COMMONWEALTH of VIRGINIA

MIRA SIGNER
ACTING COMMISSIONER

DEPARTMENT OF
BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
Post Office Box 1797
Richmond, Virginia 23218-1797

Telephone (804) 786-3921
Fax (804) 371-6638
www.dbhds.virginia.gov

December 3, 2019

The Honorable Thomas K. Norment, Jr., Co-chair
The Honorable Emmett W. Hanger, Jr., Co-chair
Senate Finance Committee
The Honorable S. Chris Jones, Chair
House Appropriations Committee
900 East Main Street,
Richmond, VA 23219

Dear Senator Norment, Senator Hanger, and Delegate Jones:

Item 312. S. of the 2019 Appropriation 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,

Mira Signer
Acting Commissioner

Enc.

Cc: Hon. Daniel Carey., M.D.
Marvin Figueroa
Susan Massart
Mike Tweedy

Virginia Department of Behavioral Health & Developmental Services

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

October 1, 2019

DBHDS Vision: A Life of Possibilities for All Virginians

1220 BANK STREET • P.O. BOX 1797 • RICHMOND, VIRGINIA 23218-1797
PHONE: (804) 786-3921 • FAX: (804) 371-6638 • WEB SITE: WWW.DBHDS.VIRGINIA.GOV

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 2019 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

Table of Contents

Introduction

In the 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 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 the CSBs in a 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: A Plan for Community-Based Children's Behavioral Health Services in Virginia.

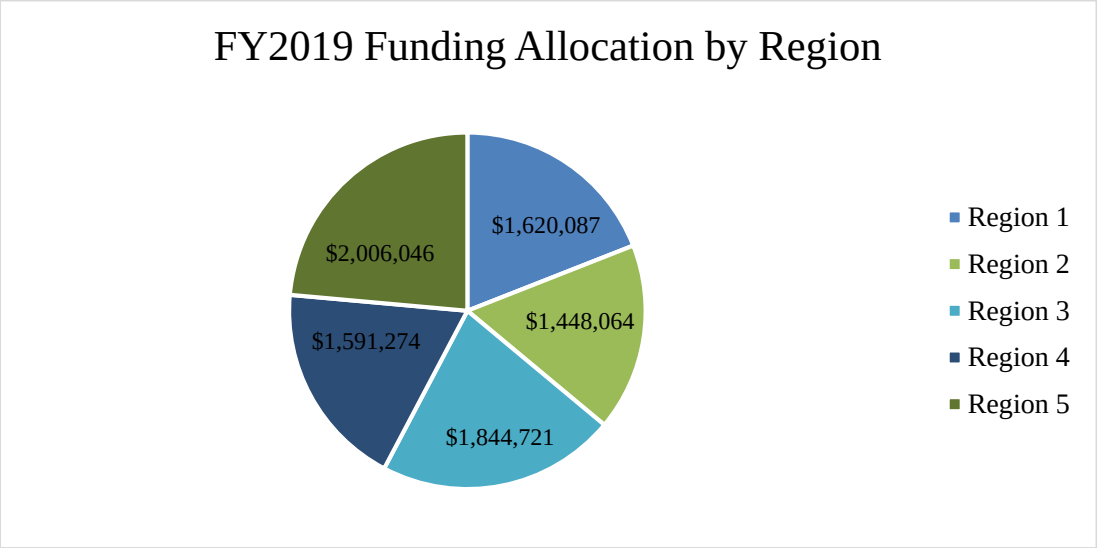
DBHDS awarded funding for regional crisis services through a request for proposals and application review process to each of the five regions. A map showing the primary DBHDS regional structure can be found in Appendix A. Each region has a lead CSB, which are:

- 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 have experienced growth in the number of children served through 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. Since FY 2016 there has been a 24% increase in the number of children that received a mobile (ambulatory) crisis service and since the first year of operation, crisis stabilization units have seen a 371% increase of the number of children seen. Funding for FY 2019 remains steady at $8.4 million. Budget language allocates funding to regions based on the availability of services with a report on the use and impact of funding due annually. Due to the flexible nature of the appropriations language, each region uses funds differently, leading to the variability in access and types of services across the Commonwealth.

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, 2018 through June 30, 2019. Figure 1 illustrates the distribution of funding by each of the five regions in FY2019.

Figure 1: Regional Funding Allocation



Services and Impact

The following describes the impact of funding in three strategy areas. CSBs report data on community services in the DBHDS Community Consumer Submission (CCS) application. A map of the CSBs regional structure can be found in Appendix A. 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:

1. Psychiatry Services,
2. Ambulatory crisis stabilization services, and
3. Residential crisis stabilization services.

Strategy 1: Child and Adolescent Psychiatry Services

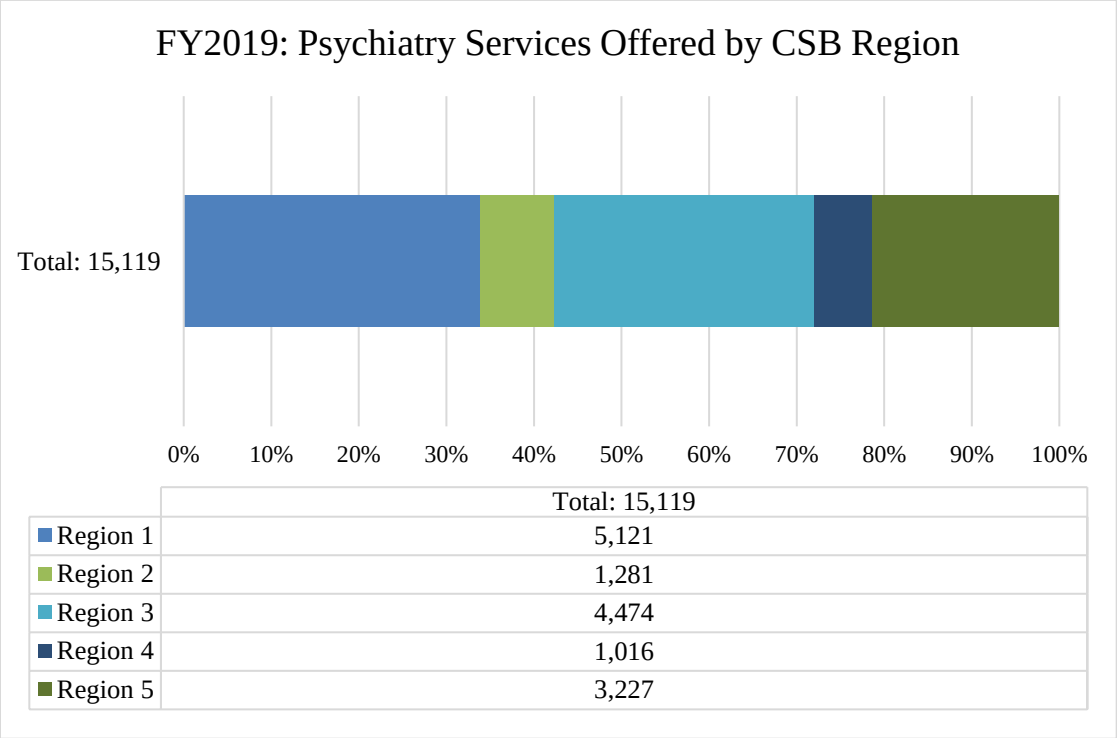
In order to extend the reach of very limited child psychiatry resources, regions were asked to provide child psychiatry in one or more of the following three venues:

- 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 are reported in the Medical Services category in CCS. Medical Services are defined as the provision of psychiatric evaluations and psychiatric, medical, psychiatric nursing, and medical nursing services by licensed psychiatrists, physicians, psychiatric nurse practitioners, other nurse practitioners, and nurses and the cost of medications purchased by the CSB and provided to individuals. Medication services include prescribing and dispensing medications, medication management, and pharmacy services. Medication only visits

are provided to individuals who receive only medication monitoring on a periodic (monthly or quarterly) basis from a psychiatrist, other physician, psychiatric nurse, or physician's assistant. Figure 2 depicts the number of children served by psychiatric services in FY 2019.

Figure 2: Psychiatry Services by Region in FY2019

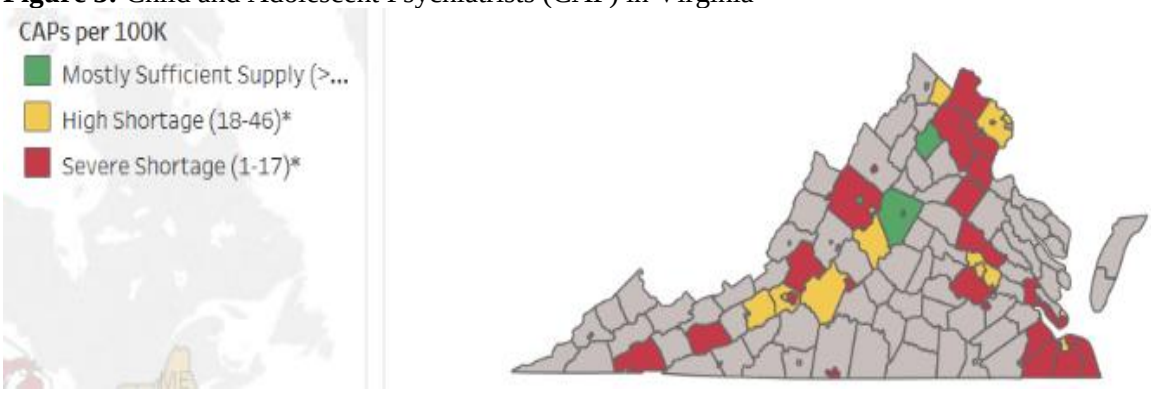


	Total: 15,119
Region 1	5,121
Region 2	1,281
Region 3	4,474
Region 4	1,016
Region 5	3,227

Note: In 2017 Medical Services was broken out of Outpatient Services as a standalone category. Prior to FY2019, regions were using a manual reporting document to track psychiatry services. Since data from prior fiscal years was reported manually and not through CCS 3 it could not be accurately compared. Thus only fiscal year 2019 is reported in figure 2.

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 (a temporary psychiatrist), to fill the need. Tele-psychiatry is used to increase access to child psychiatrists. The figure below illustrates the shortage of child psychiatrists throughout the Commonwealth.

Figure 3: Child and Adolescent Psychiatrists (CAP) in Virginia



Note: The counties in gray do not have a child and adolescent psychiatrist.

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, funding for child psychiatry, through this General Assembly allocation, is utilized for children receiving mobile crisis stabilization services by the Children's Regional Crisis Response (CR2) program. All CSBs in Region 2 provide child psychiatry.

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 to any crisis stabilization services offered in Region 3 are seen within 72 hours, some even the same day. Region 3 has been able to increase continuity of care by having the same psychiatrist who provides medication management services in the Crisis Stabilization Unit (CSU) to follow the child back into the community post discharge.

Region 4:
While children are receiving services at St. Joseph's Villa's Crisis Stabilization Unit (CSU), Region 4 partners with InSight Physicians to provide tele-psychiatry and psychiatric consultation. The region plans on expanding child psychiatry to their community-based mobile crisis program, Children's Response and Stabilization Team (CReST). After several years of continuous recruiting, the program will have a 20-hour per week child and adolescent psychiatrist on board as of August 2019.

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. Eight out of nine CSBs in Region 5 provide outpatient child psychiatry.

Strategy 2. Ambulatory Crisis Stabilization Services

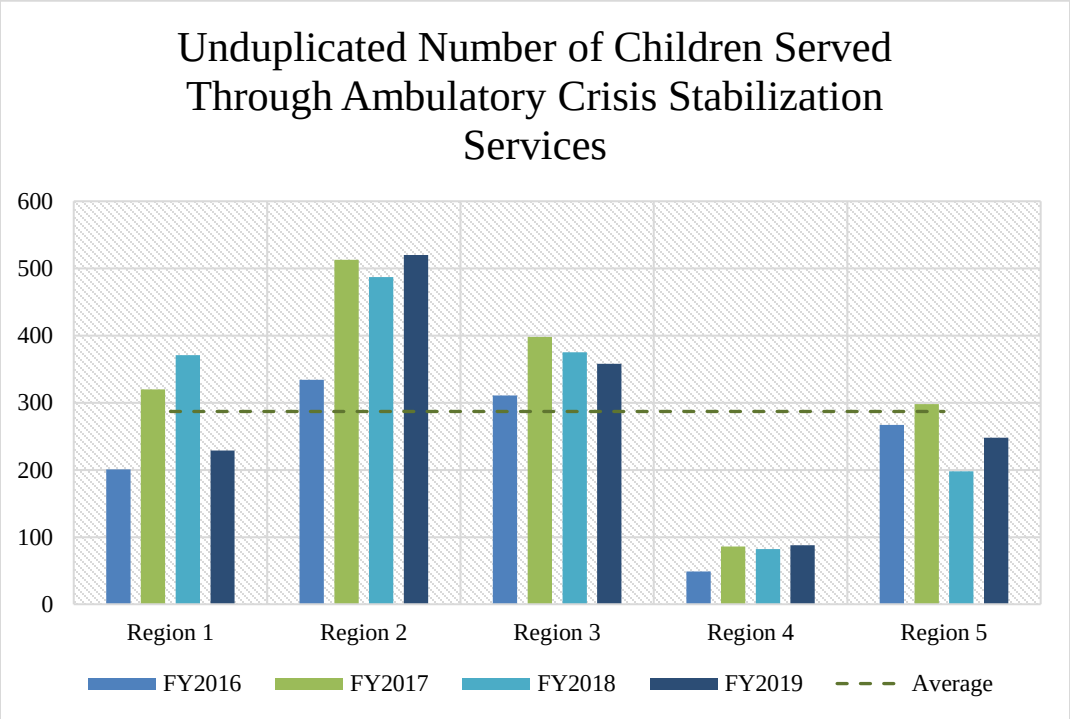
Ambulatory crisis services provide direct care and treatment to non-hospitalized children and are available 23 hours per day. The goals are to avoid unnecessary hospitalization, re-hospitalization, or disruption of living situation, assure safety and security and stabilize children in crisis. Services may involve mobile crisis teams. Ambulatory crisis stabilization services may be provided in an individual's home or in a community-based program. The following table and figure offer data on the number of children served through ambulatory crisis stabilization.

Table 1: Unduplicated Number of Children Served through Ambulatory Crisis Stabilization Services

Region	FY2016	FY2017	FY2018	FY2019	Percent Change (Since 2016)
1	201	320	371	229	+14%
2	334	513	487	520	+56%
3	311	398	375	358	+15%
4	49	86	82	88	+80%
5	267	298	198	248	-7.1%
Totals	**1,162**	**1,615**	**1,513**	**1,443**	**+24%**

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.

Figure 4: Trend over Time of the Number of Children Served through Ambulatory Crisis Stabilization



Region 1:
Horizon Behavioral Health has center based crisis stabilization services located in Lynchburg and Amherst. These services provide evidence based strategies and interventions in their ambulatory crisis stabilization units. For FY19, eight out of the nine CSB's provided crisis services to children and youth in their catchment areas. Crisis services are provided in the home, school, and community settings. Alleghany Highlands CSB is in the process of hiring their first crisis clinician under Region 1 funding. Once Alleghany begins this position, all 9 Region 1 CSB's will have Region 1 crisis staff able to provide crisis services.

Horizon Behavioral Health stopped providing center based crisis stabilization at one of their clinics during this fiscal year. This may account for the decrease in numbers served from FY2018 to FY2019.

Region 2:
The Children's Regional Crisis Response (CR2) program in Region 2 provides 24 hours a day, seven days a-week mobile crisis stabilization services. Staff are mobile and provide short-term crisis services, linkages to new or current community providers, and tele-psychiatry, as needed. Service duration is based on time needed to resolve the existing crisis with an average length of services in FY19 of 22 days and a maximum length of service of 45 days. During FY 2019, CR2 added two clinicians to the ambulatory crisis stabilization teams. These positions were funded through Fairfax County and serve the region.

In February, 2018, CR2 stopped providing Regional Educational Assessment Crisis Response and Habilitation (REACH) crisis services.

Region 3:
In Region 3, there is one mobile crisis stabilization program and two programs with combined mobile crisis stabilization and center-based services. These 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), which provides mobile crisis services. The CReST team is working with Pediatric Emergency Departments, Schools, CSB Emergency Services, 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. In addition to CReST, St. Joseph's Villa in Region 4, provides two day beds that offer center-based crisis stabilization services.

Due to the way services are reported in CCS by Region 4, the numbers of children served by Region 4's mobile crisis services are likely underreported. It is likely that the services that are reported in Table 1 and Figure 4 are likely the children that receive center-based crisis stabilization.

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.

While overall there was a decrease in the numbers served from FY2016 until FY 2019, there was an 11% increase in the number of children served between FY2018 and FY2019.

Strategy 3. Residential Crisis Stabilization Services/Crisis Stabilization Units

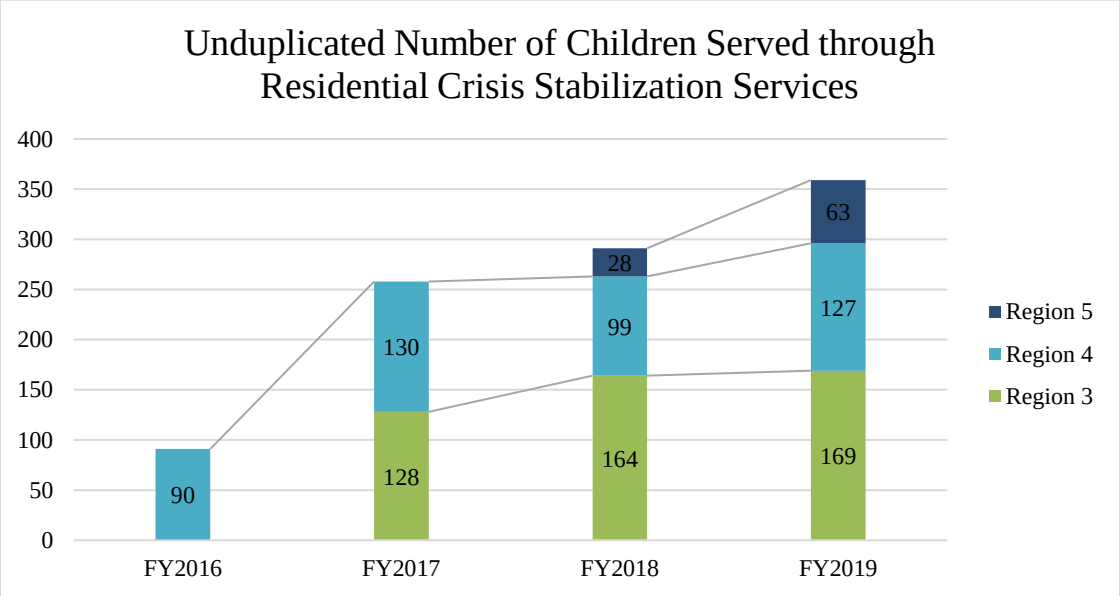
Based on service gaps identified in their proposals, each region has different needs and resources for residential crisis stabilization services. All residential crisis stabilization services are short-term and focused on maintaining family contact and returning children to their homes and schools. Three regions now have residential crisis stabilization units. The table and figure below provide data on the number of children served through residential crisis stabilization services.

Table 2: Unduplicated Number of Children Served through Residential Crisis Stabilization Services/Crisis Stabilization Units

Region	FY2016	FY2017	FY2018	FY2019	Percent Change Since 1st Year of Operation
1	NA	NA	NA	NA	-
2	NA	NA	NA	NA	-
3	NA	128	164	169	+32%
4	90	130	99	127	+48%
5	NA	NA	28	63	+125%
Totals	**90**	**158**	**291**	**424**	**+371%**

Numbers of children are unduplicated.

Figure 5: Trend over Time of the Number of Children Served through Residential Crisis Stabilization/Crisis Stabilization Units



Region 1:
Region 1 continues to be interested in opening an eight to twelve bed crisis stabilization unit (CSU) to divert children from inpatient psychiatric hospitalization. This continues to be a high need for Region 1 due to the private and public hospitals often being full when beds are needed for inpatient psychiatric care. Funding has been a barrier to starting this program.

Region 3:
Region 3 has an eight bed crisis stabilization unit 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 and the capacity for both overnight and day-only services. In order to facilitate admissions, the CSU accepts direct referrals from the community. St. Joseph's Villa works closely with both CReST and REACH to ensure youth are accessing the most appropriate level of crisis care at the right time.

Region 5:
A six-bed Crisis Stabilization Unit (CSU) opened in November 2017, in Region 5. The Region collaborates with: regional emergency services departments, local inpatient and residential facilities, and other CSB departments to divert children from inpatient hospitalization. The CSU utilizes family systems therapy.

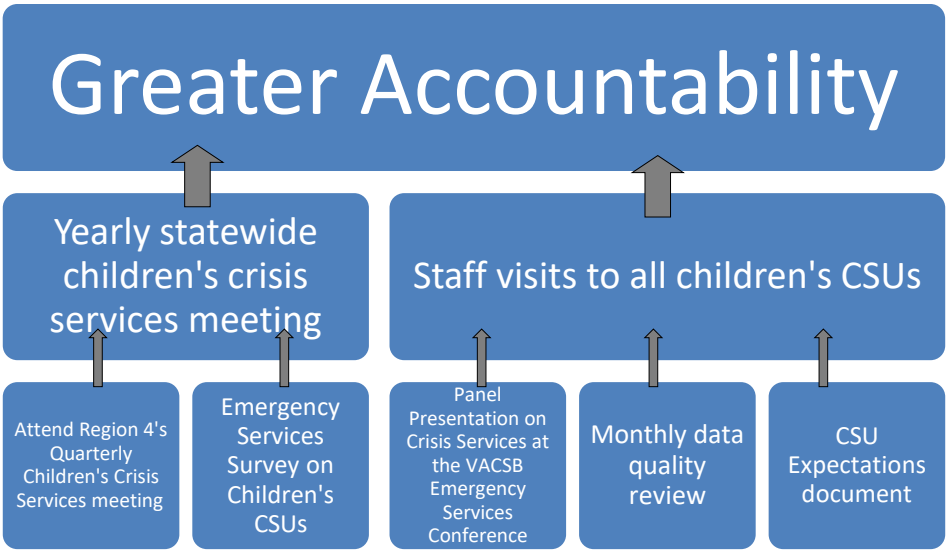
Conclusion

This report provides the opportunity to look at seven years of implementation of crisis response and child psychiatry services using a regional model. Perhaps the greatest improvements in service capacity have been in child psychiatry access through a combination of one or more of the following services: face-to-face visits, tele-psychiatry 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, most service categories have shown growth in services provided. However, full funding for crisis services has not been achieved. A fully funded crisis system will avert the need for psychiatric inpatient treatment and will allow communities to address acute mental health needs in a community based setting at the earliest possible time.

This dedicated funding has created the opportunity to test service models and determine where adjustments are necessary. The regions have found the approaches that work best for their unique demographic and geographic needs.

While regional programs are aligned with local demographic and geographic needs, DBHDS has recognized some of the challenges in creating a consistent statewide system of crisis services. Regionally developed programs support innovation, but there is fragmentation of access and inconsistency in services; different regional models and approaches to mobile crisis and ambulatory stabilization services; lack of a statewide mobile crisis model and other levels of care in the crisis continuum and challenges with recruiting child psychiatrists. DBHDS has recently increased monitoring of these funds to make improvements including consistency in data and financial reporting and clearer expectations around basic program requirements available in region. Some of the strategies deployed by DBHDS to ensure greater accountability for this General Assembly allocation include:



Through System Transformation Excellence and Performance (STEP-VA) and potentially Behavioral Health Redesign (if approved), DBHDS will continue to work to strengthen the crisis continuum standardizing services and expectations around mobile crisis, crisis stabilization units, and identifying other levels of care needed in the crisis continuum for children and adolescents to increase access and consistency. Specific attention is planned for mobile (ambulatory) crisis service to: (1) develop a standard definition and (2) develop a reporting mechanism. While considerable progress has been made over the past seven fiscal years, DBHDS will continue to analyze trends and challenges and strategize with the regions to increase accessibility to these important services.

Appendix

Appendix A: Map of Virginia Showing Primary CSB Regional Structure