DBHDS

Virginia Department of
Behavioral Health and
Developmental Services

Report on Funding for Child Psychiatry and Children's Crisis Response Services (Item 315.W., 2013 *Appropriation Act*)

to the Chairs of the
House Appropriations and Senate Finance Committees
of the General Assembly

October 7, 2013

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October 7, 2013

The Honorable Walter A. Stosch, Chair
Senate Finance Committee
10th Floor, General Assembly Building
910 Capitol Street
Richmond, VA 23219

Dear Senator Stosch:

This report was developed in accordance with Item 315.W. of the 2013 *Appropriation Act* which addresses the management of the general fund appropriation for child psychiatry and children's crisis response services for children with mental health and behavioral disorders.

This language was included in the current budget to address certain recommendations included in the department's 2011 report "A Plan for Community-Based Children's Behavioral Health Services in Virginia" (Report Document 267, Item 304.M.), which described the comprehensive service array needed to meet the needs of children with behavioral health problems.

Should you have questions in the interim regarding the progress of this project or the estimated timeline, please feel free to contact me at (804) 786-3921.

Sincerely,

James W. Stewart, III

Enc.
Cc: Hon. William A. Hazel Jr., M.D.
Hon. Emmett W. Hanger, Jr.
Joe Flores
John Pezzoli
Janet Lung
Ruth Anne Walker

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October 7, 2013

The Honorable Lacey E. Putney, Chair
House Appropriations Committee
General Assembly Building
P.O. Box 406
Richmond, VA 23218

Dear Delegate Putney:

This report was developed in accordance with Item 315.W. of the 2013 *Appropriation Act* which addresses the management of the general fund appropriation for child psychiatry and children's crisis response services for children with mental health and behavioral disorders.

This language was included in the current budget to address certain recommendations included in the department's 2011 report "A Plan for Community-Based Children's Behavioral Health Services in Virginia" (Report Document 267, Item 304.M.), which described the comprehensive service array needed to meet the needs of children with behavioral health problems.

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Sincerely,

James W. Stewart, III

Enc.
Cc: Hon. William A. Hazel Jr., M.D.
Hon. Riley E. Ingram
Susan Massart
John Pezzoli
Janet Lung
Ruth Anne Walker

Child Psychiatry Services and Children's Crisis Response In Virginia

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Executive Summary

This report was developed in accordance with Item 315.W. of the 2013 *Appropriation Act* which addresses the management of the general fund appropriation for child psychiatry and children's crisis response services for children with mental health and behavioral disorders. Specifically, the language states:

> W. Out of this appropriation, $1,500,000 the first year and $3,650,000 the second year from the general fund shall be used to provide child psychiatry and children's crisis response services for children with mental health and behavioral disorders. These funds, divided among the health planning regions based on the current availability of the services, shall be used to hire or contract with child psychiatrists who can provide direct clinical services, including crisis response services, as well as training and consultation with other children's health care providers in the health planning region such as general practitioners, pediatricians, nurse practitioners, and community service boards staff, to increase their expertise in the prevention, diagnosis, and treatment of children with mental health disorders. Funds may also be used to create new or enhance existing community-based crisis response services in a health planning region, including mobile crisis teams and crisis stabilization services, with the goal of diverting children from inpatient psychiatric hospitalization to less restrictive services in or near their communities. The Department of Behavioral Health and Developmental Services shall report on the use and impact of this funding to the Chairmen of the House Appropriations and Senate Finance Committees beginning on October 1, 2013 and each year thereafter

This language was included in the current budget to address certain recommendations included in the 2011 report "A Plan for Community-Based Children's Behavioral Health Services in Virginia," (Report Document 267, Item 304.M.) by the Department of Behavioral Health and Developmental Services (DBHDS). That report described the comprehensive service array needed to meet the needs of children with behavioral health problems.

Included in that plan were the results of a survey of community services boards (CSBs) which indicated that, of all the services in the comprehensive service array, crisis response services including both mobile crisis and crisis stabilization, were the least available services in the state.

At least part of the reason crisis response services are in short supply is because of the expense of such service models, which require highly trained clinicians who are available on a 24/7 basis to respond to crisis situations. Rural CSBs are particularly challenged in supporting these service models. For these reasons, a regional approach was proposed to allow the services to be shared across a health planning region.

Through a competitive Request for Applications, three regional proposals were selected from those submitted from all five health planning regions:

Region I – Horizon Behavioral Health is the lead CSB for the region
Region III - Mount Rogers is the lead CSB for the region
Region IV - Richmond Behavioral Health Authority is the lead CSB for the region

This report covers the first 10 months of funding following the application process (September 1, 2012 through June 30, 2013) and the $1,500,000 million appropriated for FY2013.

Overall, the three regions achieved good outcomes in keeping children with their parents and attending school. They established child psychiatry access through face-to-face visits, tele-psychiatry and consultation to pediatricians and primary care practitioners and reduced their utilization of the DBHDS Commonwealth Center for Children and Adolescents (CCCA), the state's only public inpatient facility for children. It is early in the life of these regional projects, but in all three funded regions admissions and bed days have been reduced. Though there were good outcomes in all three regions, start-up challenges in Region IV resulted in fewer families and children served.

I. Introduction and Background

This report was developed in accordance with Item 315.W. of the 2013 *Appropriation Act* which addresses the management of the general fund appropriation for child psychiatry and children's crisis response services for children with mental health and behavioral disorders. Specifically, the language states:

> W. Out of this appropriation, $1,500,000 the first year and $3,650,000 the second year from the general fund shall be used to provide child psychiatry and children's crisis response services for children with mental health and behavioral disorders. These funds, divided among the health planning regions based on the current availability of the services, shall be used to hire or contract with child psychiatrists who can provide direct clinical services, including crisis response services, as well as training and consultation with other children's health care providers in the health planning region such as general practitioners, pediatricians, nurse practitioners, and community service boards staff, to increase their expertise in the prevention, diagnosis, and treatment of children with mental health disorders. Funds may also be used to create new or enhance existing community-based crisis response services in a health planning region, including mobile crisis teams and crisis stabilization services, with the goal of diverting children from inpatient psychiatric hospitalization to less restrictive services in or near their communities. The Department of Behavioral Health and Developmental Services shall report on the use and impact of this funding to the Chairmen of the House Appropriations and Senate Finance Committees beginning on October 1, 2013 and each year thereafter.

In its 2011 report to the General Assembly, Item 304.M. "A Plan for Community-Based Children's Behavioral Health Services in Virginia," the Department of Behavioral Health and Developmental Services (DBHDS) described the comprehensive service array needed to meet the needs of children with behavioral health problems. A survey of community services boards (CSBs) indicated that, of all the services in the comprehensive service array, crisis response services including mobile crisis services and crisis stabilization services, were the least available services in the state. These services are in short supply due at least in part to the expense of such service models which require highly trained clinicians available on a 24/7 basis to respond to crisis situations. Rural CSBs are particularly challenged in supporting these service models. For these reasons, a regional approach was proposed to allow the services to be shared across a health planning region.

Child psychiatry is an integral part of all crisis response services, and it was also one of the highest-rated needed services in the survey for the 304M Plan. The 2012 Session of the General Assembly considered many budget amendments that were intended to increase access to the services highlighted in the 304.M plan, including child psychiatry and crisis response services.

Item 315.W. provides $1.5 million the first year and $1.75 million the second year from the General Fund for regional funding for child psychiatry and children's crisis response services. The language allocates funding to health planning regions based on the availability of services with a report on the use and impact of funding due annually beginning in 2013.

This report covers the first 10 months of funding following the application process (September 1, 2012 through June 30, 2013) and the $1,500,000 million appropriated for FY2013.

II. Request for Applications and Selection Process

When the funding became effective on July 1, 2012, DBHDS issued a competitive Request for Applications for regional proposals that included the following key requirements:

- Funding must be used for community-based services for children who would otherwise need publicly-funded inpatient or residential services.
- The goal should be to divert children from these services to less restrictive services, and to keep children with, or as close to, their families as possible.
- The target population for the services are children through age 17 who:
  - (i) have a mental health problem, and
  - (ii) may have co-occurring mental health and substance abuse problems,
  - (iii) may be in contact with the juvenile justice or courts systems,
  - (iv) may require emergency services, or
  - (v) may require long term community mental health and other supports.

All services must include a child psychiatrist and crisis response services should include:

1. ***Mobile crisis response teams*** – clinical team that goes to homes, schools and other community locations to help keep a child at home. Mobile teams are dispatched within 2 hours of a call to the CSB and are available 24 hours, 7 days a week. CSB emergency services may refer children and families to the mobile crisis team
2. ***Crisis stabilization units*** – short-term 6-bed or less units with 24/7 bed-based care to divert children from inpatient and residential care
3. ***Combinations*** of mobile crisis teams and crisis stabilization units

Five proposals were received, one from each Virginia Health Planning Region, and three proposals were selected: Region I, Region III and Region IV. Funding was awarded and became effective September 1, 2012. This report describes the services provided from September 1, 2012 through June 30, 2013.

III. Description of Selected Regional Programs

The following is a summary of the services included in each selected proposal:

Region I (Horizon is the lead CSB for the region)

Out of eight CSBs in Region I, five do not have access to child psychiatry. Through this regional partnership, a child psychiatrist will provide consultation to primary care physicians and pediatric practices on children's mental health needs. Tele-psychiatry will be available for all CSBs in Region I that are in need of child psychiatry time. A mobile crisis response team will serve children in the Horizon Behavioral Health area. Horizon Behavioral Health, one of the CSBs with the most complete array of children's services, will partner with CSBs in Region I to provide consultation in the development of programs to decrease utilization of inpatient hospitals and to develop mobile crisis teams in other parts of the region.

Region III (Mount Rogers is the lead CSB for the region)

Region III, a large rural area in southwestern Virginia, has a severe shortage of child psychiatrists and crisis clinicians with specific expertise in children's services. Tele-psychiatry will be available to the 10 community services boards in Region III. Three community services boards: Mt. Rogers,

Highlands, and New River Valley, will each hire a crisis clinician with the goal of stabilization of a crisis situation and determining wrap around services in the community. A project manager for these three CSBs will also identify primary care physicians and pediatricians who may benefit from consultation with a child psychiatrist and arrange these consultations.

Region IV (Richmond Behavioral Health Authority is the lead CSB for the region)
Children in crisis who may be at risk for hospital or other long-term care will be stabilized in a 6-bed crisis stabilization unit under contract with a local provider. In addition, regional services will be expanded to include mobile crisis response to all CSBs in Region IV, except the far southside of the region. (Because of its distance, Southside Community Services Board will provide a mobile crisis team for its own locality.) The VCU Virginia Treatment Center for Children will provide tele-psychiatry consultation to the mobile crisis units. Finally, education on children's mental health issues to pediatric and primary care practices in the region will be provided by the Children's Mental Health Resource Center at VCU Virginia Treatment Center for Children.

IV. Results, Including Data and Case Examples from Programs

The following is information on community services provided by the funded regions. Data on community services is reported by CSBs in the DBHDS "Community Consumer Submission" (CCS) automated data system. The data provided is from the service categories in the CCS that are provided to children in crisis:

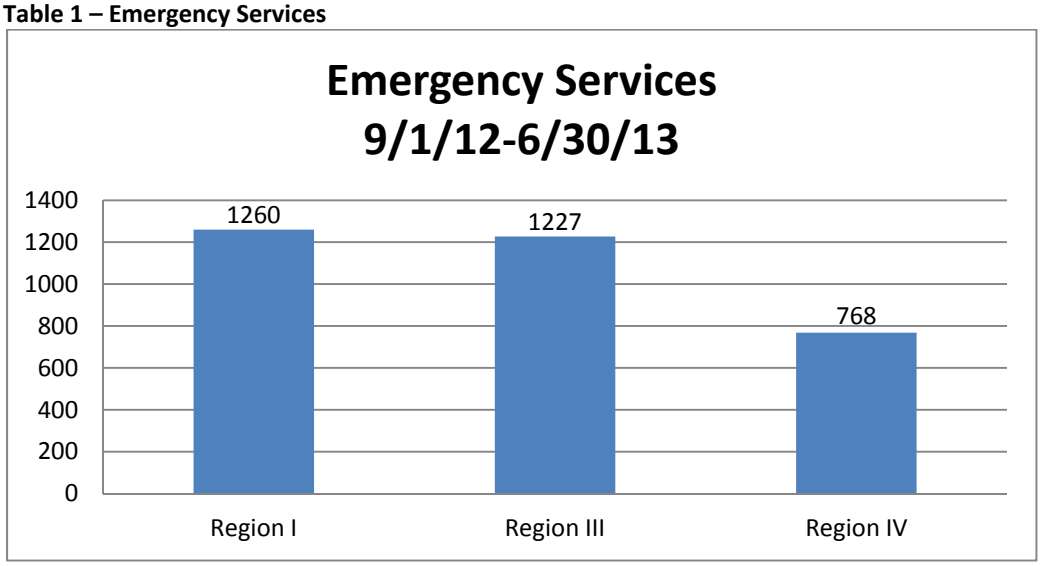
- Emergency Services;
- Outpatient Services;
- Ambulatory Crisis Stabilization; and
- Residential Crisis Stabilization.

Because the categories in CCS are not specific enough to this initiative, some additional information was collected manually from the funded regions. For example, child psychiatry is reported within the Outpatient Services category and is not broken out separately. Therefore, Table 3 reports child psychiatry services separately to give a picture of the numbers of children who received each type of child psychiatry service.

Emergency Services

Emergency services are scheduled or unscheduled services that include crisis counseling and psychiatric services to children who are in a crisis situation. Services must be available 24 hours per day and seven days per week to children and others seeking services for them. Also included are the code-mandated prescreening services that CSBs provide to assess the need for inpatient psychiatric hospitalization, or other activities associated with the judicial admission process. Presecreening services are provided by certified prescreeners who meet state criteria and have completed training modules to assure their competency.

Table 1 – Emergency Services

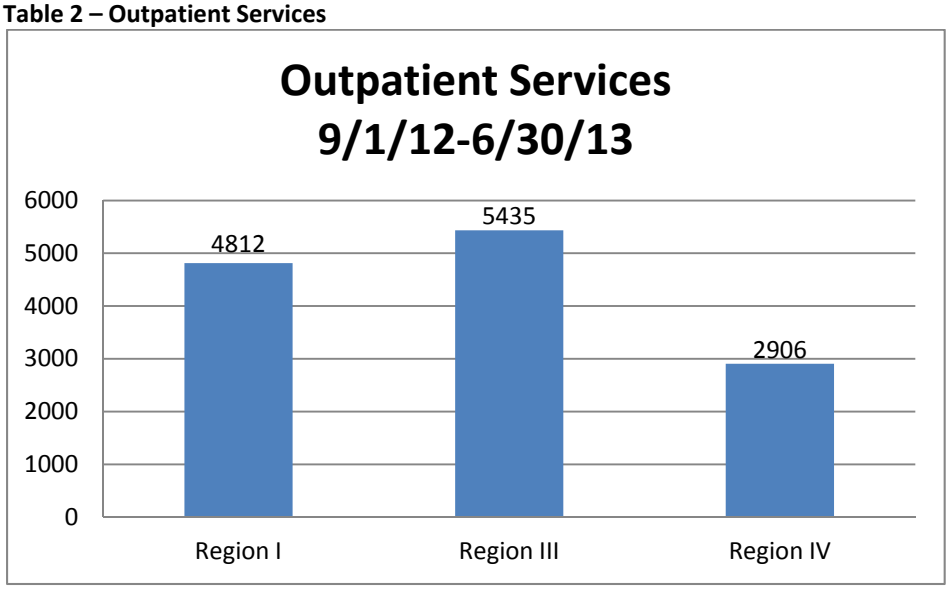


*Numbers of children are unduplicated.

Outpatient Services (Including Child Psychiatry)

Outpatient services include individual, group and family therapy sessions provided in the office. Also included are child psychiatry and medication services, which are broken out separately in the section below. Table 2 provides the total unduplicated number of children who received outpatient services. Table 3 and Table 4 provide the child psychiatry services provided as part of this initiative.

Table 2 – Outpatient Services



*Numbers of children are unduplicated.

Child Psychiatry Services (Separate from Outpatient Services)

In order to extend the reach of very limited child psychiatry resources, the funded programs were asked to provide child psychiatry in three venues:

- Face-to-face office visits with children;
- Tele-psychiatry services to children in remote sites; and
- Child psychiatry consultations to other providers, such as pediatricians, primary care providers and others.

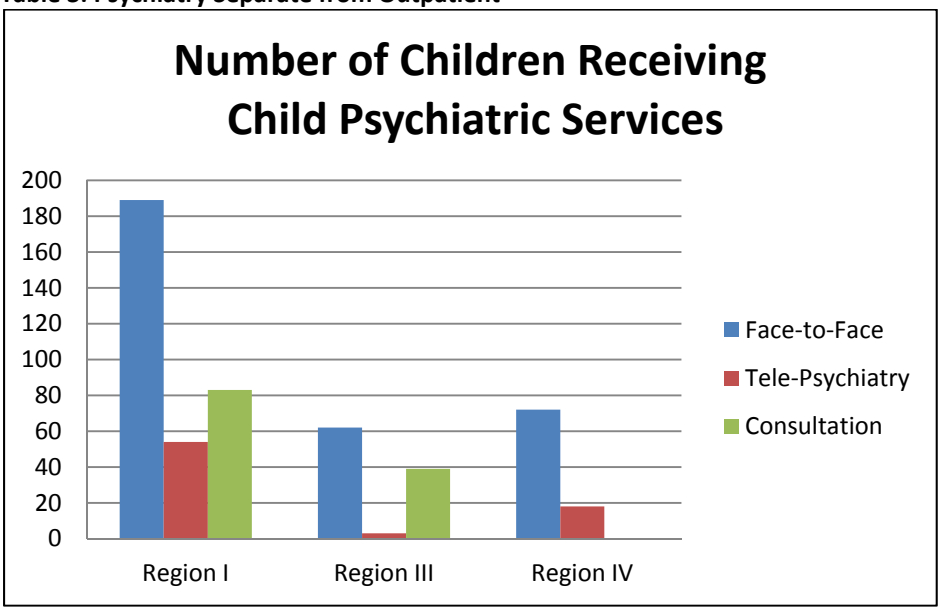
Child psychiatry services are being provided face-to-face and via tele-psychiatry in all three regions. Region I, led by Horizon Behavioral Health served the largest number of children using all three approaches, with 189 children receiving a face-to-face visit with the child psychiatrist employed by the CSB.

The consultative approach was used for 83 children in Region 1 and 39 children in Region III. While consultative services were planned for Region IV, delays in getting a child psychiatry contract have prevented the use of this approach. Beginning in FY2014, Region IV has signed a contract and will be able to proceed with the consultative services.

Overall, child psychiatry services were an extremely successful aspect of this initiative, adding capacity in an environment of extreme scarcity of board-certified child psychiatrists. Child psychiatrists provided face-to-face, tele-psychiatry, and consultative approaches to 520 children in Virginia. There were some delays experienced in start-up due to lengthy contracting processes with universities and challenges in getting appropriate tele-psychiatry equipment in all of the CSBs. The largest number of children receiving child psychiatry services (326) was in Region I, where a CSB-employed child psychiatrist was hired soon after the funding was awarded, pointing to the benefits of this approach.

Tele-psychiatry and consultation have gone exceptionally well in Region I, where the same CSB-employed physician provides these services and is available for face-to-face, tele-psychiatry and consultation appointments. In Region III and IV, delays were experienced with planned contracts with universities. These delays have been resolved in Region I. Region IV has contracted with a community psychiatry group for child psychiatry, though availability of sufficient child psychiatry hours continues to be a challenge. A nurse practitioner is providing services on site two days per week at the designated local provider, but additional child psychiatry hours are greatly needed. Region IV has several strategies as a path to solving these problems, including a plan use the model employed by Region I, embedding a psychiatrist at one of the CSBs that will be a CSB contract employee serving all CSBs in the region. Some delays with tele-psychiatry were also encountered with some CSBs that did not have compatible Polycom equipment and these challenges have been addressed.

Table 3: Psychiatry Separate from Outpatient



*Numbers of children are unduplicated.

Table 4: Child Psychiatry Services Provided by Each Region

Service	Region I	Region III	Region IV	Statewide Total
(1) Face-to Face	189	62	72	323
(2) Tele-Psychiatry	54	3	18	75
(3) Consultation	83	39	0	122
Regional Total	**326**	**104**	**90**	**520**

- Definitions used in collecting data:
  1) Face to face: total number of youth that received a face-to-face visit with the psychiatrist;
  2) Tele-psychiatry: total number of youth that received tele-psychiatry services; and
  3) Consultation services: total number of consultation contacts by the psychiatrist. Consultations include pediatricians, primary care physicians, other mental health professionals, or other psychiatrists

Ambulatory Crisis Services

Ambulatory crisis services provide direct care and treatment to non-hospitalized children and are available 23 hours per day. The goals are to avert hospitalization, re-hospitalization, or disruption of living situation, assure safety and security and stabilize children in crisis and may include mobile crisis team services. Ambulatory crisis stabilization services may be provided in an individual's home or in a community-based program licensed by the Department.

Region I served 324 children through mobile crisis team services in FY2013. Horizon, the lead CSB for the region, provided services through their team and also provided consultation and training to other CSBs in Region I that were interested in starting up new mobile crisis services.

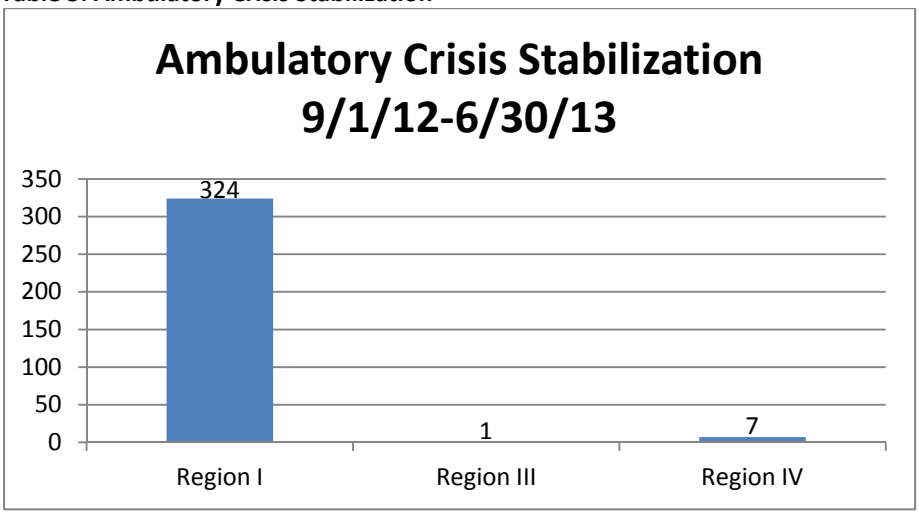
Region III's proposal did not include mobile crisis services; however New River Valley CSB reported serving one child through this approach.

Region IV proposed to use St. Joseph's Villa as a contractor for mobile crisis response services. Region IV encountered delays, specifically with Saint Joseph's Villa receiving their license to provide ambulatory crisis services. After several meetings with the provider focusing on their staffing plan for ambulatory crisis services, and the delivery of the originally-planned consultative psychiatry services and how that would work with the crisis stabilization services, DBHDS awarded their220 license in March 2013.

In April, St. Joseph's Villa launched their mobile crisis services, targeting clients who were being discharged from the Crisis Stabilization Unit. All clients admitted to the unit beginning that month were assessed for appropriateness to continue mobile crisis stabilization services as they transitioned back to their home environment, to help ensure the crisis episode was resolved and to support the child in their home environment for a short period of time.

In June, the first mobile-only client was admitted, in consultation with the referring CSB. In total, 33 hours of ambulatory care was provided to 7 children in Region IV during the fourth quarter of the fiscal year. With full implementation of mobile services beginning in FY2014, it is anticipated that this service will be well-utilized by Region IV CSBs and more children will be served in FY2014.

Table 5: Ambulatory Crisis Stabilization



*Numbers of children are unduplicated. Note: Region III's proposal did not include ambulatory crisis stabilization services.

Residential Crisis Services

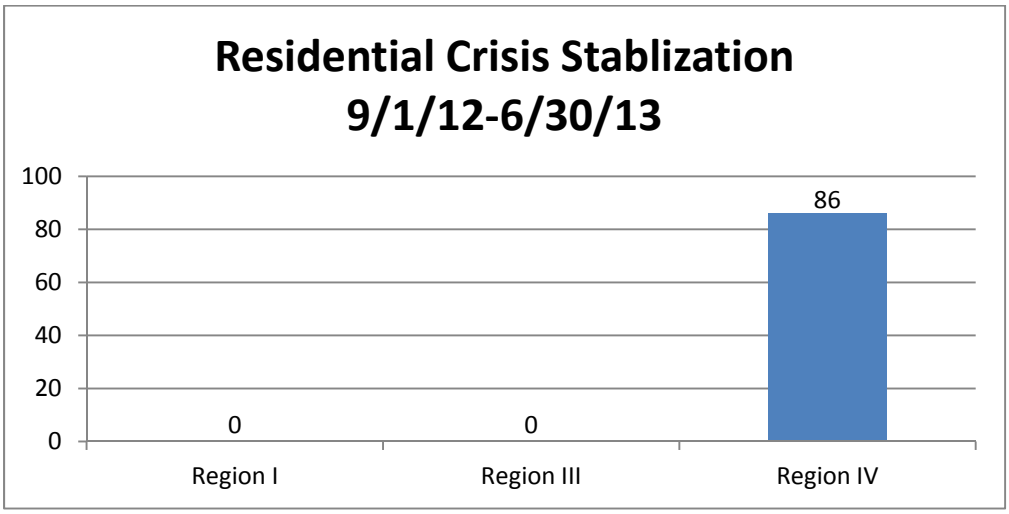
Residential crisis stabilization services were included in the proposals from Region I and Region IV. (Region III did not include this service, as this large rural area needed to focus first on building a basic infrastructure with children's services clinicians and child psychiatry services.)

Region IV has a contract with the chosen local provider where a unit has been designated for the purpose of crisis stabilization. This public-private partnership has reflected a strong commitment on

both parts to making bed-based crisis stabilization available in the region. Despite this strong collaboration, and though 86 children were served and most were returned to their parents or foster parents after the crisis was stabilized, the unit has been underutilized. Numerous strategy meetings between DBHDS, Richmond Behavioral Health Authority and the other CSBs in Region IV, and the provider have been held to analyze referral and utilization patterns and to develop appropriate approaches to increasing utilization. The region and the provider continue outreach efforts to increase awareness in the community to help ensure appropriate utilization. Further, to increase safety and security, and to enable the unit to serve more seriously disturbed youth, plexiglass covers were installed on all the windows on the unit located on the second floor of one of the cottages.

In Region I, shortly after receiving notice that they were awarded funding for crisis response and child psychiatry services, Horizon CSB, the lead CSB for the project and fiscal agent, learned that they would not be able to provide the bed-based crisis stabilization at The Bridges, a residential facility owned by Centra Mental Health Services. Because the provider was part of an Institution for Mental Disease, services provided there could not be reimbursed by Medicaid. The budget for the program was dependent upon this reimbursement. After consultation between DBHDS, DMAS and Horizon, it was determined that the plan to provide bed-based crisis stabilization had to be abandoned. Horizon redirected their efforts into providing more day crisis services and child psychiatry consultations based at the CSBs in the region.

Table 6: Residential Crisis Stabilization



*Numbers of children are unduplicated. Note: Region III's proposal did not include ambulatory crisis stabilization services.

Living Status and School Status of Children Served

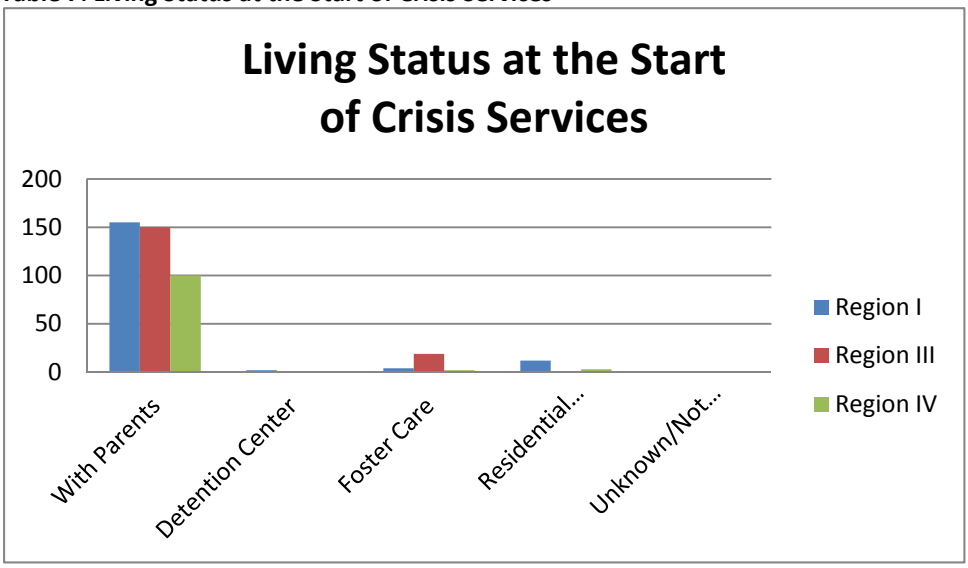
With the focus of the initiative being to preserve home and community life, regional programs are asked to report the living status and school status of children as outcome indicators.

▪ Living Status of Children

The charts and tables below show the living status (i.e., with parents, detention center, foster care, residential) of children upon entry to crisis response services and at the end of services. The data show that the largest majority of the children entered crisis response services while living with their

parents and also returned to their parent's home at the end of crisis services. In the case of Region I, three children were served as a step-down from psychiatric inpatient care and were returned to their parent's home after the crisis services.

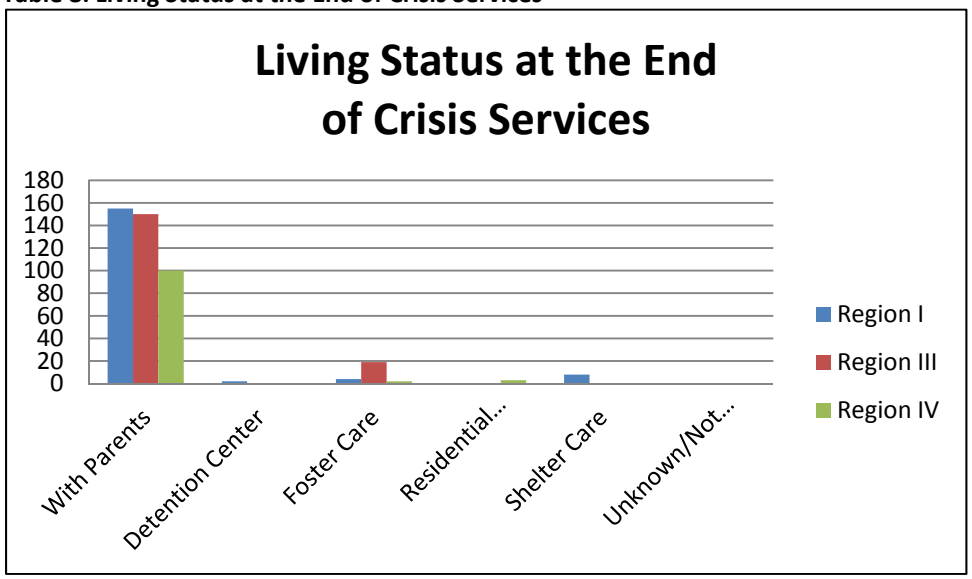
Table 7: Living Status at the Start of Crisis Services



*Numbers of children are unduplicated.

Status	Region I	Region III	Region IV
With parents	155	150	100
Detention Center	2		
Foster Care	4	19	2
Residential Placement			3
Unknown/Not Collected			
Shelter Care	8		
Inpatient facility	3		
Total	**173**	**169**	**105**

Table 8: Living Status at the End of Crisis Services



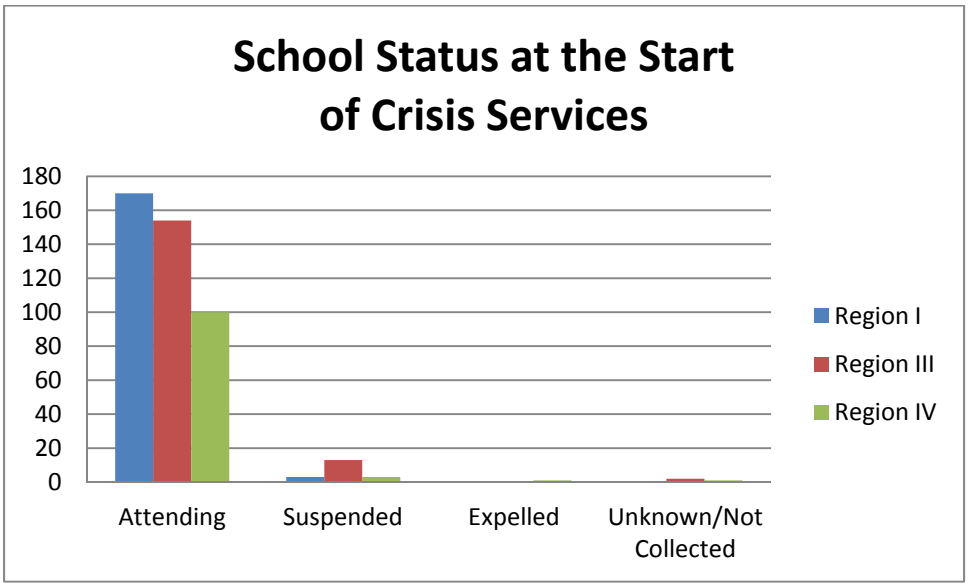
*Numbers of children are unduplicated.

Status	Region I	Region III	Region IV
With parents	158	146	87
Detention Center	2		
Foster Care	5	18	3
Residential Placement			8
Unknown/Not Collected		5	7
Shelter Care	8		
Inpatient Facility			
Total	**173**	**169**	**105**

▪ School Attendance Status of Children

Attending school in the community is one of the most important outcomes sought in a program designed to keep children in their homes and communities. Programs are asked to report school status on children served. The majority of the children receiving crisis response services were attending school when the services commenced and were still attending school at the end of services demonstrating the effectiveness of serving the children in their homes and communities.

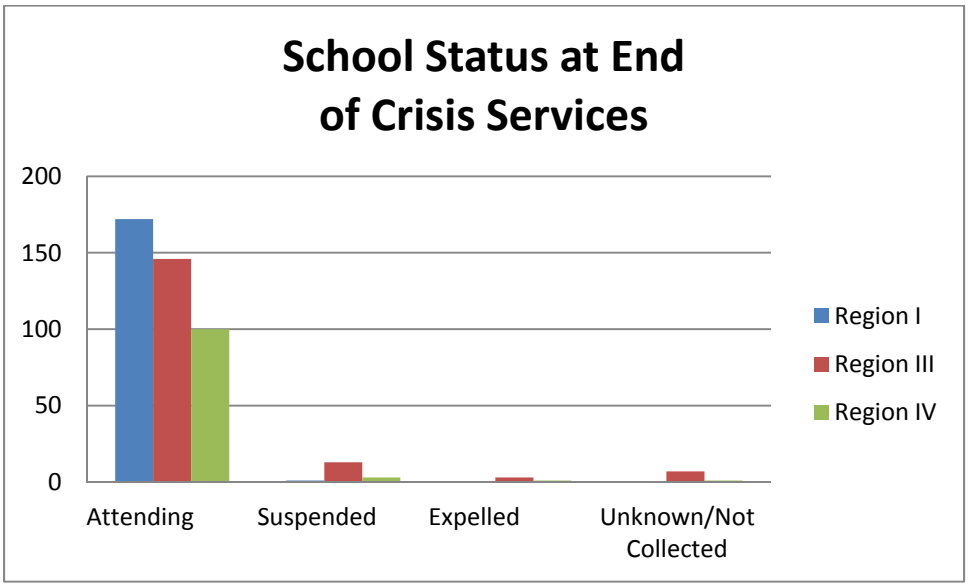
Table 9: School Attendance at the Start of Crisis Services



*Numbers of children are unduplicated.

Status	Region I	Region III	Region IV
Attending	170	154	100
Suspended	3	13	3
Expelled			1
Unknown/Not Collected		2	1
Total	173	169	105

Table 10: School Status at the End of Crisis Services



*Numbers of children are unduplicated.

Status	Region I	Region III	Region IV
Attending	172	146	100
Suspended	1	13	3
Expelled	0	3	1
Unknown/Not Collected	0	7	1
Total	**173**	**169**	**105**

Impact on Utilization of the DBHDS Commonwealth Center for Children and Adolescents

Crisis response services are intended to intervene early and stabilize crises in the community. Even with community crisis response services, inpatient services will still be needed for some children at certain times. One of the goals of crisis response services is to avoid the use of state facility services whenever possible, while preserving the welfare of the child and family, and public safety. When children do need to be hospitalized, the focus is on reducing length of stay. The tables below compare FY2012 and FY2013 regional data from the data system (named "Avatar") that tracks utilization of DBHDS state facilities. It is early in the life of these regional projects, but in all three funded regions admissions and bed days have been reduced. Region III has experienced the greatest reduction in admissions and bed days. Data for individual CSBs in each region is included in Table in Appendix C: State Facility Services Provided at the Commonwealth Center for Children and Adolescents.

State Facility Services Provided at Commonwealth Center for Children and Adolescents

Table 11: Comparison of State Facility Admissions FY2012 and FY2013

	FY2012 Admits Unduplicated	FY2013 Admits Unduplicated	FY2012 Admits	FY2013 Admits	FY2012 Readmissions	FY2013 Readmissions
Region I Total	173	172	229	208	97	75
Region III Total	140	102	179	129	65	44
Region IV Total	107	104	127	125	41	42
Total	**420**	**378**	**535**	**462**	**203**	**161**

Table 12: Comparison of State Facility Bed Days FY2012 and FY2013

	FY2012 Bed Days	FY2013 Bed Days	Change in Bed Days	% plus or minus
Region I Total	3678	3027	-651	-17.7
Region III Total	2929	1841	-1088	-37.1
Region IV Total	2366	2193	-173	-7.3
Total	8973	7061	-1912	-62.1

Case Vignettes Illustrating Outcomes for Children and Families

As part of their quarterly reports, funded programs were asked to submit actual case examples to demonstrate the impact of the services they provided to children and families. The following is a selection of the case examples submitted.

- **Case Vignette - Mobile Crisis Services**

A 16 year-old female client was referred to the emergency mobile crisis team because she was oppositional and defiant in shelter care, was threatening to run away, stated that she did not think her life was worth living, and had been suspended from school twice. The shelter care staff requested hospitalization, but the emergency mobile clinician was able to convince the staff that a less restrictive option was more appropriate. The client was placed in crisis intervention services and received crisis counseling. The client responded immediately to the crisis clinician, stating "someone is finally listening to me." Subsequently, the client did not have any further suspensions from school, her behavior and attitude improved in shelter care, and she was actively engaged in the counseling sessions. During treatment, the clinician was in contact with the Department of Social Services (DSS), the client's probation officer, and the guidance counselor at the school. Her grades began to improve, she did not make any more threats to run away, and her thoughts of worthlessness and hopelessness began to significantly decrease. The client requested that the clinician write a letter to the judge explaining her issues, progress, and to request that it would not be

in her best interest to return home. During the court hearing, the client was placed in DSS custody and placed in a therapeutic foster care home. She has not had any further suspensions, has indicated that she wants to be a nurse, and has adjusted well to her foster home. Client has completed crisis counseling and was referred to a private provider for outpatient therapy. After completing two sessions, the client stated that she believes she is "on the right track" thanks to the immediate intervention she received.

- **Case Vignette- Residential Crisis Stabilization**

A 17-year-old female, was referred to the crisis stabilization unit for self-mutilation and suicidal ideation. The client presented as depressed and hopeless. She expressed her fear that things would not change. The client remained on the unit for 16 days. On the very first day, she agreed to treatment, but was wary of family involvement. The client expressed the family relationship was so strained that they could not repair it. The client desired, and knew she needed, assistance. The client's mother knew she needed help as well. The client's mother often stated she was in over her head. Their family had been seeking mental health assistance since the client's father passed away a couple years prior to the client's most recent crisis. The family hoped for assistance and guidance. Crisis stabilization unit staff members assisted the family in providing the client with the appropriate wrap-around care. Staff went to a Family Assessment and Planning Team (FAPT) meeting, coordinated with the current family therapist, and worked closely with the Department of Social Services. Crisis stabilization unit staff advocated for, and assisted the family in finding, the necessary care for the client. This meant hospital or residential care was avoided. As the client was discharged from the crisis stabilization unit, the client's mother stated on her satisfaction survey that she was satisfied with services that she and the client received, and felt that the crisis stabilization unit staff provided "a sturdy and solid platform for communicating."

- **Case Vignette - Integrated Care and Consultation with Pediatrician**

In utilizing integrated services, a fourteen year old female in foster care diagnosed with Anxiety Disorder NOS, Attention Deficit Hyperactivity Disorder (ADHD), Intellectual Disability (ID) and a significant history of sexual trauma has been able to maintain her current home placement (a sponsored Residential placement). Prior to interventions, this individual was exhibiting difficulties with appropriate personal space, picked sores on her face when anxious, communicated in an inappropriately loud tone; including frequent shrieking and growling. She had been removed from previous foster care placements due to these behaviors. Wrap around services (the sponsored residential placement , ID case management, crisis services, crisis weekend services, respite, behavioral treatment, psychiatric services, and integrated services between the CSB and the child's pediatrician) have facilitated her stabilization, with noticeable differences in her behaviors. The client is now able to sit through a movie with little to no interruptions, she has learned new coping skills to express herself and to relieve anxiety, and her bedtime routine is not as time consuming, helping her to rest more fully. In addition, this individual has been able to express joy in her day-to-day life that had not previously existed. The above collaboration has provided support to her primary caregiver to prevent placement disruption and improving the quality of life of this distressed adolescent. Through increased advocacy with local DSS staff, this individual was able to accept an ID Waiver slot, even though DSS declined enrollment two years prior to this.

- **Case Vignette - Mobile Crisis Team**

A 15 year-old male who was evaluated at Lynchburg General Hospital for hospitalization by the crisis mobile team at the request of the on-call psychiatrist. The client presented with symptoms of

depression, anxiety, and trauma-induced psychosis due to being bullied at school. His mother was extremely concerned about his rapid de-compensation and expressed that he was functioning "like he's in a bubble." The mother brought the client to the hospital in the hope of having him hospitalized at the local adolescent psychiatric unit, but the client was denied admission. The mother stated she could not travel to an out-of-area hospital and was adamant that she didn't want her son admitted to CCCA. The clinician spoke with the mother and client about less restrictive services offered through Horizon Behavioral Health. The mother was concerned because the client did not have insurance and stated that she couldn't afford a sliding fee scale. The clinician explained options that were available through the current grant-funded services. The clinician called Horizon and was able to get a two-hour initial appointment with the mobile crisis psychiatrist, for the next morning. The Crisis Stabilization Program Manager was conducted a crisis stabilization assessment after the doctor's appointment. The plan was staffed with the treating physician and he was in agreement. The mother and client stated that they were very pleased with the plan and thanked the clinician for not sending the adolescent to the state hospital just because he didn't have insurance. The client was discharged to his mother's care and returned home. The clinician discussed the client's needs and behaviors with the psychiatrist the evening after the evaluation. The client and mother attended the appointment the following morning and psychiatric and crisis stabilization assessments were completed.

- **Case Vignette - Child Psychiatry**

This client was a 16-year-old mother of a 3-month old baby. Her DSS case worker was seeking a psychiatric consultation and was not able to get an intake appointment for a couple of months. Because of this new funding initiative, the CSB was able to have her seen by a child psychiatrist the same week. The young mother had already been hospitalized once at a local hospital and was at risk of a second hospitalization. Because she does not have medical insurance, if the local hospital did not have any beds she would have been sent to CCCA. The CSB was able to prevent hospitalization. The statement from the referring program was: "I appreciate you providing your service so quickly to my client in the Program for Teen Parents. It is a very helpful counseling service to my clients. If they have medical complications, or are at high risk of harming themselves or their baby, it provides a very important support until they can get to their regular counselor." The statement from the client: "I am grateful for the help to get me in a better place. The counseling service gave me good support to change my medicine so that I did not keep having suicidal thoughts and migraine headaches."

V. Planning and Future Programming

Overall, the three regions achieved good outcomes in keeping children with their parents and attending school. They established child psychiatry access through face-to-face visits, tele-psychiatry and consultation to pediatricians and primary care practitioners, and reduced their overall utilization to CCCA, the state's only public inpatient facility for children. Greater improvements should be expected in FY2014, as they move past the early start-up phase and have a full year of operation.

The experience of the first 10 months of service will inform strategizing and planning for future development of these regional programs. Without this new funding, there would not have been the opportunity to test out the practical implications of the proposed service models and to determine where adjustments are necessary. For example, while Report Document 267, "Plan for Children's Behavioral Health Services," and the survey of available services identified residential crisis

stabilization as a service very few CSBs provided, the experiences described in Section IV indicate that it was not simply a problem of funding, but of other challenges. Region IV's utilization of the residential crisis stabilization unit has been low and several strategies are being tried to increase referrals. These efforts resulted in increased utilization in the late spring of 2013, followed by a customary drop in admissions during the summer months. As of August 2013, a change has been implemented to accept non-CSB referrals to the residential crisis stabilization unit, assuring that the referrals are screened for appropriateness. If utilization does not increase in the fall as children return to school, funding will be redirected to meet other community children's services needs.

Beginning in FY2014, all five regions will have funded crisis response and child psychiatry with Region II and Region V being added using the additional funding appropriated. Both of the newly added regions have proposed mobile crisis services, residential crisis stabilization services and child psychiatry services. Opportunity for sharing learning from the programs has been facilitated by DBHDS through regional program meetings at service sites across the state, site visits and conference calls. Knowledge and expertise from these first three children's crisis response regional programs is being applied to the establishment of the two new regional programs in Regions II and V.

Appendices

Appendix A: Request for Applications

Department of Behavioral Health and Developmental Services Instructions for Proposals for Community Crisis Response and Child Psychiatry Services

FY2013-2014

VI. *Background*

In its Final Report to the General Assembly, Item 304.M, "A Plan for Community-Based Children's Behavioral Health Services in Virginia," the Department of Behavioral Health and Developmental Services described the comprehensive service array needed to meet the needs of children with behavioral health problems. A survey of CSBs indicated that, of all the services in the comprehensive service array, crisis response services, including mobile crisis teams and crisis stabilization units were the least available services in the state. Child psychiatry is an integral part of all crisis response services, and it was also one of the highest rated needed services. The 2012 session of the Virginia General Assembly considered many budget amendments that were intended to increase access to the services highlighted in the 304.M plan, including child psychiatry and crisis response services. The final approved budget bill includes the following language:

Item 315#1c

U. Out of this appropriation, $1,500,000 the first year and $1,750,000 the second year from the general fund shall be used to provide child psychiatry and children's crisis response services for children with mental health and behavioral disorders. These funds, divided among the health planning regions based on the current availability of the services, shall be used to hire or contract with child psychiatrists who can provide direct clinical services, including crisis response services, as well as training and consultation with other children's health care providers in the health planning region such as general practitioners, pediatricians, nurse practitioners, and community service boards staff, to increase their expertise in the prevention, diagnosis, and treatment of children with mental health disorders. Funds may also be used to create new or enhance existing community-based crisis response services in a health planning region, including mobile crisis teams and crisis stabilization services, with the goal of diverting children from inpatient psychiatric hospitalization to less restrictive services in or near their communities. The Department of Behavioral Health and Developmental Services shall report on the use and impact of this funding to the Chairmen of the House Appropriations and Senate Finance Committees beginning on October 1, 2013 and each year thereafter.

Explanation: (This amendment provides $1.5 million the first year and $1.75 million the second year from the general fund to provided regional funding for child psychiatry and children's crisis response services. Budget language allocates funding to health planning regions based on the availability of services with a report on the use and impact of funding due annually beginning in 2013.)

VII. *Purpose and Restrictions for Use of the Funding*

These funds are intended to fill a significant gap in the comprehensive service array described in the 304.M plan. The comprehensive service array reflects a commitment to systems of care philosophy

and values. As such, services funded under this initiative should be child-centered, family-focused and community-based.

- Funding must be used for community-based services for children who would otherwise need publicly-funded inpatient or residential services.
- The goal should be to divert children from these services to less restrictive services, and to keep children with or as close to their families as possible.
- The target population for the services are children through age 17 who:

  (vi) have a mental health problem, and
  (vii) may have co-occurring mental health and substance abuse problems,
  (viii) may be in contact with the juvenile justice or courts systems,
  (ix) may require emergency services,
  (x) may require long term community mental health and other supports.

- These funds are restricted for at least this and the next biennium. The expenditures associated with them must be tracked and reported separately.

VIII. ***Requirements for Proposals***

Please organize your proposal according to the following key elements, assuring that you cover each one:

1. Document the need for the proposed program – you may want to reference the 304.M Plan, the CSA Gap Analysis, regional hospitalization rates, emergency services utilization, etc.

2. Describe the specific crisis response service or services that you propose to provide. **All services must include a child psychiatrist.** Examples may include
   - ***Mobile crisis response teams*** – clinical team that goes to homes, schools and other community locations to help keep a child at home. Mobile teams are dispatched within 2 hours of a call to the CSB and are available 24 hours, 7 days a week. CSB emergency services may refer children and families to the mobile crisis team
   - ***Crisis stabilization units*** – short-term 6-bed or less units with 24/7 bed-based care to divert children from inpatient and residential care
   - Combinations of mobile crisis teams and crisis stabilization units
   - Favorable consideration will be given to proposals that leverage existing crisis stabilization units or mobile crisis response teams.

3. Describe how the proposed program assures that the services are **available to children across your region**? Crisis response services and mobile crisis teams are currently available in Virginia on a very limited basis. What approach will be used to extend the service or services beyond the CSB catchment area? Include letters of support, participation and endorsement from public and private partner agencies across the region.

4. Describe how child psychiatry will be provided to children directly served by the program, as well as child psychiatry consultation across your region? **Child psychiatry services *must* be a part of the proposed program**. The psychiatrist(s) (full or part time) should be

available to assess and treat children who are provided mobile crisis services or crisis stabilization bed services. In addition, describe how the psychiatrist will be available to other parts of your region by providing in-person, tele-psychiatry or telephone consultation and training to extend the reach of the psychiatrist to other localities. Collaborative partnerships where the psychiatrist works with pediatrician and family practitioner offices are strongly encouraged.

5. Describe a plan for service availability with **24 hour, 7-day, 365 days-a-year access** to services**.**

6. Describe the **staffing** for the program, including how you will implement a **team approach** to providing crisis response services. These services, whether provided on a mobile basis or residential crisis stabilization model, should use a multi-person clinical team approach, including licensed clinicians, case managers, child psychiatrists, psychiatric nurses and others.

7. Crisis stabilization services should maximize **preservation of the family unit** and help the child remain in the community in his or her own home, kinship or foster model home, or other small, integrated residential setting not larger than 6 beds in one site. Families should be fully engaged in decision-making and planning for the children served.

8. Describe approaches that will be used for **collaboration with other agency providers**, such as social services, juvenile justice, local schools, and others.

9. Private agencies are an important resource in each community and may play a role in the implementation of this funding initiative. Funded localities may contract some or all of the services with private providers. However, as the funded public entity, the region or CSB must retain oversight, accountability and overall responsibility for implementation of the services. **Describe how private providers may be involved in the proposed program.**

10. Other funding resources.

These state funds are intended to serve all children in the target population, regardless of payment source or family ability to pay. Therefore, children who are Medicaid recipients or mandated for CSA should not be prioritized for service, nor should CSA or Medicaid eligibility be the criteria for selecting children for the program. At the same time, your application should provide a plan for **maximizing CSA and Medicaid** for eligible children when appropriate. It will be expected that CSBs work collaboratively with other children's services partners, such as their Community Policy and Management Teams and private providers to appropriately serve children. Services should not be designed to meet minimum Medicaid requirements; rather they should address the criteria in this request for proposals..

IX. ***Evaluation and Reporting Requirements***

The budget language in 315 #1c requires the DBHDS to report on the use and impact of this funding to the chairmen of the House Appropriations and Senate Finance Committees on October 1, 2013. **By submitting a proposal, the applicant agrees to provide the required narrative and numerical data reports to DBHDS and to assist DBHDS by providing the information necessary to make the report.** DBHDS will work with the funded entities to design an evaluation plan, identify appropriate data elements and will provide a brief reporting form for this purpose.

Evaluation of the programs will focus on desired outcomes, such as the following:

1. Number of children served who are maintained in their home through the use of the service.
2. Number of children served who are attending their home community school.
3. Number of children served who have not been hospitalized, arrested, placed in juvenile detention or other out-of-home placement within one year of service.

X. ***Proposal Submission and Review***

Please submit a proposal, including any additional supporting information such as appendices or letters of support, as one package. The proposal submission package must include everything that is to be considered in the review of proposals. No letters of support, or other supplemental information, that are submitted separately will be considered as part of the review of proposals. Please do not have support letters mailed directly to the Commissioner or elsewhere at DBHDS. This is to assure that we have everything in one package that should be considered as part of the application. You may either send your complete application packet, including any attachments, electronically or in hard copy. On the front page of your proposal, please provide the email address of a contact person. We will email the contact person within 1 business day confirming that we have received your proposal.

DBHDS will convene a review panel to evaluate the proposals based on the proposal requirements above. The panel will make their recommendations for awards to the Commissioner. Individual awards will vary dependent upon actual amounts requested and the total number of sites selected. **Proposals must be submitted in one electronic submission or hard copy package to:**

Office of Child and Family Services
Department of Behavioral Health and Developmental Services
1220 Bank Street
Richmond, VA 23218

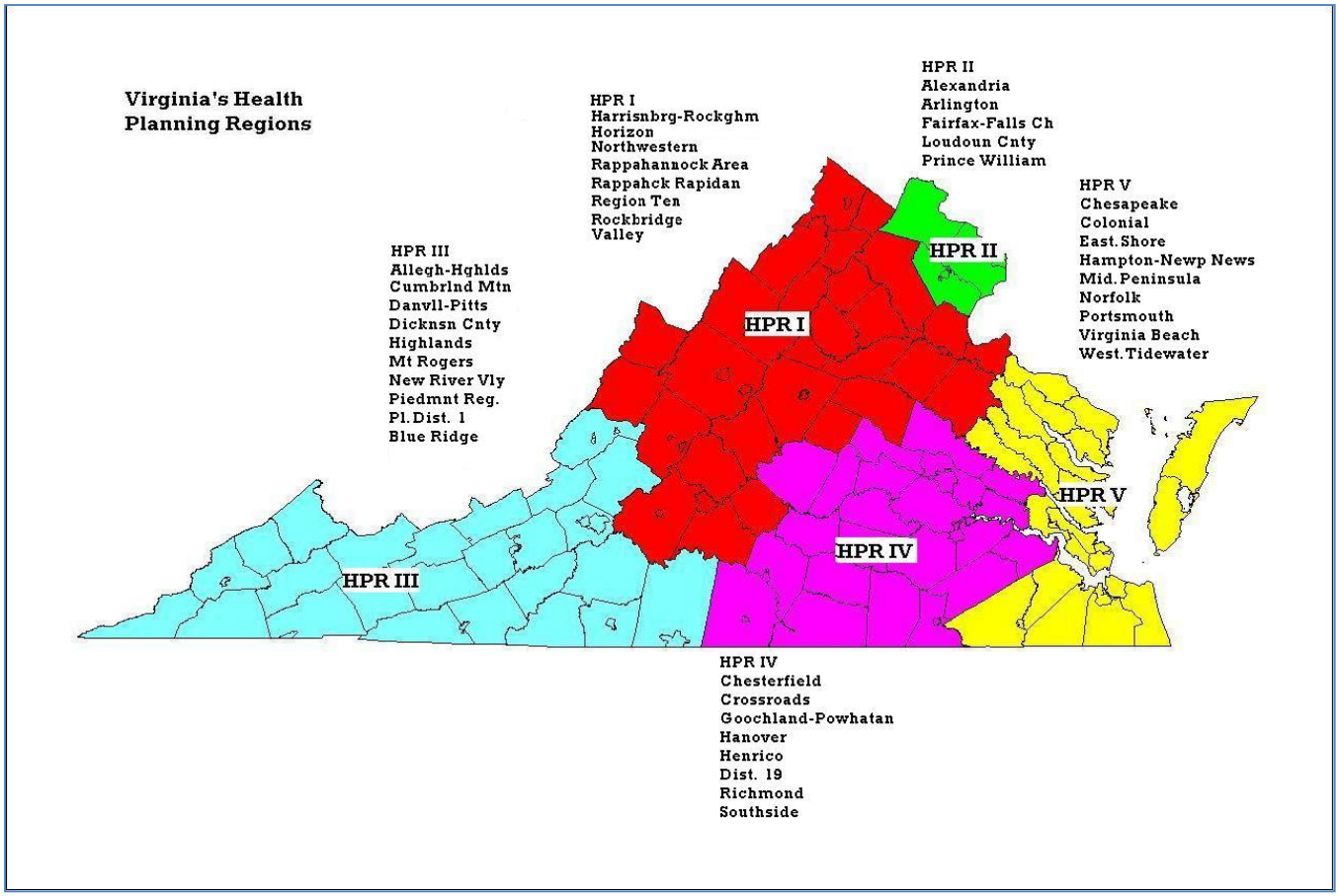
Due Date for Proposals: 5:00 PM on 7/27/12.

- DBHDS will notify the contact person by 7/30/12 that the proposal has been received.

XI. ***Technical Assistance Conference Call***

A technical assistance phone conference for prospective applicants will be held at 10:00 a.m. on June 27nd. To RSVP for participation on the call, please reply to: [specific information included when distributed]

Appendix B: Map of Virginia Showing CSB and Regional Structure



Appendix C: State Facility Services Provided at the Commonwealth Center for Children and Adolescents

	FY2012 Admits Unduplicated	FY2013 Admits Unduplicated	FY2012 Admits	FY2013 Admits	FY2012 Readmissions	FY2013 Readmissions	FY2012 Bed Days	FY2013 Bed Days	Change in Bed Days	% plus or minus
Region I										
Harrisonburg-Rockingham	15	27	18	34	7	11	278	501	223	80.2
Horizon-lead	23	**10**	34	10	**17**	3	480	167	-313	-65.2
Northwestern	25	29	34	38	17	11	592	583	-9	-1.5
Rappahannock Area	26	25	33	31	13	13	650	548	-102	-15.7
Rappahannock-Rapidan	12	6	14	6	5	1	278	78	-200	-71.9
Rockbridge	2	4	2	5	0	1	18	62	44	244.4
Region Ten	23	25	28	30	6	14	533	577	44	8.3
Valley	47	46	66	54	32	21	849	511	-338	-39.8
Total	***173**	***172**	**229**	**208**	**97**	**75**	**3678**	**3027**	**-651**	**-17.7**
Region III										
Alleghany	8	2	11	2	3	0	130	30	-100	-76.9
Blue Ridge	28	9	34	13	11	7	558	202	-356	-63.8
Cumberland Mountain	4	2	6	5	2	3	78	81	3	3.8
Danville-Pittsylvania	8	9	12	9	6	1	524	164	-360	-68.7
Dickenson	0	0	0	0	0	0	0	0	0	0.0
Highlands	9	16	10	17	1	3	160	249	89	55.6
Mount Rogers-lead	19	15	21	22	8	9	294	256	-38	-12.9
New River Valley	46	30	65	39	29	15	971	513	-458	-47.2
Piedmont	17	15	18	18	5	5	184	295	111	60.3
Planning District 1	2	4	2	4	0	1	30	51	21	70.0
Total	***140**	***102**	**179**	**129**	**65**	**44**	**2929**	**1841**	**-1088**	**-37.1**
Region IV										
Chesterfield	17	10	19	12	4	4	471	288	-183	-38.9
Crossroads	7	12	7	13	2	4	133	230	97	72.9
District 19	21	20	26	24	9	7	511	357	-154	-30.1
Hanover	13	4	14	5	4	2	218	48	-170	-78.0
Henrico	24	30	28	34	9	11	564	789	225	39.9
Goochland-Powhatan	1	0	1	0	1	0	12	0	-12	-100.0
RBHA-lead	22	27	28	34	11	12	393	471	78	19.8
Southside	4	2	4	3	1	2	64	10	-54	-84.4
Total	***107**	***104**	**127**	**125**	**41**	**42**	**2366**	**2193**	**-173**	**-7.3**

*Regional and statewide unduplicated totals may not equal the sum of the unduplicated totals by CSB