CHILD AND FAMILY MENTAL HEALTH PROGRAM INFORMATION

I. ELIGIBILITY

As mandated by Act 15, the Department of Mental Health (DMH) shall "provide a flexible comprehensive service to all citizens of the state in mental health and related problems."
See Appendix A.

II. STRENGTHS

1. ***Success Beyond Six*** (SBS) and ***Positive Behavioral Interventions and Supports*** (PBIS, aka PBS):
   See Appendix B.
2. ***Early Childhood Mental Health***
   There is collaboration in the development of Children's Integrated Services and Integrated Family Services.
3. ***Young Adults in Transition*** (YIT)
   See Appendix C or
   http://mentalhealth.vermont.gov/sites/dmh/files/report/YIT%20Building%20the%20Bridge%20to%20Adulthood%2010-13.pdf.
4. University of Vermont's ***Center for Children and Families*** and the Department of Psychiatry
   We partner extensively with this organization.
   See http://www.uvm.edu/medicine/vccyf.
5. ***Suicide Prevention***
   DMH wrote the original Vermont platform for suicide prevention. The Center for Health and Learning (CHL) applied for a federal SAMHSA grant with DMH guidance and partnership.
   See Appendix D.
6. Expansion of ***Act 264***
   See Appendix E.
7. ***Integrated Family Services*** (IFS) in Addison County
   See Appendix E, subsection C.
8. **Trauma training initiative** with *National Child Traumatic Stress Network* (NCTSN) grant
   See Appendix F.

III. TRENDS

1. We are seeing an increase in the need for acute inpatient care at the Brattleboro Retreat and residential treatment.
   See Appendix G.
2. We are responding to the mandates in Acts 15 and 79 to increase focus on a public health model (see Appendix H) through the following strategies:
   a. change funding formula to enable mental health to participate in PBIS work;
   b. increase focus on suicide prevention (cf. Appendix D);
   c. empower young adults
   d. form partnerships between pediatric medical practices and mental health providers;
   e. assure access to child psychiatric consultation for:
      1. mental health providers,
      2. pediatric practices, and
      3. child welfare workers.

f. promote positive family development in partnership with the Center for Children and Families working out of UVM's Department of Psychiatry;
g. recruit for the state new child and adolescent psychiatrists trained in strength and community based models of care in partnership with UVM's Department of Psychiatry;
h. maintain public health perspective of population-based data in partnership with the VT Department of Health through the:
   1. *Strategic Health Improvement Plan* (SHIP)
   2. *Youth Risk Behavior Survey* (YRBS)
   3. *College Health Survey* (starting in 2014)

   and the VT Children's Health Improvement Project (VCHIP) out of UVM through the:
   1. Family Integrated Health Systems' development
   2. trend monitoring for the use of psychiatric medications with children and adolescents
i. assist in further development of Integrated Family Services within the first pilot region of Addison County and beyond.

IV. RECOMMENDATIONS

Our top three recommendations are as follows.

A. Seek DVHA's approval to fund community crisis alternative services to decrease voluntary admissions to the Brattleboro Retreat as per previous planning efforts.

B. Seek payment authorization for PMNI (in response to increase in number of admissions and number of bed days) according to the federal Early Periodic Screening, Diagnosis, and Treatment (EPSDT) mandate.

C. Support the work of the federal young adult and transition grant which sunset's on October 1, 2014 and needs $1.3 million in sustaining funds.

Appendix A:

Mission

Under **Act 15**, passed in 2007:
"The department of mental health…shall centralize and more efficiently establish the general policy and execute the programs and services of the state concerning mental health, and…integrate and coordinate those programs and services with the programs and services of other departments of the state, its political subdivisions, and private agencies, so as to provide a flexible comprehensive service to all citizens of the state in mental health and related problems."

"The department of mental health shall be responsible for coordinating efforts of all agencies and services, government and private, on a statewide basis in order to promote and improve the mental health of individuals through outreach, education, and other activities."
****
The commissioner may:
"(17) ensure the provision of services to children and adolescents with a severe emotional disturbance in coordination with the commissioner of education and the commissioner for children and families in accordance with the provisions of chapter 43 of Title 33;
(18) ensure the development of community-based prevention and early intervention services for children and adults and ensure the coordination of these services throughout all parts of the public and private health care delivery system;
(19) ensure the development of chronic care services, addressing mental health and substance abuse, for children and adults and ensure the coordination of these services with other chronic care initiatives, including the Blueprint for Health, and the care coordination and case management programs of the office of Vermont health access;
(20) ensure the coordination of mental health, physical health, and substance abuse services provided by the public and private health care delivery systems;
(21) ensure the coordination of public mental health and substance abuse services with mental health and substance abuse services offered through the private health care delivery system, including services offered by primary care physicians."
….
"On or before January 15, 2008, and on January 15 of every even-numbered year thereafter, the secretary of human services, the commissioner of health, and the commissioner of mental health shall jointly report to the general assembly. The report shall describe the relationship between the commissioner of health and commissioner of mental health and shall evaluate how effectively they and their respective departments cooperate and how effectively the departments have complied with the intent of this act. The report shall address prevention, early intervention, and chronic care health services for children and adults, coordination of mental health, substance abuse, and physical health services, and coordination with all parts of the health care delivery system, public and private, including the office of Vermont health access, the office of alcohol and drug abuse, and primary care physicians."

Under **Act 79** passed in 2012, greater collaboration and integration of mental health and other health services are envisioned.

<u>Appendix B</u>:

Success Beyond Six (SBS) and Positive Behavioral Interventions and Supports (PBIS, aka PBS)

Success Beyond Six is a funding mechanism that allows schools to provide Medicaid billable, school-based, mental health services through direct contracts with their local mental health designated agencies. Through these contracts the following services are available in public schools.

1. <u>School Based Clinician</u>
    a. Assessment
    b. Individual therapy
    c. Family therapy
    d. Group therapy
    e. Community supports (specialized rehabilitation)
    f. Service planning & coordination
    g. Consultation & education/training to school personnel on MH topics
    h. Prevention and early intervention supports
    i. Interagency service coordination
    j. Development of Individual Service Plans (ISP)
    k. Support to Positive Behavioral Interventions and Supports (PBIS) framework in schools

2. <u>Behavioral Intervention Program</u>
    a. Community supports (specialized rehabilitation)
    b. Service planning and coordination
    c. Behavioral Intervention with the child/youth
    d. Social Skill Intervention with the child/youth
    e. Assist in implementation of the child/youth's IEP
    f. Conduct Functional Behavioral Assessments
    g. Develop, evaluate, and revise individual behavior change plan
    h. Apply principles of Applied Behavior Analysis (ABA)
    i. Intensive case management
    j. Parent and family support
    k. Support to PBIS framework in schools

3. <u>Autism Services</u>
    a. Behavioral Intervention support system for students with Autism.
    "Each child is provided one specially trained bachelor's level interventionist and a clinical autism specialist who develop and supervise the individualized plan. Most clinical specialists in this program are Board Certified Applied Behavioral Analysts."
    (*Success Beyond Six Legislative Report 2008*)
    b. Intensive, comprehensive Applied Behavior Analysis services
    c. Intensive case management in home, school and/or community settings
    d. Direct Instruction and reinforcement of pro-social and coping skills
    e. Use of Discrete Trial Learning (DTL) and/or Picture Exchange Communications System (PECS)

Number of children served in SBS cost center for FY12 and FY13

FY12: 3,498
FY13: 3,610

Number of specific children served in SBS cost center for FY12 and FY13 who also received mental health services under different cost centers

FY12: 2,075
FY13: 2,258

Full-time Equivalent Staff (FTEs)

FY11: 642 FY12: 627 FY13: 691 FY14: 778

Change in funding formula

In order to maximize the benefit of collaboration with the educational evidence-based practice (EBP) of Positive Behavioral Interventions and Supports (PBIS), a variation of billing for SBS services has been implemented. A Designated Agency (DA) working with schools using PBIS may shift from a fee-for-service billing model to a bundled rate. The advantages are in increased flexibility to offer consultation to school staff around population-based strategies which are the core of PBIS and less time devoted to paperwork/more time devoted to staff and students.

Success Beyond Six:
***Authorized in Grant Year**

	FY12 Total Medicaid*	FY13 Total Medicaid*	FY14 Total Medicaid*
CMC	1,991,854	1,887,259	1,887,259
CSAC	2,941,843	3,166,476	3,494,252
HC	9,939,563	11,280,570	12,065,223
HCRS	2,808,000	3,160,000	3,459,880
LCC	2,499,880	2,499,880	2,499,880
NKHS	1,301,607	1,373,689	1,690,543
NCSS	5,693,786	6,593,787	6,728,307
RMH	1,377,379	1,441,465	1,501,805
UCS	227,032	223,808	221,497
WCMH	10,599,251	10,629,566	13,456,272
Total	39,380,195	42,256,500	47,004,918

What is PBIS?

Vermont Positive Behavior Interventions and Supports (VTPBiS) is a state-wide effort designed to help school teams form a proactive, school-wide, systems approach to improving social and academic competence for all students. Schools in Vermont are engaged in using a formal system of positive behavioral supports in their schools. Involved schools who implement PBIS with fidelity and integrity see a dramatic decrease in the number of behavior problems experienced in their schools. Additionally, students in these schools enjoy greater levels of support and inclusion than those in comparative schools who do not use a system of Positive Behavioral Interventions and Supports.

The Vermont State BEST (Building Effective Strategies for Teaching Students with Behavioral Challenges) Team supports VTPBiS implementation in Vermont schools state-wide. Each year more and more Vermont schools are actively implementing systems of Positive Behavior Interventions and Supports in their schools.

To learn more about the Continuum of School-wide Instructional Positive Behavior Supports visit www.pbis.org.

You can also view this video from the National PBIS Website:
http://www.pbis.org/common/pbisresources/inVideo/FrontPBS/SWPBS_FrontVideo.wmv

Appendix C:

Young Adults in Transition

See
http://mentalhealth.vermont.gov/sites/dmh/files/report/YIT%20Building%20the%20Bridge%20to%20Adulthood%2010-13.pdf.

Appendix D:

Suicide Prevention

Under a federal grant and in collaboration with the Center for Health and Learning and other partners, we have produced:

- the *Vermont Youth Suicide Prevention Platform: A Public Health Approach to Suicide Prevention* (2012) and
- the *Umatter* public education campaign.

See:
http://www.healthandlearning.org/VYSPCDocuments.htm or
http://mentalhealth.vermont.gov/sites/dmh/files/publications/Youth_Suicide_Prevention_Platform_2012.pdf

http://www.healthandlearning.org/documents/UmatterOverview.pdf,

http://umatterucanhelp.com, and http://umatterucangethelp.com.

Appendix E:

EXPANSION OF ACT 264

A. Act 264 (1988)

A Law on Behalf of Children and Adolescents Experiencing a Severe Emotional Disturbance and Their Families

What the Law Accomplishes:

1. Creates an interagency definition of "severe emotional disturbance."
2. Creates entitlement to a Coordinated Services Plan for children and adolescents experiencing a severe emotional disturbance, who need services from multiple agencies.
3. Creates one Local Interagency Team (LIT) in each of the state's 12 Agency of Human Services' (AHS) districts to serve as a resource for treatment teams which are experiencing difficulty writing or implementing a child's Coordinated Service Plan and as a forum for addressing service system needs.
4. Creates a State Interagency Team (SIT) which functions as a backup to the Local Interagency Teams.
5. Creates a Governor-appointed, nine-member Advisory Board composed of 3 parents, 3 advocates, and 3 professionals to advise state Secretaries and Commissioners on the annual priorities for the interagency System of Care.
6. Maximizes parent involvement at both the individual and the system levels by requiring a parent representative on each LIT and the SIT and 3 parents on the Advisory Board.
7. Requires the submission to the state legislature of an annual update to the System of Care Plan.
8. Requires the creation and development of an interagency System of Care coordinated across departments.

B. Interagency Agreement (2005)

See http://mentalhealth.vermont.gov/sites/dmh/files/policies/CAFU/interagency_users_guide_06.pdf for details on how the system works.

While Act 264 was enacted on behalf of children and adolescents experiencing a severe emotional disturbance and their families, the 2005 Interagency Agreement between the Vermont Department of Education (DOE) and the Vermont Agency of Human Services (AHS) expanded the target population to include children and adolescents with disabilities who are eligible for both special education and disability-related services provided by AHS. This agreement promoted collaboration between the AHS and the DOE in order to ensure that all **required** services are coordinated and provided to students with disabilities. The areas covered by this agreement include:

- coordination of services,
- agency financial responsibility,
- conditions and terms of reimbursement, and
- resolution of interagency disputes.

The DOE, the local education agencies (LEAs) and AHS work together to assure that children and youth with disabilities, ages 3 to 22, receive services for which they are eligible in a timely and coordinated manner. Ultimate responsibility to ensure a free and appropriate public education (FAPE) to students with disabilities lies with DOE and responsibility to provide a FAPE resides with the LEA. AHS is

responsible for supporting students and their families toward successful outcomes in their broader functioning consistent with federal law including 34 CFR §300.1421 as well as state law. In the spirit of Act 264's interagency collaboration, the Advisory Board was asked to expand its original mission from the law's specified population of children and adolescents with the one disability of severe emotional disturbance (SED) to include children and adolescents with any of the fourteen disabilities under special education law. The Board agreed to this request.

Children Eligible for Coordination of Services According to the DOE/AHS Agreement:
All students who meet eligibility requirements under special education and who also are eligible to receive disability-related service delivery and coordination by at least one AHS department are entitled to coordination of services. This includes students who receive special education services within the following disability categories:

A. learning impairment;
B. specific learning disability of a perceptual, conceptual, or coordinative nature;
C. visual impairment;
D. deafness or hard of hearing;
E. speech or language impairment;
F. orthopedic impairment (result of congenital anomaly, disease or other condition);
G. other health impairment;
H. emotional disturbance;
I. autism;
J. traumatic brain injury;
K. deaf-blindness;
L. multiple-disabilities;
M. developmental delay (applies to children ages 3 to 5 years 11 months).

NOTE: Students with the above documented disabilities may or may not be eligible for special education services based on criteria established for special education. For more information about eligibility for special education, visit the DOE website and view the Vermont State Board special education rules (sections 2361 and 2362) at http://www.state.vt.us/educ/new/html/pgm_sped/laws.html#rules.

Therefore, since 2005, children and adolescents who are eligible for coordination of services as defined under **Act 264** ***and*** the DOE/AHS **Interagency Agreement** are those individuals:

- ⇒ who meet the Act 264 definition of Severe Emotional Disturbance and who may or may not be eligible for special education services; and/or
- ⇒ who are eligible for special education services and are eligible for disability-related services and service coordination provided by AHS and its member departments and agencies.

C. Integrated Family Services (2011)

Currently, AHS children's services fall in all six Departments and multiple divisions of the agency. Divisions and departments historically developed separate and distinct Medicaid waivers and Medicaid procedures for managing sub-specialty populations within various departments, and maximizing revenue from other federal sources across the age spectrum. While the best approaches available at the time, the artifacts of this history are multiple and fragmented funding streams, policies, and guidelines about our work with children and families. With the inception of the Global Commitment waiver, these siloed Medicaid funding structures no longer exist. While Medicaid is not the only federal funding stream, it provides support for a large majority of AHS children's programs.

The Integrated Family Services Initiative seeks to bring all agency children, youth, and family services together in an integrated and consistent continuum of services for families. The premise is that giving families early support, education, and interventions will produce more favorable outcomes at a lower cost than the current practice of *waiting until circumstances are bad enough* to access *high end* funding streams which often result in out of home placement.

The goal is to fully integrate human service efforts to create a continuum of services from which families choose and base service delivery on diagnostic and functional needs of the child, youth and family. Best practices will be promoted in health promotion, use of protective factors, early intervention, family support, and clinical treatment. Using the flexibility granted under Vermont's Global Commitment Waiver for federal Medicaid funding, a single Family Plan will be possible for the first time. The system will monitor outcomes and integrate AHS funding across programs to assure effective and efficient results. Integrated Family Services is the overarching "umbrella" under which other initiatives and program changes fall.

Appendix F:

National Child Traumatic Stress Network (NCTSN)

Outcomes from SAMHSA grant 2009-2012: **National Child Traumatic Stress Network Category III Center**

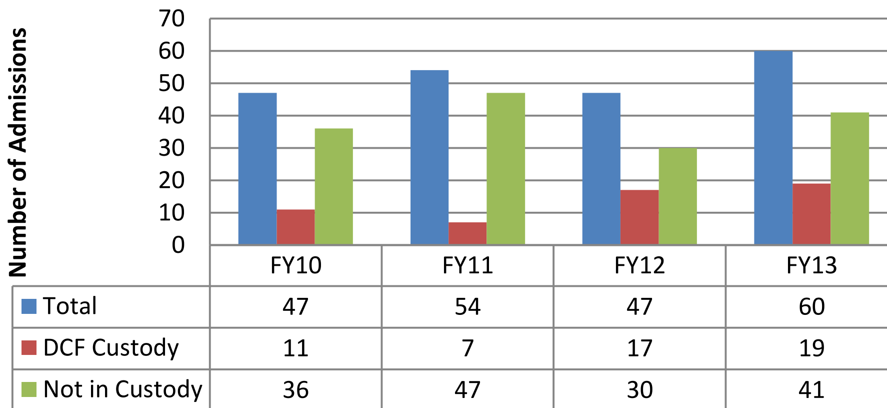
1. Statewide implementation of evidence-based practices for treatment of trauma in children:
    a. Attachment, Self-Regulation & Competency (ARC) Framework
        - 348 clients served and enrolled in evaluation. Many more children and families received ARC trauma treatment, yet did not enroll in formal evaluation
        - 60 clinicians were trained intensively in ARC Framework. Many more received informal ARC training and supervision through agency staff
        - 24 supervisors trained in providing supervision to clinicians in ARC framework
        - Over 650 professionals received ARC 2-day training
        - 30 VCTC members trained as trainers to provide full ARC 2-day trainings
        - Evaluation Results: across the different assessment tools and across the measurement periods of the longitudinal study, there are several indications of child/caregiver dyads appearing to make improvements over the time they were engaged in treatment with the ARC model. Data showed positive trends, suggesting that on the aggregate clients' lives were improving over time.
        - ARC is an evidence-based framework for treatment children with complex trauma and their families. It is a longer-term treatment framework that allows for integration of other short-term treatment models as clinically appropriate.
    b. Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)
        - 36 clients served and enrolled
        - 12 clinicians trained in TF-CBT
        - TF-CBT is a conjoint child and parent psychotherapy approach for children and adolescents who are experiencing significant emotional and behavioral difficulties related to traumatic life events. Manualized 12 to 16 sessions.
    c. Child & Family Traumatic Stress Intervention (CFTSI) Yale
        - 36 clinicians in 4 regions trained in CFTSI
        - An evidence-based early intervention, CFTSI fills the gap between standardized acute interventions and evidence-based, longer-term treatments required to deal with enduring post-traumatic reactions. Brief (4-6 sessions) manualized treatment. Implemented immediately following a potentially traumatic event or after disclosure of physical or sexual abuse. Decreases post-traumatic stress reactions and onset of PTSD by strengthening communication and family support

2. Utilization of standardized trauma assessments:
    a. Implemented statewide use of Trauma Symptom Checklist for Children; Parenting Stress Index; Achenbach System of Empirically Based Assessments (ASEBA)
    b. Workshop for agency staff: Assessment and Clinical Case Formulation: Pulling the Assessment out of the Drawer and into Practice
        - 90 clinicians trained at 11 sites.

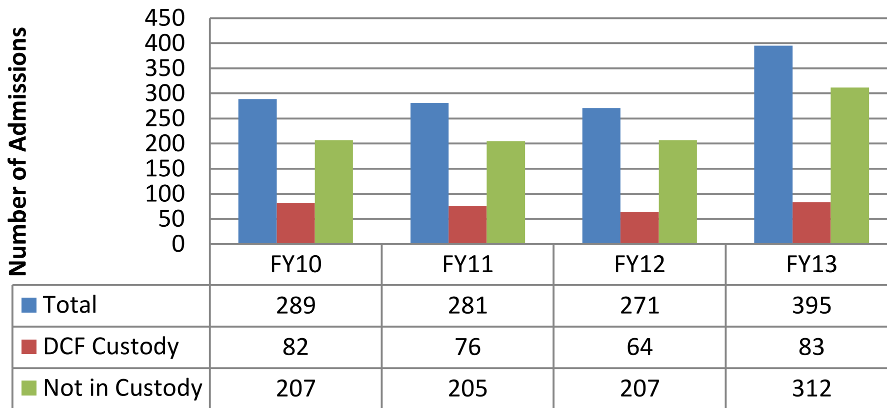
3. Trauma-informed System of Care:
    a. Trauma-Informed Care (Trauma 101) train-the-trainer series
        - 60 community mental health providers and local child-serving providers trained as trainers
        - Nearly 900 community members received Trauma 101 training

Appendix G:

Increasing Need for Voluntary and Involuntary Inpatient Hospitalizations and Residential Placements for Vermont Youth



	FY10	FY11	FY12	FY13
Total	47	54	47	60
DCF Custody	11	7	17	19
Not in Custody	36	47	30	41



	FY10	FY11	FY12	FY13
Total	289	281	271	395
DCF Custody	82	76	64	83
Not in Custody	207	205	207	312

PNMI is a funding mechanism for residential treatment of children and youth. Each Placement Authorizing Department is responsible for funding youth placed; referrals go through a centralized Case Review Committee for statewide matching with programs and triage of openings.

FY Comparisons

DMH PNMI Placements *

	FY13	FY12	FY11	FY10	FY09	*5 yr Average*	FY08	FY07
Total # admissions	**75**	**68**	**63**	**56**	**59**	*64***	**66**	**66**

* PNMI *spending* includes HowardCenter (HC) Crisis Program, because it is PNMI rate set by DRS. These numbers exclude the HC crisis bed *admissions*.

** 5 year average is 64 admissions; up from last year's 5-year average of 62 admissions.

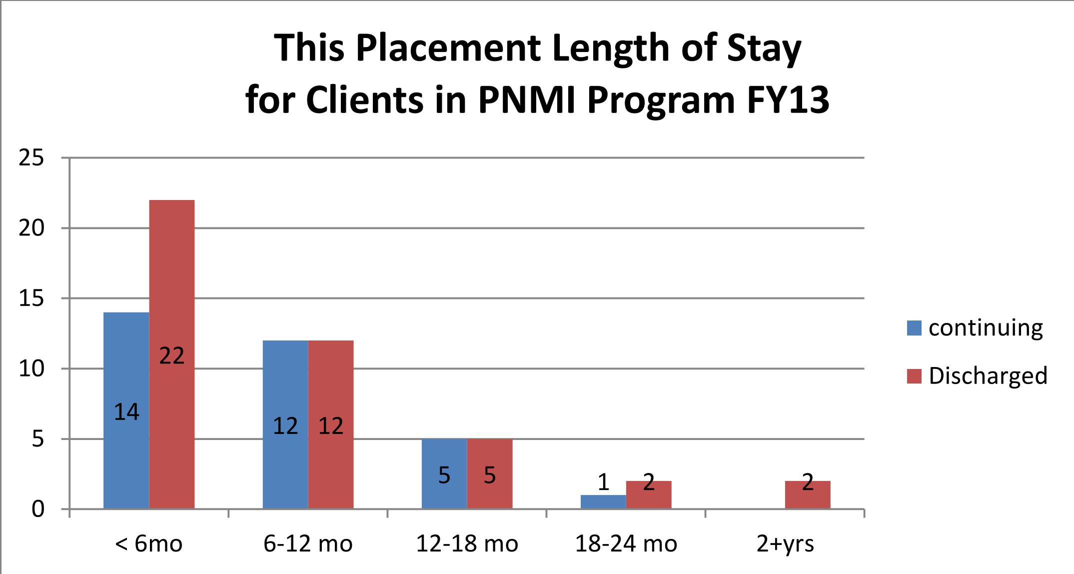
Why are we overspent?

EPSDT: If a provider determines that residential treatment is a "medical necessity" to address the child's mental health needs, and the DMH agrees, the request for residential is approved and referred to an appropriately identified treatment program. DMH has lost several cases before the Human Services Board when we disagreed with the request for residential treatment, based on the argument of EPSDT's medical necessity rule.

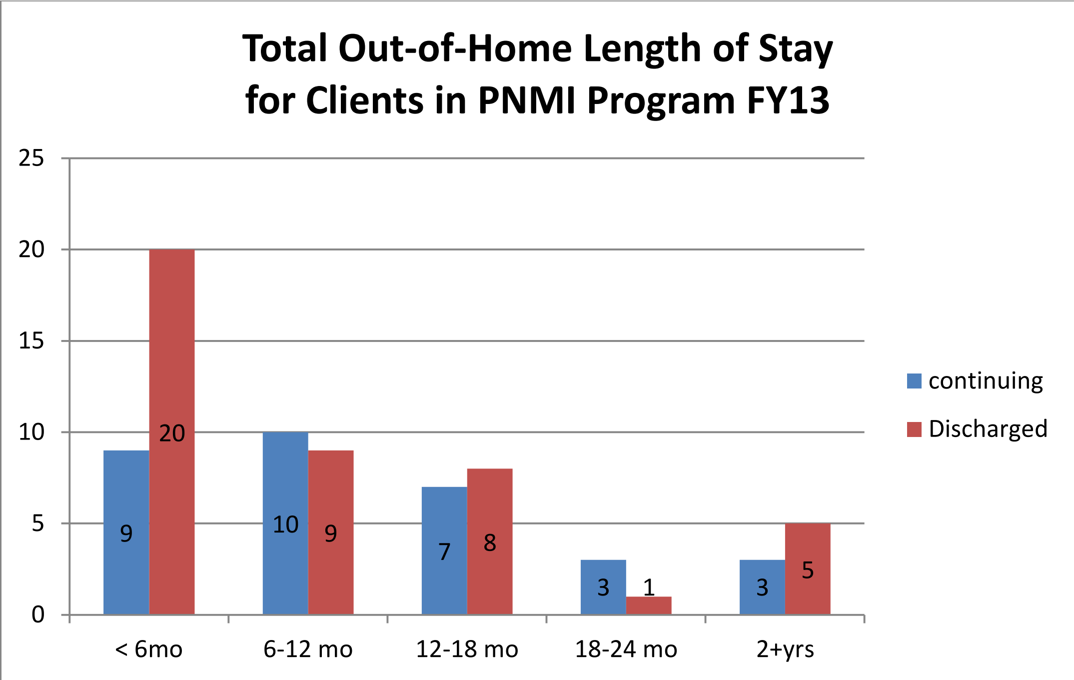
FY13 Data

DMH conducts utilization review of children/youth placed in residential (PNMI) programs to evaluate treatment progress and review discharge plan.

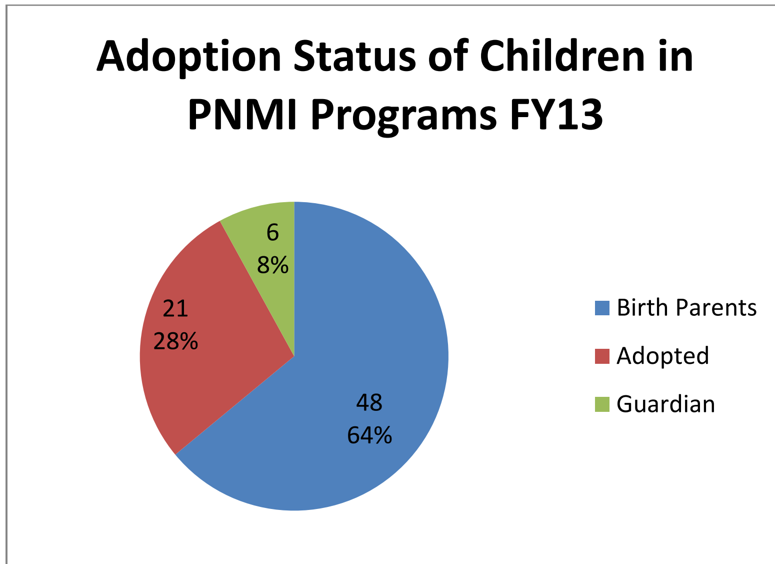
Discharge Status	**Count of Client**	**Average of LOS this placement**
Continuing into FY14	32	234.9 Days
Discharged FY13	43	236.3 Days
Grand Total	**75**	**235.7 Days**

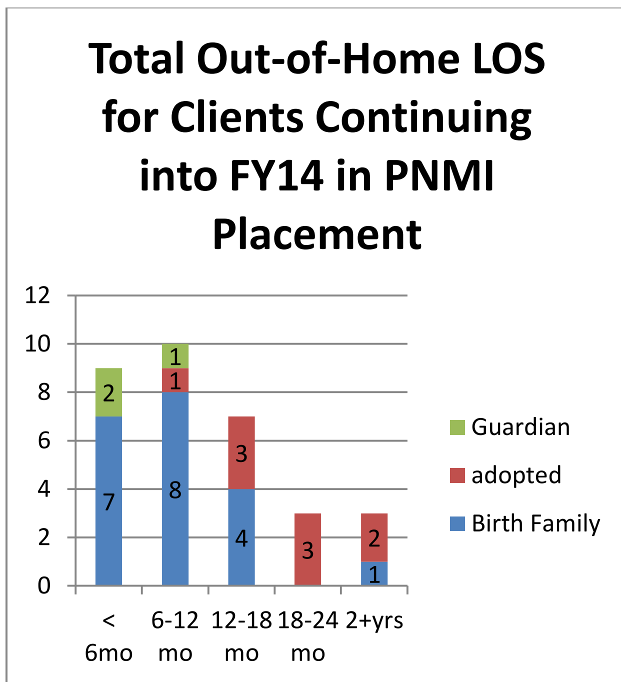


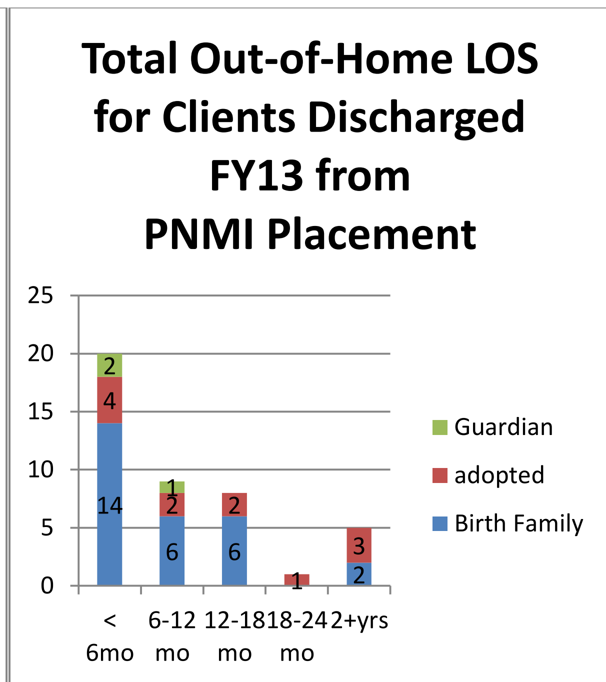
Clients may be in more than one out-of-home placement over the course of many years.



In FY13, 36% of PNMI placements were children who were adopted or under guardianship.







<u>Appendix H</u>:

Public Health Model

In order to accomplish its vision and mission, DMH must increase its focus and strategies to embrace the concept of public health.

Given current and trend data on the incidence and the human and financial cost of mental health issues, it is clear that the state needs to focus on the public health approach at this time. The numbers of Vermont's children whose families ask for treatment continue to rise and the children are often younger and have more complex presentations than ever before. Historically, children in special education with a serious emotional disability have been the most likely of all the 14 disability groups to drop out of school. Prospects for employment and a life above the poverty level for those without a high school diploma or a GED are discouraging. Further, research has shown an inverse correlation between funding for mental health services and funding for incarceration. States that pay more for mental health services typically pay less for jails and prisons and vice versa.

In order to slow the rate of incidence of poor mental health and the cost of services to individuals, we must balance the current intense focus on a medical care model of treating individuals who already have a diagnosis with an increased focus on a public health model of promoting health and preventing problems for the entire population.

There are four main elements to a strong public health model:

1. Focus on the entire population.
2. Promote methods to optimize everyone's good health and prevent problems through public policy based on accurate data and solid research.
3. Determine risk and protective factors as well as social determinants for subpopulations at higher risk.
4. Follow a process with three core functions and ten essential elements:
    a. <u>Assess the situation</u>
        i. Monitor health
        ii. Diagnose problems and investigate causes
    b. <u>Intervene through policy development</u>
        i. Inform, educate, and empower everyone
        ii. Mobilize community partnerships
        iii. Develop policies
    c. <u>Assure access to quality care</u>
        i. Enforce laws
        ii. Link people to and provide care as needed
        iii. Assure competent workforce
        iv. Evaluate

(*A Public Health Approach to Intervention: A New Framework for Strengthening Children's Mental Health and Well-Being.* National TA Center for Children's Mental Health. June 19, 2008.)