Facilitated Discussion Notes
Crisis Response and Mental Health
March 21, 2014

Below are notes distilling the comments made by participants during a Facilitated Discussion of this topic. Generally, the comments are listed in the order in which they occurred. Redundancy with respect to comments has not been eliminated. This information will be combined with input from other sources and will inform development of Connecticut's Children's Behavioral Health Plan. If you have comments about these notes, please email project staff at: info@plan4children.org.

General Notes

- Location: Connecticut Valley Hospital, Middletown, CT
- Approximately 24 people in attendance

Strengths

- EMPS
  - a valued service: a good partner; a critical component in the community
  - involved in school system
  - regularly used as an intervention with hospitals
  - effective collaboration
  - integral in preventing escalation and ED utilization
  - timely response
  - training for all EMPS clinicians, early in their involvement, standardization of workforce development
  - EMPS does very well addressing needs for kids with high acuity who do not have other services available to them
  - Strong collaboration between EMPS and EDs
- With respect to EMPS, it has been helpful to have a broader definition of "crisis" that includes psychiatric mental health, exposure to trauma, behavioral problems, poor family functioning
  - has expanded services to more youth
- Seems that the state rallied around Newtown and Sandy Hook to enhance availability of services
- Inpatient system: a network of C/A psychiatric inpatient hospitals
  - kids getting in fairly promptly
  - for the most part, that system is working
- Layers of care seem to be robust; inpatient, sub-acute, residential, outpatient, care coordination
- SBHCs have been important in providing services
- For 90-95% of Connecticut youngsters, the system works well (see below for other 5-10%)
- CSSD detention centers make good services available to those youth
- EDs that are open 24/7 for youth in crisis, and the talented individuals staffing EDs
- Referral volume for outpatient services is through the roof
- Wonderful 211 system

Concerns

- EMPS is not available 24/7, kids have needs at all hours of the day
- Lack of inpatient hospitals in all parts of the state
- The volume of children in crisis, and the volume of youth who need psychiatric hospitalization
- The full service continuum is not available uniformly across the state

- There are so many children with highly acute and chronic needs;
    - Increasingly high intensity of clinical needs among youth who are presenting to routine outpatient settings
    - Reduction in congregate care has resulted in higher acuity in community settings
- There are subpopulations of children who cannot access center-based MH care
- Remaining 5-10% of youth for whom the crisis system is not working includes children with special needs, children who rotate through system; families w/ commercial insurance
- ED should not be the first option for children in crisis
- Not enough "Medicaiders" in this state
    - Many psychiatrists and APRNs do not take Medicaid, many take no insurance at all
- APRN, psychiatrists, PCPs don't feel comfortable managing psychiatric concerns
- Parents feel frustrated about navigating the system, especially when kids are in crisis
- Stigma: Many people don't want to be seen walking into a community-based clinics
- Too many people are not aware that 211 line to EMPS exists
- Many parents don't access the system until they are in crisis
- Many young people who present to inpatient may not have been there if there was better screening, assessment, prevention, and early intervention in the community
- There are many kids that should not have to come to the ED
    - There are few prevention and early intervention services
- Transportation problems accessing various forms of center-based care
- "Emergency services are only as good as the system that surrounds them"
    - The rest of the system needs to be robust to prevent crisis, especially intermediate levels of care
- Fitting kids into what exists rather than what is appropriate for that young person; Just throwing a number of services at a child is often not helpful, without matching services to the needs of the individual and coordinating their care
- There are some kids that need medication but do not receive it
- Working with pediatric groups: PCPs are more willing to prescribe when they collaborate with child psychiatrists
    - Medical Home Model can help with this
- Ratio of SW and MH support in school-systems is not sufficient
    - 1/3 of all children in EDs are referred directly from school
- Cuts to DDS, kids with intellectual disabilities and autism
    - One individual suggested they have a 10 year waiting list
    - Case managers eliminated—they were a resource to families
    - Services available to kids in DDS described as a "travesty" for many of those children
- Kids who struggle most with the system: Children with intense and chronic needs; kids with child welfare involvement
- Working class families with commercial insurance do not have sufficient access to services
- Far North corners and far south of the state do not have a comprehensive array of services
    - There are no psychiatric emergency centers in Fairfield Co.
    - There is no partial hospitalization program in Fairfield Co.
    - One lower Fairfield Co. provider often goes into NY for hospitals
    - All of the above also true in the Northeast corner of the state
- Where you live may dictate what services are available to you
- Children coming out of residential need a system of supports; the state will spend $200K on their out of state care, but spend very little on maintaining that child when they return

    - Little continuity of care beyond the setting
    - No contract with providers to ensure those services are available
- Reimbursement model for evidence base practices (EBPs) does not encourage keeping youth in EBPs for longer periods of time; makes it difficult for families to move between EBPs with some continuity
- Inpatient hospitals will not take children currently in detention
    - VO does not authorize for children in detention; this makes no sense
- One hospital indicated that they cannot contact a community-based provider and get good information from them about treatment planning
- State insurance much better for BH than private insurance
    - Self-insured plans are not governed by state insurance commission; those plans do not provide parity
    - Commercial insurance does not reimburse for IICAPS
    - Cost shifting of commercial insurance to public system
- Deterioration of mental health expertise within DCF
- ECCs have secret wait lists to get around the access metrics
- Voluntary Services funded out of discretionary funds without contracts/accounts, entirely based on what the case managers are able to advocate for each month
- There has been a shift away from funding non-traditional services and supports
- There is no funding for collaboration but it is increasingly expected and takes up a lot of time

<u>Recommendations</u>

- Increase availability of EMPS
    - However, next phase of EMPS development should consider 24/7, 7 days/week, longer days, more availability
- Embed providers within Primary Care offices. That would help obtain a range of services
- Need to work with schools so they are not overwhelmed; need to educate them about mental health symptoms and services
    - Consider education programs in schools such as MHFA, Parents and Teachers as Allies
- Medical Home Model required to integrate behavioral health in pediatric practices
- Educate police and first responders about behavioral health problems; reduce referral of youth with MH concerns to JJ system
- Need an "elite team" to work with the kids who are highly acute and chronic; high-utilizers
- Need Wraparound services for children with complex needs
- Public Service Announcements to inform families where they can get crisis services: television, internet, grocery stores, wherever families are.
- State could use an 800 Number for bed tracking
    - VO has this for Medicaid involved children, can this be centralized for all children?
- Accountability through transparency
    - VO keeps data on the inpatient hospitals
    - Need that for all elements of the service system, all programs need basic data on their service delivery, access, quality, and outcomes
    - Hold state agencies accountable through data on quality, RBA
- Expand in-home services for children
    - Specifically for 6-11 year old youth
- Need IOP in community-based clinics that will see children more frequently, run groups, arrange for medication management

- Address cost shifting from commercial providers to public system (e.g., the use of voluntary services to get mental health services)
- Re-evaluate distribution of fiscal resources as they shift more to community-based services
    - Shifting from inpatient, residential, congregate care to community-based care needs to result in higher grant funds in community-based care
    - Also, in the case of EMPS, no increase in Medicaid rates; no new grant money from DCF
- Expand funding in order to scale up the services that are known to work
- Look at extracurricular services, non-traditional services beyond simply therapy services
    - Opportunities for making connections to school and community
    - Therapeutic mentoring
    - Peer mentoring
    - Other alternative interventions: Music, riding, and pet therapy
- Increase awareness among youth directly, of EMPS; Youth want to be used as resources to educate their peers
    - Youth help create models of service that work for them
- Enhance prevention at all three levels (universal, selective, indicated)
- Look at nascent and emerging research for good ideas
- A more flexible model for children coming out of high-end services
    - Treatment team needs to follow the youth and their family
    - Integrating residential to in-home care
- Incentives for psychiatric providers to work in this state: loan forgiveness; higher reimbursement rates; incentives to work with PCPs and develop other collaborations
- Contracts that fund a continuum of care in single agencies across the state; ensuring that service contracts require connections between services to reduce fragmentation
- Navigation supports: a way that families can get support accessing services (Care Coordination)
- Sandy Hook School: recovery model is in effect there and it's great
- Develop PSAs that bring attention to mental health awareness and well-being
- CT should provide full financial support to fund the Care Coordination infrastructure and really implement Wraparound services that fully integrate the system
    - We used the Milwaukee model without funding the infrastructure that they have
    - The Wraparound team dictates the use of funds for whatever they think is appropriate for that young person; in the model, they hold the funds
    - You need someone to "skipper the ship" who can coordinate all services and supports, can ensure accountability
- Use peer-to-peer advocacy to enhance cultural competence of services; pair families with other families who are "like them" to help them reduce stigma, access services