Department of Mental Health
Early Childhood and Family Mental Health
February 7, 2017
House Human Services Committee

DMH's History of Early Childhood and Family Mental Health (ECFMH) and Children's Upstream Services (CUPS)

1998 Received SAMHSA System of Care grants for 6 years for $9 million.

1999 All 12 AHS districts, after gathering their local early-childhood partners, developed a plan to spend their allocations with the goals being:

- More effectivity treat children 0-6 and then families who are experiencing MH issues with coordinated service planning.
- Expansion of services that will build the resilience of our young children and families in early care and education settings.
- Expansion of other vital services, based on preparing the readiness of young children and their families to enter school.

1999-2004 24 new MH practitioners hired to consult, treat, and provide outreach to families with young children.

2004 The strong outcomes of CUPS and the early-childhood community to build an early childhood System of Care, led to the development of the Child Development Division.

2004 Mental Health sustained the CUPS grant and transferred the $600,000 of general fund to CDD so it could sustain the CUPS services in all regions. This general fund was intended to match Medicaid.

DMH's Funding History

- Since 2002, funding for early childhood mental health has been an acknowledged part of the "Kids Are Priority One" and Vermont Children's Forum legislative platforms for children with special needs. The Vermont Coalition for Disability Rights also added sustained funding for CUPS to its 2004 legislative agenda. Governor James Douglas submitted his annual budget to the 2004 Legislature with $600,000 in State General Funds toward replacement of the federal grant funds for CUPS. The rest of the funding must come from federal revenues for Medicaid (fee-for service and administrative, or EPSDT) and/or IV-e.

- During the last period of the grant, the Legislature approved the requested new $600,000 appropriation for CUPS for State FY05. In addition, the Legislature transferred authority for CUPS from the Division of Mental Health to the new Child Development Division (formerly Child Care Services) in accordance with an Agency of Human Services Reorganization.

Re-organization of the Agency of Human Services 2004 as it relates to ECFMH

- Child Development Division (CDD) was created during re-organization in 2004
- Funding associated with ECFMH/CUPS, specifically treatment dollars and funding that was used for consultation and education for childcare settings was transferred to the CDD from DMH's budget.
- Many of the DAs had determined during the days of CUPS to use some of their resources to augment ECFMH/CUPS services.

Current information regarding DAs' current services to early childhood

- DAs are serving more children 8 or younger than they did in the past from 1999 – 2015 there has been an increase of 88%
- DAs have a lot of experience in the rollout of Multi-Tiered Systems of Support in schools

- DAs have been implementing evidence based early childhood and family treatment and DMH and DCF/FSD have contributed resources jointly to train more clinicians
- There are many young children experiencing trauma and other impacts on childhood that there is a real need for treatment not just prevention, although DMH strongly supports prevention efforts as well.
- We must focus on the family/parents not just the child or the childcare setting in order to change the trajectory
- We need to continue to shift the focus to outcomes not just process or numbers served
- We need to make sure billing other insurance is part of the program design in order to maximize Medicaid dollars.
- The DA's are very experienced in developing and implementing school Mental Health Services in schools.

Adverse Family Experiences (AFEs) for Vermont Children and Youth <1-17 years old

Percentage of children and number of AFEs

- 16 % have 2 AFEs
- 9% have 3 AFEs
- 12% have 4+ AFEs

Four most Common AFEs

- 26% Divorced or Separated Parents
- 25% Family Income Hardships
- 15% Alcohol/Drug Problems in Parents
- 11% Live with a Parent who is Severely Depressed or Mental Illness or Suicide

Examples of Evidence Based Treatment Provided

Child-Parent Psychotherapy (CPP):

- For children 0-5 who have experienced at least one traumatic event and/or mental health, attachment, or behavioral problem.
- Based on attachment therapy with cognitive-behavioral, trauma, developmental theories. Sessions include child and parent (or primary guardian).
- In home or clinic. Up to 1 yr length.
- Improvements demonstrated in child PTSD symptoms, other MH diagnoses (depression & anxiety), behavioral problems (aggression), attention problems, capacity to regulate emotions and cognitive functioning. Improvements also seen in attachment between child & caregiver; and in caregiver's PTSD or other symptoms, empathy toward child(ren) and ability to interact positively with child(ren).

Parent-Child Interaction Therapy (PCIT):

- For children ages 2 1/2 - 7 with disruptive or externalizing behavioral problems ADHD, ODD, conduct) and their parents/ caregivers. Also effective with parents with abusive parental practices and/or families with attachment problems.
- Short-term intervention, mostly office-based but has been adapted for in-home. 12-20 weeks (1-1 1/2 hrs ea week).
- Direct live coaching of parent (bug-in-ear).
- Child & parent progress tracked weekly, very data-driven
- Improvements demonstrated in parent-child relationship, child self-esteem, child emotion regulation; parents learn effective, consistent & predictable parenting strategies that improve child's ability to listen and follow parental direction
- At HC: 91.6% children whose family received PCIT had behavioral improvements; 75% parents reported reduced parental stress; 93% parents reported improved parenting competence