Utah State Mental Health System Overview

Health and Human Services Interim Committee

July 18, 2018

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SUBSTANCE ABUSE AND MENTAL HEALTH

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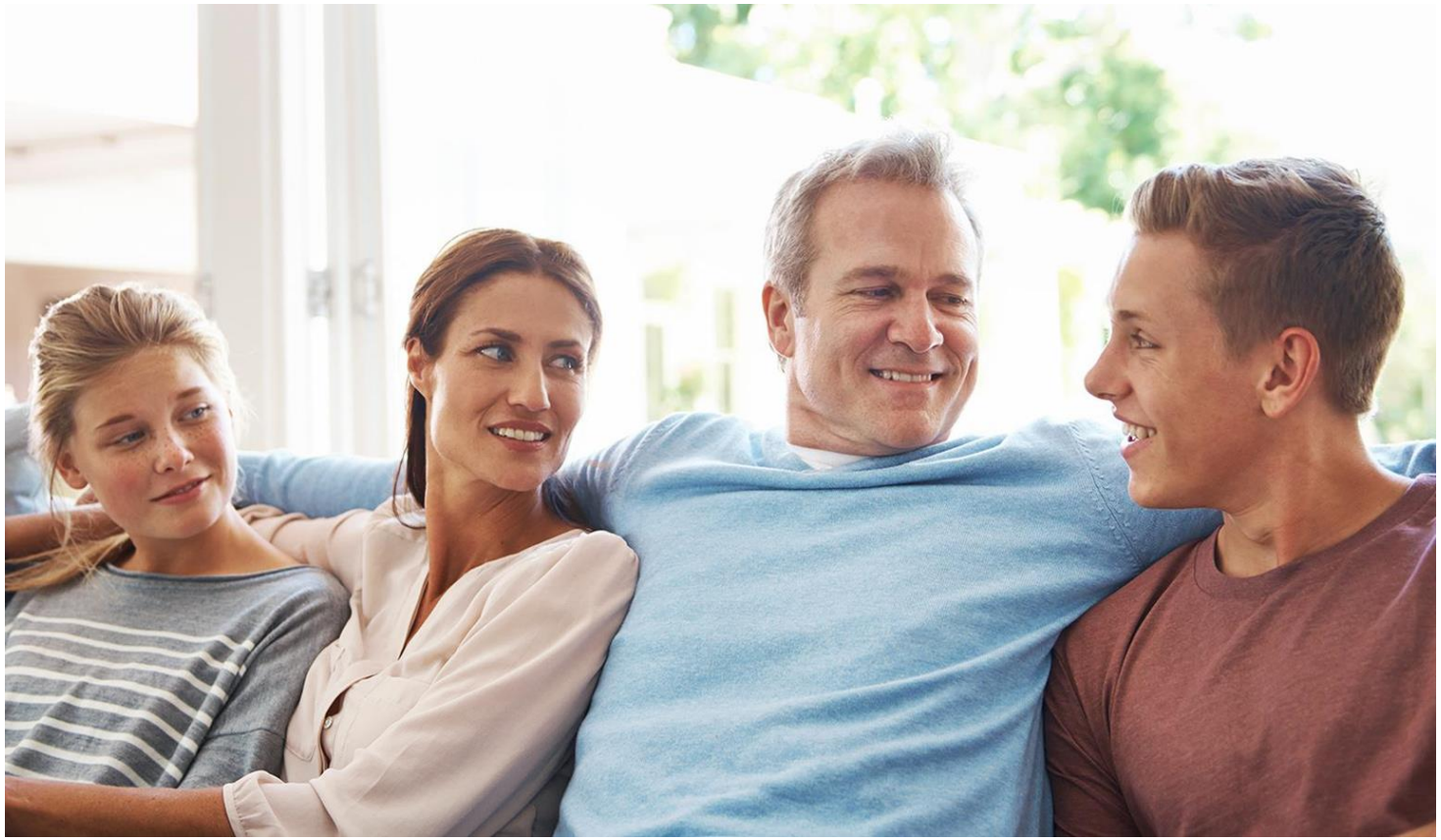


Mental Health Early Intervention (MHEI)

June 2018

Current Climate

- Nationally, 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.
- Utah's SHARP Survey Data estimated that 119,437 children and youth are in need of mental health treatment.
- In Utah, approximately only 20% of children received treatment through the public mental health system.
- Utah now has one of the lowest rates of child health insurance coverage in the nation.

Youth Suicide

- Utah has one of the highest rates of youth (10-17) suicide in the nation (11.1 per 100,000)
- Preliminary data reports 43 youth died by suicide from June 1, 2017 to May 31, 2018
- The CDC provided multiple recommendations to Utah including:
  - increasing access to mental health services,
  - identifying and supporting youth at risk of suicidal behaviors, and
  - teaching coping and problem solving skills.

School Based Behavioral Health (SBBH)

School Based Behavioral Health

- 342 schools have been served with SBBH throughout FY18
  - 157 schools in Urban areas
  - 185 schools in rural areas
- Services include:
  - Individual therapy
  - Skills development and groups
  - Case management
  - Family Resource Facilitation with Wraparound to Fidelity

Intergenerational Poverty

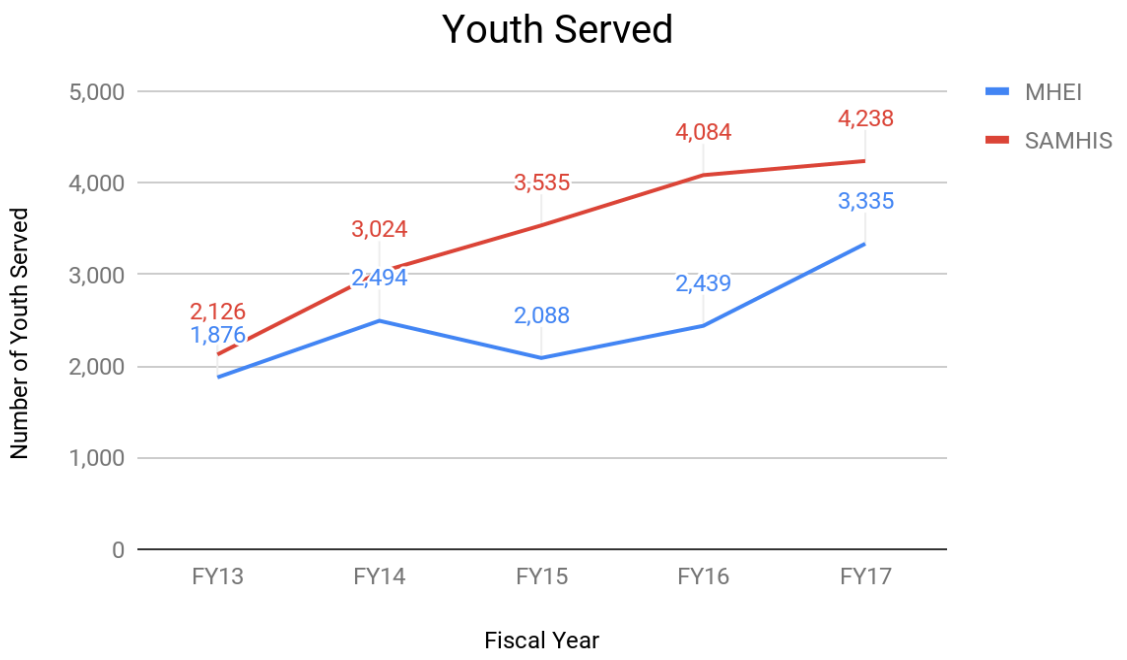
- Higher rates of IGP are shown to have increased need for behavioral health services
- In partnership with Dept. of Workforce Services, 191 school have been identified as having high levels of IGP (>10%)
- SBBH services are available in 94 of the 191 IGP schools
- IGP schools are found in urban and rural areas

Mental Health Early Intervention Funding

School Based Behavioral Health has been a major focus since the program was funded in SFY2012

Since FY2013 the number of youth served has continued to grow with State General funds remaining fixed

Unduplicated by FY Youth Served		
Fiscal Year	MHEI	SAMHIS
FY13	1,876	2,126
FY14	2,494	3,024
FY15	2,088	3,535
FY16	2,439	4,084
FY17	3,335	4,238
Total*	**12,232**	**17,007**



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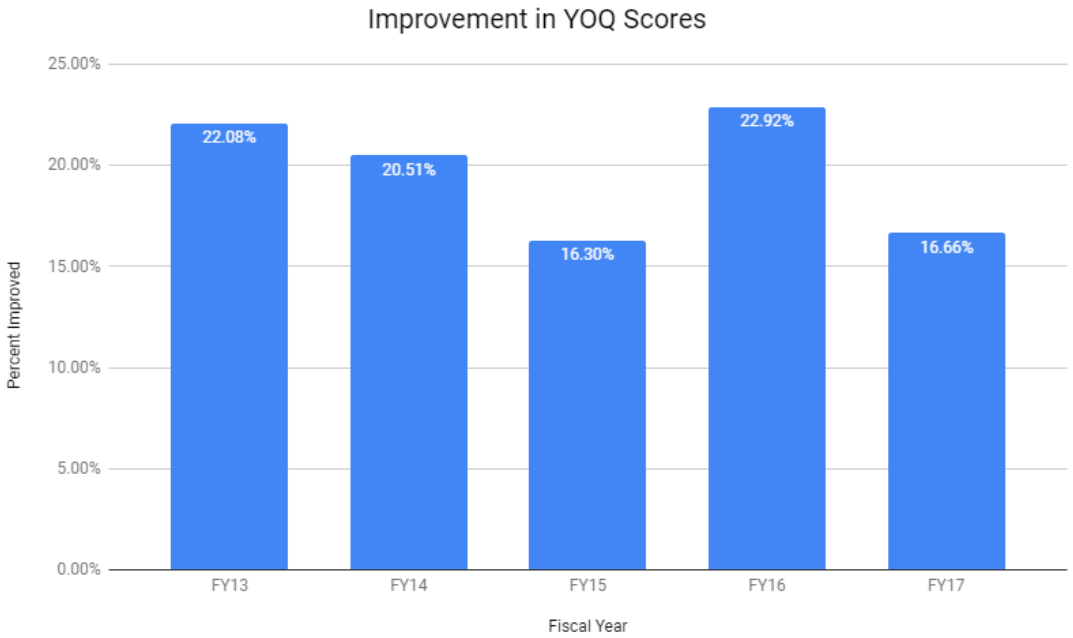
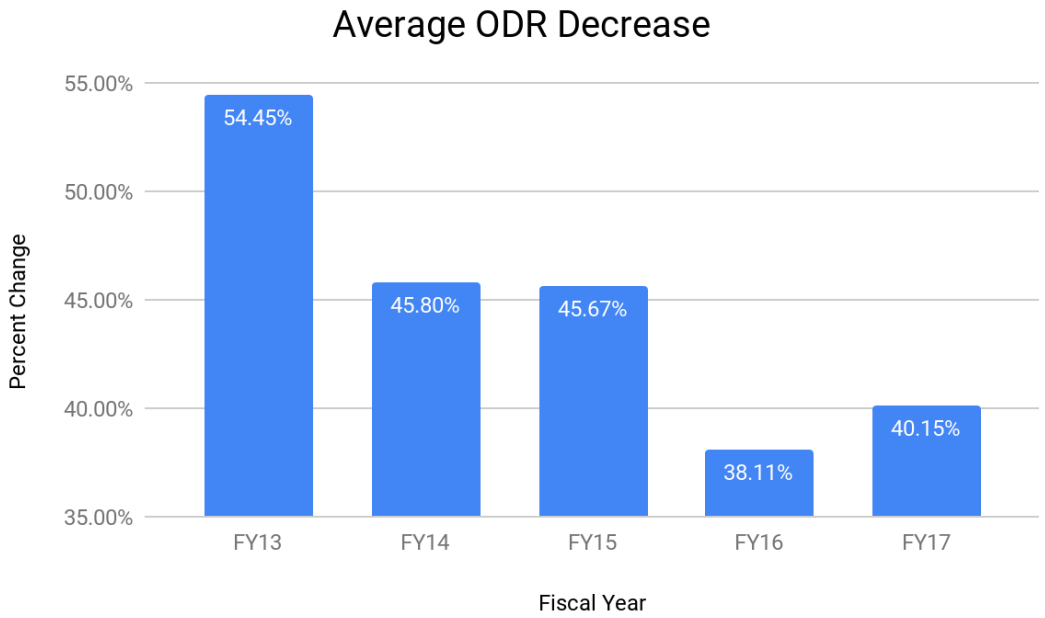
SBBH Outcomes

SBBH tracks progress by:

- Youth Outcome Questionnaire (YOQ)
  - measures symptoms of mental, emotional and behavioral distress for youth in treatment
- Office Disciplinary Referrals (ODR)
- Grade Point Average/Dynamic Indicators of Basic Early Literacy Skills (DIBELS) for elementary school children K-3





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Additional Need

School Based Behavioral Health

- to improve access to mental health services for youth, additional funding is needed to both provide more time for those already in a school and expand the current reach to additional schools

Intergenerational Poverty (IGP)

- FY19 will be the final year for the $1,500,000 TANF funding for schools with high IGP
- Additional funding is needed to continue SBBH in the identified schools with high IGP

Workforce development

- additional support is needed to develop roles for consulting with school administration, therapist availability, and consistency of services

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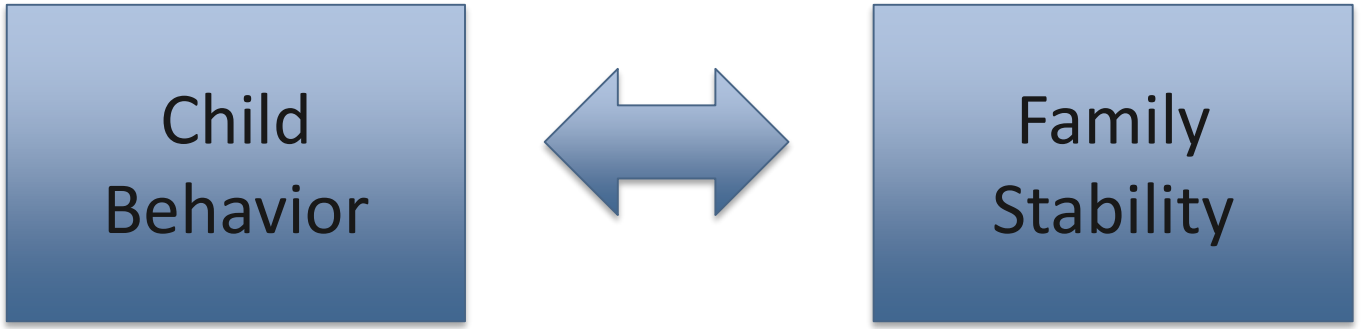
Stabilization and Mobile Response Services

June 2018

Stability…the Overarching Goal

Family stability is known to affect and be affected by a child's behavior



Family stability includes:

- Caregivers who are healthy and engaged
- Family systems that are cohesive and supportive
- Households that are safe and nurturing

Stabilization & Mobile Response (SMR)

"any child or parent with any problem at any time"

Guiding Principles:

- Every family will have a consistent quality experience accessing stabilization and mobile response services statewide
- Parent/family/caregiver defines the crisis
- Family/professional partnership defines the response
- Family/professionals partner in decision making throughout the process

Population Served

- **All children, youth and families in Utah**, *regardless of funding or custody status*
- Possible reasons SMR Services may be accessed for children/youth who:
  - Get into trouble at school or in the community
  - Display disruptive behaviors such as verbal aggression, running out of classrooms or home
  - Bully others, or are bullied
  - Refuse to attend school, skip school or are suspended from school
  - Engage in aggressive behaviors towards siblings, peers, authority figures, parents

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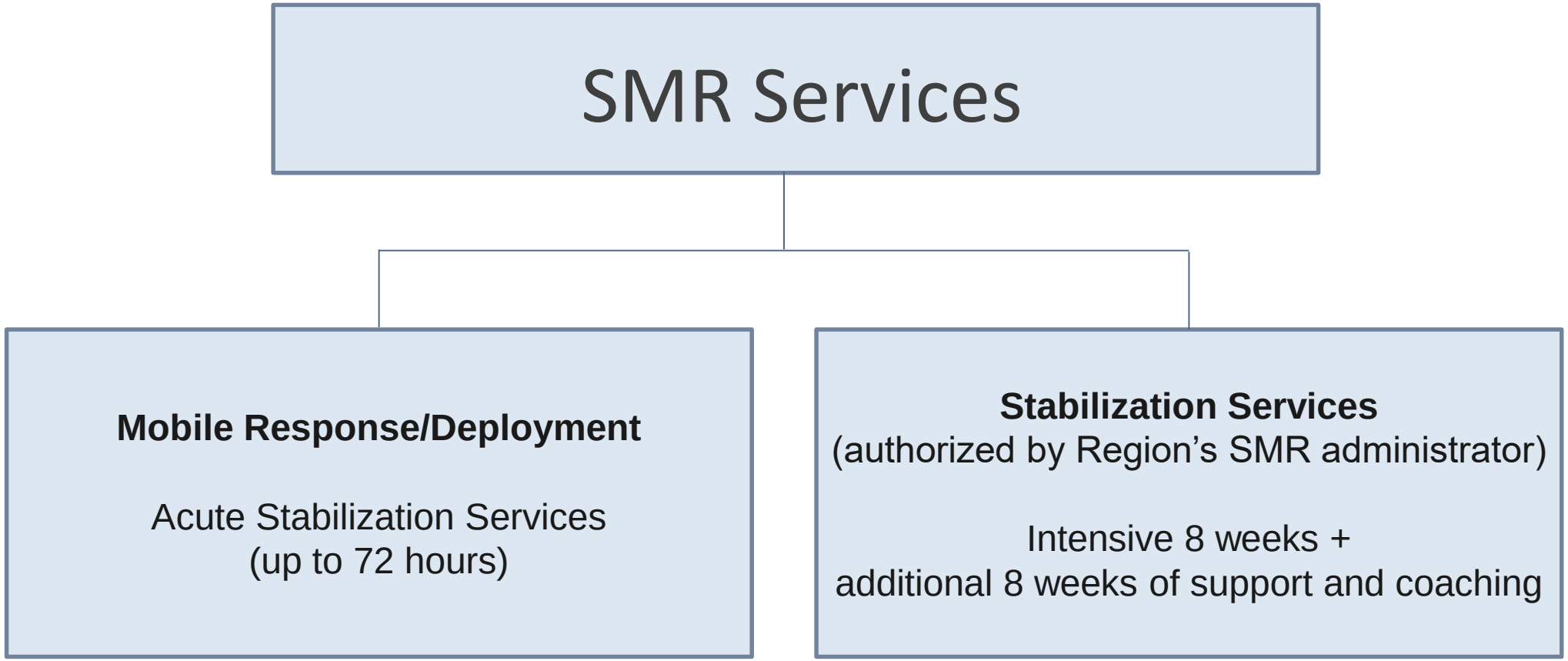
Population Served (cont.)

- Exhibit oppositional/defiant behaviors, such as leaving home without permission, stealing from parents, bringing strangers into the home, refusal to comply with rules, substance use
- Engage in destructive behaviors such as property damage, breaking siblings toys/items, putting holes in walls
- Appear to be depressed with changes in mood, sleep, and social withdrawal
- Engage in self-injurious behaviors such as cutting, promiscuous behaviors
- May have experienced and/or witnessed trauma and/or major loss

SMR Services

- Provide short term intervention and *de-escalation of immediate crisis*
- Ensure *immediate safety* of youth and his or her family/caregiver
- Engage, assess, deliver and plan *appropriate interventions* to stabilize/improve family functioning
- *Prevent/reduce the need* for more restrictive/intensive services
- *Prevent the disruption* of youth's current living situation
- Facilitate the youth and families' *transition to identified resources, services, and supports*

Two Components of SMR Services



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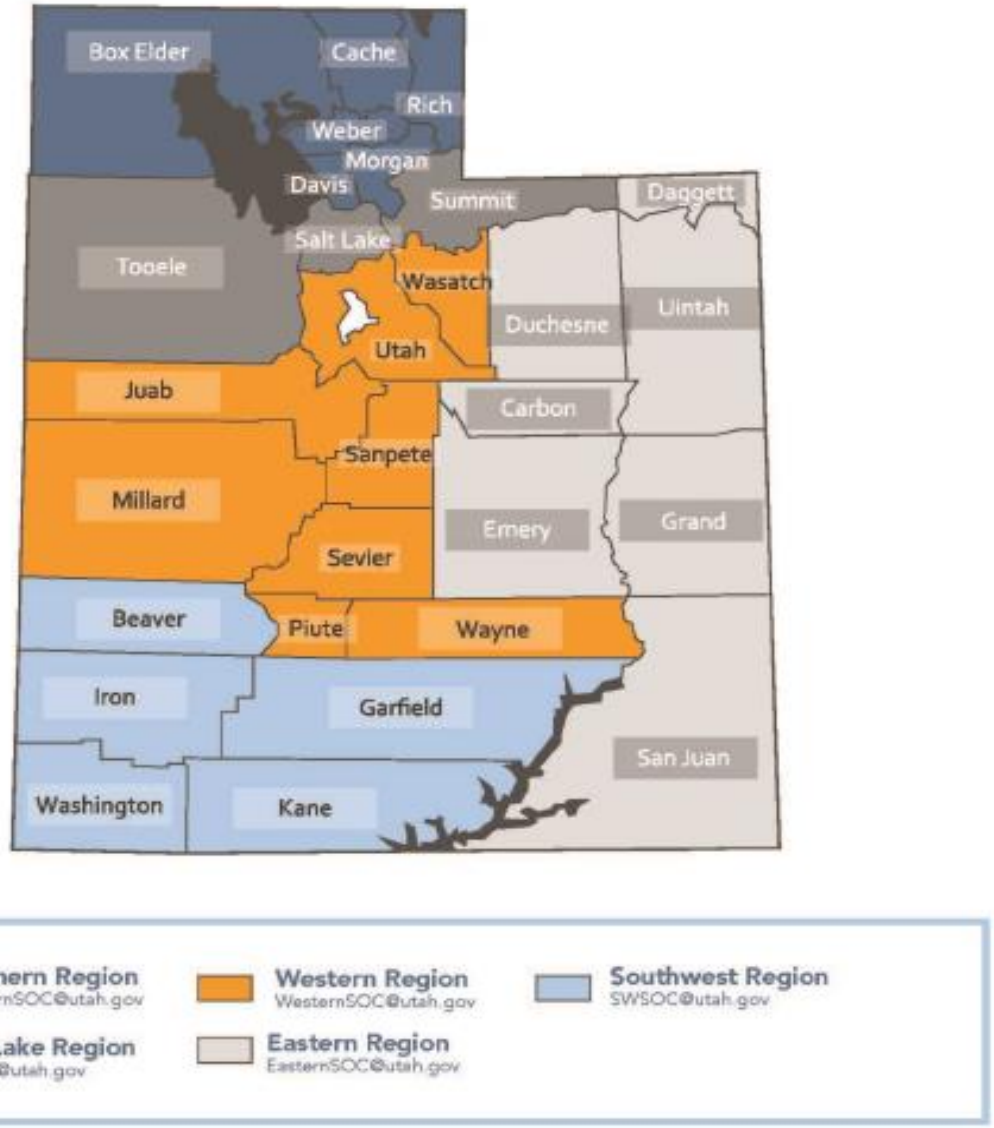
Services available in 11 counties



- Northern Region:

  Box Elder, Cache, Davis, Morgan, Rich, Weber

- Southwest Region:

  Beaver, Garfield, Iron, Kane, Washington

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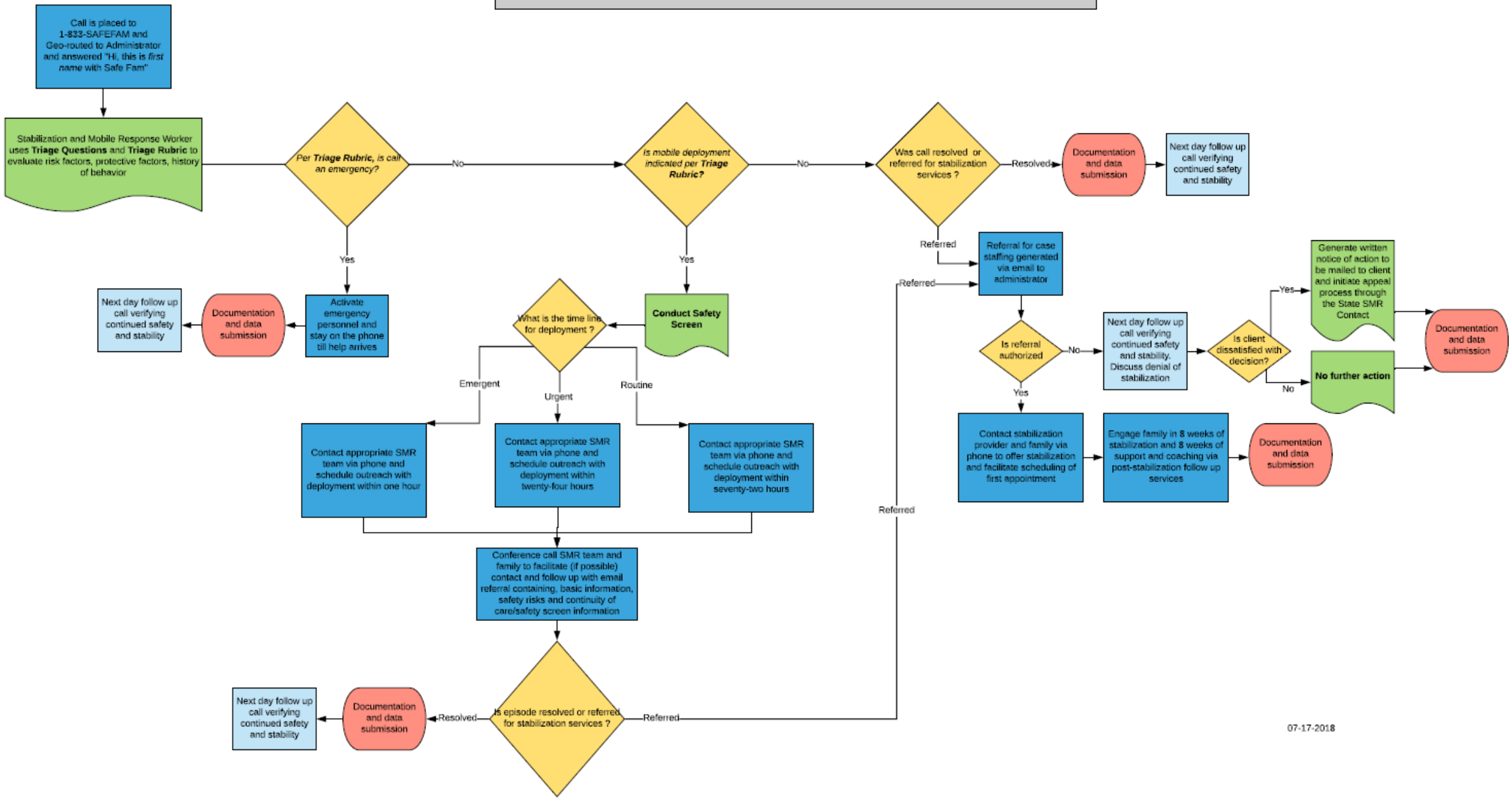
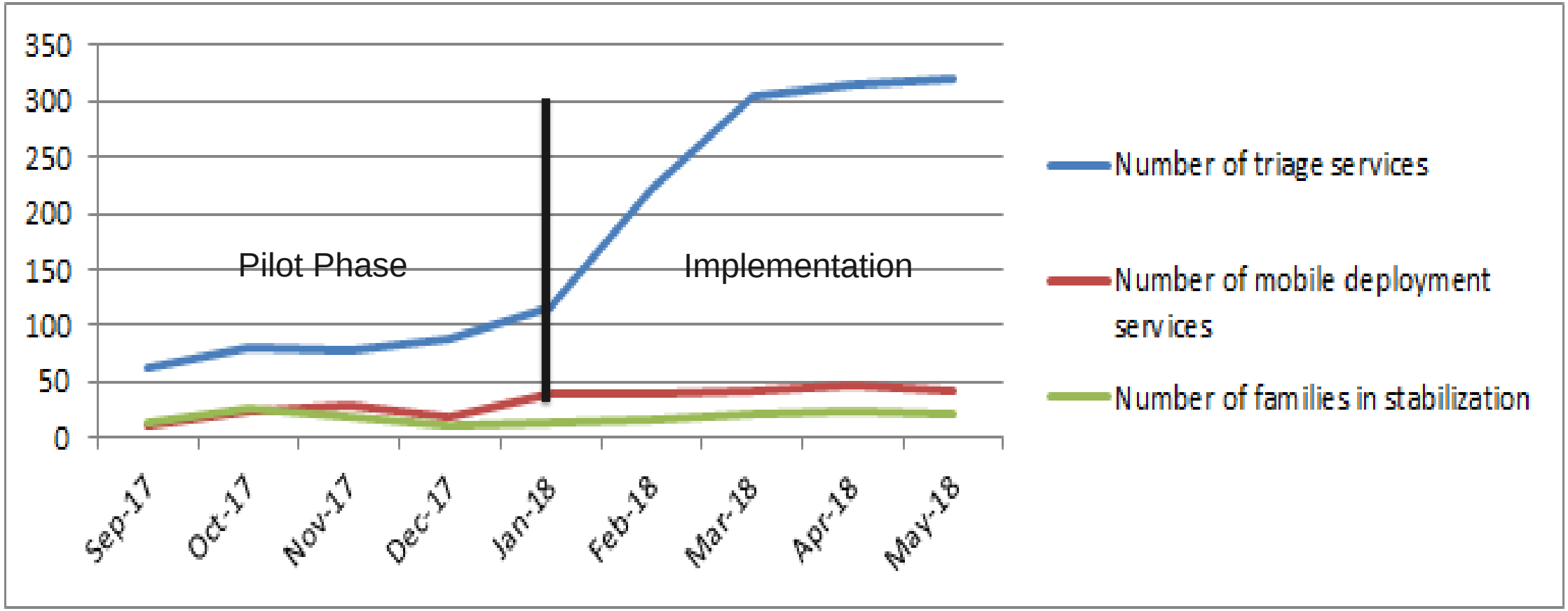
Stabilization and Mobile Response Triage Call Process



Volume (Sept. 2017 – May 2018)

After a 6-month pilot, limited services began in January 2018

(Box Elder, Cache, Davis, Morgan, Rich, Weber, Beaver, Garfield, Iron, Kane, Washington)



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Expected Outcomes

- Reduce reliance on law enforcement, detention facilities
- Reduce use of crisis services
- Reduce the likelihood of unnecessary emergency room visits; thus avoiding trauma for children, youth and families and high cost of medical care
- Effective crisis de-escalation and stabilization
- Strength-based approach empowers families
- Youth remain safely in the home
- Working with youth at younger ages and families earlier in the crisis cycle offers earlier intervention and access to treatment

Additional Need

Statewide Stabilization & Mobile Response Services

- Expand SMR Services to the other three Regions (remaining 18 of 29 counties)
- Average cost of SMR Services per Region: $1.5 Million

Assertive Outpatient Treatment in Utah

Assisted outpatient treatment (AOT) is the practice of delivering treatment services to adults with severe mental illness who have a court ordered treatment plan and meet specific criteria, such as a prior history of repeated hospitalizations or arrest.

It is a tool for assisting those individuals most at risk for the negative consequences of not receiving treatment.

*Utah Civil Commitment Laws currently allow for Community Based Civil Commitment outside of an Inpatient Facility

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Assertive Outpatient Treatment in Utah

- Over 100 individuals have received Utah AOT services in Davis and Weber Counties since October 1, 2016.

UTAH AOT WORKS:

- Improvement in all measures of overall functioning
- Improvement in all measures of social connectedness
- 11% decrease in inpatient stays
- 8% decrease in residential stays
- 11% enrolled in education (part-time)

Assertive Outpatient Treatment in Utah

AOT REDUCES ARRESTS & VIOLENCE:

- 44% decrease in harmful behaviors
- 2/3 reduction in risk of arrest in any given month
- 4x less likely to perpetrate serious violence
- ½ as likely to be victimized

THE REVOLVING DOOR'S COSTS:

- Davis Behavioral Health reports an average cost of $12,625 per inpatient hospitalization.
- Weber Human Services reports an average cost of $12,528 per inpatient stay.
- The two AOT teams reaching their four year goal of serving 226 individuals could result in a cost savings of $440,177.50 in Davis and Weber Counties through hospitalizations alone.

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Assertive Outpatient Treatment in Utah

Success Stories

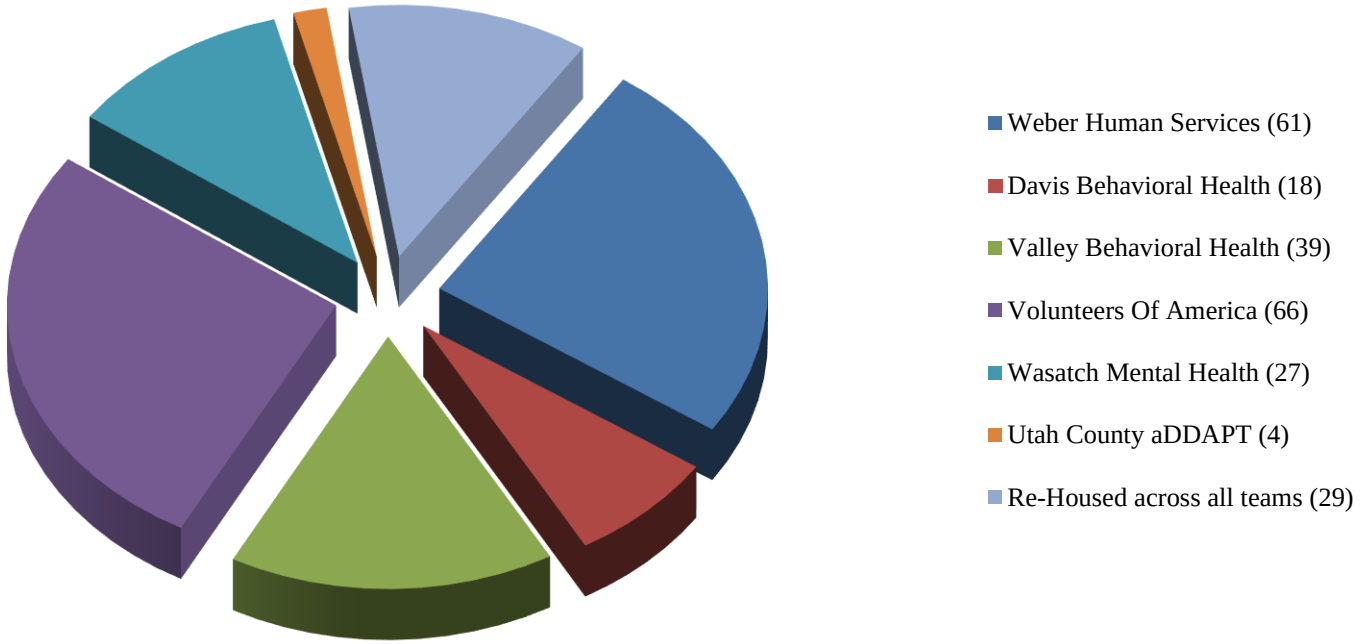
1. DBH served an individual who had been placed on commitment for just under a year and had expressed her own goal of wanting to be stable and be removed from commitment. She was able to do so and continues to engage with her medication management, medication compliance and peer services. She has been more outgoing in expressing her needs and now has goals for her future that are age appropriate and show motivation.
2. WHS served a female in her mid-twenties. This young lady was referred to AOT as she was not engaged in therapy, had numerous hospitalizations, was off her medications, and was not doing minimal self-care tasks, such as bathing, washing clothes etc. Due to her improvement, she will be discharged from off AOT once she and her mother have completed Multi Family Group (MFG). She has become one of the leaders in the MFG group, and she and her mother are engaged with AOT as well as MFG. She is taking care of all of her daily needs, has saved enough money to buy a car and is completely medication compliant.

Cooperative Agreement to Benefit Homeless Individuals –Utah (CABHI-UT

Goal: to improve behavioral health and housing coordination and provide services, permanent supportive housing and access to mainstream public health benefits for 215 (70 annually) homeless and chronically homeless veterans and other chronically homeless individuals who have behavioral health disorders across the Wasatch Front.

- Behavioral health disorders among the homeless have increased:
  - 156% since 2009 for chronic substance abuse
  - 379% increase since 2009 for mental illness.
- Participants identified using the Service Prioritization Decision Assistance Tool (SPDAT) and the Vulnerability Index (VI), that includes information on shelter nights, length of homelessness, vulnerability, engagement with police and jail, emergency room visits, and substance use and mental health history.
- Prioritize medically vulnerable individuals who have not been successful in accessing existing permanent supportive housing and place them in PSH using a Housing First (evidence-based) approach.
- Models used: Assertive Community Outreach Teams (ACOT) along with Trauma Informed Care and Motivational Interviewing to provide integrated, outreach-based recovery services.
- Treatment services and Recovery supports provided in conjunction with enrollment in mainstream resources.

Cooperative Agreement to Benefit Homeless Individuals –Utah (CABHI-UT) Outcomes October 1, 2014 through Sept 30, 2017



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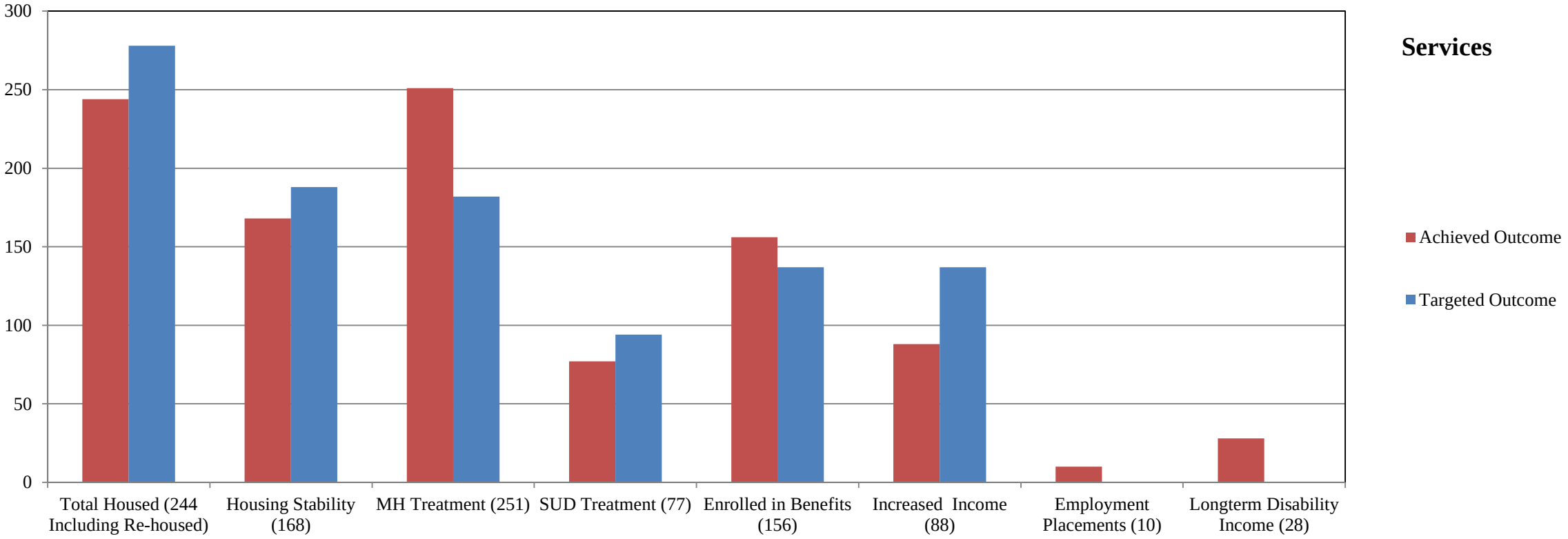

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Responses to Questions from Earlier Presentations and Questions?