CHILD, YOUTH AND FAMILY MENTAL HEALTH

KEY INITIATIVES AND UPDATES

APRIL 2021

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OVERVIEW

CHILDREN'S SYSTEM OF CARE

INITIATIVES

COVID IMPACTS

TAKEAWAY: CHILDREN AND FAMILIES ARE STRUGGLING – DMH IS WORKING ON THE FOLLOWING KEY INITIATIVES

- Re-open schools
  - Continue to work with Agency of Education on strengthening Success Beyond Six
  - Integration of service delivery where children, youth & families are (PCP, early care settings, school)
- Mobile response & stabilization services
  - Rutland pilot in Big Bill
- Support for workforce recruitment efforts, partnerships with higher ed, licensure reciprocity
  - Task force for a 5-year strategy to strengthen workforce

SAMHSA & Vermont's
History of Child & Family System of Care

1982

The last ward of the VT state hospital closed for children

CMS awarded VT DMH the first **Home and Community Based Services Medicaid Waiver** (1915c) for children with Severe Emotional Disturbance (SED)

1984

Children's **System of Care** was promoted by SAMSHA

1984-1988

Vermont awarded first Child & Adolescent Service System Program (CASSP) grant from SAMHSA to create **System of Care in VT**

1988 & 1990

- passage of **Act 264**
- First state chapter of **Federation of Families** for Children's Mental Health established in VT

1993

Success Beyond Six school MH authorized

Established core values, concept of working together to address the needs of children & families

Expanded service array for children with mental health challenges

Family Voice was paramount

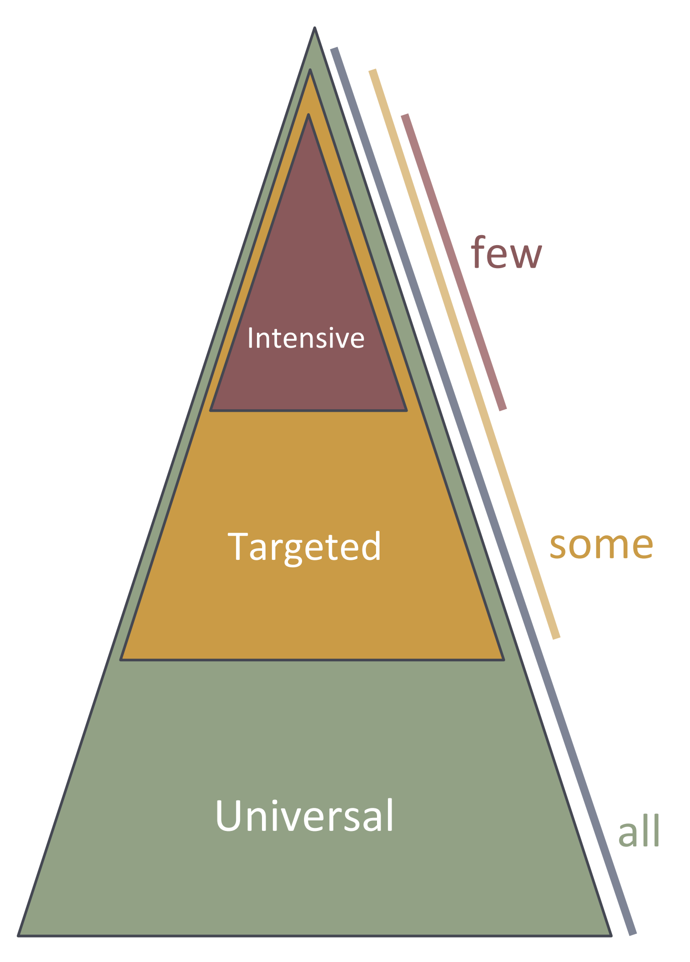
Work is coordinated across agencies and departments

Act 264 (1988)

- An interagency definition of severe emotional disturbance
- A Coordinated Services Plan
- A Local Interagency Team (LIT) in each of the twelve Agency of Human Services' districts
- A State Interagency Team (SIT)
- A governor appointed advisory board
- Prioritized parent involvement at all levels

www.act264.vt.gov

VERMONT'S VISION: ALL CHILDREN AND FAMILIES ARE MENTALLY HEALTHY



Provide intervention and treatment services to children, youth, and families with mental health needs (Intensive Intervention)

Provide prevention services to reduce risk factors and increase resiliency and protective factors for children, youth, families and, communities at risk (Targeted)

Promote mental wellness for all children, youth, families, and communities (Universal)

CHILDREN'S MENTAL HEALTH SYSTEM OF CARE

Children and Families

Intensive Intervention

- Inpatient Care
- Crisis Beds and Services
- Out-of-home treatment
- Intensive Home and Community Based Services

Community Intervention

- Respite
- Specialized Rehab Services
- Clinic-based Therapy
- School-based Services
- Mental Health Consultation (child-focused)
- Integrated Care (Primary Care)

Promotion and Prevention

- Mental Health Consultation (population-based)
- Child Psychiatric Consultation (population-based)
- School Mental Health role with PBIS/MTSS
- Wellness and psycho-education
- Young adult leadership training

WORKFORCE

VFFCMH
Advocacy, Youth and Family Voice

DVHA
Inpatient, Crisis Beds Other Medicaid providers

UVM
Child Psychiatry, VCHIP

DMH
10 DAs, 1 SSA, 1 DH

DAIL
DS, VOC REHAB

DOC
Services for YIT

VDH
ADAP, EPI, MCH

DCF
Family Services, CDD

AOE
LEAs

The number of children and Youth Served has increased over time

Number of Children Served
FY1986-FY2020

12000
10000
8000
6000
4000
2000
0

1986 1988 1990 1992 1994 1996 1998 2000 2002 2004 2006 2008 2010 2012 2014 2016 2018 2020

Success Beyond Six – School Mental Health Medicaid

Success Beyond Six (SB6):

Authorized in 1993 to help reduce cost burden to education and state by leveraging Medicaid for Medicaid-enrolled students

School Districts contract with DAs for SB6 school mental health in nearly every school district in Vermont and 13 independent schools.

Participation in past decade has remained fairly stable; however, acuity of need has increased:

- In FY 2010 3,386 students served
- In FY 2020 3,656 students served

SB6 Services:

- School-Based Clinicians
- Behavioral Intervention Programs
- Concurrent Education Rehabilitation and Treatment (CERT) therapeutic schools

Review of Success Beyond Six: School Mental Health Services Act 72 (2019), Section E.314.1.

SCHOOL MENTAL HEALTH

- Regional differences exist, due to:
  - School/district's own resources
  - Relationship between district and DA
  - Workforce available to support school mental health programming
- Long-term discussions about equity and sustainability, including consideration of an alternative payment model for the BI programs.
  - Sustainable for schools & DAs
  - Flexibility to respond to changing school and student needs
  - Primary goal is that students' MH needs are addressed so they are available to learn

SCHOOL-BASED MENTAL HEALTH DURING COVID-19

- Partnerships with local schools essential (and strained) during pandemic
- SBMH continuously adapting to student/family, educator/school needs
- Increased parent/guardian contact, coaching & psychoeducation: how to support their child's educational/ behavioral plans and addressing basic needs
- Identified other spaces to meet with students following COVID precautions – or using telehealth – when not in school building
- In-person supports continued where clinically indicated; resumed where school in-person
- Anecdotal reports of anxiety, mood disorders, family stress – impacts of social isolation

Vermont's Pre-Covid Landscape

Higher among students of color and LGBTQ youth

Higher among females, students of color and LGBTQ youth

Major Depressive Episodes nearly doubled from 2004-2019 for youth aged 12–17

About **1 in 3** youth reported feeling sad or hopeless, compared to 1 in 4 in 2017

6.5% of youth reported they had attempted suicide at least once

17.7% increase in ED visits among children/youth primarily for a mental health concern from 2016 to 2019.

Nationally

Rising rates of depression among adolescents.

Rising rates of adolescents utilizing mental health services.

ANXIETY AND DEPRESSION INCREASED FROM 2019 TO 2020 AMONG VT YOUTH

PACE Study

- Youth (12-17) reported significantly more depressive symptoms in Fall 2020 than in Fall 2019
- Reported anxiety among youth (12-17) was elevated in Fall 2020 compared to Fall 2019
- Reported anxiety in young adults (18-25 years) was significantly higher in Fall 2020 compared to Fall 2019, and mirrored the trend among youth
- Around 70% of youth reported that the COVID-19 pandemic made their anxiety/worry, mood or loneliness “a little” or “ a lot” worse

YOUTH REPORTING LACK OF COMMUNITY CONNECTION

School Based Mental Health Services Data

- Students assessed using the Child and Adolescent Needs and at Strengths (CANS)
  - 56% of children and youth were identified as lacking community connection
  - 48% of children and youth were identified as lacking optimism
  - 39% of children and youth were identified with a need related to anxiety

Mental Health-Related Emergency Department Visits in Vermont Youth

- In 2020, the rate of youth ED visits for mental health-related concerns increased

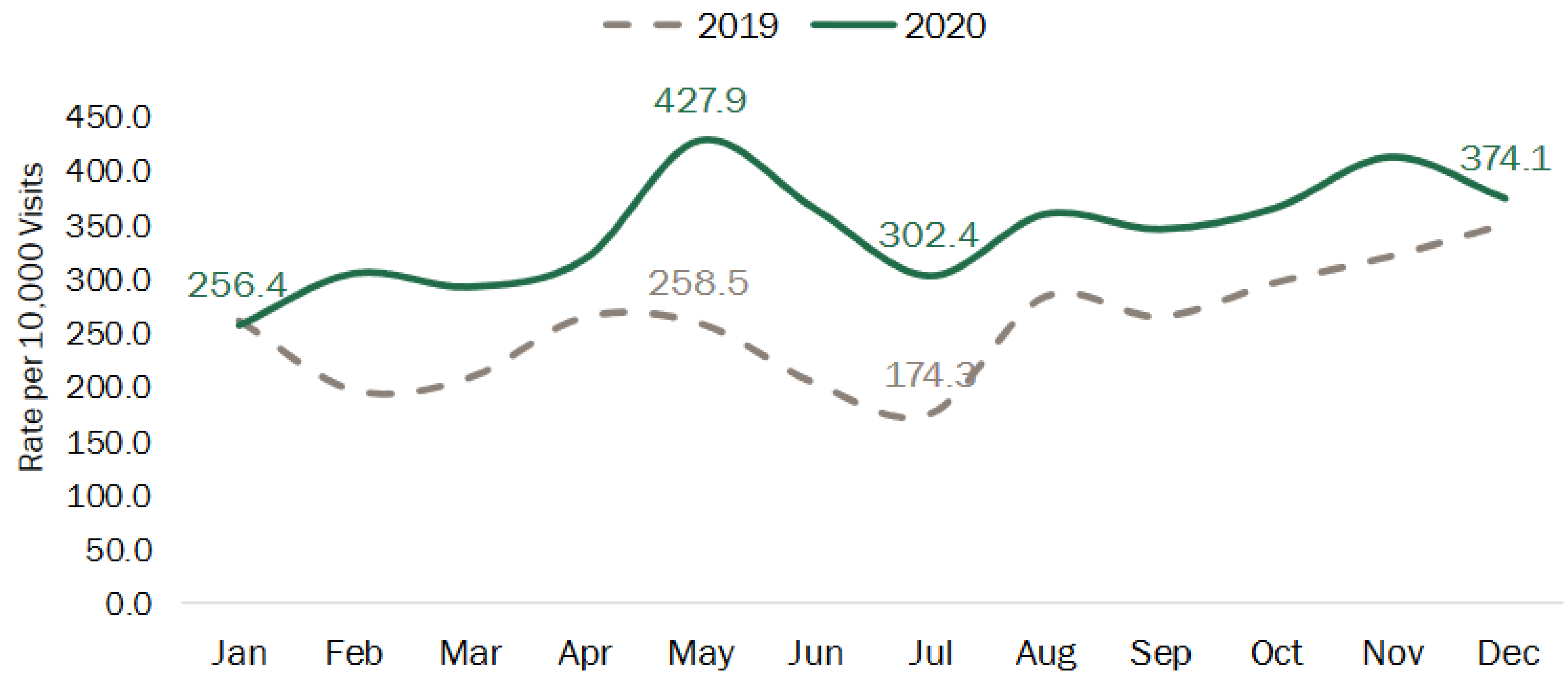
PEDIATRICIANS SEEING WORRYING TRENDS IN PATIENT'S MENTAL HEALTH

- Pediatric Emergency Physician – " *The adolescent age children are struggling. There are increased number of emergency department visits for acute mental health needs"*
- Primary Care Pediatrician – *"My practice has 11 mental health providers that we contract with. In September, we had no waitlist – now we have 70+ on the waitlist. 75%-80% of what I see every day is mental health related in the last 6-9 months"*
- Primary Care Pediatrician – *"The children are NOT okay. Every single day the bulk of my time in pediatrics is spent managing mental health concerns of kids between the ages of 11 and 18"*

SCHOOLS MATTER: WHERE YOUTH ACCESS SERVICES & SUPPORTS

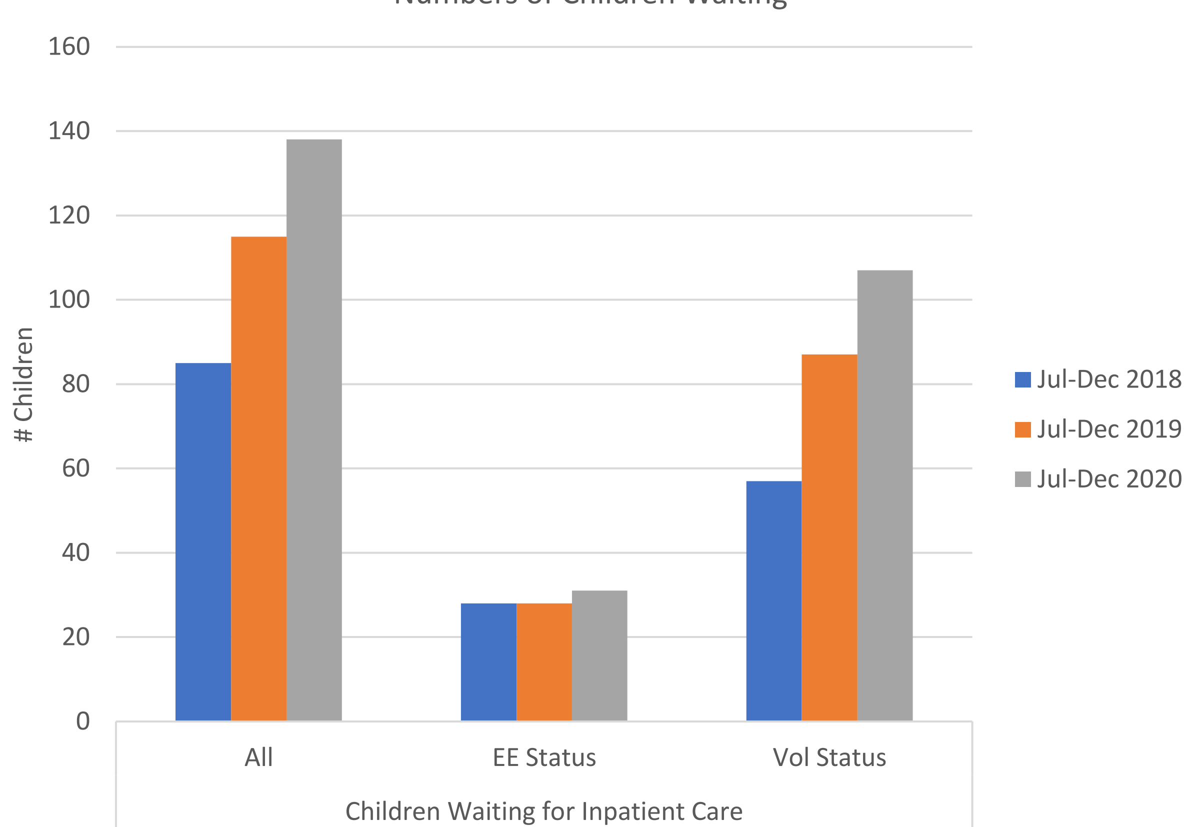
- In CY2020, 48% of Medicaid members (0-18) received mental services in a school during CY2020
  - Total Medicaid Members (0-18) who received Mental Health Services: 24,205
  - Total Medicaid Members (0-18) who received those services in a school location: 11,548
- The number of students served through school based mental health in the 2019/2020 school year increased 13% over the prior year
- Department for Children and Families has seen a 21% decrease in calls to Centralized Intake and Emergency Services (CIES) between 2019 and 2020

RATE OF PEDIATRIC EMERGENCY DEPARTMENT VISITS FOR MENTAL HEALTH



Prepared by Vermont Department of Health
https://www.healthvermont.gov/sites/default/files/documents/pdf/HSVR_Injury_MentalHealthEDVisits_March2021.pdf
Source: Electronic Surveillance System for the Early Notification of Community Based Epidemics (ESSENCE), 2019-2020.

CHILDREN WAITING FOR INPATIENT PSYCHIATRIC CARE COMPARISON OF JULY – DECEMBER 2018 - 2020



Top 5 MH reasons for ED visit (2019)

1. Anxiety disorders
2. Suicidal ideation, attempt, intentional self-injury
3. Depressive disorders
4. Trauma/stress-related disorders
5. Disruptive, impulse-control, conduct disorders

(Kasehagen, 2020. Source: Vermont Health Care Uniform Reporting and Evaluation System (VHCURES))

Wait Times (2020)

Mean: 64 hours (2.7 days)

Median: 48 hours (2 days)

Maximum: 292 hours (12.2 days)

Data provided by the Vermont Department of Mental Health Research & Statistics Unit. Analysis based on data maintained by the VPCH admissions department from paperwork submitted by crisis, designated agency, and hospital screeners. Wait times are defined from determination of need to admission to disposition, less time for medical clearance. Wait times are point in time and are categorized based on month of disposition.

ED VISITS AMONG "HIGH UTILIZER" CHILDREN/YOUTH BY HEALTH SERVICE AREA (2018 DATA)

Member HSA	# Members	# ED MH Visits	Avg ED Visits/Member
Burlington	1056	631	0.60
Barre	644	481	0.75
St Albans	577	230	0.40
Rutland	505	626	1.24
Bennington	470	411	0.87
White River Jct	447	252	0.56
Brattleboro	290	292	1.01
St Johnsbury	277	152	0.55
Springfield	269	243	0.90
Newport	268	126	0.47
Morrisville	264	80	0.30
Randolph	200	80	0.40
Middlebury	124	77	0.62
Grand Total	**5391**	**3681**	**0.68**

Rutland is the only HSA with more ED visits than # members of high utilizer group. This means multiple ED visits among some high utilizer members

Project of Depts of Vermont Health Access (DVHA), Mental Health (DMH), and Onpoint Health Data Consultant

RRMC ED WAIT TIMES IN HOURS

Wait Time in Hours, # Youth
Involuntary and Voluntary Status
Waiting at RRMC ED

		Jan-Jun 2019	Jul-Dec 2019	Jan-Jun 2020	Jul-Dec 2020
All	# Youth	20	26	20	56
	Mean	65	59	36	58
	Median	36	43	25	43
	Minimum	14	0	7	0
	Maximum	355	217	92	283
Involuntary	# Youth	3	3	8	6
	Mean	189	47	38	56
	Median	166	32	26	37
	Minimum	46	21	21	21
	Maximum	355	88	92	111
Voluntary	# Youth	17	23	12	50
	Mean	43	61	35	58
	Median	22	52	24	43
	Minimum	14	0	7	0
	Maximum	143	217	87	283

Of the 56 children who waited at RRMC ED during this period, 66% were admitted to a psychiatric inpatient setting.

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MOBILE RESPONSE AND STABILIZATION SERVICES (MRSS) RUTLAND PILOT

- MRSS are defined more broadly than traditional crisis intervention services and are not limited solely to crisis screening, triage, and referral. MRSS provide an **upstream response.**
- A mobile face-to-face response is provided to a **family-defined crisis** to provide support and intervention for a child/youth and their family, **before** emotional and behavioral difficulties escalate
- Children & youth have **different developmental needs** and require different interventions than adults
- Provided to children and families **in their natural environments**, for example, at home or in school
- Specialized child and adolescent trained staff and do not rely on predominantly adult-oriented crisis response workers
- Build on natural support structures and reduce reliance (and therefore costs) on hospitals and formal crisis response systems
- Connect families to follow-up services and supports

ANTICIPATED OUTCOME IMPACTS WITH MRSS

1. Reduce ED visits for mental health needs (#, LOS, $)
2. Decrease use and lengths of stay in higher levels of care such as inpatient, hospital diversion (#, LOS, $)
3. Prevent and/or reduce lengths of out-of-home treatment (#, LOS, $)
4. Increase placement stability for children involved with child welfare
5. Improve the health and well-being of children, youth and families
6. Improve access to MH services
7. Reduce use of law enforcement to respond to family crises
8. Timely response of MRSS
9. Consumer (child, youth, family) & stakeholder satisfaction

The COVID-19 pandemic has significantly effected children, youth and families such that mental health concerns and the need for support continues to be on the rise.

While we may never see reductions in utilization or spending compared to prior years with the implementation of MRSS, we would **bend the curve** of the alternative trajectory and avert unnecessary out-of-home intervention and higher levels of care for children and families who are struggling now.

POINTS OF CARE

WORKFORCE

Mobile response

Hospital Care
(Brattleboro Retreat)

Other Hospital

In Crisis
at Emergency Dept.

Intensive
Non-Hospital Care

Struggling in Community

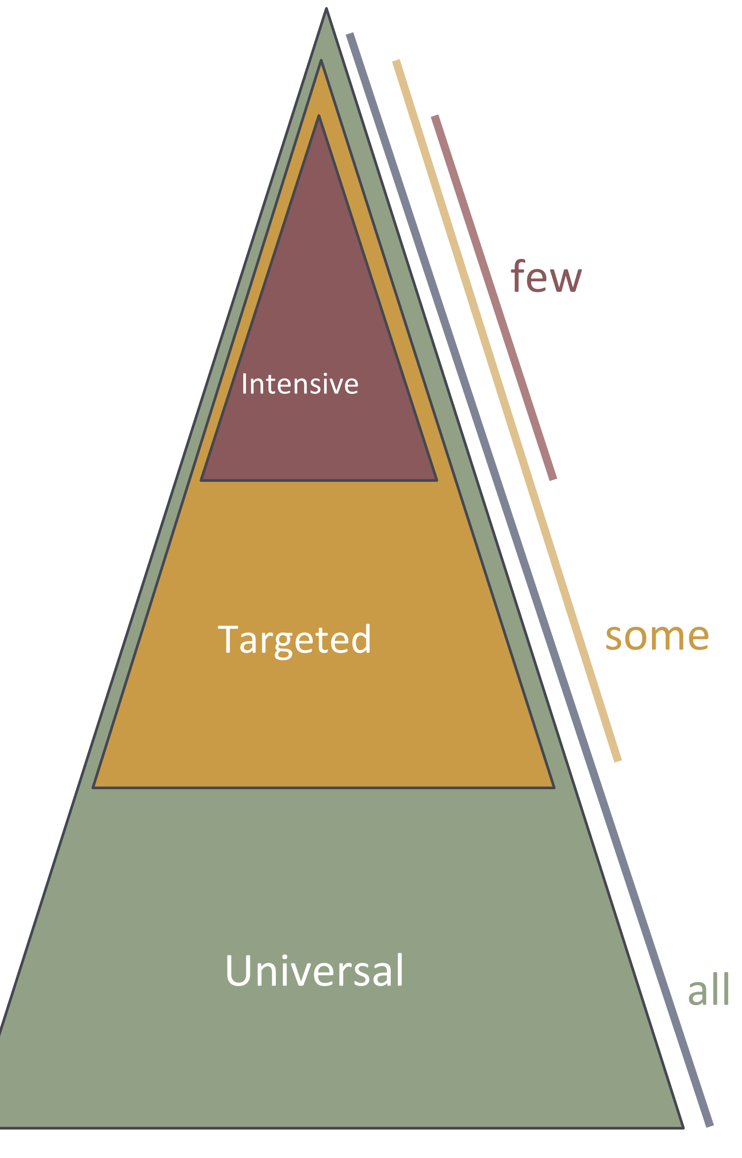
Community Supports

Community Supports

Stable in Community

Long Term Wellness

School Mental Health Services



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ADDITIONAL DATA FOR REFERENCE

HOW ARE CHILDREN, YOUTH AND FAMILIES DOING? DURING (& ANTICIPATED BEYOND) PANDEMIC

Nationally

- Reports to Abuse and Neglect Hotlines went down across the country by as much as 50%
- **ED visits for youth for mental health reasons** increased 31% for 12–17-year-olds and 24% for 5–11-year-olds from March to October 2020 compared to 2019 (CDC)
- Among adolescents who received any mental health services during 2012 to 2015, 35% received their **mental health services exclusively from school settings**. School closures will be especially disruptive for the mental health services of that group (CDC)
- Studies of past pandemics revealed 1 out of 3 children who had **been subject to disease containment measures needed mental health services** (Judge Baker's Children's Center Issue Brief 9/2020)
- "History has shown that the mental health impact of disasters outlasts the physical impact, suggesting today's elevated mental health need will continue well beyond the coronavirus outbreak itself" (https://www.kff.org/report-section/the-implications-of-covid-19-for-mental-health-and-substance-use-issue-brief/)

HOW ARE CHILDREN, YOUTH AND FAMILIES DOING? DURING (& ANTICIPATED BEYOND) PANDEMIC

VERMONT

- **ED visits for MH reasons:** drop in total number of youth (voluntary and involuntary) waiting in EDs in April and May (correlated with the initial Stay Home/Stay Safe and remote learning period), with that drop being primarily among youth on voluntary status. Increased over Fall (Hospital reports to DMH)
- 32% of youth served through the DA/SSA mental health system received some of those services through **SB6 school mental health.** Services have continued via telehealth, but capacity cannot meet current need and significant concerns about “The Coming Child Mental Health Tsunami”
- The number of students served through SB6 in school year 2019/2020 increased 13% over the prior 2018/2019 school year and that was also 13% increase over the 10-year average of SB6 students served
- We are not seeing increases in prescriptions for anti-depressants among youth