



**Voices for Virginia's Children
Presentation to the Behavioral Healthcare Subcommittee of the
Joint Commission on Health Care
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Good afternoon Mr. Chairman and Subcommittee members. My name is Ashley Everette and I am the mental health policy analyst at Voices for Virginia, a nonprofit, nonpartisan children's advocacy organization. I also coordinate our Campaign for Children's Mental Health, an advocacy initiative that began in 2009 supported by more than 65 organizations around the state. The Campaign seeks to transform the children's mental health system in Virginia so that more children are able to obtain needed treatment regardless of where in Virginia they live or what system identifies their need.

I appreciate the opportunity to provide you with an update on the impact of the funding the General Assembly has allocated during the last three sessions to expand crisis response services for kids and child psychiatry. The expansion of these specific mental health services for kids has been a major focus of advocacy for the Campaign for Children Mental Health.

In the fall of 2011, the General Assembly received a final report from the Department of Behavioral Health and Developmental Services (Item 304.M. – Final Report: A Plan for Community-Based Children's Behavioral Health Services in Virginia) identifying the strengths and deficiencies in Virginia's child mental health system. The report outlines a comprehensive array of services that should be available to children with mental health challenges in every area of our state. Four services were identified as "base services" that should be available for children at every community services board: crisis response services, child psychiatry, case management, and intensive in-home services. The most acute gaps in services were found in the areas of child psychiatry and crisis response services, which is a finding that has guided the work of the Campaign for Children's Mental Health.

Over the last three sessions, we have been working methodically to help fill in these service gaps and have been grateful for the bipartisan support to fund regional projects that provide the much needed community-based crisis response services

for children and have allowed for greater access to child psychiatrists. In fiscal year 2013 three health planning regions (Southwest, Central Virginia and Richmond) were awarded funding totaling \$1.5 million to provide child psychiatry, crisis stabilization, and mobile crisis services to children with behavioral health disorders. While access has not been added to every area of the state, capacity is expanded as new funding is allocated. In fiscal year 2014, an additional \$1.9 million was added for a total ongoing allocation of \$3.65 million, making these crisis services available in the two remaining regions of the state –Northern Virginia and Hampton Roads. While access to these services is not available in every area of the state, capacity is expanded as new funding is allocated. That is why we are pleased that the General Assembly added an additional \$500,000 in FY15 and \$1.0 million in FY15 to build capacity.

This funding has allowed for a robust array of crisis response services across the state including: Mobile crisis intervention, ambulatory crisis stabilization, residential crisis stabilization, mobile crisis intervention, telepsychiatry, in person psychiatry, consultation by psychiatrists with pediatricians and family physicians.

- **Mobile crisis intervention and ambulatory crisis stabilization:** Horizon Behavioral Health in Region I (Central Virginia) has had success in adding capacity to its already exiting mobile team to be able to serve non-Medicaid children. Because private insurance does not cover these services, these children were previously being hospitalized in a crisis. Uninsured children had no options for treatment except CCCA. Horizon can send clinical staff out to the hospital or elsewhere in the community to evaluate a child in crisis and put a crisis plan in place; they can then transition the child to the Ambulatory Crisis Stabilization program at Horizon’s offices if needed, where they are served intensely for up to 15 days without the child being hospitalized. They can then follow up with additional community-based outpatient and in-home services to ensure stability.
- **Residential crisis stabilization and mobile crisis intervention.** Region IV (Richmond) has a 6-bed residential unit at St. Joseph’s Villa for those children who may be at-risk for hospital or long-term care. While successful for the children served but underutilized at first, Region IV expanded access to child psychiatry, added “day programming” stabilization, simplified the intake process, increasing utilization by 41% over FY13. In Region V (Hampton Roads/Tidewater) Virginia Beach has had 94 youth referred for crisis services since starting mobile crisis 11 months ago. Only 40% of youth referred for this service have had Medicaid, meaning that without the state money this service would not have been available to the majority of youth served. Additionally, 87% of youth served during this year have been successfully maintained in the home during crisis service provision, avoiding the higher costs of inpatient hospitalization, residential placement, or foster care. Region II (Northern Virginia) has two mobile crisis teams that began providing services June 20th, 2014. It should be noted that, due to local

government contracting delays, Region II was unable to start providing services until the end of June 2014.

- **Telepsychiatry, in-person psychiatry and consultation.** Overall, this funding initiative has significantly improved access to child psychiatry for those children in crisis and other children in rural areas with no local child psychiatrist. Rappahannock Area CSB (Fredericksburg area in Region I) has been using telepsychiatry to cut wait times for kids who need to be seen sooner. Telepsychiatry allows kids to get an appointment in one to two weeks (or sooner if in crisis) instead of the typical four to six month wait to see their child psychiatrist face to face.

The funding the General Assembly allocated during the past three sessions has greatly improved the ability of some communities to stabilize children in psychiatric crisis with hospitalizing them. It has also significantly improved access to child psychiatry for those children in crisis and other children in rural areas with no local psychiatrist, allowing for proper diagnosis and medication. Funding has allowed for an increased capacity of some primary care providers to treat children with mental health diagnosis on an ongoing basis through consultation, training, and expedited access to psychiatrist for kids. Additionally, there has been a significant increase in collaboration, sharing of resources, and expertise among community service boards in each region. Lastly, partnerships among public/private providers and families have seen a positive impact because of this funding.

Based on the data available, ongoing conversations with CSBs in these regions, and personal visits we have concluded that there are a few reasons why this funding has been successful:

- Regional approach—each CSB doesn't have to figure out a model for itself, sharing of resources, collaboration with private providers
- Flexibility—regions have the ability to tailor services to meet the needs in their region and to fit in with what they already have
- Fidelity to intent of funding—being used for the 2 purposes intended despite flexibility

We encourage you to visit the CSBs in your region and learn more about how funds are used and where there are still gaps in service. If you have not already done so and would like to tour the crisis stabilization units or meet with staff, Voices would love to work with you and the CSBs to arrange visits.

*The Department of Behavioral Health and Developmental Services is in the process of preparing the annual report to the General Assembly on Children's Crisis Response and Child Psychiatry and should be made available in the next few weeks.

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