Overview Training:**

Who needs to attend: Judges (Juvenile and Circuit Court), County Attorneys, Commonwealth Attorneys, Court Appointed Special Advocates, Guardian ad litems, Probation Officers, Police Officers, Social Services Workers, School Social Workers, Mental Health Providers (Community Mental Health and Private Providers), Family Assessment and Planning Team Members, foster families and other potential community team members.

When: Case managers are to attend this training at their first available opportunity.

Time frame: One day training.

**TOPICS**

a. Overview of sexual abuse family dynamics.
b. Identifying sexually abusive youth (Offending vs. Sexual Reactive)
c. Overview of best practices including roles and responsibilities of team members; and understanding the *"Community Containment Approach to Collaboration".*
d. Review of the Northern Virginia Regional Standards for Treatment and Case Management of Sexually Abusive Youth.

e. Assessment, Diagnosis and Treatment: Understanding and defining sexually abusive youth, and its distinctive approach. (Examples: Sexually Reactive vs. Sexual Offending, Sociopaths and Psychopaths)
f. Legal issues: Criminal vs. Civil Court. What do Judges and Attorneys need to understand about juvenile sexual abusers/offenders and residential facilities and the length of treatment? Is the juvenile offender amenable to treatment? How long is treatment? What are the treatment levels? What does "Step Down" mean? Should the juvenile serve time? Role of court system in ensuring offender accountability.
g. Educational issues – Clarifying legal eligibility and limitations of youth in accessing public school services while in treatment of sexually abusive behavior.

II. **Specialized Sexual Abuse Case Management Training**:

Who needs to attend? Social Services Workers, Probation Officers, Therapists, School Social Workers/Case Managers and Supervisors (Supervisors whose staff case manage Sexual Abuse Cases, need to attend training to have a better understanding of the specifics of treatment and case planning.)

When: Case managers are to attend this training at their first available opportunity.

Time Frame: One full day training.

**TOPICS**

a. Case managers will learn the basics of juvenile sexual abusers and family sexual abuse dynamics.
b. Specialized social services case management (Required for an understanding of how DSS moves families through the system and the interaction and teaming of agencies.)
c. Case Managers will learn the importance of: *Treatment Contracts, Visitation Contracts, and Safety Plans.*
d. Full day training to be provided to all targeted case managers and then at least annually as needed, as determined by the regional training team.

III. **In-Service Trainings:**

Who needs to attend: Training available to all who want to attend.

Level of training: In-service trainings will be categorized as moderate or advanced depending on the level of experience, prior training and expertise of the case managers for whom the training is targeted.

When: Selected topics will be provided when identified by the regional training team and an available presenter can be located.

Time frame: The topics will be presented in a ½ day format.

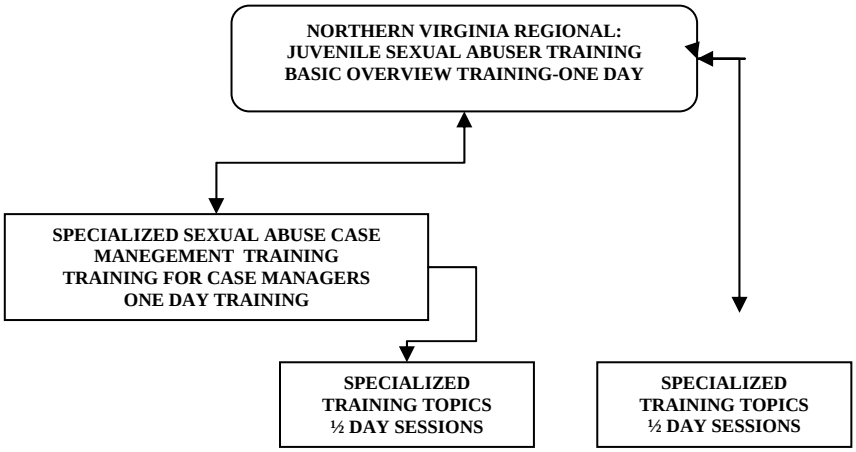
**TOPICS**

Sample In-service topics might include:

a) Psycho-sexual Risk Assessment: What is it? When is it used? Trainees will develop an understanding of the uses of the Psycho-sexual Risk Assessment, the Risk Assessment Tools used, and utilization of the Psycho-sexual Risk Assessment in treatment/service planning, and treatment and visitation contracts.
b) Mental health aspects of treatment including: How is treatment different for sex offenders? Understanding differences in treating male vs. female perpetrators. Treatment modalities. Victim treatment: How to team cases with the perpetrator's therapist. Co-morbidity.
c) Understanding Court and the Legal System: definitions, requirements.
d) Treatment providers: CSOTP and certification, What does it mean? Who is best to work with this population?
e) Supervision of sexually abusive youth, (in the home and the community.)
f) The Community Containment Model, "A Collaborative Approach to working with Juvenile Sex Offenders and their families.

IV. **Recommendations:**

In order to consolidate efforts, maximize fiscal efficiency, and ensure consistency, regional training collaboration is recommended.

a) Regional Training Coordinator –A regional training coordinator should be assigned to coordinate all of the initial trainings.
    i. Explore contracting with a coordinator and all participating localities for initial period of training.
    ii. Coordinator responsibilities to include setting up locations, times and trainers, and keeping up with best practices.
b) Regional training team should be selected to continue oversight of training process and content.
    i. Team to include one representative from each locality with rotating leadership.
    ii. Participation from all jurisdictions with trainings rotated around each jurisdiction.
c) Agreed implementation from all jurisdictions
d) Videotaping training should be explored to allow the trainings to be offered multiple times.
e) The Center for Sex Offender Management (CSOM**)** should be utilized to provide training to participants. CSOM will provide the faculty but we must provide the space. Their training is geared towards Judges, Probation Officers, Victim Advocates, Mental Health Providers, etc. They can design the training to meet our needs. Primary training includes 1. what's happening on a national level, 2. supervision of juvenile offenders, 3. assessment, 4. secondary trauma for professionals working with offenders etc. Training by CSOM is targeted for late summer and fall 2005.

## TRAINING MODULES