



The Campaign for Children's Mental Health

Children's Mental Health: Challenges and Opportunities

SJ 47, Special Populations Workgroup

October 28, 2014



For Virginia's
Children

What is Children's Mental Health?

- **Social and emotional development** and well-being from birth to adulthood
- Affected by **genes and the environment** and the interaction of the two
- Can affect **physical health and behavior**

Types of Mental Health Disorders

- Types of disorders that affect children and adolescents:
 - anxiety disorders
 - attention deficit hyperactivity disorder (ADHD)
 - autism spectrum disorders
 - bipolar disorder
 - depression
 - eating disorders
 - schizophrenia

(NIMH)

Scope of Children's Disorders

- Half of all lifetime cases of mental illness begin by age 14, and 75% of cases begin before age 24 (NIMH)
- Mental health disorders in children are common:
 - In Virginia, an estimated 118,000 - 144,000 children ages 9-17 have serious emotional disturbance; 65,000 – 92,000 have extreme impairment (VDBHDS)
- Prevalence in juvenile justice system much higher:
 - 57% of youth at DJJ Reception and Diagnostic Center have symptoms of a mental health disorder (excluding Attention Deficit and Disruptive Behavior Disorders and Substance-Related Disorders)
 - 54-58% of juveniles reported having a previous or current prescription for at least one psychotropic medication. (DJJ)

Scope of Children's Disorders

- An estimated 20% of children with mental health disorders get the treatment they need. (NIMH)
- Barriers to treatment include:
 - Lack of prevention and early intervention strategies
 - Stigma
 - Lack of treatment services
 - Shortage of mental health professionals specific to children's treatment
 - Fragmentation of existing services; confusion about how to access
 - Local and regional variation

Treatment

- Untreated children's mental health disorders result in increased risk of suicide, juvenile justice involvement, substance abuse and other negative and costly outcomes.
- Children's mental health disorders can be treated effectively; goals for children focus on resilience and recovery.
- Specifics about evidence based treatment found in Commission on Youth's *Collection*.

What can go wrong?

- The foundation for childhood mental health is begun prenatally.
- Caregiver attachment is a critical milestone in infancy and early childhood.
- Trauma and other adverse experiences in childhood change the way the brain is wired.
- Growing up in poverty can create exposure to “toxic stress”: high levels of ongoing stress that actually affect a child’s brain development

What can we do to have an impact?

Policy interventions at three levels:

- Prevention
- Early identification and intervention
- Treatment

Prevention policies

- **Two-generation prevention:**
 - **Prenatal care;** an effective way to improve prenatal care is through health insurance coverage
 - **Home visiting programs** for vulnerable families: improved health outcomes, lower rates of abuse and neglect (e.g. CHIP and Healthy Families)
 - **Treatment** for parental mental illness and substance abuse
- **School-wide universal prevention programs,** e.g. Positive Behavioral Intervention and Supports (PBIS)

Early intervention policies

- **Trauma response services** (e.g. ChildSavers) for kids who have witnessed or experienced violence or other trauma; can be tied to law enforcement response
- **Training of law enforcement, health professionals, child care and school staff** on recognizing mental health issues in children (e.g. Mental Health First Aid, CIT)
- **Mental health consultations for young children** at risk of being expelled from child care for behavior and their families

Treatment policies

- **Fund a comprehensive service array** widely available and not dependent on insurance status, location, or custody status of child
- **Emphasize early intervention and treatment** rather than solely focusing on crisis treatment or criminal/juvenile justice involvement
- **Emphasize identifying and treating children** rather than waiting until adulthood; include the family in treatment

Comprehensive Service Array

Defined in 2011 report from DBHDS: *Item 304.M. – Final Report: A Plan for Community-Based Children’s Behavioral Health Services in Virginia*

- Assessment and evaluation*
- Peer support/family navigation
- Outpatient and office-based services*
- Case management
- Home and community-based services
- Intensive community supports
- Community crisis response services
- Residential treatment
- Inpatient hospitalization*

*only services typically reimbursed by private health insurance

2011 DBHDS Report

- 4 base services that all CSBs should have:
 - Child psychiatry
 - Crisis intervention
 - Intensive in-home services
 - Case management
- Most lacking and most needed of base services: **child psychiatry and crisis response services**

2011 DBHDS Report

- *“The priority recommendation is to expand the array and capacity of services to assure a consistent base level of services for children and families statewide. The consistent availability of the base services would have the greatest potential to reduce unnecessary reliance on inpatient and residential care.”*

GA Actions in last 3 sessions

2012, 2013, 2014: \$4.15 million in ongoing annual funding (phased in, will be \$4.65 annually in FY16) for **children's crisis response and child psychiatry services**

- Projects in all five health planning regions (not statewide coverage, though)
- Funding goes to DBHDS to regional consortia of CSBs, which determine regional priorities and provide or contract out for services

GA Actions in last 3 sessions

- **HPR I (Central Virginia):** mobile crisis team, day crisis stabilization unit, extensive expansion of in-person and telepsychiatry and psychiatric consultation
- **HPR II (Northern Virginia):** started two mobile crisis teams with telepsychiatry in June (public-private)
- **HPR III (Southwest Virginia):** crisis counselors (mobile and center-based) at 3 CSBs, telepsychiatry region-wide, health liaison to address child mh crises in primary health care settings
- **HPR IV (Richmond area):** 6-bed crisis stabilization unit and day crisis stabilization (public-private)
- **HPR V (Tidewater):** multiple mobile crisis teams and urgent care child psychiatry center

GA Actions in last 3 sessions

2013: Funding for **Mental Health First Aid** (\$600,000) and **Suicide Prevention** efforts (\$500,000) to DBHDS

- 127 trainers trained in adult MHFA, and 88 trainers trained in youth MHFA
- These trainers have conducted 31 trainings in MHFA statewide.
- 37 ASIST trainers trained (suicide prevention), who have conducted 18 trainings
- Part of larger statewide suicide prevention effort coordinated by region

GA Actions in last 3 sessions

2014: Funding for demonstration projects for **transition-age mental health services** for youth 16-25

- \$3.5 million in FY15 and \$4 million in FY16 (with additional \$.5 m from Federal MH Block Grant)
- DBHDS issued a Request for Proposals for *Evidence-Supported Programs and Practices for Treating Young Adults with Serious Mental Health Conditions, Including First Episode Psychosis (FEP)*
- 8 CSBs selected: Alexandria, Fairfax, Loudoun, Henrico, Highlands, Prince William, Rappahannock-Rapidan, and Western Tidewater

Urgency

- Demand for services is increasing, especially for kids in crisis
- Commonwealth Center for Children and Adolescents (CCCA) serves as a warning for the whole system; current pace is unsustainable
 - 48 beds in Staunton
 - Only state run hospital; hospital of last resort
 - Serves children with difficult behaviors, complex medical conditions, justice-involved, co-occurring ID/DD/autism, most of whom private hospitals will not accept

CCCA Admissions

Most recent month	Admissions	Rank (1 = busiest month in previous 10 years)	Prior 10 Year Avg.	Increase over 10 year Avg.
Oct 13	70	3	46.2	52%
Nov 13	66	3	58.8	12%
Dec 13	67	1	48.0	40%
Jan 14	73	2	45.8	59%
Feb 14	82	1	46.3	77%
Mar 14	90	2	50.0	80%
Apr 14	90	1	64.8	39%
May 14	90	1	61.2	47%
Jun 14	70	1	63.0	11%
Jul 14	49	3	42.3	16%
Aug 14	60	1	37.7	59%
Sep 14	74	1	48.2	54%
Total Avg	73.4	-	51	44%

CCCA Admissions

- Short-term partial solution: purchase additional bed capacity at private providers (very limited)
- Long-term solutions:
 - Increase capacity of entire continuum of services
 - Align resources around prevention and early intervention and treatment
 - Ensure quality of services
 - Ensure access, regardless of geography and insurance status

Questions?

Margaret Nimmo Crowe
Executive Director
Voices for Virginia's Children

www.vakids.org; www.1in5kids.org

margaret@vakids.org

804-649-0184