COMMONWEALTH of VIRGINIA

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October 1, 2017

The Honorable Thomas K. Norment, Jr., Co-chair
The Honorable Emmett W. Hanger, Jr., Co-chair
Senate Finance Committee
14th Floor, Pocahontas Building,
900 East Main Street,
Richmond, VA 23219

Dear Senator Norment and Senator Hanger:

Item 315. S. of the 2016 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, 2014 and each year thereafter."*

Please find enclosed the report in accordance with Item 315.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
900 East Main Street
Pocahontas Building, 13th Floor
Richmond, Virginia 23219

Dear Delegate Jones:

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Report on Funding for Child Psychiatry and Children's Crisis Response Services
(Item 315.S.)

October 1, 2017

DBHDS Vision: A Life of Possibilities for All Virginians

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Report on Funding for Child Psychiatry and Children's Crisis Response Services

Preface

This report is submitted in response to Item 315.S. of the 2016 Appropriation Act to address the use and impact of funding appropriated for child psychiatry and children's crisis response services for children with mental health and behavioral disorders.

> *S. Out of this appropriation, $8,400,000 the first year and $8,400,000 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, 2014 and each year thereafter.*

Report on Funding for Child Psychiatry and Children's Crisis Response Services

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Executive Summary

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 and crisis stabilization services, were the least available services in Virginia. These services are in short supply at least in part because the expense of such service models that 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 among CSBs . 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. DBHDS awarded funding through a request for proposals and application review process to each of the five regions. A map showing the primary DBHDS regional structure can be found in Appendix A. Each region has a lead CSB. The regional leads are:

- Region 1 - Horizon Behavioral Health
- Region 2 - Arlington County CSB
- Region 3 - Mount Rogers CSB
- Region 4 - Richmond Behavioral Health Authority
- Region 5 - Hampton-Newport News CSB

The regions have experienced the most growth in the number of children served through child psychiatry access from one or more of the following psychiatry services: face-to-face visits, telepsychiatry, and consultation with pediatricians and primary care physicians. As the general fund allocation has increased from $1.5 million in FY 2013 to $8.4 million in FY 2017, there has been significant growth in the number of children who received mobile crisis, and crisis stabilization services. Budget language allocates funding to regions based on the availability of services with a report on the use and impact of funding due annually.

The Request for Applications and Selection Process

When the funding first became available on July 1, 2012 (FY 2013), DBHDS issued a competitive request for applications (RFA) for regional proposals that addressed the key requirements described below. As new funding was added for FY 2014, FY 2015, and FY 2016, DBHDS asked the regions to respond to an updated RFA (Appendix B) to receive additional funding. A review team evaluated the regional proposals using a standard set of criteria, including a focus on the following requirements:

- Funding must be used for community-based services for children who can be served in their homes and communities to avoid or reduce the need for publicly-funded inpatient or residential services.
- The goal should be 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 use disorder 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 access to child psychiatric services. Additionally, crisis response services should include the following modalities.

1. Mobile crisis response teams – Clinical teams that go into 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 a day and seven days a week. CSB emergency services may refer children and families to the mobile crisis team.
2. Residential crisis stabilization units – Short-term, approximately six beds, with 24 hours a day and seven days per week bed-based care to divert children from inpatient or residential care.
3. Combinations of mobile crisis teams and residential crisis stabilization units.

As the funding has increased, services have grown in capacity across Virginia. Table 1 shows the increase in funding from FY 2013 to FY 2017. In the first year of FY 2013, five proposals were received, one from each region. Three proposals were selected: Region 1, Region 3, and Region 4. In FY 2014, Regions 2 and 5 were added. This report describes the services provided by all five regions from July 1, 2016 through June 30, 2017.

Table 1: Regional Funding by Fiscal Year

Region	FY 2013	FY 2014	FY 2015	FY 2016	FY2017
Region 1	$500,000	$711,978	$999,999	$1,399,999	$1,620,087
Region 2	0	$839,117	$839,117	$1,239,117	$1,448,046
Region 3	$300,000	$482,480	$694,459	$1,594,459	$1,844,721
Region 4	$700,000	$839,117	$839,117	$1,248,046	$1,591,274
Region 5	0	$839,117	$839,117	$1,239,117	$2,006,046

Summaries of Regional Programs

For this report, DBHDS asked each region to provide a progress report summarizing its work in FY 2017. DBHDS also asked the regions to share case vignettes that illustrate examples of how specific children and families used the services. A map of the CSBs' regional structure can be found in Appendix A and a sampling of case vignettes is included as Appendix C.

Region 1 (Horizon Behavioral Health is the lead CSB for the region)

Mobile crisis is provided to children and youth transitioning out of the hospital setting, to prevent hospitalization, as well as to prevent removal from school or home settings. Eight out of nine

Region 1 CSBs are providing mobile crisis services in the home, school, and community settings using mobile crisis clinicians. The one CSB that is not providing mobile crisis services has been recruiting for this position for over a year but has not been successful in finding a qualified candidate.

Two out of nine Region 1 CSBs are providing crisis stabilization services in the home and therapeutic settings. While the other seven CSBs do not provide crisis stabilization services in therapeutic settings, they are able to provide crisis stabilization in the home setting if appropriate. Mobile crisis clinicians are providing transportation to and from therapeutic settings, as well as providing weekend supports in the home or community. Intensive individual and group therapy is used to help children and youth stabilize emotionally, behaviorally, and socially. Mobile crisis clinicians provide daily and consistent communication with families, while children are receiving this service.

Funding for child psychiatry is used to provide psychiatric care for children and youth at the four CSBs with the highest need for child psychiatry. The CSB executive directors in the region met and determined which four CSBs would receive funding. Psychiatrists are providing consultation, as needed, with other providers. The psychiatrists are consistently willing to speak with primary care physicians, crisis staff, as well as other parties involved in the child's treatment in order to provide the highest level of care for the child. Psychiatric care is provided as long as it is clinically needed; most often transitioning the child to a private psychiatrist once the child's crisis has abated.

Region 2 (Arlington is the lead CSB for the region)

The Children's Regional Crisis Response (CR2) program provides 24 hours a day, seven days a-week mobile crisis stabilization services. During FY 2017, CR2 added two clinicians to the mobile support teams. CR2 provides short-term case management to ensure linkages with ongoing services in the community. Service duration is designed to last 45 days, consisting of a tiered approach with two phases: an intensive phase for the first 15 days and a follow-up phase for the subsequent 30 days. Length of stay and duration of phases may vary based on the clinical needs of the child.

CR2 continues to have limited ability, at times, to accept new children due to staffing limitations within the program, as well as increased referral rates. During these times, children are referred for crisis management to the local emergency services, emergency departments, National Counseling Group Crisis Stabilization programs (Medicaid clients), and other community supports.

The CR2 has incorporated Regional Educational Assessment Crisis Response and Habilitation (REACH) services into the region's crisis response continuum. REACH is a regional crisis intervention and prevention program designed to serve children with an intellectual or developmental disabilities (including autism) who may also have a mental illness or behavioral challenge.

CR2 and REACH have continued to build and maintain working professional relationships with local CSBs, emergency services, DSS agencies, schools, physicians' offices, hospitals, and private mental health providers; presentations and marketing continue throughout the region to build awareness of the program and service availability. Both REACH and CR2 have maintained more than 80 percent of clients receiving services in their homes at the time of discharge.

Region 3 (Mount Rogers is the lead CSB for the region)

Each CSB in Region 3 has at least one child-focused crisis staff. These positions not only meet the individual CSB's unique needs, they support regional efforts by acting as points of contact for children in crisis that require access to the regional telepsychiatry services or admission to the crisis stabilization unit (CSU). There is one ambulatory crisis stabilization program in the region and two programs with combined ambulatory crisis stabilization and center-based services.

Region 3 recently opened another CSU. When needed, the region provides transportation assistance to overcome geographic barriers. A behavior analyst is available at the CSU to provide the expertise needed to address the needs of children with developmental disabilities. Psychological testing when requested is an additional service provided by the CSU.

Region 3 has a contract with the University of Virginia's Department of Psychiatry and Neurobehavioral Sciences (UVA) to provide telepsychiatry. In times of need, up to 42 hours per week of psychiatry care can be requested. The wait to obtain a psychiatric intake tends to be six-12 weeks or more. Since the region has a telepsychiatry contract with UVA, children referred for an emergency intake are scheduled within the week of request. Children that are admitted in to crisis stabilization services are seen within 72 hours, some even the same day.

Region 4 (Richmond Behavioral Health Authority is the lead CSB for the region)

Through a contract with St. Joseph's Villa (SJV), Region 4 operates a CSU that offers both residential and site-based crisis stabilization services. In January 2017, the CSU moved to a larger, more secure facility which enabled the unit to expand capacity from six to eight beds. The CSU has variety of other community partners, including organizations or individuals that teach yoga or provide therapy dogs.

Crisis Response Services are provided through Children's Response and Stabilization Team (CReST). The CReST team is working with Pediatric Emergency Departments as well as acute inpatient hospitals. The team is assisting hospitals with children who are ready to discharge from the hospital but are at risk of re-hospitalization without active services. Additionally, there is a joint clinician with CReST and the REACH program which has led to more complete regional rollout for CReST and increased the capacity for REACH.

Telepsychiatry services for Region 4 are offered through the CSU. This service is available during working hours but also in the evening and weekends. The psychiatrist collaborates with other physicians and providers in the community.

Region 5 (Hampton-Newport News is the lead CSB for the region)

Currently there are eight mobile crisis units in Region 5. Only one CSB in Region 5 has not been able to find qualified candidates to staff a mobile crisis team. For this CSB, funding has been used to support a case manager to provide crisis services.

Region 5 also has a Children's Behavioral Health Urgent Care Center. The Center provides rapid access to crisis intervention and psychiatric care to the entire region and is able to maintain cases until children are linked with long term providers. Telepsychiatry is available at two CSBs in the region with another CSB interested in utilizing the service.

A six-bed CSU is being developed with an anticipated opening date in September 2017. Admissions are expected to come from Regional Emergency Services Departments as well as local and state psychiatric facilities. The CSU will utilize family systems therapy.

Results and Statewide Data

CSBs report data on community services in the DBHDS Community Consumer Submission (CCS) application. 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 services, and
- Residential crisis stabilization services.

Because child psychiatry is included in the outpatient services category of CCS, separate data on child psychiatry services are not available from the CCS application. Since child psychiatry is an important part of this initiative, a manual report from the regions was used to gather data on child psychiatry services. These data are shown in Table 4 and provide 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 on their behalf. Also included are preadmission screening mandated by the *Code of Virginia* that CSBs provide to assess the need for inpatient psychiatric hospitalization and other activities associated with the judicial admission process. Preadmission screening services are provided by certified preadmission screening evaluators who meet state requirements and have completed training modules to assure their competency

Table 2: Unduplicated Number of Children Served through Emergency Services

Region	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	Percent Increase (Since 2013)
1	1,777	2,133	2,682	2,950	**3,601**	72.25%
2	1,845	2,071	2,183	2,301	**2,773**	50.29%
3	1,692	2,437	2,531	2,269	**1,840**	8.74%
4	1,260	1,444	1,485	1,501	**1,599**	26.90%
5	986	1,325	1,656	1,746	**1,849**	87.52%
Totals	7,560	9,410	10,537	10,767	**11,122**	47.11%

Numbers of children are unduplicated. In fiscal year 2016, Allegany-Highlands moved from Region 3 to Region 1 and Southside moved from Region 4 to Region 3.

Outpatient Services (Child Psychiatry is part of this category)

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

Table 3: Unduplicated Number of Children Served through Outpatient Services

Region	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	Percent Increase (Since 2013)
1	5,729	6,540	6,690	7,015	**6,966**	21.59%
2	2,681	2,940	2,969	2,962	**2,971**	10.81%
3	6,266	7,032	7,171	7,483	**7,349**	17.28%
4	3,648	4,008	3,717	3,264	**2,879**	-21.08%
5	3,885	4,021	4,150	4,094	**4,923**	26.71%
Totals	22,209	24,541	24,697	24,818	**25,088**	12.96%

Numbers of children are unduplicated. In fiscal year 2016, Allegany-Highlands moved from Region 3 to Region 1 and Southside moved from Region 4 to Region 3.

In 2016, Southside CSB moved from Region 4 to Region 3 and there was a slight decrease in the number of children served through outpatient services in Region 4. This decrease continued in 2017. A variation in the number of children served is not unusual when there is a change in services. However, the continuation of this trend requires careful research in order to ascertain that all children will continue to receive the necessary services. Over the coming year, DBHDS will work with the region to identify the reasons that there has been a slight decrease in services.

Child Psychiatry Services (Separate from Outpatient Services)

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

- Face-to-face office visits with children,
- Telepsychiatry 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 through one or more of the following services: face-to-face, telepsychiatry and through consultation in all five regions.

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, some regions still experience 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 child psychiatrists. SB1009 and HB 1797, passed during the 2017 General Assembly Session, allows psychiatrists to prescribe certain controlled substances via telemedicine. This new legislation is expected to increase the number of children receiving psychiatric services in all regions.

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

Service	Region 1					Region 2				Region 3				
	2013	2014	2015	2016	2017	2014	2015	2016	2017	2013	2014	2015	2016	2017
(1) Face-to Face	189	487	369	503	**889**	0	0	0	**0**	62	80	104	103	**110**
(2) Tele psychiatry	54	93	152	524	**434**	1	202	105	**85**	3	303	405	412	**490**
(3) Consultation	83	170	189	112	**419**	0	66	12	**4**	39	76	39	50	**24**
Total	326	750	710	1139	**1742**	1	268	117	**89**	104	459	548	565	**624**

Service	Region 4					Region 5			
	2013	2014	2015	2016	2017	2014	2015	2016	2017
(1) Face-to Face	72	68	28	0	**0**	694	3775	2953	**2851**
(2) Tele psychiatry	18	89	153	152	**155**	106	133	179	**169**
(3) Consultation	0	11	51	56	**74**	11	23	82	**256**
Total	90	168	232	208	**229**	811	3931	3214	**3276**

Service	Statewide Total					Percent Change (Since 2013)
	2013	2014	2015	2016	2017	
(1) Face-to Face	323	1329	4276	3559	**3850**	1092%
(2) Tele psychiatry	75	592	1045	1372	**1333**	1677%
(3) Consultation	122	268	368	312	**777**	536%
Total	520	2189	5689	5243	**5960**	1046%

Definitions used in collecting data on child psychiatry: (1) Face to face: total number of youth that received a face-to-face visit with the psychiatrist. (2) Telepsychiatry: 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.

While the three approaches to child psychiatry have created greater flexibility and access to these critical services, there are still challenges to providing the service. In Region 2, the CR2 program solely provides telepsychiatry and it is voluntary to any participant in the program. Most either decline or have an outside provider who they prefer to see. Education is provided to families who decline the service. Those that have private providers have the option to utilize telepsychiatry as

a second opinion or in addition to their current provider, but most decline this as well. Region 4 continues to have difficulty recruiting a full time psychiatrist to work with both the REACH and the mobile crisis teams. The ability to recruit a psychiatrist who is willing to commit to full-time practice with both teams serving all populations has been a challenge.

Ambulatory Crisis Stabilization 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.

Table 5: Unduplicated Number of Children Served through Ambulatory Crisis Stabilization Services

Region	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	Percent Change (Since 2013)
1	419	281	270	201	**320**	-23.62%
2	1	1	488	334	**513**	51,200%
3	3	151	239	311	**398**	13,166.66%
4	6	25	19	49	**86**	1,333.33%
5	14	70	209	267	**298**	2,028.57%
Totals	443	528	1,225	1,162	**1,615**	**264.55%**

Numbers of children are unduplicated. In fiscal year 2016, Allegany-Highlands moved from Region 3 to Region 1 and Southside moved from Region 4 to Region 3.

In Region 1, the largest decrease in the number of children served through ambulatory crisis stabilization services was in FY 2014 where there was a -32.93 percent decrease between FY 2013 and FY 2014. This decrease could be attributed an inconsistency in reporting the service. Technical assistance has been provided to clarify reporting procedures. Each year thereafter, there has only been a slight variability in the numbers of children served. When comparing the service year to year, the largest percent change in children served at 59.20 percent was between FY 2016 and FY 2017. In 2016, Region 4 implemented a new model for ambulatory crisis services. As this new model continues to develop, it is expected that the number of children served will continue to grow.

Residential Crisis Stabilization Services

Based on service gaps identified in their proposals, each region has different needs and resources for residential crisis stabilization services. All residential crisis stabilization services are short-term and focused on maintaining family contact and returning children to their homes and schools. Three regions now have residential crisis stabilization units.

Table 6: Unduplicated Number of Children Served through Residential Crisis Stabilization Services

Region	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	Percent Change (Since 2013)
1	18	0	3	1	**0**	-100%
2	1	0	45	51	**62**	6100%
3	1	0	1	0	**128**	12,700%
4	76	97	100	90	**130**	71.05%
5	3	1	2	0	**0**	-100%
Totals	99	98	151	142	**320**	223.23%

Numbers of children are unduplicated.

St. Joseph's Villa and Region 4 have continued to analyze referral and utilization patterns to increase service 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. With the allocation of new money for FY 2016, Region 3 opened a residential crisis stabilization unit. They encountered significant start-up delays due to finding an appropriate building. However, the unit is now open. Region 5 is in the process of opening a residential crisis stabilization unit. The anticipated opening date is late summer 2017. In Region 1, shortly after receiving notice that they were awarded funding for crisis response and child psychiatry services, the region 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, federal regulations stipulate 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 Region 1, it was determined that the plan to provide bed-based crisis stabilization had to be abandoned. The region redirected their efforts into providing more day crisis services and child psychiatry consultations based at the CSBs in the region.

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
- Still Receiving Services
- Unknown/Not Collected

The data shows the disposition of children in each region over the last five fiscal years by their living status. The majority of these children resides and are served in their homes or communities when they enter crisis response services and when they leave 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 1					Region 2				Region 3				
	2013	**2014**	**2015**	**2016**	**2017**	**2014**	**2015**	**2016**	**2017**	**2013**	**2014**	**2015**	**2016**	**2017**
With parents	155	353	976	2484	**3541**	1	276	334	**260**	150	212	431	695	**870**
Detention Center	2	4	6	0	**18**	0	1	0	**0**	0	0	0	0	**7**
Foster Care	4	7	17	11	**42**	0	7	7	**2**	19	12	17	36	**40**
Residential Placement		4	10	11	**23**	0	1	1	**4**	0	0	1	0	**6**
Shelter Care	8	0	0	0	**0**	0	0	0	**0**	0	0	0	0	**0**
Inpatient Facility	3	0	0	0	**0**	0	0	0	**0**	0	0	0	0	**0**
Unknown/ Not Collected	0	0	3	9	**5**		2	22	**52**	0	1	10	11	**11**
Total	173	368	1012	2515	**3629**	1	287	364	**318**	169	225	459	742	**934**

Status	Region 4					Region 5			
	2013	**2014**	**2015**	**2016**	**2017**	**2014**	**2015**	**2016**	**2017**
With parents	100	167	223	265	**317**	533	700	814	**833**
Detention Center		2	1	2	**0**		1	2	**0**
Foster Care	2	3	3	8	**0**	6	10	16	**15**
Residential Placement	3	4	2	0	**0**	23	15	2	**4**
Shelter Care	0	0	0	0	**0**	0	0	0	**0**
Inpatient Facility	0	0	0	0	**0**	0	0	0	**0**
Unknown/ Not Collected	0	0	0	0	**0**	111	48	16	**24**
Total	105	176	229	275	**317**	673	774	850	**876**

Numbers of children are unduplicated.

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

Status	Region 1					Region 2				Region 3				
	2013	**2014**	**2015**	**2016**	**2017**	**2014**	**2015**	**2016**	**2017**	**2013**	**2014**	**2015**	**2016**	**2017**
With parents	158	353	985	2476	**3537**	1	245	321	**252**	146	205	400	693	**569**
Detention Center	2	4	16	8	**18**	0	4	0		18	1	0	0	**5**
Foster Care	5	7	3	15	**47**	0	8	5	**3**	0	15	22	38	**25**
Residential Placement	0	4	5	7	**22**	0	5	16	**10**	0	1	2	3	**7**
Shelter Care	8	0	0	0	**0**	0	0			0	0	0		
Still Receiving services									**52**					**324**
Unknown/ Not Collected	0	0	3	9	**5**	0	25	22		5	3	35	8	**4**
Total	173	368	1012	2515	**3629**	1	287	364	**317**	169	225	459	742	**934**

Status	Region 4					Region 5			
	2013	**2014**	**2015**	**2016**	**2017**	**2014**	**2015**	**2016**	**2017**
With parents	87	150	219	259	**312**	518	685	770	**776**
Detention Center	0	0	0	0	**0**	5	2	2	**0**
Foster Care	3	5	3	5	**1**	6	9	13	**15**
Residential Placement	8	12	6	11	**4**	32	13	6	**3**
Shelter Care	0	0	0	0	**0**	0	0	0	**0**
Unknown/ Not Collected	7	9	1	0	**0**	112	32	59	**82**
Total	105	176	229	275	**317**	673	741	850	**876**

Numbers of children are unduplicated.

School Attendance Status of Children

Attending school 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 data show the disposition of children in each region over the last five fiscal years by their school status. The majority of these children are attending school when they enter crisis response services and when they leave crisis 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 1					Region 2				Region 3				
	2013	**2014**	**2015**	**2016**	**2017**	**2014**	**2015**	**2016**	**2017**	**2013**	**2014**	**2015**	**2016**	**2017**
Attending	170	363	975	2451	**3549**	1	277	325	**259**	154	201	408	691	**863**
Suspended	3	4	26	50	**66**	0	5	16	**6**	13	20	34	37	**50**
Expelled	0	1	7	7	**8**	0	1	1	**1**	0	1	5	7	**14**
Unknown/ Not Collected	0	0	4	7	**6**	0	4	22	**52**	2	3	12	7	**12**
Total	173	368	1012	2515	**3629**	1	287	364	**318**	169	269	459	742	**939**

Status	Region 4					Region 5			
	2013	**2014**	**2015**	**2016**	**2017**	**2014**	**2015**	**2016**	**2017**
Attending	100	164	223	250	**296**	342	586	770	**583**
Suspended	3	6	3	15	**18**	25	73	21	**42**
Expelled	1	3	1	6	**2**	2	5	6	**8**
Unknown/ Not Collected	1	3	2	4	**1**	304	110	53	**243**
Total	105	176	229	275	**317**	673	774	850	**876**

Numbers of children are unduplicated.

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

Status	Region 1					Region 2				Region 3				
	2013	**2014**	**2015**	**2016**	**2017**	**2014**	**2015**	**2016**	**2017**	**2013**	**2014**	**2015**	**2016**	**2017**
Attending	172	363	1000	2498	**3581**	1	253	338	**263**	146	214	398	713	**565**
Suspended	1	4	5	3	**35**	0	5	3	**2**	13	4	13	18	**22**
Expelled	0	1	3	8	**7**	0	2	1	**1**	3	1	2	2	**8**
Still Receiving services									**52**					**317**
Unknown/ Not Collected	0	0	4	7	**6**	0	27	22		7	6	46	9	**27**
Total	173	368	1012	2516	**3629**	1	287	364	**318**	169	225	459	742	**939**

Status	Region 4					Region 5			
	2013	**2014**	**2015**	**2016**	**2017**	**2014**	**2015**	**2016**	**2017**
Attending	100	164	219	264	**311**	369	631	749	**584**
Suspended	3	6	2	2	**3**	2	14	11	**13**
Expelled	1	3	1	5	**1**	3	20	6	**1**
Unknown/ Not Collected	1	3	7	4	**2**	299	96	84	**278**
Total	105	176	229	275	**317**	673	761	850	**876**

Numbers of children are unduplicated.

Conclusion

This report provides the opportunity to look at five years of implementation of crisis response and child psychiatry services using a regional model. Overall, the regions continue to achieve good outcomes in maintaining children in their homes, with their parents and attending school. This is a significant achievement, as research clearly supports that the best outcomes for children 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 a combination of one or more of the following services: face-to-face visits, telepsychiatry and consultation to pediatricians and primary care practitioners.

As funding has increased significantly from $1.5 million in FY 2013 to $8.4 million in FY 2017, each service category has shown growth in services provided:

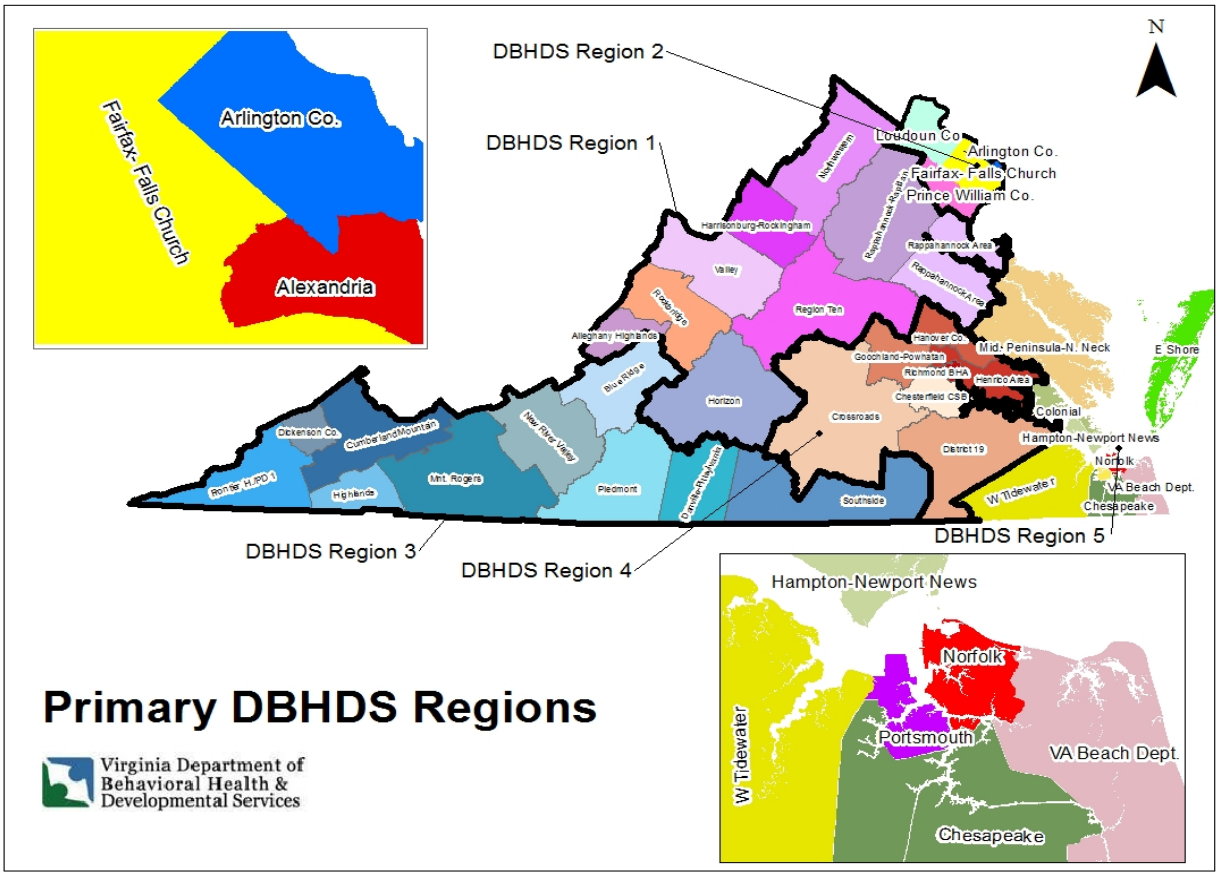
- Emergency services – 47.11%
- Outpatient services – 12.96%
- Ambulatory crisis stabilization – 264.55%
- Residential crisis stabilization – 223.23%
- Child psychiatry services – 1,046%

This dedicated funding has created the opportunity to test service models and to determine where adjustments are necessary. These services evolved from recommendations in Item 304.M. “A Plan for Community-Based Children’s Behavioral Health Services in Virginia,” and the accompanying survey of available services. Using those recommendations as a guide, the regions have found the approaches that work best for their unique demographic and geographic needs.

While considerable progress has been made over the past five fiscal years, DBHDS will continue to analyze trends and challenges and strategize with the regions to increase accessibility to these important services. In addition, through our Children’s Behavioral Health Academy, funded through federal grants, DBHDS will provide continuing education and opportunities for sharing experiences from the programs.

Appendices

Appendix A: Map of Virginia Showing Primary CSB Regional Structure



Appendix B: Request for Applications

Department of Behavioral Health and Developmental Services Instructions for Proposals for Community Crisis Response and Child Psychiatry Services FY2016

V. ***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 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 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 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 Regions based on the availability of services with a report on the use and impact of funding due annually beginning in 2013.)

VI. ***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.

VII. ***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.

VIII. ***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.

IX. ***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.

X. ***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 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 15-year old male was referred to the mobile crisis services by a CSB. The initial crisis incident involved escalated anger, aggression towards mother, and expressed suicidal ideation.

At the start of services, the child and his parents pinpointed the main concerns as difficulty controlling anger and fear of consequences. The child expressed that his passive suicidal ideation stems from intense anger. Throughout the sessions, the clinician assisted the child in developing awareness of how his anger escalates. The child was linked to outpatient therapy at a private provider at the end of crisis services. This linkage will assist the child in receiving ongoing intervention for anger management.

- **Case Vignette- Residential Crisis Stabilization Unit (CSU)**

An 11 year old male diagnosed with Attention Deficit Hyperactivity Disorder, Asperger's Syndrome, and Unspecified Mood Disorder was referred for crisis services. The child was attending a day school due to his inability to be maintained in a traditional school setting. Initially, a mobile crisis counselor met with the child at school; this intervention helped to maintain him in that placement and avoid suspension. The child's symptoms became increasingly concerning and the child was admitted to the residential crisis stabilization unit (CSU). The family expressed concern about transportation and the CSU was able to provide the transportation necessary to overcome that barrier.

At the CSU the child, participated in activities that built upon his coping skills, improved his mood, and enhanced his overall well-being. His diet became organic and caffeine free, there were no electronic devices (cell phones, computers, or tablets) to distract him from the work he needed to do on the unit, and the child tried mindfulness activities for the first time. He learned how practices such as meditation, deep breathing, yoga, nature walks, daily gratitude's, and affirmations can improve his overall well-being and prepare him for adverse life events. At the end of crisis services, the child was placed in a facility that can be address his clinical needs.

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

An 11-year old male who is diagnosed with Autism Spectrum Disorder with a significant increase in behavioral issues was referred for crisis intervention and a crisis psychiatric evaluation. The child's mother had initiated services at a local hospital for a psychiatric evaluation. The child's behavioral issues intensified and the mother was instructed to take her son to the Emergency Department (ED). While in the ED, child's symptoms grew worse and the child remained there for three days. Child REACH became involved and the child was referred to the Urgent Care Unit for immediate psychiatric access to avert hospitalization.

The mother and child attended the crisis family therapy session. The child was extremely agitated upon arrival; expressing fear of being taken away. The child was given the space to

move and vocalize. He was also given sensory objects to play with as the clinician spoke with the mother. The child was able to relax and be evaluated by the psychiatrist. The child was able to experience a mental health setting where he felt safe and supported without the threat of inpatient care. The child subsequently returned to the clinic for rechecks without the fear of appointments. At the end of crisis services, the child's behavior was stable.

Appendix D: State Hospital Services Provided to Children at the Commonwealth Center for Children and Adolescents 7/1/16-6/30/17

	Admissions	Admissions Unduplicated	Discharges	Discharges Unduplicated	Readmissions	Readmissions Unduplicated	Bed Days
Region 1							
Harrisonburg-Rockingham	19	15	19	15	6	4	139
Horizon-lead	14	12	14	12	2	2	182
Northwestern	41	34	41	34	15	11	550
Rappahannock Area	18	16	19	16	5	4	211
Rappahannock-Rapidan	13	12	13	12	4	4	157
Region Ten	35	29	35	29	16	12	391
Rockbridge	6	5	6	5	2	1	54
Valley	52	41	53	42	28	20	548
Total	**198**	**164**	**200**	**165**	**78**	**58**	**2232**
Region 2							
Alexandria	14	11	14	11	5	4	124
Arlington	13	10	13	10	3	1	129
Fairfax-Falls Church	29	28	32	30	6	5	426
Loudoun	26	22	26	22	6	5	277
Prince William	36	28	35	28	12	9	443
Total	**118**	**99**	**120**	**101**	**32**	**24**	**1399**
Region 3							
Alleghany	0	0	0	0	0	0	0
Blue Ridge	25	22	25	22	8	7	265
Cumberland Mountain	8	5	8	5	4	2	70
Danville-Pittsylvania	27	23	26	22	5	2	223
Dickenson	1	1	1	1	0	0	15
Highlands	5	5	6	5	2	2	56
Mount Rogers-lead	38	32	37	31	11	8	335
New River Valley	31	27	32	27	11	9	270
Piedmont	20	17	20	17	3	3	219
Planning District 1	2	2	2	2	1	1	9
Total	**134**	**134**	**157**	**132**	**45**	**34**	**1462**
Region 4							
Chesterfield	22	15	23	16	9	2	229

	Admissions	Admissions Unduplicated	Discharges	Discharges Unduplicated	Readmissions	Readmissions Unduplicated	Bed Days
Crossroads	8	8	9	9	0	0	101
District 19	16	13	16	13	7	5	144
Goochland-Powhatan	4	4	4	4	0	0	27
Hanover	37	31	37	31	15	12	371
Henrico	2	2	2	2	0	0	22
RBHA-lead	18	17	19	18	3	3	148
Southside	4	4	4	4	2	2	55
Total	**111**	**94**	**114**	**97**	**36**	**24**	**1097**
Region 5							
Chesapeake	28	13	28	13	19	6	403
Colonial	18	15	19	16	4	2	221
Eastern Shore	3	3	3	3	2	2	23
Hampton-Newport News	16	14	17	15	3	2	141
Middle Peninsula	12	8	12	8	11	7	175
Norfolk	24	20	24	19	11	8	309
Portsmouth	6	6	7	7	3	3	134
Virginia Beach	20	17	21	18	6	6	207
Western Tidewater	17	17	18	18	3	3	215
Total	**144**	**112**	**149**	**116**	**62**	**38**	**1828**
GRAND TOTAL	**728**	**603**	**740**	**611**	**253**	**178**	**8018**