Addressing Complex Behavioral Needs with Youth

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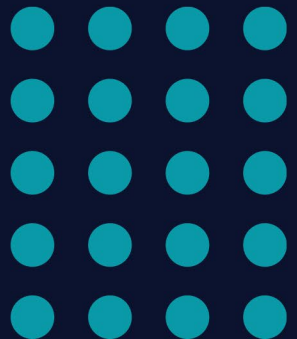

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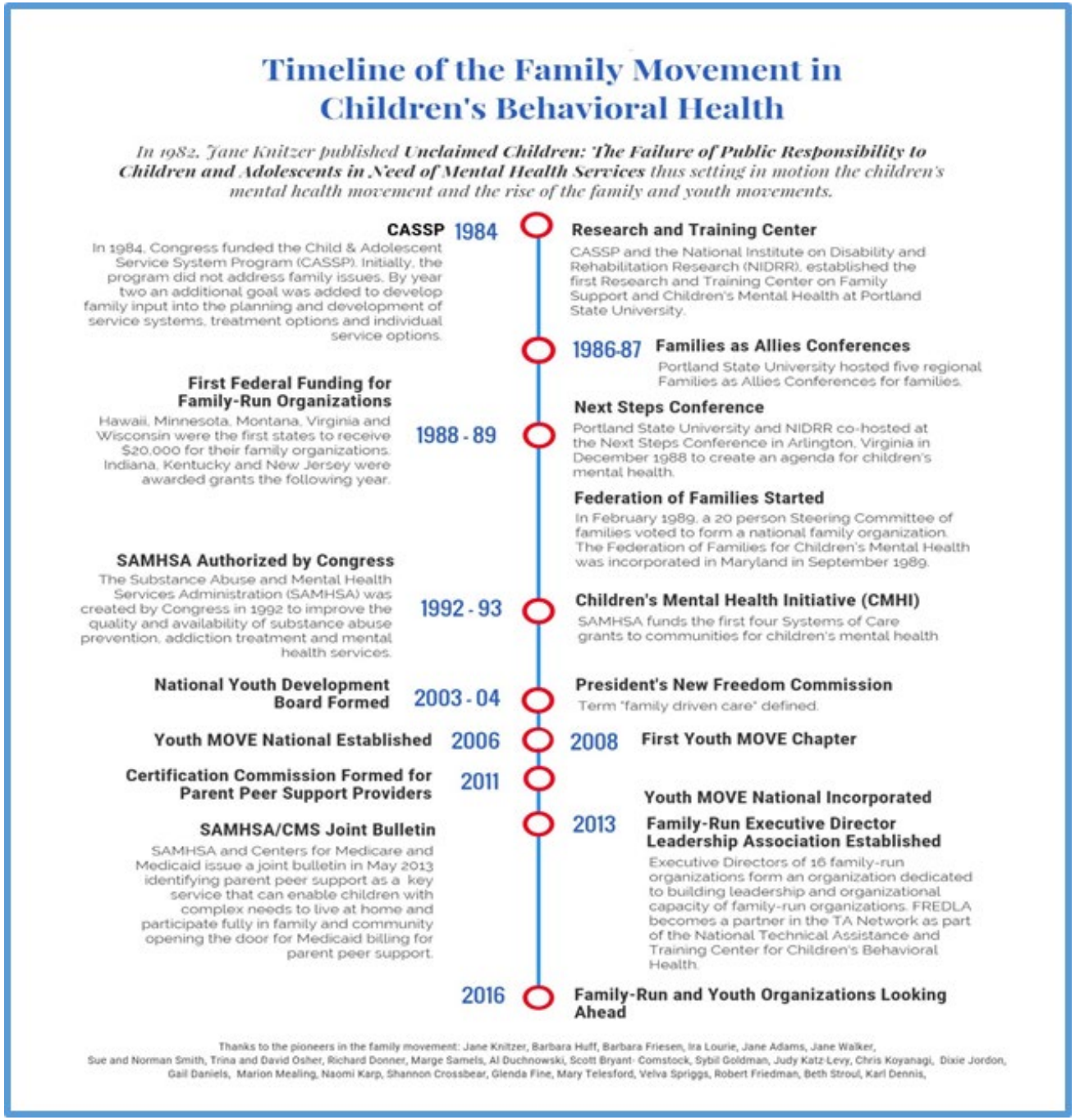
What works best is anything that increases the quality and number of relationships in a child's life. People, not programs, change people.

Dr. Bruce Perry, Mind and Heart Foundation

" It is thought that families who receive consistent support will not only achieve higher community integration and wellbeing but will also become less entangled and dependent upon formal services."

Focal Point, Winter 2006

Strengthening Social Support Research Implications for Interventions in Children's Behavioral Health



Children's Behavioral Health in the U.S.

- **Nearly 20%** of children and young people ages 3-17 in the United States have a mental, emotional, developmental, or behavioral disorder
- **Over 10%** have a Serious Emotional Disorder (SED)
- Suicidal behaviors among high school students **increased more than 40%** from 2010-2019
- Rates of emergency department visits for MH **increased by 25%** for children between 2016 and 2018
  - Rates for older age groups showed no statistically significant change.
- In 2020, **only 44%** of adolescents ages 12-17 with a major depressive episode in the last 12 months reported receiving treatment.

2022 National Healthcare Quality and Disparities Report. Rockville, MD: Agency for Healthcare Research and Quality; October 2022. AHRQ Pub. No. 22(23)-0030.

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Children & Youth with Serious Behavioral Health Conditions are a Distinct Population from Adults with Serious and Persistent Mental Illness

Do not have the same high rates of co-morbid physical health conditions.

Are multi-system involved – two-thirds typically are involved with CW and/or JJ systems and 60% may be in special education – systems governed by legal mandates.

To improve cost and quality of care, focus must be on whole family – takes time – implies lower staffing ratios and higher rates

Have different mental health diagnoses (ADHD, Conduct Disorders, Anxiety; not as much Schizophrenia, Psychosis, Bipolar), and diagnoses change often

Coordination with other children's systems (CW, JJ, schools), between behavioral health providers, as well as family issues, consumes most of care coordination activities, not coordination with primary care.

Human Service Collaborative

Pires, S. March 2013 *Customizing Health Homes for Children with Serious Behavioral Health Challenges.* Human Service Collaborative.

PYRAMID OF CHILDREN AND SERVICE NEEDS

Public Health Approach

Most Complex Needs

Less Complex Needs

Intensive Behavioral Health Supports

Intensive care coordination utilizing a Wraparound approach; intensive services & supports

8-12%

Intermediate Behavioral Health Supports

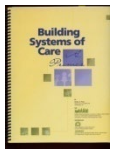
Targeted interventions; service & support access; intermediate care coordination

30%

Universal Health Promotion

Early identification & screening; universal health & behavioral health care promotion & prevention

60%



Pires, S. (2010)

The Challenge:

- 50% of all adult mental health challenges begin by the age of 14
- 75% of all adult mental health challenges begin by the age of 24

Kessler RC, Berglund P, Demler O, Jin R, Merikangas KR, Walters EE. (2005). Lifetime Prevalence and Age-of-Onset Distributions of DSM-IV Disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62 (6) pp. 593-602. doi:10.1001/archpsyc.62.6.593.

Children MH Facts 9-21-16_rev (nami.org)

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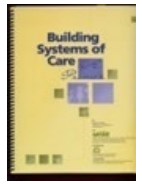
A Word About Language:

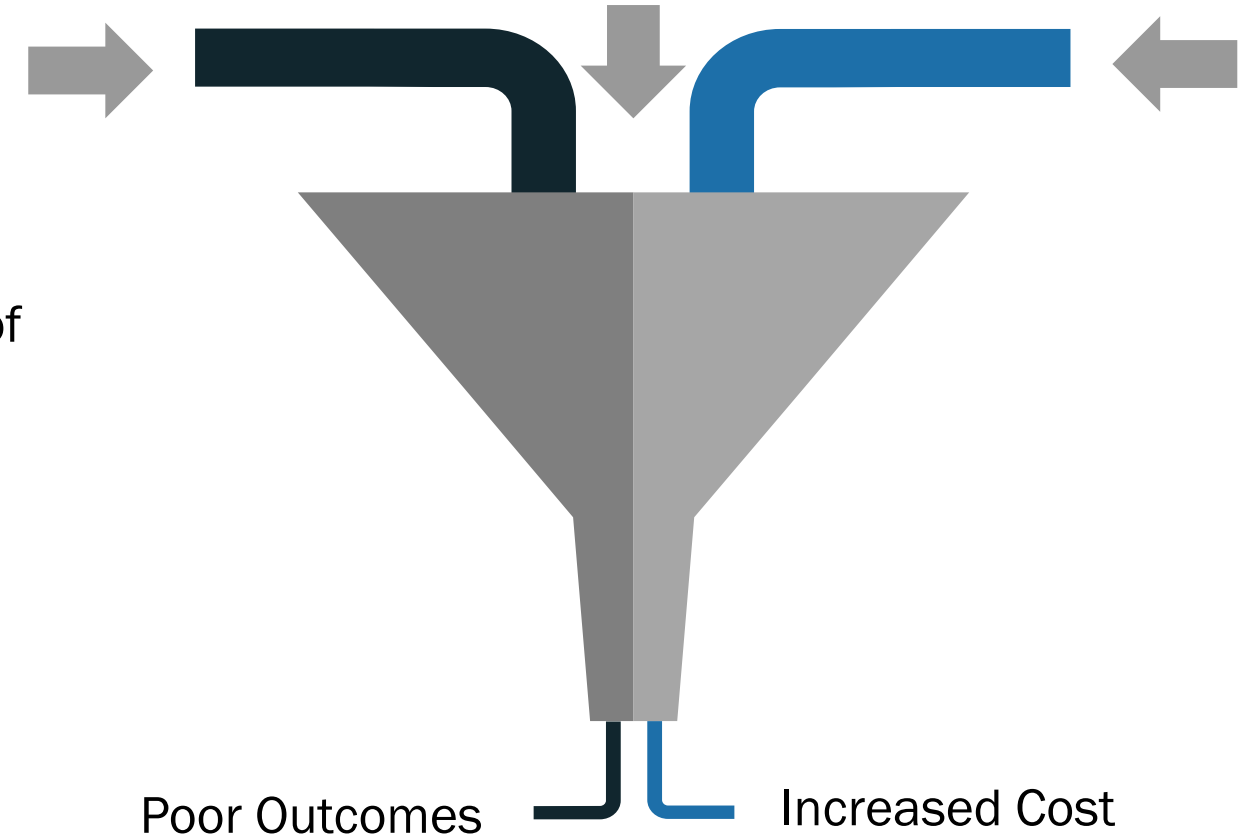
NO Case
NO Client
NO Kiddo
NO Placement



HISTORIC/CURRENT SYSTEM PROBLEMS

Deficit-based/medical models;
Racial/ethnic disproportionality and disparities;
Knowledge, skills and attitudes of key stakeholders

Lack of home and community-based services and supports; limited types of interventions; patterns of utilization



Administrative inefficiencies; fragmentation; rigid financing structures

Poor Outcomes

Increased Cost

Pires, S. (2010). *Building systems of care: A primer, 2nd Edition.* Washington, D.C.: Human Service Collaborative for Georgetown University National Technical Assistance Center for Children's Mental Health.

Human Service Collaborative

Getting help can be hard and confusing…

Systems of Care can help

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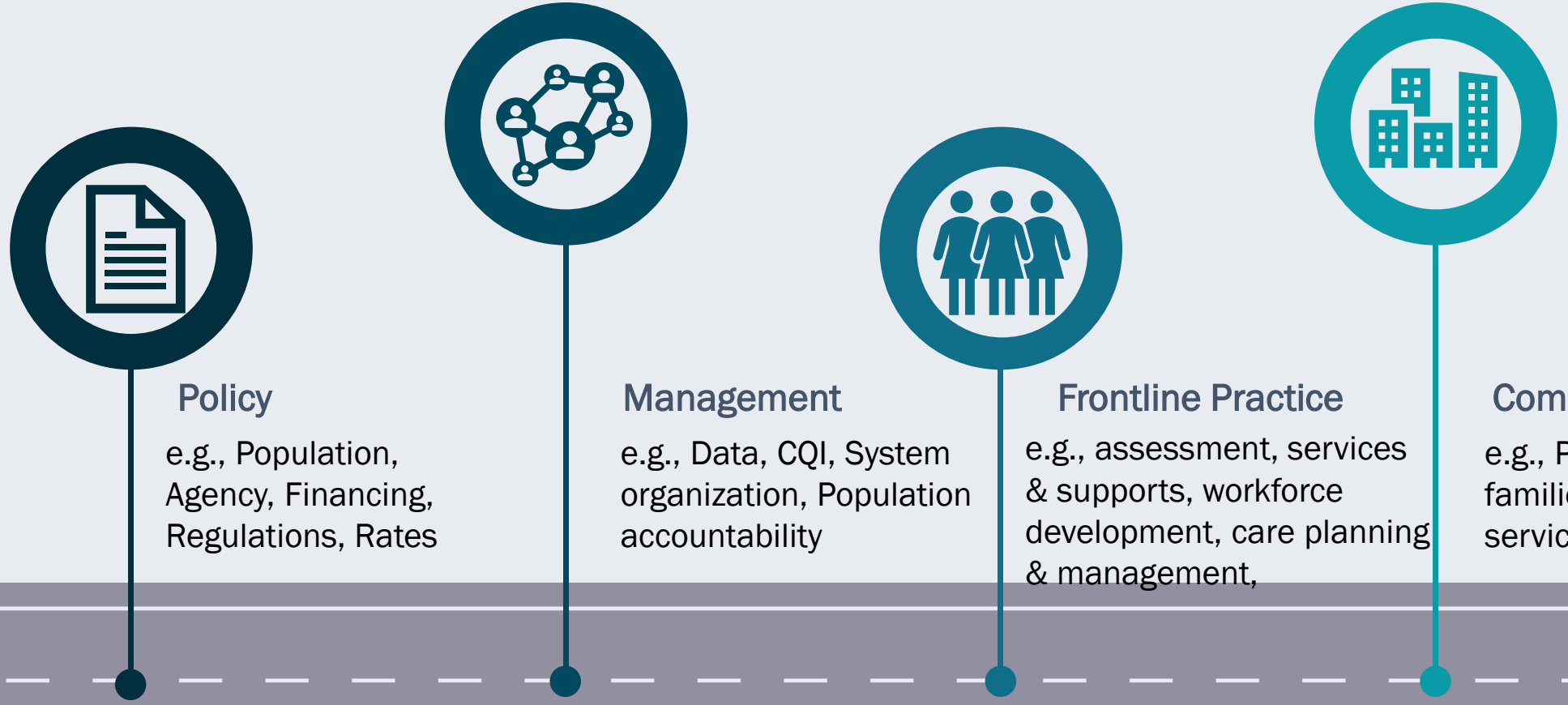
SYSTEM CHANGE/TRANSFORMATION FOCUS



Policy

e.g., Population, Agency, Financing, Regulations, Rates

Management

e.g., Data, CQI, System organization, Population accountability

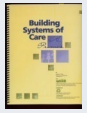
Frontline Practice

e.g., assessment, services & supports, workforce development, care planning & management,

Community

e.g., Partnerships with families, Non-traditional services & supports, Buy-in

ACROSS ALL LEVELS



Pires, S. (2010)

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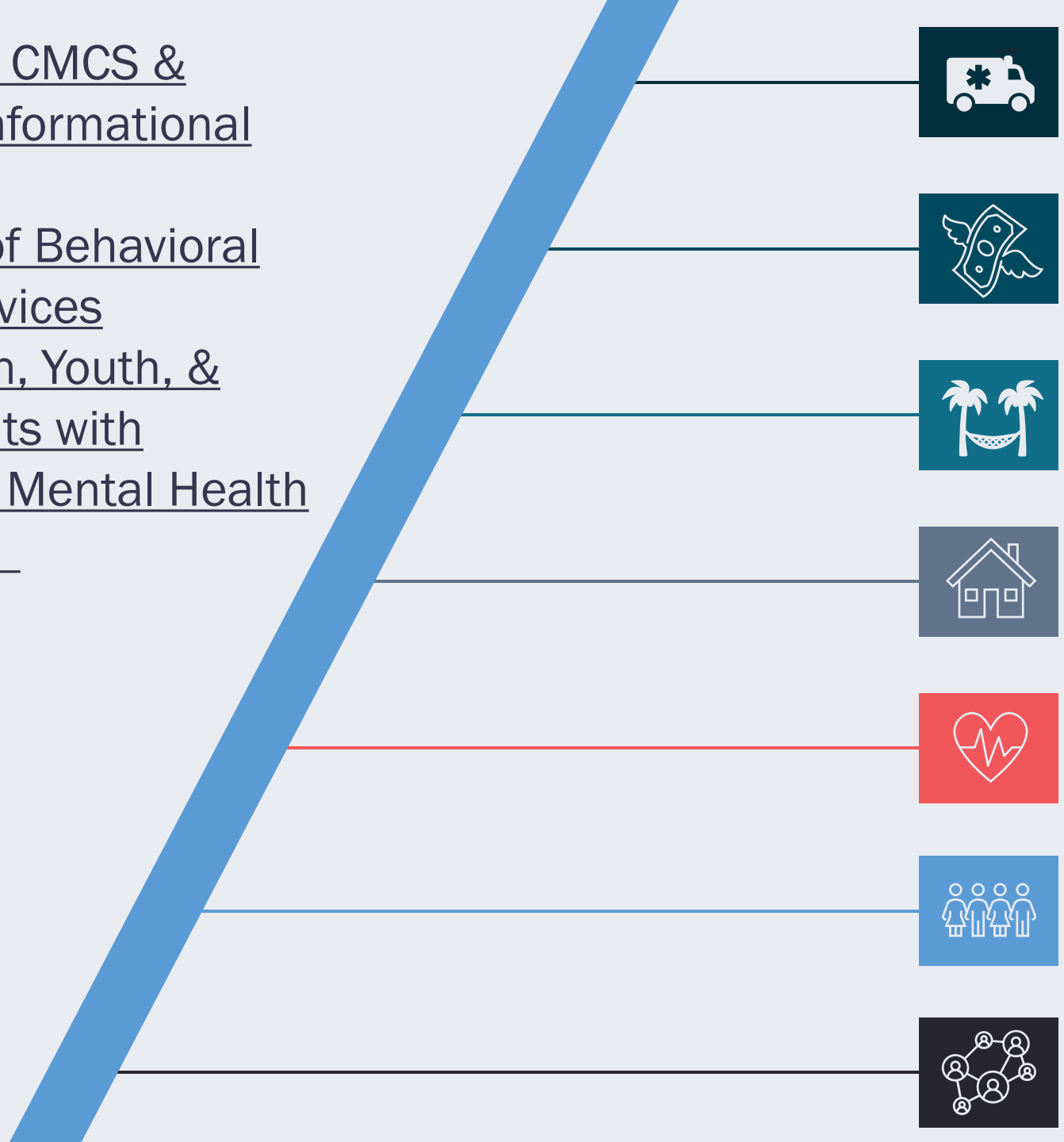
Challenges to Transformation

- Funding
- Technology
- Communication
- Workforce
- Silos

Joint 2013 CMCS & SAMHSA Informational Bulletin: Coverage of Behavioral Health Services for Children, Youth, & Young Adults with Significant Mental Health Conditions



- Mobile response & stabilization services
- Flex or discretionary funds
- Respite
- Intensive in-home services
- Trauma-informed systems & evidence-based treatments to address trauma
- Peer parent & youth support services
- Intensive care coordination utilizing a fidelity Wraparound approach

The Silos

- Behavioral Health
- Intellectual/Developmental Disabilities
- Substance Use
- Child Protection
- Juvenile Justice
- Education
- Pediatricians
- Vocational

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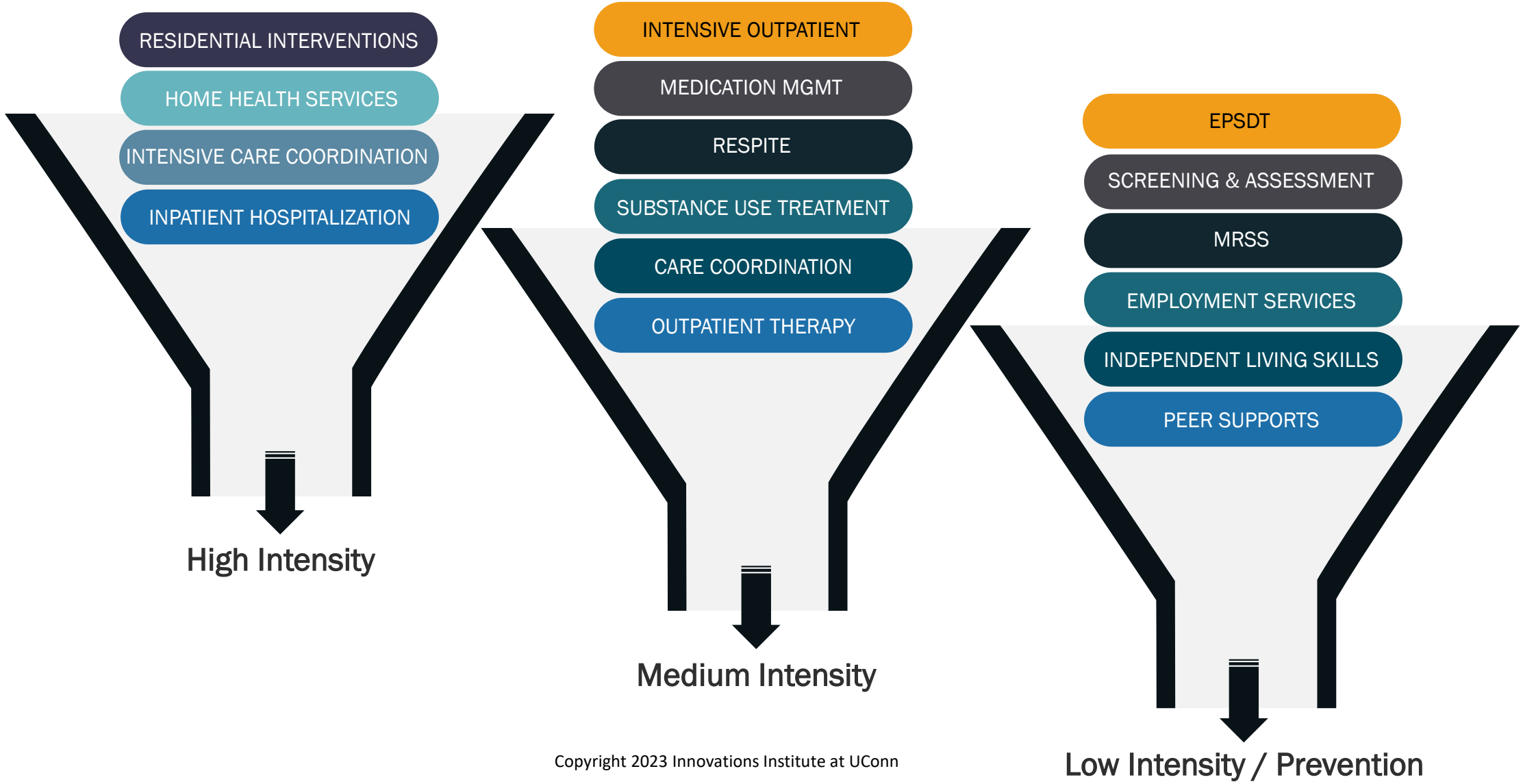
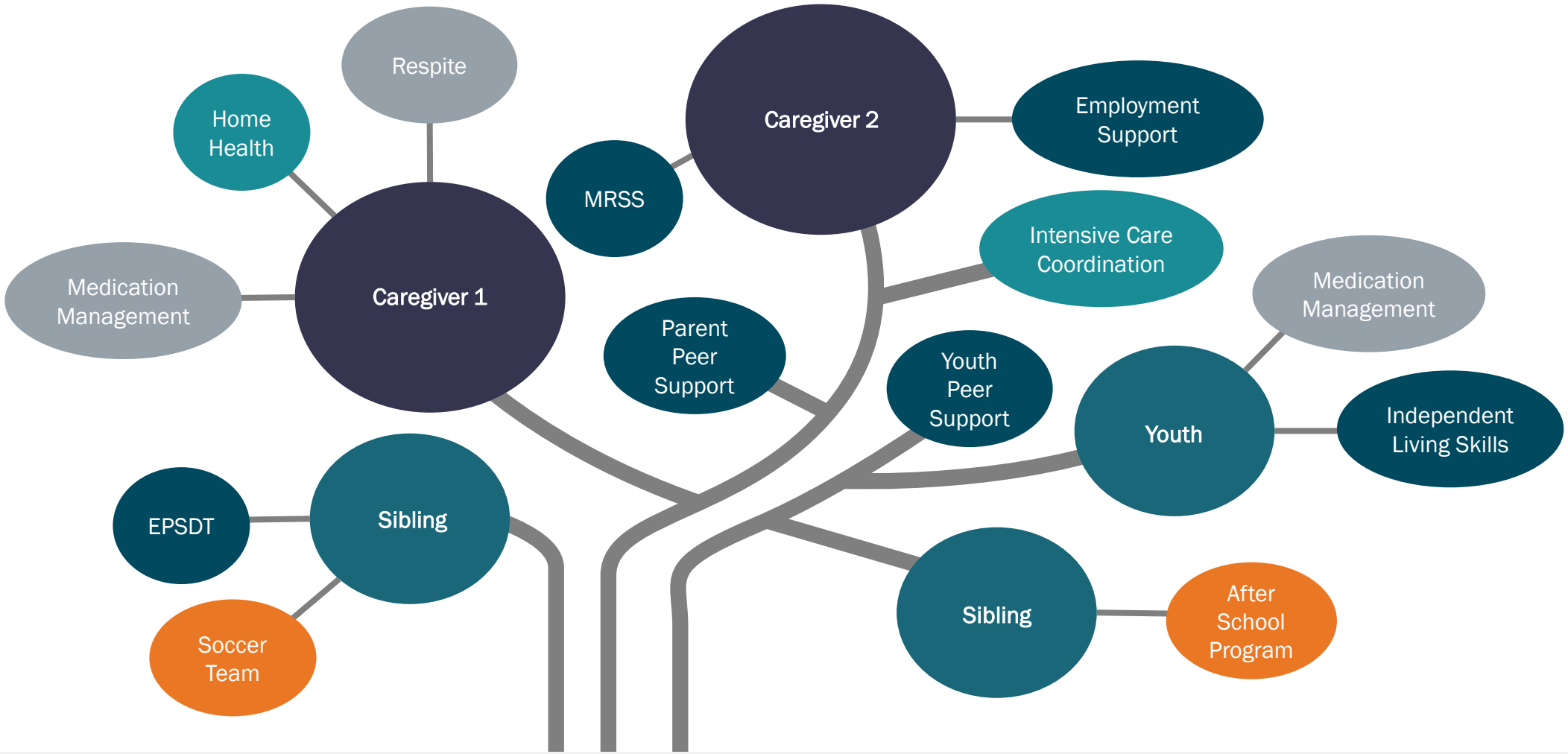
CURRENT STRUCTURES OF SERVICE ARRAY BY INTENSITY OF CRITERIA

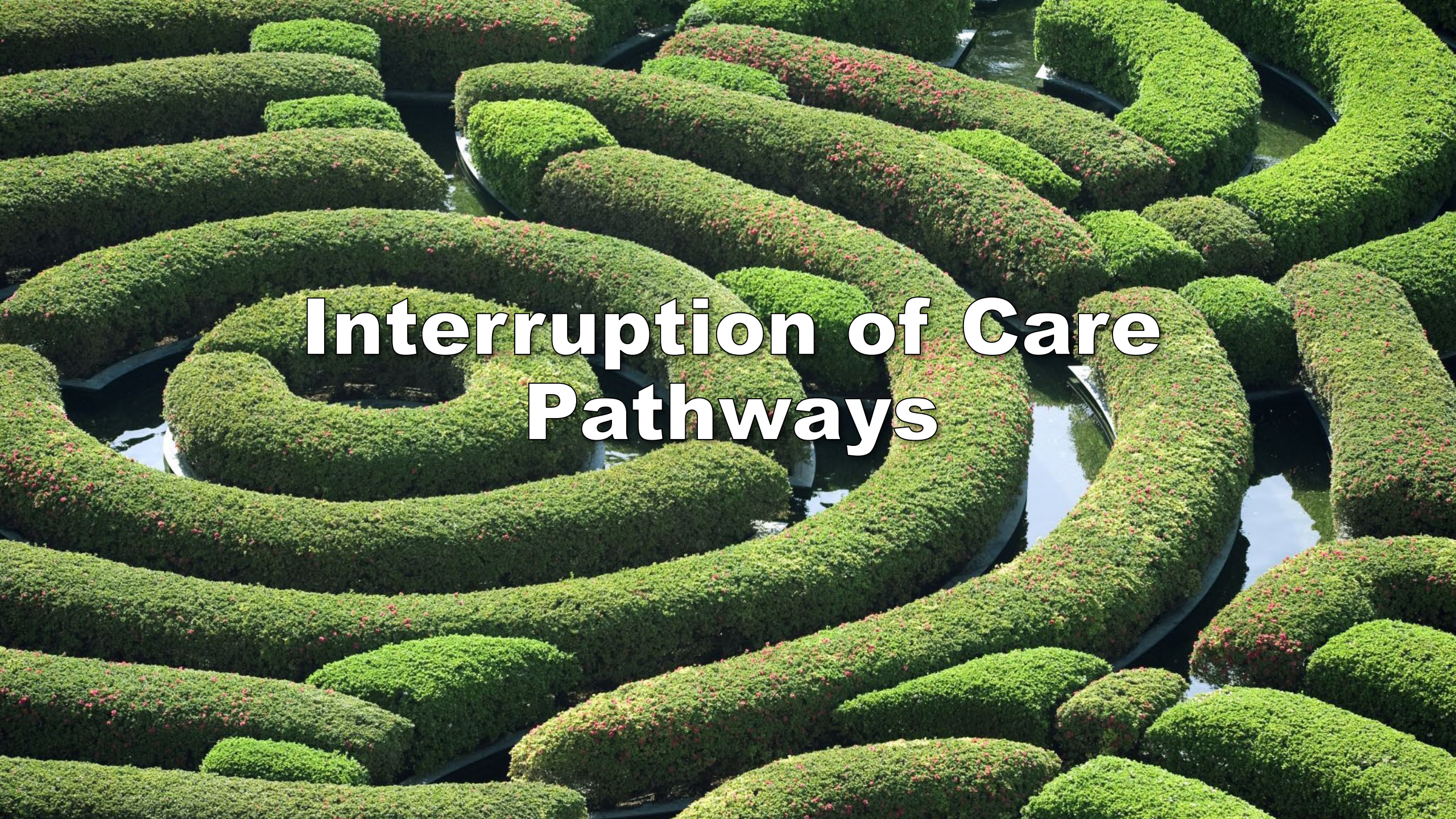
BUT… How do we ensure families can get what they need regardless of level of intensity of service or need?



Comprehensive Service Array



Families accessing what they need
regardless of identified level of intensity of need


Interruption of Care
Pathways

Children's Crisis Systems Are Different

Crisis System Core Elements

- ✓ Crisis is defined by the family/young adult recognizing family/young adult's sense of urgency
- ✓ Single point of access with a youth specific triage and connection to mobile teams
- ✓ Available 24/7/365 with face-to-face response
- ✓ 100% immediate mobile response by teams trained to work with youth, young adults, and families
- ✓ Response does not include law enforcement unless deemed necessary after risk/safety screening and parent/caregiver agrees
- ✓ Developmentally appropriate assessment
- ✓ Focuses on shifting care pathways from high intensity services recognizing natural intervention points
- ✓ Recognizes that the exposure to higher intensity services can be trauma inducing
- ✓ Recognizes and supports the natural support system
- ✓ Recognizes the healing potential within communities

Mobile Response and Stabilization

A Publication of the
National Mobile Response & Stabilization Services Quality Learning Collaborative

MRSS Core Services

At any point throughout MRSS there should be immediate access to clinical and psychiatric consultation. Services should also include use of standardized and validated suicide screening, youth and family-specific assessment tools, and written crisis and safety plans developed collaboratively with the parent/caregiver and youth.

1. Someone to Contact – Access Point
   - Uses single point of access that is or includes 988.
   - If the access point is a lifespan service, the triage processes for youth and their families are customized with mobile responses being the standard rather than the exception.
   - Screens and assesses for risk of self-harm at all points of engagement.
   - Screens for general safety that informs response decisions inclusive of where to meet.
   - If parent/caregiver and/or youth is not available for immediate responses, deferred in person response is offered and scheduled at their convenience within 24 hours.
   - Has established protocols for mobile response, engagement, and knowledge of community resources.
   - Provides warm hand-off to mobile response team.
   - Has the ability to remain on the line with callers until the mobile response team arrives, if needed.

2. Someone to Respond – Mobile Response
   - Has capacity to respond with two person teams based on established protocols with consideration to safety as well as the needs of both responders and youth and families.
   - Responds without law enforcement, unless essential for safety reasons and as a last resort. Must include youth and family's input in the decision to use law enforcement and ensure youth/family is aware of use of law enforcement prior to arrival.
   - Allows for multiple 24/7/365 in-person responses for up to 72 hours, as needed.
   - Conducts essential operational functions:
     - ‡ Provides initial de-escalation.
     - ‡ Performs a safety assessment and administers a child- and family-specific assessment tool with developmentally appropriate suicide screening protocol.
     - ‡ Assesses immediate basic needs the family may have such as food, income, stable housing, medical care, and facilitates access to community services.
     - ‡ Develops and implements an initial crisis and safety plan.
     - ‡ Honors and aligns with the family and youth/young adult's culture and facilitates connection to natural/informal supports.

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MRSS Goals

Maintain	• Maintain youth in their current living situation and community environment, reducing the need for out-of-home placements, which reduces the need for inpatient care and residential interventions.
Support	• Support youth and families in providing trauma informed care.
Promote	• Promote and support safe behavior in home, school, and community.
Reduce	• Reduce the use of emergency departments (ED), hospital boarding, and detention centers due to a behavioral health crisis.
Assist	• Assist youth and families in accessing and linking to ongoing support and services, including intensive clinical and in-home services, as needed.

WHY EFFECTIVE CARE COORDINATION IS NEEDED

- Youth with complex behavioral health challenges have multiple & overlapping areas of need
- Families often have unmet basic needs
- Traditional services do not attend to health, mental health, substance use, & basic needs holistically
- Prioritization of what to work on is hard to figure out

- Child-serving systems are complex & difficult to navigate, & families often do not know how or where to access services.
- Families & youth often feel that the system is not working for them
- Limited engagement leads to treatment dropouts & missed opportunities

- Systems do not work together well for individual families unless there is a way to bring them together
- Youth get passed from one system to another as problems get worse
- Families relinquish custody to get help
- Youth are placed out of home

Locus of Accountability: Intensive Care Coordination

Residential Interventions within a System of Care

- **Home Like Environment**
- **Trauma Responsive**
- **Non-Coercive**
- **Goal is for the youth to feel better**
- **No breaks for the team when the youth is in an out of treatment intervention**
- **Prioritize Family Engagement and Community Engagement**

Connections

- Family
- School
- Community

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Workforce Development

Practice Shifts:

- Youth, Parent/Caregivers Driven Care
- Language and Culture Shifts
- Workforce Development: Training, Coaching and Mentoring
- Care Planning with a Focus on Teaming
- Non-Traditional Supports and Informal Support
- Community Engagement and Resource Development is Prioritized
- Data and Continuous Quality Improvement

A Center of Excellence (COE) is an organized center or partnership that supports state and/or local child- and family-serving agencies in designing, implementing, and sustaining services, practices, and frameworks that have been shown to be effective with specific populations of children, youth, young adults, or families.

Inside the COE

We can't forget to check ourselves…

- Regular review of system utilization including referrals and eligibility criteria
  - Are we partnering with families at the right time and place?
  - Is anyone left out?
  - Service & support gaps?
- Workforce quality
  - Skill development
  - Fidelity to implemented models
  - Access to expert coaching and support
- Policy and procedure review
  - Have barriers been identified
  - Is there a need for more specificity or clarity
- As systems evolve, don't forget to check in around what is working to ensure it continues working amidst any future reform

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Outcomes are important – quality assurance must be routine & overt across all system levels

System rebalanced with more diversion & financing going to prevention & home & community-based supports	Behavioral health access & treatment to address disparities	Emergency room visits for behavioral health needs	Police response due to behavioral health needs
Residential intervention	Inpatient hospital stays	School attendance, graduation, suspension & expulsion rates	Juvenile justice involvement, detention & commitment rates
Child welfare involvement, out of home stays, incident reports with child protection & placement disruptions	Expulsions & suspensions from childcare settings due to behavioral concerns	Engagement in primary care early childhood visits	Suicide rates

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Outcomes are important – quality assurance must be routine & overt across all system levels

- Families report:
  - ✓Ease of access to needed services & supports
  - ✓Satisfaction with provided services & supports
  - ✓They are better off because of the services & supports provided

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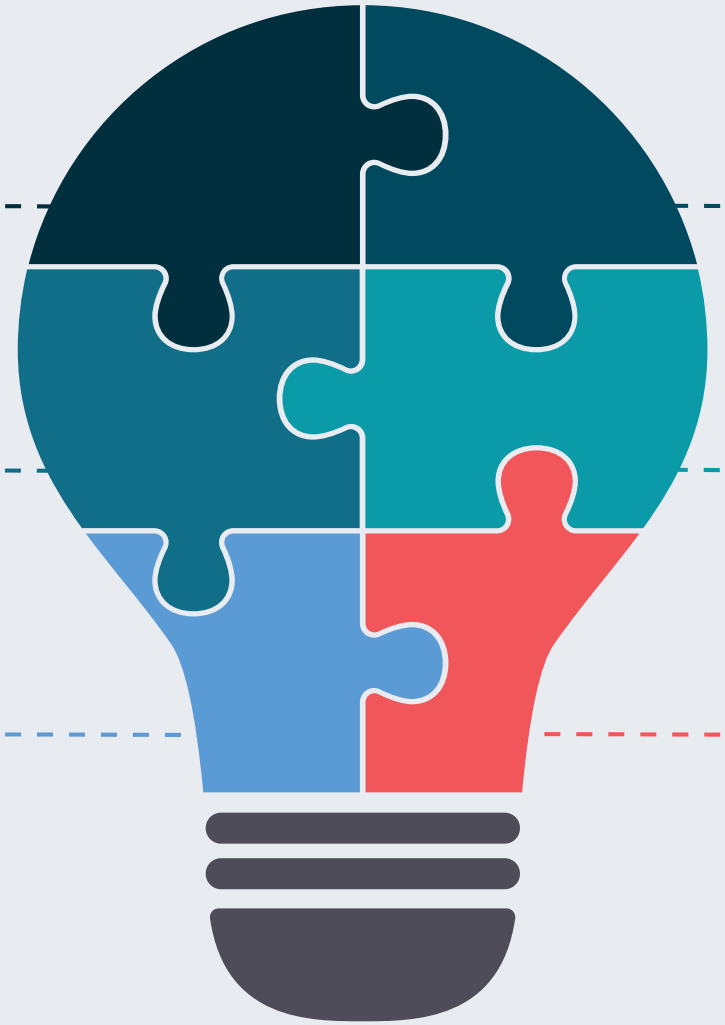
Best Advice & Lessons Learned from the Field

Set the vision & don't move away from it

It is not a program, but systems transformation

Communicate, communicate, communicate



Youth & Parent voices are the drivers for innovation

Community engagement & participation is essential

The building blocks to systems of care work in coordination and not as well in isolation

Any & ALL things are possible

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