COMMONWEALTH of VIRGINIA

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October 1, 2018

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 312. S. of the 2018 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 annually on the use and impact of this funding to the Chairmen of the House Appropriations and Senate Finance Committees by October 1."*

Please find enclosed the report in accordance with Item 312.S. Staff at the department are available should you wish to discuss this request.

Sincerely,

S. Hughes Melton, MD, MBA

Enc.

Cc: Hon. Daniel Carey., M.D.
Marvin Figueroa
Susan 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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Virginia Department of Behavioral Health & Developmental Services

Report on Funding for Child Psychiatry and Children's Crisis Response Services
(Item 312.S.)

October 1, 2018

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 312.S. of the 2018 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 annually on the use and impact of this funding to the Chairmen of the House Appropriations and Senate Finance Committees by October 1.*

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

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Introduction

DBHDS awarded funding through a request for proposals and application review process to each of the five regions. Each region was given the latitude to design a crisis response services based on the funding that was available and that met their needs at that time. Therefore, regionally variation in crisis services exists. . A map showing the primary DBHDS regional structure can be found in Appendix A. Each region has a lead CSB, which 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 continue to experience the most growth in the number of children served through residential crisis stabilization services and child psychiatry access from one or more of the following psychiatry services: face-to-face visits, tele-psychiatry, 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 growth in the number of children who received mobile crisis, and crisis stabilization services. Funding remains level as there was no budget increase in FY 2018. Budget language allocates funding to regions based on the availability of services with a report on the use and impact of funding due annually.

As the funding has increased, services have grown in capacity across Virginia. Table 1 shows the increase in funding from FY 2013 to FY 2018. In the first year of funding, 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, 2017 through June 30, 2018.

Table 1: Regional Funding by Fiscal Year

Region	FY 2013	FY 2014	FY 2015	FY 2016	FY2017	FY2018
Region 1	$500,000	$711,978	$999,999	$1,399,999	$1,620,087	$1,632,160
Region 2	0	$839,117	$839,117	$1,239,117	$1,448,046	$1,458,837
Region 3	$300,000	$482,480	$694,459	$1,594,459	$1,844,721	$1,858,468
Region 4	$700,000	$839,117	$839,117	$1,248,046	$1,591,274	$1,603,132
Region 5	0	$839,117	$839,117	$1,239,117	$2,006,046	$2,020,997

FY2018 payments include the FY2018 COLA increase

Services and Impact

A map of the CSBs' regional structure can be found in Appendix A and a sampling of case vignettes is included as Appendix B. The following describes the impacts of funding in three areas of data reporting. 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,
- Ambulatory crisis stabilization services, and
- Residential crisis stabilization services.

Because child psychiatry has historically been included in the outpatient services category of CCS, separate data on child psychiatry services has previously not been available from the CCS application. Since child psychiatry is an important part of this initiative, a manual report from the regions is used to gather data on child psychiatry services. These data shown in Tables 3, 4 and 5 provide the numbers of children who received each type of child psychiatry service.

Emergency Services

Emergency services are scheduled or unscheduled services that may include crisis counseling and psychiatric services to children who are in a crisis situation. In FY 2014, the bed of last resort legislation changed the role and landscape of emergency services. After the legislation passed, many CSB emergency services departments strictly provide preadmission screening. Preadmission screenings are mandated by the *Code of Virginia*. CSBs provide preadmission screenings 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	FY2018	Percent Increase (Since 2016)
1	1,777	2,133	2,682	2,950	3,601	3,341	13.25%
2	1,845	2,071	2,183	2,301	2,773	2,948	28.12%
3	1,692	2,437	2,531	2,269	1,840	1,966	-13.35%
4	1,260	1,444	1,485	1,501	1,599	1,603	6.8%
5	986	1,325	1,656	1,746	1,849	1,863	6.7%
Totals	7,560	9,410	10,537	10,767	11,122	**11,721**	**8.86%**

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.

Child Psychiatry Services

As noted previously, CSB regions were asked to report child psychiatry data separately because CCS outpatient services does not distinguish between outpatient therapy and psychiatric care. This section describes the self-reported psychiatric care data. In order to extend the reach of very limited child psychiatry resources, regions were asked to provide child psychiatry in one or more of the following 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 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. Tele-psychiatry is used to increase access to child psychiatrists.

Table 3: Face to Face Child Psychiatry Services Provided by Each Region Compared by Year

Region	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY2018	Percent Increase (since 2016)
1	189	487	369	503	889	1190	136.58%
2	NA	NA	NA	NA	NA	NA	NA
3	62	80	104	103	110	137	33.01%
4	NA	NA	NA	NA	NA	NA	NA
5		694	3,775	2,953	2,851	3,911	32.44%
Totals	323	1,329	4,276	3,559	3,850	**5,238**	**47.18%**

NA: As part of the Child Psychiatry and Crisis Response Services funding, regions 2 and 4 do not report on face to face child psychiatry.

Table 4: Tele-psychiatry Services Provided by Each Region Compared by Year

Region	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY2018	Percent Increase (since 2016)
1	54	93	152	524	434	795	51.72%
2		1	202	105	85	56	-46.67%
3	3	303	405	412	490	846	105.34%
4	18	89	153	152	155	149	-1.97%
5		106	133	179	169	268	49.72%
Totals	75	592	1,045	1,372	1,333	**2,114**	**54.08%**

Table 5: Psychiatry Consultation Services Provided by Each Region Compared by Year

Region	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY2018	Percent Increase (since 2016)
1	83	170	189	112	419	173	54.46%
2		0	66	12	4	0	0%
3	39	76	39	50	24	58	16%
4	0	11	51	56	74	68	21.43%
5		11	23	82	256	367	347.56%
Totals	122	268	368	312	777	**666**	**113.46%**

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) 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.

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.

Region 1:
Funding for child psychiatry in Region 1 is used to provide psychiatric services both through face-to-face visits and tele-psychiatry for children and youth at five CSBs with the highest need for child psychiatry: Horizon, Rappahannock Area, Rappahannock Rapidan, Region Ten, and Harrisonburg/Rockingham. The Region 1 face-to-face psychiatric services are provided at both Horizon and Region Ten CSBs for children in crisis. Region 1 psychiatrists, located at Horizon, provide tele-psychiatry for children in crisis at Rappahannock Area CSB, Rappahannock Rapidan CSB, and Harrisonburg/Rockingham CSB. Psychiatrists provide consultation, as needed, with other providers. The psychiatrists are consistently collaborating with primary care physicians, crisis staff, as well as other care providers involved in a child's treatment in order to offer the highest level of care.

Region 2:
In Region 2, the only child psychiatry numbers that are reported are for children receiving ambulatory crisis stabilization services through the Children's Regional Crisis Response (CR2) program. All CSBs in Region 2 provide child psychiatry while the CR2 program solely provides tele-psychiatry and it is voluntary to any participant in the program. Most either decline or have an outside provider who they prefer to see. Those that have private providers have the option to utilize tele-psychiatry as a second opinion or in addition to their current provider, but most decline this as well. In January 2018, CR2 stopped providing Regional Educational Assessment Crisis Response and Habilitation (REACH) ambulatory crisis services, these services were moved to another contractor in the region. This may account for the decrease in the numbers of children served through tele-psychiatry and psychiatric consultation

Region 3:
Region 3 has a contract with the University of Virginia's Department of Psychiatry and Neurobehavioral Sciences (UVA) to provide tele-psychiatry. 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 6-12 weeks or more. Since the region has a tele-psychiatry 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. The ability for Region 3 to use the same UVA psychiatrist for the CSU assessment as the same psychiatrist that follows up once the child is returned to the home CSB has added an element of continuity of care that isn't typically found in traditional hospital transitions.

Region 4:
Region 4 reports on the numbers of children that receive tele-psychiatry and psychiatric consultation while they are receiving crisis stabilization services at St. Joseph's Villa. The region partners with InSight Physicians to provide this service. The region plans on expanding child psychiatry to the Children's Response and Stabilization Team (CReST) however, there continues to be difficulty in recruiting a full time psychiatrist to work with both the REACH and the

CReST. 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.

Region 5:
Region 5 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. With the exception of one CSB, all CSBs in Region 5 provide outpatient child psychiatry.

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 6: Unduplicated Number of Children Served through Ambulatory Crisis Stabilization Services

Region	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY2018	Percent Change (Since 2016)
1	419	281	270	201	320	371	84.58%
2	1	1	488	334	513	487	45.81%
3	3	151	239	311	398	375	20.58%
4	6	25	19	49	86	82	67.35%
5	14	70	209	267	298	198	-25.84%
Totals	443	528	1,225	1,162	1,615	**1,513**	**30.21%**

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.

Region 1:
Two CSBs in Region 1 provide ambulatory crisis stabilization services: Horizon Behavioral Health and Region Ten. These ambulatory crisis stabilization services provide center-based services. Horizon Behavioral Health has units, located in Lynchburg, Amherst, Campbell County, and Bedford. Region Ten has one ambulatory crisis stabilization unit

Region 2:
The Children's Regional Crisis Response (CR2) program in Region 2 provides 24 hours a day, seven days a-week ambulatory crisis stabilization services. During FY 2017, CR2 added two clinicians to the ambulatory crisis stabilization 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.

Region 3:
In Region 3, there is one ambulatory crisis stabilization program and two programs with combined ambulatory crisis stabilization and center-based services. The ambulatory crisis services are provided at Mt. Rogers, Cumberland Mountain, and Highlands CSBs. The region has expressed interest in expanding these services to other CSBs. Geographical barriers for CSBs that cover several rural counties has been an obstacle in expanding ambulatory crisis services.

Region 4:
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.

Region 5:
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. During FY 2018, there were staffing issues which attributed to the decrease in children served.

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 8: Unduplicated Number of Children Served through Residential Crisis Stabilization Services

Region	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY2018	Percent Change (Since 2016)
1	NA	NA	NA	NA	NA	NA	NA
2	1	0	45	51	62	62	21.57%
3	NA	NA	NA	NA	128	164	16,400%
4	76	97	100	90	130	99	10%
5	NA	NA	NA	NA	NA	28	2,800%
Totals	99	98	151	142	320	**353**	**148.59%**

Numbers of children are unduplicated.
NA: The region did not have a residential crisis stabilization unit.

Region 1:
Region does not have residential crisis stabilization unit. The region, in its initial application for funding had proposed opening a residential crisis stabilization unit but was unable to open the

unit as proposed. Funding for the unit was directed toward other crisis response services. If funding were to become available, Region 1 would be interested in opening a unit.

Region 2:
Fairfax-Falls Church in Region 2 in a partnership with United Methodist Family Services provides an eight bed Crisis Stabilization Unit. This eight bed crisis stabilization unit is for children that live in Fairfax-Falls Church and is not funded through state general funds.

Region 3:
Region 3 has an eight bed CSU located at the Mt. Rogers Community Services Board. 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 4:
Through a public-private partnership, Region 4 has an eight bed crisis stabilization unit at St. Joseph's Villa. The region and the provider, St. Joseph's Villa, provide outreach to increase awareness in the community to help ensure appropriate utilization. DBHDS plans to explore with Region 4 the reasons why the number of children served has decreased from FY2017 to FY2018.

Region 5:
In Region 5, a six-bed CSU opened in November 2017. During the startup phase, the Region is working with: regional emergency services departments, local inpatient and residential facilities, and other CSB departments to provide information about this new service. The CSU is utilizing family systems therapy.

Conclusion

This report provides the opportunity to look at six years of implementation of crisis response and child psychiatry services using a regional model. Perhaps the greatest improvements in service capacity have been seen in residential crisis stabilization and access to child psychiatry through tele-psychiatry..

Over the last fiscal year there were some regional bright spots:

- Members from the CR2 program in Region 2 along with a team from Fairfax-Falls Church attended a mobile crisis stabilization services meeting in New Jersey to learn best practices from other states.
- Region 5 opened a six bed residential crisis stabilization unit.

As funding has increased significantly from $1.5 million in FY 2013 to $8.4 million in FY 2017, most service categories have shown growth in services provided. It is important to note that funding remains level as there was no budget increase in FY2018.

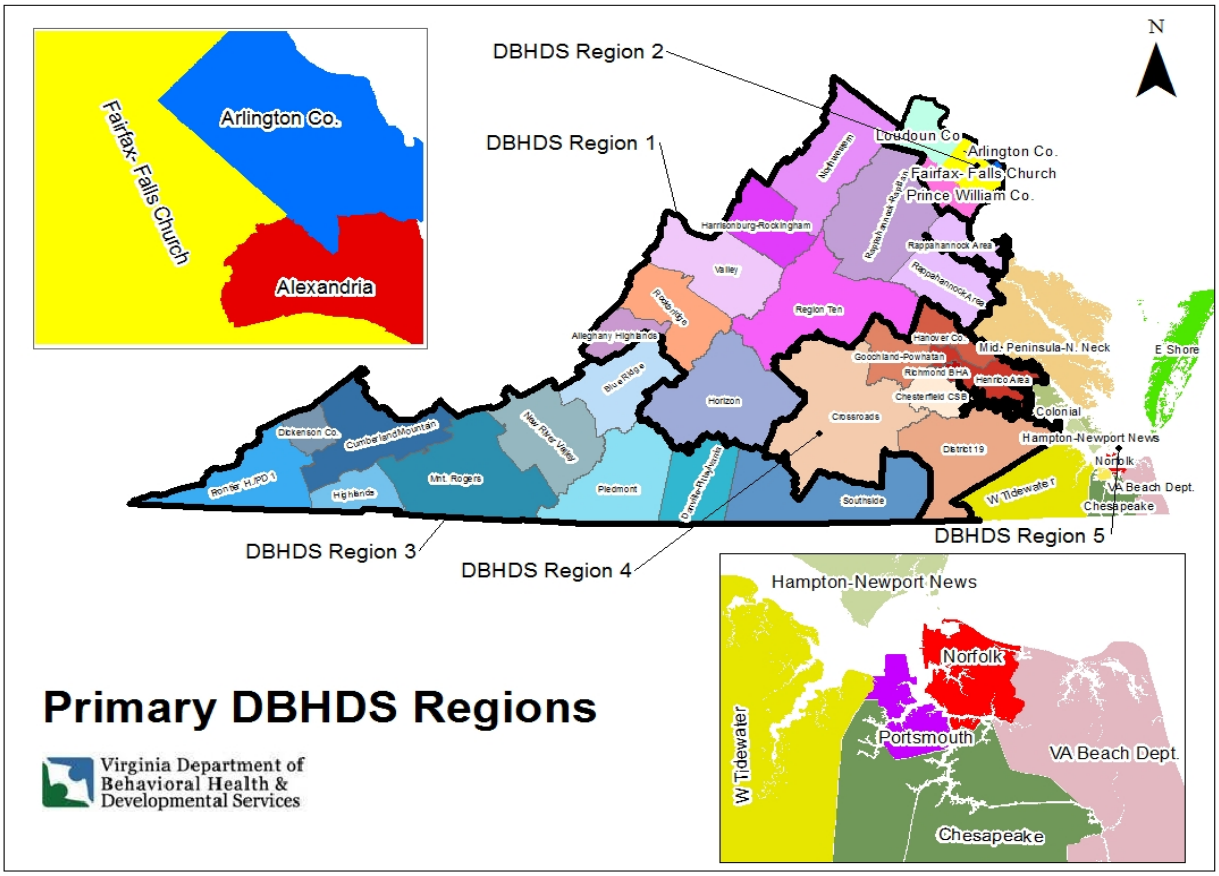
Service Category	Percent change since FY2016
Ambulatory crisis stabilization	30.21%
Residential crisis stabilization	148.59%
Child psychiatry services	52.93%

This dedicated funding has created the opportunity to test service models and to determine where adjustments are necessary. 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 six fiscal years, DBHDS will continue to analyze trends and challenges and strategize with the regions to increase accessibility to these important services. No region offers a comprehensive children's service array which makes it difficult to fully analyze and understand the impacts of these crisis services. To help address the need for robust community based crisis response DBHDS has identified next steps to explore the use of these services. A survey has gone out to all CSB Emergency Services Departments to determine their barriers to accessing residential crisis services. DBHDS will analyze crisis response data quarterly in order to address any needs in a timely manner. In addition, the Office of Child and Family Services will work with the DBHDS Crisis Coordinator and regional CSB leads to ascertain crisis services access needs.

Appendices

Appendix A: Map of Virginia Showing Primary CSB Regional Structure



Appendix B: Case Vignettes Illustrating Outcomes for Children and Families

- **Case Vignette - Mobile Crisis Services**

A youth was referred to the mobile crisis services after his father brought him to the emergency room following an increase in aggressive behaviors at school. The youth was opened to mobile crisis services, and he reported that he would like to work on not getting into trouble at school.

The mobile crisis clinician was able to participate in a meeting at school in which goals were developed for the youth to work toward. The youth was linked to intensive in-home services and psychiatric services during his time in the mobile crisis program. The mobile crisis Clinician also attended an intake session with in-home provider and coordinated with this ongoing provider for a "warm hand-off" of services with the family. Additionally, the parents were linked with resources to help manage behaviors in the home and ongoing supports to prevent future crises.

- **Case Vignette-Crisis Stabilization, Psychiatric Evaluation**

A 16 year old African American female was referred for crisis stabilization services due to making verbal threats regarding harming others in the school setting, and ongoing depressive symptoms. The child's family struggles with significant mental health issues and substance use. The child has received sporadic mental health services. This year her symptoms shifted from suicidal thoughts and cutting to anger and homicidal ideation. She could no longer cope with the violence and chaos in the home with new challenges of bullying in her new school. She received multiple rounds of crisis stabilization services, acute care, and was placed on homebound instruction with the school.

The crisis team quickly worked with the family and Child Protective Services to come up with a plan for this child to reach her. While crisis interventions were started, the child struggled with deep depression, intrusive suicidal thoughts, low self-esteem, anger, hopelessness, and then numbness. The crisis team provided a variety of CBT, art therapy, and mindfulness activities. The child utilized her appreciation of art, her natural talent, and therapeutic strategies to cope with her environment that continued to decompensate. With the help of crisis services, it was recognized that much of her anger and verbal threats were rooted from her chaotic home life. Her resiliency, her mother's willingness to bravely address her current abilities and inabilities, and the strength of the community has provided the child and her family with a variety of resources. The on-going treatment plan for the child continues to be successful, and the child has been successfully discharged from crisis stabilization services.