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October 1, 2015

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

Dear Senator Stosch and Senator Colgan:

Item 308. S. of the 2014 Appropriations Act appropriated funds "*to provide child psychiatry and children's crisis response services for children with mental health and behavioral disorders*". The language also required the Department of Behavioral Health and Developmental Services to *"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."*

Please find enclosed the report in accordance with Item 308.S. Staff at the department are available should you wish to discuss this request.

Sincerely,

Jack Barber, M.D.

Enc.

Cc: William A. Hazel, Jr., M.D.
Joe Flores
Susan E. Massart
Mike Tweedy

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The Honorable S. Chris Jones, Chair
House Appropriations Committee
General Assembly Building
P.O. Box 406
Richmond, VA 23218

Dear Delegate Jones:

Item 308. S. of the 2014 Appropriations Act appropriated funds "*to provide child psychiatry and children's crisis response services for children with mental health and behavioral disorders*". The language also required the Department of Behavioral Health and Developmental Services to *"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."*

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Report on Funding for Child Psychiatry and Children's Crisis Response Services (Item 308.S., 2014 *Appropriation Act*)

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

October 1, 2015

Child Psychiatry Services and Children's Crisis Response In Virginia

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Executive Summary

This report was developed in accordance with Item 308.S. of the 2014 *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:

> *S. Out of this appropriation, $3,650,000 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 Virginia.

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 health planning regions.

Funding was awarded through a request for proposals and application review process to each of the five health planning regions. Each region has a lead CSB. The regional CSB leads are:

- **Region I – Horizon Behavioral Health**
- **Region III - Mount Rogers**
- **Region IV - Richmond Behavioral Health Authority**

- **Region II- Arlington**
- **Region V- Hampton-Newport News**

All regions have been operational for at least one fiscal year. Overall, the regions have achieved good outcomes in maintaining children in their homes, with their parents and attending school. They also increased child psychiatry access, serving more children than prior years through face-to-face visits, tele-psychiatry and consultation with pediatricians and primary care physicians.

I. Introduction and Background

This report was developed in accordance with Item 308.S. of the 2014 *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:

> *S. Out of this appropriation, $3,650,000 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 Virginia. 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 304.M Plan.

Item 308.S. provides $3.65.5 million general fund dollars the first year and $3.65 million general fund dollars the second year for 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.

II. Request for Applications, Selection and Funding Process

When the funding first became effective on July 1, 2012 (FY 2013), DBHDS issued a competitive Request for Applications for regional proposals that included the key requirements described below. As new funding was added for FY 2014 and FY 2015, the regions were asked to respond to the same Request for Applications to seek additional funding.

- 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 maintaining 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. Additionally, crisis response services should include:

1. ***Mobile crisis response teams*** – Clinical teams that goes to homes, schools and other community locations to help keep a child at home. Mobile teams are dispatched within two 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.

As the funding appropriation has grown over three fiscal years, services have grown in capacity across the Commonwealth. In the first year, FY 2013, five proposals were received, one from each Virginia Health Planning Region. Three proposals were selected: Region I, Region III and Region IV. In FY 2014, Regions II and V were added. This report describes the services provided by all five regions from July 1, 2014 through June 30, 2015.

Children's Behavioral Health Crisis Response and Child Psychiatry Services FY13-15

Region	Lead CSB	FY13 TOTAL	FY14 TOTAL	FY15 Total
Region I	Horizon	500,000	711,978	999,999
Region II	Arlington	0	839,117	839,117
Region III	Mt. Rogers	300,000	482,480	694,459
Region IV	RBHA	700,000	839,117	839,117
Region V	Hampton	0	839,117	839,117
Totals		**1,500,000**	**3,711,809**	**4,211,809**

III. Description of Regional Programs

Each region was requested to provide a progress report on their work in FY 2015. The following are summaries provided by the regions:

Region I (Horizon is the lead CSB for the region)
Child Psychiatry
The recruitment of a second child psychiatrist has been a challenge. The second position has been filled with a locum tenens (locum tenens physicians fill in for other physicians on a temporary basis); unfortunately, this solution is more costly than having a full time psychiatrist on staff at a CSB.

With additional funding, the region purchased telepsychiatry equipment for Horizon, Northwestern, Rappahannock/Rapidan and Region Ten in order to increase telepsychiatry/psychiatry/consultation time across Region I.

Region I’s current child psychiatry and children’s crisis response services funding provides for child face-to-face psychiatry/telepsychiatry and consultation to the following:

Telepsychiatry & Consultation	Face-to-Face & Consultation
Rappahannock Area (3 sites)	Horizon (5 sites)
Rockbridge (Bath County)	Rappahannock/Rapidan
Northwestern	Region Ten (3 sites)
Rappahannock/Rapidan (Culpepper)	Rockbridge

In order to provide increased access to child psychiatry services, two full time registered nurse (RN) case managers have been hired. Their job responsibilities include:

- Opens chart – completes state paperwork requirements
- Liaison to multiple CSBs receiving telepsychiatry services
- Expansion of RN responsibilities for CSBs across Region I:

- Paperwork: Releases, consents
    - Vital signs and nursing assessment (enters BMI – Body Mass Index)
    - Height, weight
    - Educational services to parents and children
- Liaison to pharmacies across Region I
    - Preauthorization paperwork
- Maintain doctors' schedules
- Provide nursing case management for up to 20 Private Provider/intensive in-home cases

Looking ahead: FY 2016

By combining behavioral health child psychiatry and crisis response funding with funding for crisis services for children with intellectual or developmental disabilities, the region will increase the capacity of crisis services. Mobile crisis teams will be available at eight CSBs. Additionally, with the FY 2016 child psychiatry and children's crisis response services funding, mental health clinicians will be hired across the CSBs in the region. A regional director to coordinate services across the CSBs and one part-time person to track data for the region will also be added through the new funding.

Region II (Arlington is the lead CSB for the region)

Mobile Crisis Teams

Children's Regional Crisis Response (CR2) is a short term crisis stabilization program for youth 17 or younger serving all of Health Planning Region II. The program offers symptom management, individual and family counseling and psychiatric/medication evaluations to youth who are at risk of psychiatric hospitalization. Services are delivered in the home environment with the goal of preventing or deterring hospitalization when clinically appropriate. The CR2 program works collaboratively with other treating professionals and provides intensive case management to assist the families in connecting to long term supports.

CR2 Program Manager and staff conducted extensive marketing and presentations to private mental health providers, Department of Family Services, local CSBs, hospitals, community health clients, doctors' offices, foster care agencies, community fairs, and, schools across the region to build awareness of the program and services available. Calls quickly began to flood the Crisis Line (844-N-Crisis) for new referrals, case consults/staffing, or to identify appropriate resources for families. The program began to utilize an MSW intern to assist with calls during high call volume times thus allowing staff to be in the field more frequently.

The overarching eligibility criteria are that a youth has to be at-risk of psychiatric hospitalization. If the client is not at risk of hospitalization due to suicidal ideation or homicidal ideation, difficulty with reality testing or self-harm, he/she would unfortunately not be eligible for the program. The CR2 program experienced several calls that did not meet the eligibility level for services. In those situations, CR2 staff has made appropriate referrals and recommendations to assist families in connecting to necessary supports.

The CR2 program experienced some staff turnover within the last year; however the program is currently fully staffed with eight licensed eligible clinicians and a licensed Program Manager. CR2 is a small team of eight for a very large service area: Loudoun, Prince William, Fairfax/Falls Church, Alexandria, and Arlington Counties. There have been times that the program was at capacity and not able to accept new clients, during those times CR2 staff identified other resources with/for the families and referring to Emergency Services, 911, or the local Emergency Room as needed.

Within the first year of the program, CR2 has received positive feedback from families, professionals, and other community stakeholders.

CR2 is able to work with youth that are intellectually disabled or on the Autism Spectrum to provide crisis intervention/stabilization services and link to appropriate long term supports; however, the program does not have an Applied Behavioral Analysis (ABA) certified therapist on staff. This is an area of need not only for CR2 program, but within community resources as a whole.

CR2 has interfaced with several families that would benefit from additional long term supports, such as home-based or wrap-around services that would need to be accessed through CSA funds.

Along with Arlington DHS, CR2 has been identifying strategies to establish territories in the region for CR2 staff relative to counties being served. By establishing set territories for the staff, this will prevent extended travel time needed to get to and from clients and it will increase the number of clients being served if they are in the same catchment areas.

Looking ahead: FY 2016

The FY 2016 child psychiatry and children's crisis response services funding allocation will allow for the expansion of CR2. This is an exciting opportunity to increase the reach of the CR2 program moving forward.

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

Telespsychiatry

Telepsychiatry services continue to be provided via a contract with the University of Virginia. An additional 10 hours per week were added using child psychiatry and children's crisis response services funding, totaling 30 hours per week. The demand for telepsychiatry services has grown significantly as three additional agencies were awarded funds to assist in the development of youth crisis services.

Nearly all of the children have successfully transitioned to a local provider for ongoing services, once stabilized on medications. This transition may require 3-4 follow up appointments, but the majority of cases are successfully discharged from telepsychiatry services within three months. Increased collaboration with local providers has made this transition possible, benefitting the child who needs immediate services and the providers who now have a means of filtering youth into services versus experiencing a bottleneck in scheduling. Most urgent appointments are provided within 72 hours of the request.

Positive Alternatives to Hospitalization
Mount Rogers CSB continues to provide the Positive Alternatives to Hospitalization (PATH) program, which includes crisis intervention and mobile crisis stabilization services. This program has maintained its excellent track record for preventing hospitalization and expediting services to assist youth and families with urgent needs. Of the 59 youth who received PATH services this last half of the fiscal year, none required subsequent hospitalization. That totals 101 youth who received PATH and only one subsequent hospitalization for the entire year.

Integrated Care
New River Valley Community Services (NRVCS) has continued to increase integration of behavioral and primary care services. In May of 2015, NRVCS partnered with New River Valley (NRV) Pediatrics to place integrated behavioral health staff in their clinics four days a week. The behavioral health consultant has been working to provide on-site triage, assessment and counseling services for patients of the pediatric practice. This partnership furthers the goal of moving toward a more integrated system and utilizes some core principles of primary and behavioral health integration such as co-location, using the "warm hand off" model, and a shared electronic health record. The providers at NRV Pediatrics and NRVCS have also begun to utilize a collaborative model of care that works to serve clients of both of our agencies on a continuum of care. This collaborative model allows NRV Pediatrics clients to have access to psychiatric consultations and services, and facilitates professional consultation between the physicians at NRV Pediatrics and NRVCS to provide optimal services for all patients.

Emergency Services and Crisis Stabilization Specialists
Highlands Community Services has employed two full-time positions: a Children and Youth Emergency Service Specialist and a Children & Youth Crisis Stabilization Specialist. The Children and Youth Emergency Service Specialist is a certified prescreener and performs face-to-face evaluations for children and youth in crisis at various internal locations and community settings to determine the least restrictive placement. In addition, this position provides face-to-face crisis interventions to children and youth through scheduled appointments, allowing individuals whose symptoms have escalated to divert from inpatient hospitalization by providing the consumers and their families with additional services. The Children and Youth Crisis Stabilization Specialist provides services to children and youth enrolled in the Crisis Stabilization Unit, The Safety Zone. Individuals enrolled in the program receive on-site and community based outpatient treatment for their symptoms, allowing consumers to be diverted from inpatient treatment. Both positions allow for children and youth in crisis to stay in the community, preventing them from being placed several hours away at inpatient hospitals outside of the region.

In the past year, several challenges have made it difficult to provide services to children and youth in crisis. Crisis services, by definition, are emergency services which are high intensity, high risk services. Retaining individuals that are qualified, dedicated, and, compassionate with sincere interest in individuals in crisis has proved challenging. In order to meet this need, Highlands Community Services has made several personnel adjustments and transfers internally to ensure that the needs of the consumers remain the top priority. Although at times the transitions were challenging, presently both positions are occupied by qualified individuals that possess a seamless combination of passion, understanding and dedication to successfully serving this unique population. In addition, due to the high volume of children and youth in crisis,

availability at The Safety Zone is frequently limited. Space and personnel constraints frequently result in youth being hospitalized when, if available, hospitalization could have potentially been diverted.

Crisis Counselor

Piedmont Community Services (PCS) designed the new crisis counselor position in November of 2014, to offer crisis intervention to children by being the primary crisis contact for the local school systems. The majority of services are provided in the PCS office; however, the crisis counselor is able to travel onsite to the school to assist children during a crisis as necessary. The school system has enjoyed having one primary person they can call to help assist when a child is presenting with a mental health crisis. The provider can do a prescreen to determine whether or not hospitalization is needed, and if it is not, quickly do assessments to get the child enrolled in less restrictive mental health services, either at the CSB or in the school setting as applicable. Since January 1, 2015 there have been 64 prescreens conducted by this new position. Of those 64, only 14 children were hospitalized. Of these 64 adolescents seen, 63 are receiving services, 62 are attending school, one was suspended, and one adolescent's school status is unknown. Again, several factors have contributed to the success in establishing a high percentage of children being stabilized with less restrictive care than inpatient. One of the main factors is the ability to assess for services at the time of the crisis visit. This has made the transition easier for all parties involved.

Child and Adolescent Emergency Services Clinician

Danville-Pittsylvania Community Services (DPCS) had originally requested funding for a Youth Crisis Counselor. When initial recruitment attempts were unsuccessful, the position was re-advertised. Interviews occurred during the first weeks of January 2015. Unfortunately, a change in crisis intervention regulations created a situation in which ideal candidates were no longer qualified to provide that service. As a result, DPCS has elected to seek a Child & Adolescent Emergency Services Clinician instead. This clinician will work primarily with children and adolescents in crisis. Services provided to children and adolescents include emergency evaluations and assessments, brief or intensive counseling to enhance coping skills in order to minimize the need for inpatient care and preadmission screenings. The clinician will be able to coordinate and make referrals for treatment or services from other DPCS programs or for other community-based services as needed. In addition, consultation may be provided to courts, schools or other community agencies. Efforts to fill this position are currently underway.

Kids in Crisis Program

Blue Ridge Behavioral Healthcare (BRBH) began the Kids in Crisis (KIC) program on August 1, 2014. The program was designed to meet the needs of children and adolescents in crisis in the community. Specifically, those children and adolescents who do not meet criteria for Medicaid funded crisis services are the target population of the KIC program. The program has one full time staff person, but can be supplemented by other staff, if needed. To date, the program has served 48 children, adolescents and their families. The Therapeutic Behavioral Specialist (TBS) works with families for 30-45 days, focusing on the specific issue that caused the crisis, while teaching alternative coping skills to the client and supportive skills to their family. While working with the child, the TBS also makes recommendations and referrals for additional services which may include longer term clinical services.

The current challenge is to determine and secure appropriate discharge services within the time frame that the TBS works with the client and family. Some community based services, outpatient counseling and psychiatric services, have wait times and the first appointment does not always fall within the 30-45 day framework. To address this issue, if the client is eligible and appropriate for Medicaid funded Case Management services or Mental Health Initiative (MHI) funded Care Coordination, then the client can be opened to one of these services in a timely manner. The follow through of the discharge plan is then completed by the Case Manager or Care Coordinator.

Another challenge is that the limited amount of funds available to provide non-Medicaid funded crisis services. BRBH has been able to combine the child psychiatry and children's crisis response services funds with MHI funds to cover the costs of one position and support periodic additional support of other staff. However, the response to this program from the community has been very positive and at times, overwhelming. With additional funds, the program could expand and further meet the needs of the community.

Moving forward, BRBH is closely examining the feasibility of providing Medicaid-funded Crisis Intervention services to children and adolescents. A preliminary analysis of the calls received by the KIC program show that very few potential clients both have Medicaid coverage and meets the strict eligibility guidelines to be served through Crisis Intervention. As alternative funding is limited, BRBH will continue to investigate creative revenue options to support and sustain the program.

Looking Ahead: FY 2016

Region III is in the process of developing a regional residential crisis stabilization unit. This unit will be a resource for prescreeners to divert children from inpatient psychiatric hospitalization and to provide more intense crisis services in the community.

Region IV (Richmond Behavioral Health Authority is the lead CSB for the region)

Seven of the eight CSBs/BHA in Region IV are linked with the demonstration project through the children's crisis stabilization services contracted through St. Joseph's Villa (SJV); Southside CSB continues to operate its own carve-out of the region's demonstration project. The goal of the region has been to continue to increase accessibility to these crisis services, since project funding was initiated in FY 2013.

Residential Crisis Stabilization Unit

At the end of the fiscal year, 129 children and adolescents (unduplicated count) were served by the residential CSU and received 1,374 bed days of service. A total of 146 CSU admissions occurred during the year. Nineteen readmissions occurred over the course of the year; as such, the CSU staff in collaboration with the CSB/BHA partners will more intensely review these cases to problem-solve any needed changes in therapeutic approach or discharge planning, including levels of engagement with wrap-around services post-discharge. At this time, the CSU staff is assessing each re-admission and situation to explore any trends and/or changes in approach to facilitate successful change for the youth and his/her families. Consistent with earlier reports, 86% of children were discharged to the community following an episode of care with St. Joseph's Villa (SJV) CSU.

Children admitted to the CSU continued to experience a relatively short to moderate length of stay (LOS). Although it increased to an average 9.2 days this period, it is still consistent with one of the program's goals to quickly stabilize the child and return him/her to the community with natural supports in place.

The relative increase in LOS over prior years can be explained, in part, by the increased complexity of family and psychiatric issues presented during this period. A number of families required assistance from CSU staff in navigating multiple systems and/or agencies, in order to augment fluid and effective treatment and discharge planning to cement stabilization. Throughout the year, the youth and families were linked with 786 community resources, such as the regional CSBs, schools, Departments of Social Services, court services, outpatient psychiatry and other behavioral health providers, and pediatricians. As well, CSU worked to link children with theater groups, mentoring programs, and other activities related to the youth's interests.

Ambulatory Crisis Stabilization Services

As of June 30, 24 children participated in ambulatory crisis stabilization services onsite at SJV via "day programming" either as a stand-alone service or as a step-up to or step-down from the residential unit. A total of 837.5 hours of ambulatory services were provided.

While the number of children served via mobile/ambulatory service from FY 2014 to FY 2015 actually decreased, the number of hours from year-to-year increased substantially, as the "day programming" component has become more widely accepted as a complementary service to the residential CSU. Regardless, the regional planning team will continue to monitor the use of this service; CSBs/BHAs will continue to educate staff about the availability of this option especially for younger children; and SJV will continue to review each residential referral and admission for this service when appropriate.

St. Joseph's Villa continues to be a solid, valued partner with the Region IV CSBs with regard to providing a piece of the continuum of services for youth in crisis.

Psychiatry Services

After working with several temporary psychiatrists, SJV hired a new psychiatrist via partnership with Insight Telemedicine. Since this transition, the CSU has increased the number of available telehealth hours and consultations. Children in the program have access to the psychiatrist five days a week and, if necessary, on the weekends. This level of accessibility enables each child to be seen by the doctor within 24 hours or next business day.

All children served by SJV had either a face-to-face or telemedicine contact with the psychiatrist, and more than 138 hours of psychiatry were provided. There was consistent provision of psychiatric services, covering day and evening hours for all youth. Many of the children admitted who had either no previous success with medication or had never been prescribed medication were able to experience successful medication trials initiated by the CSU's psychiatrist. Psychiatric services included active engagement of parents/guardians in the discussion of treatment recommendations. With the new psychiatrist on board, CSU staff was able to put in place a more routine structure for psychiatric consultations with other medical practitioners and behavioral health providers; thus, the program demonstrated a significant increase in the number of consultations provided from FY 2014 to FY 2015.

Emergency Crisis Response and Telepsychiatry, Southside CSB
Southside CSB (SCSB) is currently providing its catchment area with Emergency Services that are available seven days a week, 24 hours a day. Outpatient services are available at every location on a walk-in basis where individuals can be opened to services and go through the triage process to determine level of need, which can include an emergency assessment at any time during regular business hours. All of SCSB's services are doctor-driven and so all individuals must see the psychiatrist to obtain an evaluation and approve the individual service plan. Further, SCSB offers emergency psychiatric appointments on an as-needed basis, as well as opportunities to walk in for psychiatric services for individuals who have difficulty keeping appointments.

Children who are seen by emergency services but who are not sent to the hospital are referred within 24 hours for a follow-up appointment in the nearest location for either outpatient or telepsychiatry services as needed. They receive outreach the following business day and are either given an appointment for that day (or a time when it is convenient for the child and his/her family) or advised that they can walk in and be seen that day. Children who are hospitalized are set up for a follow up appointment with either the therapist or psychiatrist within 7 days or less of discharge.

During FY 2015, SCSB provided 110 prescreens for 88 unique individuals in Child and Family Services. The large majority of the prescreens and hospitalizations occurred in the first half of the fiscal year with multiple prescreens occurring for a small number of children who were in need of a higher level of care in residential settings; SCSB took these children through that process and were able to obtain the necessary level of care.

SCSB currently has no waiting lists for services for either outpatient or psychiatry. It has been able to decrease the number of hospitalizations by working with community partners to obtain the appropriate level of care for the children that were seen multiple times by emergency services the first half of the year and has developed a treatment team to help manage the cases that appear to be crisis driven to provide consistent services across all settings.

SCSB has modified its capacity for children's telepsychiatry services by moving to different providers that have the ability to see more individuals in the same time period and see walk-in clients and emergency assessments as needed. New processes are in place for emergency prescreenings for children that include same-day follow-up assessments and, if the individual is not hospitalized, appointments within 24 hours of a prescreen. SCSB has also provided increased training for afterhours prescreeners regarding crisis assessment for children.

During the year, SCSB has worked through a number of challenges, including addressing transportation as one of the barriers to treatment with both outpatient and psychiatry. SCSB worked with the Region IV office to incorporate a way to provide transportation to clients into its Memorandum of Agreement as a means of mitigating this barrier. The board is currently working on developing relationships with transportation companies and cab companies to provide transportation for individuals to their psychiatric appointments. The board continues to work to provide the emergency services staff increased training in child and family crisis intervention and ongoing education regarding diversionary treatment options for children, such as crisis stabilization, to decrease the use of hospitalization.

Looking ahead: FY 2016
Region IV partners will continue to work together to monitor services, service quality, access, and utilization of the project elements described above, as we enter another year of service.

At the time of this report submission, Region IV had been notified of child psychiatry and children's crisis response services funding awarded to expand the continuum of regionally-operated crisis-oriented services for youth. During the next six months, regional partners and stakeholders will begin the Crisis Response and Stabilization Team (CReST).

This clinical response team will be incorporated into the existing array of crisis response services in the region and collaborate with the eight (8) Region IV CSBs/BHA, St. Joseph's Villa, VCU Health Systems/Virginia Treatment Center for Children, other hospitals and emergency departments, child REACH, and other partners to be identified in this process to serve children in crisis who are not able to access inpatient or CSU beds. Building capacity around child psychiatry, with the active recruitment of a full-time child psychiatrist underway, is also a primary objective for this next six month period.

For the next fiscal year, Southside CSB has set a goal to have all clinicians in children and family services certified as prescreeners prior to the end of 2015. As well, they plan to increase hours of services to include evening hours at least two days a week at all locations.

Region V (Hampton-Newport News is the lead CSB for the region)
Region V has utilized the child psychiatry and children's crisis response funding to develop and implement four mobile crisis units and one urgent care center. These programs provide services for children and adolescents ages 5-17 experiencing a psychiatric crisis. The children being served by all of the programs in the region are experiencing either an acute psychiatric crisis that places them at risk for an out of home placement (hospitalization/detention), a marked reduction in psychiatric, adaptive or behavioral functioning or an extreme increase in personal distress.

Mobile Crisis Teams
Services provided by the mobile crisis units may occur at an office, the child's home, school or any other setting appropriate to the needs of the child. The flexibility of the location of service provision eliminates barriers families may encounter when trying to access services. The following services are offered by the mobile crisis units:

- Assessment of immediate safety
- Short term counseling to stabilize the children and their families
- A safety plan for the child based on the child's and the family's strengths
- Collaboration with community stake holders related to the child
- Linkage with ongoing service providers to prevent a future crisis

Access to mobile crisis services ranges from immediate access to 48 hour access. All clients referred to a mobile crisis unit are triaged to determine the immediacy of their needs. Immediate crises are scheduled or referred to emergency services or the nearest emergency room. All clients are provided with emergency contacts and appropriate resources in case the crisis intensifies before the initiation of services with the mobile crisis unit. Service providers for the

crisis services are licensed clinicians, licensed eligible clinicians or Qualified Mental Health Providers.

The Virginia Beach Department of Human Services, Western Tidewater CSB, Colonial Services Board and the Middle Peninsula/Northern Neck Community Services Board provide the Children's Mobile Crisis Services to their own catchment areas.

Behavioral Health Urgent Care Center

The Children's Behavior Health Urgent Care Center offers the following services:

- Same day or next day psychiatric evaluation
- Comprehensive mental health and substance abuse assessments
- Safety assessment and safety planning
- Crisis oriented individual and family counseling
- Discharge Planning
- Ongoing support until the family is engaged in community based services

The community services boards in the region that are experiencing a physician shortage and a delay in the ability to offer psychiatric care have the opportunity to refer children in crisis for immediate psychiatric evaluations and the initiation of medication management. The urgent care center coordinates among emergency services workers, case managers, therapists, and physicians with the local community services boards. Additionally there is collaboration with emergency room crisis staff, school personnel, social services, court services and other community stake holders involved with children.

The Hampton Newport News Community Services Board partnered with Bon Secours Maryview Medical Center to create the Children's Behavioral Health Urgent Care Center which offers crisis intervention to the entire HPR-V.

The mobile crisis units and the urgent care center in the region have served over 700 children this year. Due to these crisis services, out of home placements for children experiencing a psychiatric crisis have been averted whenever possible. Families have been able to receive immediate support reducing the fear, anxiety and isolation that is experienced during a crisis. These services enable a child in crisis to be supported until they can be linked to appropriate community services.

Looking ahead: FY 2016

The goal in the region is to expand the staffs for all of the boards that have existing programs. Additionally, a goal is to have each catchment area in the region covered by children's mobile crisis services.

IV. Results

The following is information on community services provided by the regions. Data on community services are reported by CSBs in the DBHDS automated data system, the "Community Consumer Submission" (CCS). The data provided in this report are from the

service categories in the CCS that are most frequently provided to children in crisis. Those services include:

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

Because child psychiatry is included within the outpatient services category of CCS, separate data on child psychiatry services are not available from the automated system. A manual report from the regions was used to gather data on child psychiatry services. Table 3 reports manually collected data from the programs on child psychiatry services to give a picture of the numbers of children who received each type of child psychiatry service. Throughout this section on results, data that shows improvement in program outcomes is highlighted in green.

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 on their behalf. 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. Pre-screening services are provided by certified pre-screeners who meet state criteria and have completed training modules to assure their competency. All regions continued to provide more emergency services to children in FY 2015 than in FY 2014.

Table 1 – Emergency Services

Emergency Services				
Region	**FY 2013**	**FY 2014**	**FY 2015**	**Percent Increase (Since 2013)**
I	1777	2133	2682	51%
II	1845	2071	2183	18%
III	1692	2437	2531	50%
IV	1260	1444	1485	18%
V	986	1325	1656	68%
Totals	**7560**	**9410**	**10537**	**39%**

*Numbers of children are unduplicated.

Outpatient Services (Child Psychiatry is part of this category)

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. Most regions provided more outpatient services to children in FY 2015 than

in FY 2014. Table 3 and Table 4 provide the child psychiatry services provided as part of this initiative.

Table 2 – Outpatient Services

Outpatient Services				
Region	**FY 2013**	**FY 2014**	**FY 2015**	**Percent Increase (Since 2013)**
I	5729	6540	6690	17%
II	2681	2940	2969	11%
III	6266	7032	7171	14%
IV	3648	4008	3717	2%
V	3885	4021	4150	7%
Totals	**22209**	**24541**	**24697**	**11%**

*Numbers of children are unduplicated.

Child Psychiatry Services (Separate from Outpatient Services)

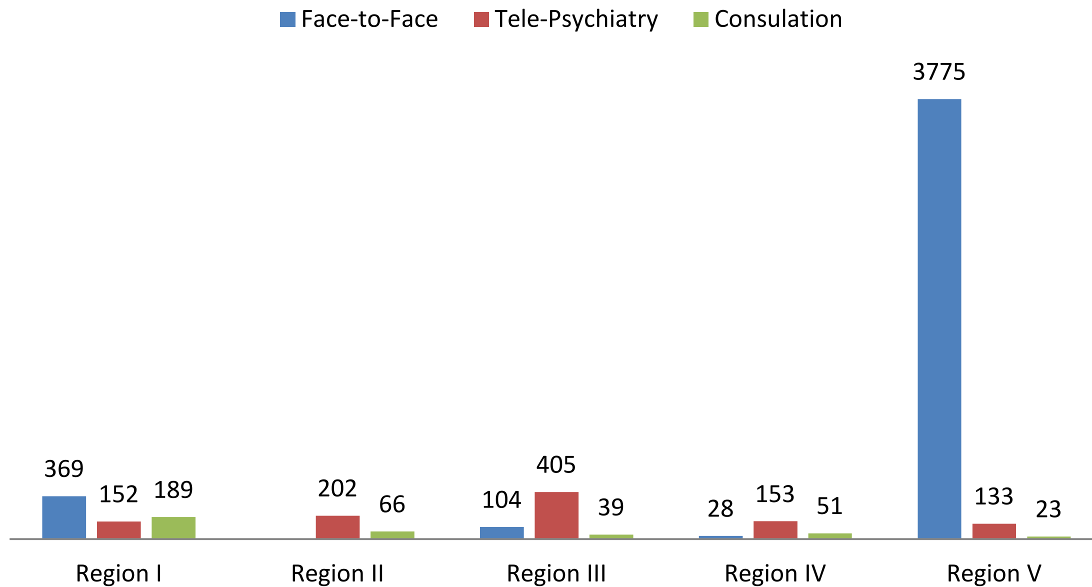
In order to extend the reach of very limited child psychiatry resources, the funded programs were asked to provide child psychiatry in three venues:

- 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 five regions. Region V, led by Hampton-Newport News, served the largest number of children using all three approaches, with 3,775 children receiving a face-to-face visit with the child psychiatrist.

Overall, child psychiatry services continue to be a successful aspect of this initiative, adding capacity in an environment of extreme scarcity of board-certified child psychiatrists. However, there are delays with hiring because of the shortage of child psychiatrists in the Commonwealth. Regions persistently advertise and utilize different approaches, such as locum tenens, to fill the need. Additionally, telepsychiatry is used to increase access to a child psychiatrist. Child psychiatrists provided face-to-face, tele-psychiatry, and consultative approaches to 5,689 children in Virginia; a significant increase over the 2,189 children that were served during the previous fiscal year. The largest number of children receiving child psychiatry services (3,931) was in Region V.

Table 3: Child Psychiatry



*Numbers of children are unduplicated.

Table 4: Child Psychiatry Services Provided by Each Region Compared by Year

Service	Region I			Region II		Region III		
	2013	2014	2015	2014	2015	2013	2014	2015
(1) Face-to Face	189	487	369			62	80	104
(2) Tele-Psychiatry	54	93	152	1	202	3	303	405
(3) Consultation	83	170	189		66	39	76	39
Total	**326**	**750**	**710**	**1**	**268**	**104**	**459**	**548**

Service	Region IV			Region V		Statewide Total		
	2013	2014	2015	2014	2015	2013	2014	2015
(1) Face-to Face	72	68	28	694	3775	323	1329	4276
(2) Tele-Psychiatry	18	89	153	106	133	75	592	1045
(3) Consultation		11	51	11	23	122	268	368
Total	**90**	**168**	**232**	**811**	**3931**	**520**	**2189**	**5689**

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. (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 avoid unnecessary hospitalization, re-hospitalization, or disruption of living situation, assure safety and security and stabilize children in crisis. Services may involve mobile crisis teams. Ambulatory crisis stabilization services may be provided in an individual's home or in a community-based program licensed by DBHDS.

Region II, one of two regions to be funded in FY 2014, had the greatest increase and served the most children through ambulatory care in FY 2015. While Region V had the fourth highest number of children served, it significantly increased the number of children served from FY 2014 to FY 2015, as shown below in Table 5.

Table 5: Ambulatory Crisis Stabilization

Ambulatory Crisis Stabilization				
Region	**FY 2013**	**FY 2014**	**FY 2015**	**Percent Change (Since 2013)**
I	419	281	270	-36%
II	1	1	488	48700%
III	3	151	239	7867%
IV	6	25	19	217%
V	14	70	209	1393%
Totals	**443**	**528**	**1225**	**177%**

*Numbers of children are unduplicated.

Residential Crisis Services

Region IV contracts with Saint Joseph's Villa, a private provider, for a unit for the purpose of crisis stabilization. This public-private partnership has reflected a strong commitment on both parts to making overnight crisis stabilization services available in the region. St. Joseph's Villa and Region IV have continued to analyze referral and utilization patterns to increase utilization. The region and the provider continue outreach efforts to increase awareness in the community to help ensure appropriate utilization. These efforts have helped to maintain a steady number of admissions to the unit. Region II is expected to show increased utilization in the next fiscal year, as they experienced start-up delays in their first year. With the allocation of new money for FY 2016, Region III has proposed to open a Residential Crisis Stabilization Unit. Providing there are no start up delays, it is anticipated that utilization will increase in FY 2016. Due to a long-standing community commitment to serve children in the community and to avoid residential care, Region V has very low utilization numbers as shown in Table 6.

Table 6: Residential Crisis Stabilization

Residential Crisis Stabilization				
Region	**FY 2013**	**FY 2014**	**FY 2015**	**Percent Change (Since 2013)**
I	18	0	3	-83%
II	1	0	45	4400%
III	1	0	1	0%
IV	76	97	100	32%
V	3	1	2	-33%
Totals	**99**	**98**	**151**	**53%**

*Numbers of children are unduplicated.

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 regional programs reported the living status of children at the start of crisis response services and at the termination of crisis response services in the following categories:

- With parents
- Detention Center
- Foster Care
- Shelter Care
- Inpatient Facility
- Unknown/Not Collected

The data below for three fiscal years show that the largest majority of the children entered crisis response services while living with their parents and also remained in their parent's home at the end of crisis services. This supports the intent of the crisis response services – to intervene when there is a crisis and maintain family and community stability.

Table 7: Living Status at the Start of Crisis Services by Each Region Compared by Year

Status	Region I			Region II		Region III		
	2013	2014	**2015**	2014	**2015**	2013	2014	**2015**
With parents	155	353	976	1	276	150	212	431
Detention Center	2	4	6	0	1			
Foster Care	4	7	17	0	7	19	12	17
Residential Placement		4	10	0	1	0	0	1
Shelter Care	8	0	0	0	0	0	0	0
Inpatient Facility	3	0	0	0	0	0	0	0
Unknown/Not Collected	0	0	3		2	0	1	10
Total	**173**	**368**	**1012**	**1**	**287**	**169**	**225**	**459**

Status	Region IV			Region V	
	2013	2014	**2015**	2014	**2015**
With parents	100	167	223	533	700
Detention Center		2	1		1
Foster Care	2	3	3	6	10
Residential Placement	3	4	2	23	15
Shelter Care	0	0	0	0	0
Inpatient Facility	0	0	0	0	0
Unknown/Not Collected	0	0	0	111	48
Total	**105**	**176**	**229**	**673**	**774**

*Numbers of children are unduplicated.

Table 8: Living Status at the End of Crisis Services by Each Region Compared by Year

Status	Region I			Region II		Region III		
	2013	2014	**2015**	2014	**2015**	2013	2014	2015
With parents	158	353	985	1	245	146	205	400
Detention Center	2	4	16	0	4	18	1	0
Foster Care	5	7	3	0	8	0	15	22
Residential Placement	0	4	5	0	5	0	1	2
Shelter Care	8	0	0	0	0	0	0	0
Unknown/Not Collected	0	0	3	0	25	5	3	35
Total	**173**	**368**	**1012**	**1**	**287**	**169**	**225**	**459**

Status	Region IV			Region V	
	2013	2014	**2015**	2014	**2015**
With parents	87	150	219	518	685
Detention Center	0	0	0	5	2
Foster Care	3	5	3	6	9
Residential Placement	8	12	6	32	13
Shelter Care	0	0	0	0	0
Unknown/Not Collected	7	9	1	112	32
Total	**105**	**176**	**229**	**673**	**741**

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. Tables 9 and 10 below show school attendance at the start and at the end of crisis services. 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 Status at the Start of Crisis Services by Each Region Compared by Year

Status	**Region I**			**Region II**		**Region III**		
	2013	2014	**2015**	2014	**2015**	2013	2014	**2015**
Attending	170	363	975	1	277	154	201	408
Suspended	3	4	26	0	5	13	20	34
Expelled	0	1	7	0	1	0	1	5
Unknown/Not Collected	0	0	4	0	4	2	3	12
Total	**173**	**368**	**1012**	**1**	**287**	**169**	**269**	**459**

Status	**Region IV**			**Region V**	
	2013	2014	**2015**	2014	**2015**
Attending	100	164	223	342	586
Suspended	3	6	3	25	73
Expelled	1	3	1	2	5
Unknown/Not Collected	1	3	2	304	110
Total	**105**	**176**	**229**	**673**	**774**

*Numbers of children are unduplicated

Table 10: School Status at the End of Crisis Response Services by Each Region Compared by Year

Status	**Region I**			**Region II**		Region III		
	2013	2014	**2015**	2014	2015	2013	2014	**2015**
Attending	172	363	1000	1	253	146	214	398
Suspended	1	4	5	0	5	13	4	13
Expelled	0	1	3	0	2	3	1	2
Unknown/Not Collected	0	0	4	0	27	7	6	46
Total	**173**	**368**	**1012**	**1**	**287**	**169**	**225**	**459**

Status	**Region IV**			**Region V**	
	2013	2014	**2015**	2014	**2015**
Attending	100	164	219	369	631
Suspended	3	6	2	2	14
Expelled	1	3	1	3	20
Unknown/Not Collected	1	3	7	299	96
Total	**105**	**176**	**229**	**673**	**761**

V. Summary

Overall, the regions have achieved good outcomes in maintaining children, in their homes, with their parents and attending school. This is a significant achievement in and of itself as research clearly supports the notion that the best outcomes for children and youth in crisis are achieved

when family stability and unity are maintained and school attendance is not disrupted. Perhaps the greatest improvements in service capacity have been seen in child psychiatry access through face-to-face visits, tele-psychiatry and consultation to pediatricians and primary care practitioners. The numbers of children receiving child psychiatry services increased from 520 in FY 2013 to 2,189 in FY 2014.

This new funding has created the opportunity to test 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 was low and several strategies have increased referrals. These efforts resulted in increased utilization in the spring of 2015, followed by a customary drop in admissions during the summer months. As of August 2013, a change was implemented to accept non-CSB referrals to the residential crisis stabilization unit, assuring that the referrals are screened for appropriateness.

While considerable progress has been made over the past fiscal year, DBHDS will continue to analyze trends and challenges and strategize with the regions to increase accessibility to these services. DBHDS will provide continued opportunity for sharing experiences from the programs through regional program meetings at service sites across the state, site visits and conference calls.

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 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 budget included 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

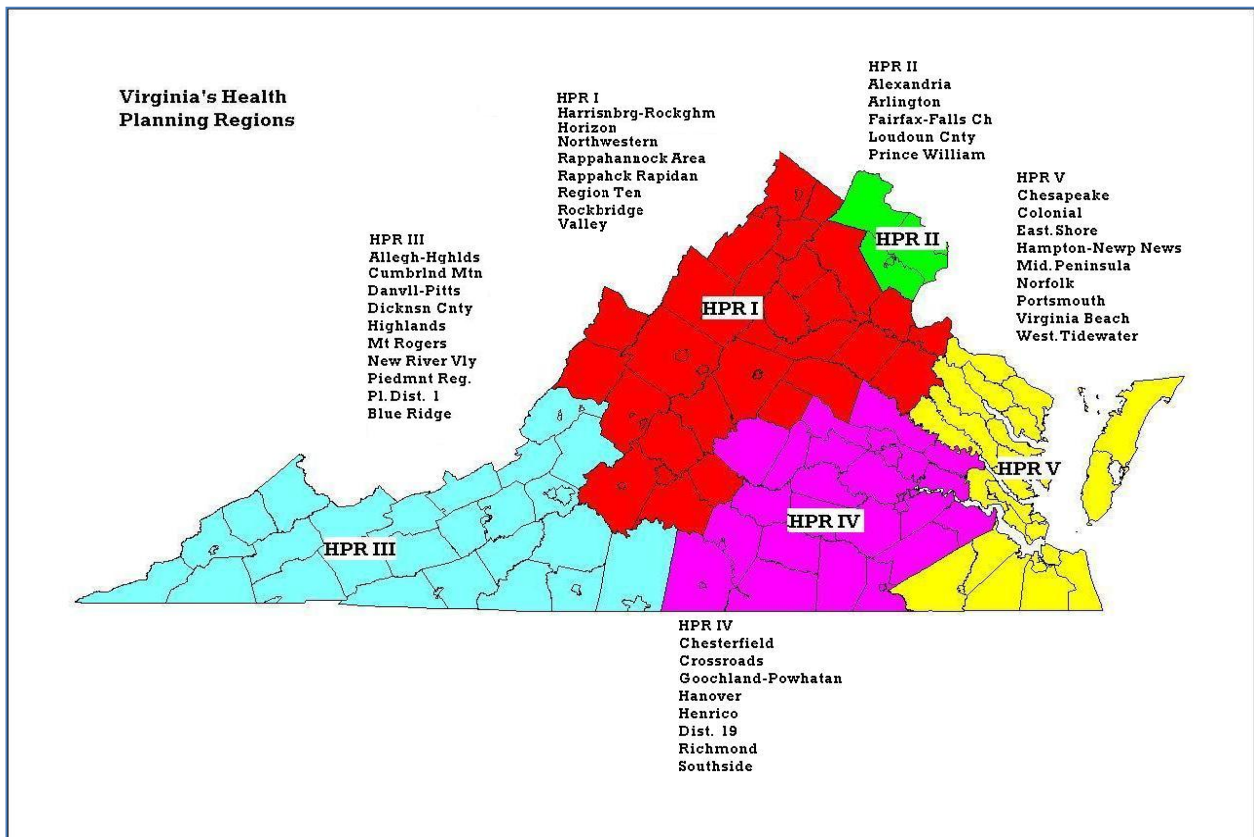
Due Date for Proposals: 5:00 PM on 7/27/12.

- 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: Case Vignettes Illustrating Outcomes for Children and Families

As part of their quarterly reports, funded programs are 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 13 year old female with no insurance, presented with her father for a crisis assessment with the Youth Mobile Crisis Intervention Program. She was referred by her private practice outpatient therapist upon discovery of self-injurious behaviors (cutting on her arm). She was treated at the emergency department for the cuts and subsequently screened for acute psychiatric hospitalization. She did not meet criteria for hospitalization but needed a higher level of service than traditional outpatient therapy would be able to provide. She reported to the crisis clinician that she originally wanted to kill herself by taking her father's "anxiety pills". During the crisis intake assessment, she denied any present thoughts of wanting to harm herself or anyone else, and denied any current urges to cut herself.

During the provision of crisis services, the clinician created a safety plan with the young woman and her family. Assessments for safety and identifying triggers were ongoing, and coping skills were identified to decrease her depressive symptoms and self-injurious behaviors. The crisis clinician obtained a psychiatric evaluation for her during this time, and linked her to more intense outpatient therapy services before ending crisis services.

She regressed soon after discharge from crisis services, but was able to be reassessed for another episode of crisis services. During the second crisis assessment in the family home, she reported being in possession of an additional sewing needle and scissors which she willing gave to clinician as part of her safety planning. She also reported that her father's girlfriend's 19-year old son had made sexual advances toward her and had sexually assaulted her. She reported that she was "scared he was going to rape her". Because of the increased risk of self-injury and report of sexual assault, the crisis clinician coordinated a short term stay at a local shelter.

The crisis clinician made a CPS report as well as a report to the Special Victims Unit. During her stay at a local shelter, efforts were made to further develop a safe and effective transition plan. After intervention from CPS, detectives with the Special Victims Unit, linkage with case management and ongoing psychiatric care, she was able to stabilize and return home successfully. She has since been able to avoid any escalation in behaviors that would put her at risk for an acute psychiatric admission. She has also consistently denied any suicidal ideation and urges to again self-cut. She was also referred to and has begun trauma-specific outpatient therapy.

She is now safe in her home without fear of sexual assault and has made significant progress since her first episode of crisis care. Without the benefit from the Youth Mobile Crisis Intervention Program, it is doubtful that she would have been able to remain in her home and likely that she would have been hospitalized, engaged in serious self-injury or even made a potentially lethal suicide attempt.

- **Case Vignette- Residential Crisis Stabilization**

A 16-year-old male who was referred to the Crisis Stabilization Unit (CSU) following a discussion with his CSB therapist regarding his decline in functioning, including suicidal ideation with thought given to plan and means. He was dealing with symptoms of depression for approximately 2 years and had been receiving therapy for the past 6 months. Though therapy had been helpful, the young man continued to experience depressive symptoms including fatigue, cognitive drag, and difficulty engaging with others. He had also been experiencing several significant situational stressors, including the chronic, severe illness of his father. At the time of referral, he independently identified the CSU as a possible source of support for his needs, and a crisis evaluation indicated that this was an appropriate level of care. Upon admission to the CSU, the young man, his parents, and the CSU treatment team worked together to formulate treatment goals

He met with the CSU psychiatrist on several occasions to discuss medication. He was recommended a trial of bupropion, and after a review of the literature and discussion with his family, he agreed to the trial. He was somewhat slow to respond but did report that he noticed a change. He had also been taking a Vitamin D supplement at home, which was continued on the unit in order to ensure that Justin's presentation on the unit was representative of his home functioning. Upon taking both the Vitamin D and bupropion, He reported that he noticed a

difference in his cognitive and affective functioning. He was discharged after he remained at the CSU for the maximum 15 day stay. He was able to contract for safety and reported being ready to return to home, school, and the community.

- **Case Vignette – Crisis Stabilization Services with Child Psychiatry Intervention**

Children's Crisis Services received a referral for an 11-year-old Caucasian male diagnosed with autism spectrum disorder and diabetes, who presented with a long history of disruptive behaviors including physical aggression and agitated behaviors; most recently throwing a laptop, acting out aggressively and threatening others in the home, including making statements about killing his father. Additionally, he was non-compliant with medication management and diabetes management. He had numerous psychiatric hospitalizations (eight to CCCA and two to a private hospital) and placements in two residential programs and was most recently discharged from CCCA a week prior to referral.

He was resistant to fully engaging in services. The initial work focused on working with the family to facilitate medication management, monitoring client's symptom and behavior and coordination of care with client's primary care physician and the CSB psychiatrist. CCS provider responded to a crisis call from the family and provided supportive services to the client and his family in their home. Family was taught different approaches/interactions to de-escalate the problem behaviors, and family was assisted in identifying possible community programs for him to participate in during the summer.

He was referred for in-home services with Virginia Autism Spectrum Services (VASS). The plan is for this agency to provide ongoing supports, and ID/DD case management services.

The client's family indicated at discharge that they felt overall the goals were met, were satisfied that the client remained safely in the community and that he was successfully referred to additional/on-going support services. The client's family expressed that it was their goal for client to continue to work on expressing anger and frustration in socially acceptable ways as part of ongoing services with VASS. The family also reported that the client and his father are getting along better since father began using the newly learned techniques for de-escalating the client.