

## Fiscal Highlights

### **Human Services Reports Outcomes for Early Intervention Mental Health Pilot Project** - Stephen C. Jardine

During the September 12, 2013 meeting of the Social Services Appropriations Subcommittee, the Department of Human Services reported outcomes for the Mental Health Early Intervention Pilot Project. [This report](#) complied with legislative intent language requiring the department to provide, "detailed uses of the \$3,500,000 FY 2013 one-time funding provided during the 2012 General Session for the Mental Health Early Intervention Pilot Program and . . . measurements used to determine the effectiveness of the pilot program" (H.B. 3, Item 85 and S.B. 2, Item 89, 2012 General Session).

#### **Performance and Outcomes**

In Fiscal Year 2013, 3,983 children, youth, and their families received services through the Mental Health Early Intervention Pilot Project. Of the 3,983:

- 1,876 were served through school-based behavioral health services at a cost of \$1,725,100 and an average cost of \$919 per individual.
- 1,044 were served through the family resource facilitator component at a cost of \$856,300 and an average cost of \$820 per individual.
- 1,063 were served by mobile crisis teams at a cost of \$968,000 and an average cost of \$910 per individual.

#### *School-Based Behavioral Health/Family Resource Facilitator Services*

The children and youth participating in school-based behavioral health services are given a Youth Outcome Questionnaire (YOQ) when they begin receiving services. It is intended to be administered every 30 days. The YOQ measures symptoms of mental, emotional, and behavioral distress. There were 1,415 children and youth who completed the YOQ questionnaire. Out of those who participated in these school-based services, Human Services reported the average student's YOQ score decreased by 22.53%, indicating a lowered amount of mental, emotional, and behavioral distress in their lives.

Outcomes also reflect a decrease in disciplinary reports, suspensions, truancy, absenteeism, and tardies. Office Disciplinary Referrals (ODR) are one form of disciplinary reports that were used. Referrals were tracked per school and per child participating in school-based services. Based on the average number of total referrals per participating schools for children and youth receiving school-based services, Human Services reported a reduction in ODRs of 39.84%.

Schools also tracked the number of suspensions which occurred over the past school year. Although there was limited data provided for the number of suspensions students received, there was an overall reduction for those schools reporting data on suspensions. The reports were on students in school-based programs and saw an 81.63% drop in total suspensions from the previous year. Human Services also reported that one high school identified 51 students who were not on track for graduating with their class. These students were then referred to school-based services. After receiving services, 43 of the students either graduated early or were on track for graduating with their class.

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### *Mobile Crisis Teams*

There were 1,063 unduplicated callers for this service. Of the 1,063 calls, use of a mobile crisis team helped: 26% avoid out-of-home placements, 14% avoid legal involvement, 27% receive assistance in relation to a "danger to harm" situation, 43% avoid a call to the police (the total of these percentages is greater than 100% because there may be more than one outcome per caller).

### *Data and outcome collection*

Data and outcomes for early intervention services were reported to Human Services through quarterly reports submitted by local mental health authorities. These reports included the number of children and youth served, and outcomes relevant to each of the early intervention services provided. Additional data specific to family resource facilitator services was collected from the Utah Family Coalition database. The Substance Abuse and Mental Health Information System (SAMHIS) was used at fiscal year-end to access statewide aggregated YOQ results for children and youth with a diagnosable mental illness who received school-based services and/or family resource facilitator services. Many of the Mental Health Early Intervention services were provided to youth who were in crisis or who displayed mental, emotional, or behavioral health symptoms, but did not have a diagnosable mental illness and therefore were not recorded in SAMHIS.

### **Original Funding Request**

In making its original request for funding, Human Services pointed out that:

- The onset of half of all lifetime mental illnesses takes place by age 14, and three-fourths by age 24.
- Almost 1 in 5 young people have one or more mental, emotional, or behavioral disorders that cause some level of impairment within a given year.
- Fewer than 20% of these young people receive mental health services.
- Mental, emotional, or behavioral disorders are often not diagnosed until multiple problems exist. Similarly, adverse childhood experiences and resulting mental, emotional, or behavioral disorders are often not recognized until a person has dropped out of school, been hospitalized, entered the criminal justice system, or died from suicide.
- The Institute of Medicine and the Centers for Disease Control indicate clear windows of opportunity are available to prevent mental, emotional, and behavioral disorders and related problems before they occur.
- Risk factors are well established, with first symptoms typically preceding a disorder by 2 to 4 years.
- Prevention and early intervention can effectively reduce the development of mental, emotional, and behavioral disorders.

The Social Services Appropriations Subcommittee, in response to this request, funded \$3,500,000 one-time as a pilot project to address this need. Based upon input from Human Services, the funding was allocated to support three evidence-based services:

1. School-based Behavioral Health,

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2. Family Resource Facilitation Meeting Specified Standards, and

3. Mobile Crisis Teams.

It was determined that the Local Mental Health Authority (LMHA), in consultation with Human Services, would implement or expand a minimum of one of the three services in their community to serve new clients in FY 2013. This funding was designated for children and youth who may or may not have a Serious Emotional Disturbance designation, but are at risk to become so without early intervention services. Human Services developed applications and funding requirements for each of the three services. LMHAs applied for funds in each of the applicable categories according to local needs and resources. Only LMHAs with urban areas were allowed to apply for mobile crisis team funds.

All three of the funded services were developed in conjunction with community partners. School-based services were provided in partnership with local education communities. Family resource facilitators partnered with multiple child serving agencies, and access was increased by having family resource facilitators assigned to work in community settings such as: schools, child service provider offices, family advocacy organizations, child welfare or juvenile justice offices, and one was assigned to a children's mental health court.

*Program specific services*

1. *School-Based Behavioral Health*: Parental consent as well as parental involvement was seen as integral for all school-based services. Services currently vary by school and may include: individual, family, and group therapy; parent education; social skills and other skills development groups; family resource facilitation; case management; consultation services; and wraparound services (individualized community-based services that focus on the strengths and needs of the child and family). The value of these behavioral health services in schools was to promote healthy children and youth, and in turn increase academic success. Mental Health Early Intervention school-based programs are now currently accessible in 138 schools: 86 elementary schools, 32 junior high schools, and 20 high schools. Human Services presented a [list of the participating schools](#) to the subcommittee.

2. *Family Resource Facilitators* provide four different services:

- Family Advocate/Advisor: develop working partnerships with provider agencies to help families navigate and access services.
- Resource Coordinator: act as a resource coordinator to provide local resource information to any family requesting assistance.
- Information and Support: link families to local support and information groups or help develop groups if and when no other resources are available.
- Family Wraparound Facilitator: work with families and youth who have complex needs to build a plan that incorporates both formal supports (e.g. - mental health/substance abuse treatment, educational assistance, juvenile court engagement, etc.) and informal supports (e.g. - family members, Boy Scouts, clergy, etc.) that will help the child and his/her family exit the mental health system to live full and productive lives.

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Human Services informed the subcommittee that a 40-hour training was also conducted by the Utah Family Coalition for 24 new family resource facilitators in FY 2013. The Utah Family Coalition also provided ongoing supervision, coaching, and training for the new family resource facilitators.

Human Services pointed out that the wraparound planning process results in a set of community services and natural supports individualized for each child and family. Also, this planning process facilitates a partnership with all child service agencies involved and facilitates coordination of service plans to help prevent fractured or duplicated services. Additionally, many family resource facilitators also partner with schools and community agencies by facilitating or participating in local interagency coordinating committees.

Family resource facilitators, along with wraparound services, are available in 27 of Utah's 29 counties. Human Services provided a [map](#) showing access to family resource facilitator services in Utah.

*3. Mobile Crisis Teams:* Human Services pointed out that mobile crisis teams help a community respond to situations where a child or adolescent is involved in a mental, emotional, or behavioral crisis. In establishing mobile crisis units in local areas, a national model with national technical assistance was used before individualizing each local community's team based upon local needs. Common elements in each of Utah's youth mobile crisis teams include: 24-hour crisis line, mobile response, 2-person response, and a licensed therapist as part of the response team. Services include therapeutic intervention and safety planning. Services may also include crisis respite and linking to community resources. When necessary, access to medication services may also be available.

Mobile crisis teams are now accessible in four of the five Utah counties that have a population over 125,000. Human Services provided a [map](#) to the Subcommittee of the mobile crisis team locations. Access to crisis services is intended to increase the likelihood that families are linked to help before a tragedy occurs. Mobile crisis teams are also intended to help children and adolescents remain in their own home, school, and community and avoid out-of-home placements. Mobile crisis teams also help reduce police and juvenile justice involvement.