

Mental Health Oversight Committee Testimony

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Kathleen Holsopple

Executive Director VT Federation of Families for Children's Mental Health

I attended the September 23rd mental health oversight committee meeting, and agree with many of the statements made by our partners at DMH and local mental health agencies.

VT System of Care for Children and Families

Vermont's ACT 264 process, giving families coordination of services, is the envy of the nation. We hear that from our counterparts in other states. While that may be true, ACT 264 did not answer all questions or fix all problem areas.

Families who do not have Medicaid do not have access to as full a range of supports and services as those families who do have Medicaid. When we talk about the VT System of care for Children and Families we must talk about for all families. How do we overcome this barrier?

Respite is a critically important service, for families, that allows time for family members to recover from 24/7 care responsibilities or to attend to other personal and family needs. Respite care gives a family a short break or relief by having someone else temporarily take care of their child/youth with emotional/behavioral challenges. Respite can be for a few hours or a few days. In recent years, more respite funds have become available. However, the word has not gotten out to many families. We also hear from families that some local mental health agencies say the service is not available. One clear need, for families and mental health workers, is finding people to provide the respite, so the respite programs can be more available to families in need.

Coordination of services does not always go smoothly. One of the results we see and hear about when this coordination does not work well is a concern about safety/behavior versus mental health need. This has become a more common topic when decisions are made for kids with mental health or other disabilities that also include challenging behaviors. When a child needs intervention and treatment for behaviors stemming from a mental health or other disability, the questions often become, "is this mental health or safety and who takes the lead and pays for services." The behaviors do not, themselves, fit the medically necessary definition of our payment system. The safety risk the behaviors present is often the reason the child cannot be kept safely at home. The child, and their family, need intense treatment, intervention or skill building to give them different behavioral responses to distressing situations or symptoms of the disability.

Higher needs and high end services

More of the families, who are calling us, in recent months, are coming with a higher level of need. Some of them have not yet accessed lower level mental health supports and services, and come in with a need for intense services.

I spoke with one of the parents whose child had come into services in one such mental health crisis. This child had previously undisclosed trauma, and went from fairly reasonable functioning to suicidal in a few months time. This parent's ideas of what might have happened differently are:

1. Schools need to recognize sooner what a child in mental health distress looks and acts like. The behaviors can look like a child who is just not obeying rules, is oppositional or defiant, or is acting out in other ways. A child who does not normally act in this way and over a short period of time displays these behaviors is a red flag that something else may be going on.
2. Our system of care is not set up to react quickly to a mental health crisis that may require a high level intensity of services for a prolonged period, especially if the child is new to services at the time of crisis. Services that may have been helpful or could be available were not available in that short of notice. Getting a child into a needed higher level of care can take too long and make it impossible to keep kids safe.

Families should not have to exhaust all community based service options before looking at higher level interventions when that level of need exists. If the high level of needs shows up suddenly, there is not time to exhaust every possible community based service and still keep the child safe.

Another issue is one of coordination and communication between systems, service providers and families. In recent years, DVHA has become a part of our system of care around children's mental health. We find some decisions that are made about medical necessity and payment can negatively impact families and children, yet we do not yet see a feedback loop with that information. An example is when children are at the Brattleboro Retreat for crisis mental health hospital stabilization. The definition of medical necessity is often different from the perspective of DVHA, the Retreat, local mental health agencies and parents. The parents are not clear about what treatment can or cannot happen at the hospital or what results they can expect from that treatment. They sometimes feel they are not ready for the child to come home as local services are not already in place to meet the new needs after a hospitalization and the needs that put them there in the first place. Again, our system is not set up to respond quickly in these situations. Families can feel pressured to bring their child home with no clear understanding of their level of stability, also knowing that local services may not be in place. There needs to be a discussion with all parties. We are asking the State Interagency Team to convene a meeting with interagency partners to discuss all aspects of this issue and come up with family and child friendly solutions. These situations also show the need for a step down process at a regional level for some children who have been hospitalized or in intense residential treatment.

When children reach a high level of care, the way decisions are made can vary greatly based on who has custody or what system partner is taking the lead. The principles and values of ACT 264 are not consistently the driving force behind decisions for children and families at this high level of need.

We see the need for at least 2 hospital settings for children, one central to more northern Vermonters and the Retreat in the south. Driving long distances for meetings and supports and services while a child is in hospital just does not work well for families who live in the north. Families want to be actively involved in their child's care and the distance makes that hard or impossible.

Integrated Family Services, IFS

We are fully in support of IFS and the ideas of intervening earlier, flexible family driven services, assistance based on need not necessarily a diagnosis, and the many other good approaches IFS proposes. Family voice has been an integral part of creating the IFS approach and must continue as IFS is rolled out across the state. We, VFFCMH, have had a Parent Support Provider in Addison County, who has been supporting families and creating family advisory voice, for the IFS implementation over the past 9 months. We'd like to see other regions start out with family voice and advisory when they implement IFS, and are happy to partner with regions to make this happen. Some results of IFS and Family voice in Addison are: We have a strong committed group of parents to advise the IFS process, the IFS leadership is very responsive to the questions and advice of the parent advisory group. According to Addison, CSAC, data in the first year of IFS implementation, more youth and young children were served and more kids with developmental needs were served.