Rhode Island KIDS COUNT

October 2022

CHILDREN'S MENTAL HEALTH IN RHODE ISLAND

Mental health in childhood and adolescence is defined as reaching expected developmental, cognitive, social, and emotional milestones and the ability to use effective coping skills. Mental health influences children's physical health as well as their behavior at home, in school, and in the community. Mental health conditions can impair daily functioning, prevent or affect academic achievement, increase involvement with the juvenile justice and child welfare systems, result in high treatment costs, diminish family incomes, and increase the risk for suicide.[1,2,3,4]

Mental health conditions affect children of all backgrounds. In Rhode Island, one in five (19%) children ages six to 17 has a diagnosable mental health problem and one in ten (10%) has significant functional impairment.[5] In 2021, only about one in five (22%) of Rhode Island high school students reported receiving the help they needed when feeling anxious or depressed, down from 33% in 2019.[6]

During the COVID-19 pandemic, children have experienced many changes in their daily lives, including school closures and virtual learning, isolation from their peers and caring adults, disruptions in their schedules, economic insecurity, increased stress and uncertainty, and the loss of parents, caregivers, and other loved ones.[7] Nationally, children and youth were experiencing mental health challenges before the pandemic, but since the onset of the pandemic the number of children experiencing anxiety and depression has increased. We are currently in a mental health crisis both nationally and in Rhode Island.[8,9,10]

STATE OF EMERGENCY IN CHILDREN'S MENTAL HEALTH

In April 2022, **the Rhode Island Chapter of the American Academy of Pediatrics, the Rhode Island Council of Child and Adolescent Psychiatry, Hasbro Children's Hospital, and Bradley Hospital declared a Rhode Island State of Emergency in Child and Adolescent Mental Health** and provided recommendations for how to address this emergency in Rhode Island.

- Increase state funding, including Medicaid rates, for evidence-based mental health screening, diagnosis and treatment.
- Fully fund and prioritize comprehensive, community-based systems of care.
- Accelerate strategies to address longstanding workforce challenges.
- Support effective models of combining school-based mental health care with clinical strategies.
- Support models of integrating mental heath care into primary pediatric care settings.
- Address the acute care mental health needs of children and youth.

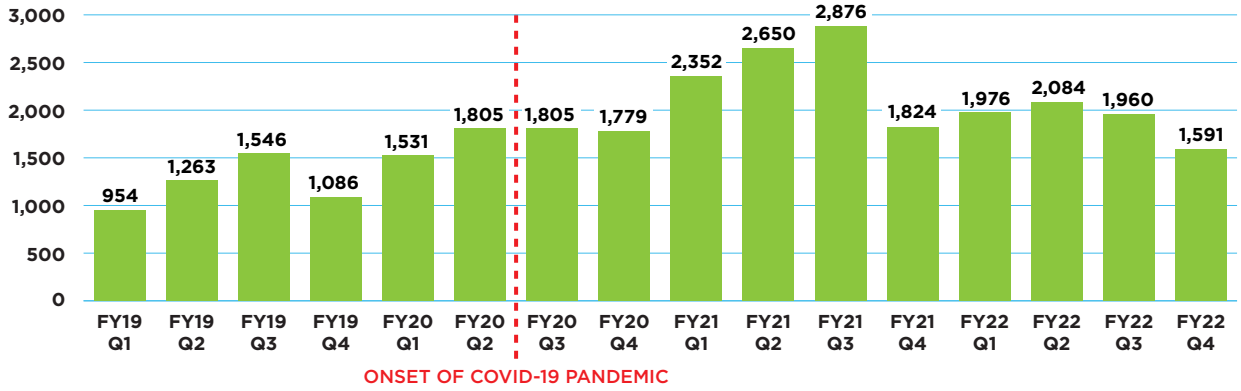
Source: Declaration of a Rhode Island State of Emergency in Child and Adolescent Mental Health. (2022). *Rhode Island Medical Journal* (2013), 105(4), 74.

A **Rhode Island Behavioral Health System of Care Plan for Children and Youth** was released earlier this year. Implementation of this system should align with and strengthen current systems to help create a seamless and coordinated system of care that emphasizes prevention and early identification and provides the right care, at the right time, in the right place and supports children as they grow and transition to adults.

KIDS' LINK: A BEHAVIORAL HEALTH TRIAGE AND REFERRAL SERVICE

- Kids' Link RI is a behavioral health triage service and referral network that is available 24 hours a day, seven days a week to help triage children and youth in need of mental health services and refer them to treatment providers. This important resource has been critical throughout the COVID-19 pandemic and continues to support the mental health needs of children and youth.[11]

KIDS' LINK CALLS, RHODE ISLAND, FY 2019 THROUGH FY 2022



Source: Lifespan, FY 2019 through FY 2022. **Note:** Q1 October–December, Q2 January-March, Q3 April-June, Q4 July-September.

- In FY 2021, there were 9,702 calls to Kids' Link RI, twice the number of calls received in FY 2019 (4,849), prior to the onset of the COVID-19 pandemic. The number of calls peaked in FY 2021, but remain higher in FY 2022 than prior to the onset of the COVID-19 pandemic.[12]

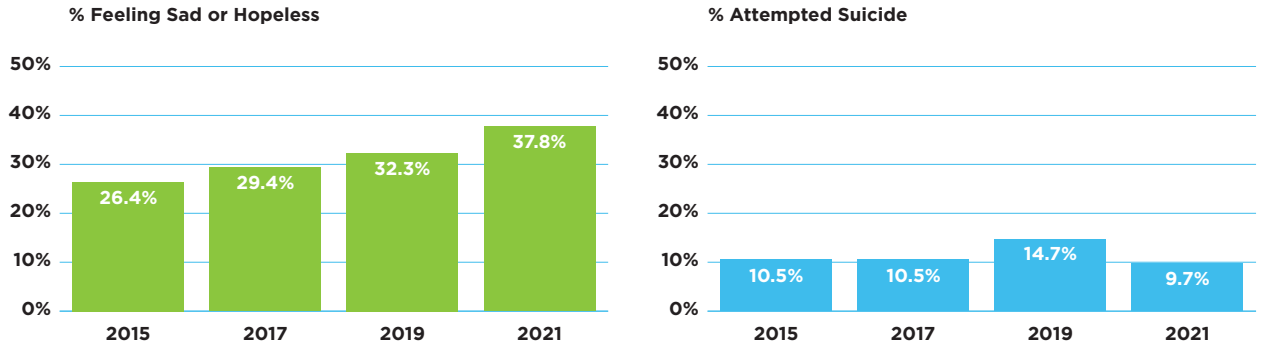
kids' link RI™
PEDIATRIC BEHAVIORAL HEALTH TRIAGE AND REFERRAL
1-855-543-5465

CRISIS INTERVENTION SERVICES

- **Children's Mobile Crisis Response (CMCR)** was a pilot program started in August of 2020 that was designed to stabilize mental health crises for children/youth in Rhode Island during the COVID-19 pandemic. Youth could be referred to CMCR by a hospital, school, the Department of Children, Youth, and Families (DCYF) or initiate a self-referral. Once a referral was made, the crisis response team met the youth in the community or at home for an assessment and crisis evaluation. Once services were initiated, 24/7 clinical support was available.[13]
- From August 2020 to April 2022, 202 youth with an average age of 13 were served by CMCR. The most common diagnosis was an anxiety or depressive disorder. Three-quarters (74%) of youth that completed their mobile crisis response team care plan did not need to be hospitalized and were placed on an aftercare plan. CMCR was not able to serve all referred youth due to ongoing workforce challenges.[14] The state is working to continue and sustain mobile crisis programs to meet the ongoing state of emergency in children's mental health.
- In 2020, Congress implemented a three-digit dialing code that operates through the **National Suicide Prevention Lifeline**. The new **9-8-8** dialing code was created to provide a more efficient way to access crisis call centers and strengthen and expand their network. On July 16, 2022, 9-8-8 became available nationwide in multiple languages for calls and by texting for English language users. 9-8-8 is a free, 24/7, confidential service designed to meet the growing need for mental health crisis service and suicide prevention.[15]
- In Rhode Island, $1.9 million in federal funding was allocated to support 9-8-8 implementation and the coordination of call centers.[16] Effective implementation of 9-8-8 will reduce the stigma associated with mental health and benefit children, adolescents, and families across Rhode Island.

SUICIDE AMONG RHODE ISLAND CHILDREN AND YOUTH

SUICIDALITY AMONG RHODE ISLAND HIGH SCHOOL STUDENTS, 2015-2021



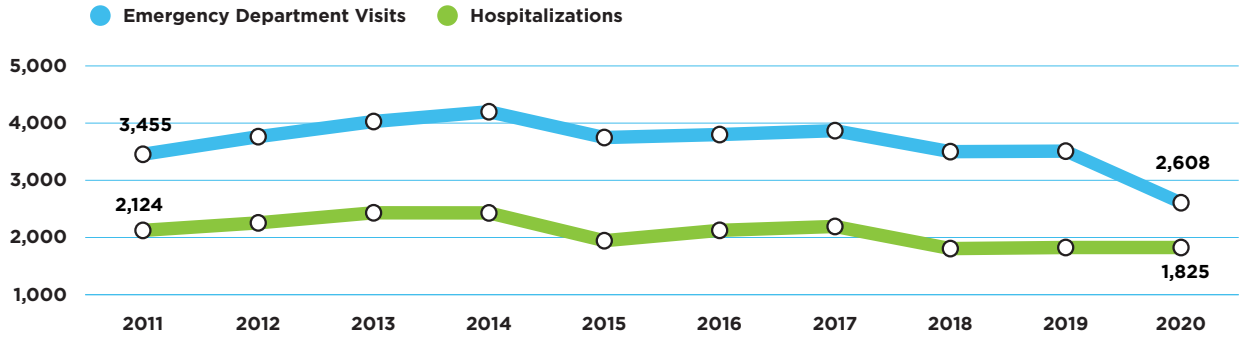
Source: *Rhode Island Youth Risk Behavior Survey,* 2015-2021.

- In 2021, 38% of Rhode Island high school students reported feeling sad or hopeless for more than two weeks during the past year, continuing an upward trend. Girls were twice as likely as boys to report these feelings, and LGBTQ students reported higher rates of sadness and hopelessness than their peers. Almost 10% of Rhode Island high school students reported attempting suicide one or more times during the past year.[17]
- In 2020 in Rhode Island, 467 teens ages 13 to 19 were admitted to the emergency department after a suicide attempt (75% were girls and 25% boys) and 334 teens ages 13 to 19 were hospitalized after a suicide attempt (79% were girls and 21% boys).[18]
- Of the 13 youth ages 15 to 19 who died from suicide between 2016 and 2020 in Rhode Island, 92% were male.[19]

EMERGENCY CARE FOR CHILDREN AND YOUTH WITH MENTAL HEALTH NEEDS

- Nationally, more than 50% of youth who seek psychiatric attention for the first time do so through hospital emergency departments, rather than outpatient services.[20]

EMERGENCY CARE FOR PRIMARY DIAGNOSIS OF MENTAL DISORDER, CHILDREN UNDER AGE 18, RHODE ISLAND, 2011-2020*



Source: Rhode Island Department of Health, Hospital Discharge Database, 2011-2020. *Data are for emergency department visits and hospitalizations, not children. Children may visit emergency department or be hospitalized more than once. *Emergency department counts include all visits regardless of outcome and are not comparable to previous Factbooks. *Note: Effective October 1, 2015, the International Classification of Disease (ICD) codes changed from the 9th classification to the 10th classification, which may impact comparability across the years.*

- In 2020, there were 2,608 emergency department visits and 1,825 hospitalizations of Rhode Island children with a primary diagnosis of a mental disorder. From 2019 to 2020, there was a 26% decrease in emergency department visits due to a primary diagnosis of a mental disorder.[21] This trend, seen both locally and nationally, has been attributed to the effects of the COVID-19 pandemic.[22,23] While overall emergency department visits decreased from 2019 to 2020, the intensity of youth mental health cases increased.[24,25]

RHODE ISLAND'S MENTAL HEALTH CARE SYSTEM: FRAGMENTED AND CRISIS-DRIVEN

Mental health treatment systems tend to be fragmented and crisis-driven with disproportionate spending on high-end care and often lack adequate investments in prevention and community-based services.[26,27,28] Many youth need mental health care but cannot (or do not) access it due to the stigma associated with mental health conditions, insurance barriers and limitations, clinician and provider shortages, and increasingly long waitlists.[29,30,31] Increasing investment in community-responsive, outpatient mental health treatment for youth could reduce the dependency on higher-end care and alleviate stresses in the system by intervening prior to severe mental health crises.[32]

PSYCHIATRIC HOSPITALS

CHILDREN UNDER AGE 18 TREATED AT RHODE ISLAND PSYCHIATRIC HOSPITALS, OCTOBER 1, 2020 – SEPTEMBER 30, 2021 (FFY 2021)

	BRADLEY HOSPITAL GENERAL PSYCHIATRIC SERVICES		BRADLEY HOSPITAL DEVELOPMENTAL DISABILITIES PROGRAM		BUTLER HOSPITAL ADOLESCENT PSYCHIATRIC SERVICES	
	# TREATED	AVERAGE LENGTH OF STAY	# TREATED	AVERAGE LENGTH OF STAY	# TREATED	AVERAGE LENGTH OF STAY
Inpatient	607	27 days	100	55 days	606	9 days
Residential	225	49 days**	36	4.7 years	--	--
Partial Hospitalization	600	36 visits	140	36 visits	758	6 visits
Home-Based	0	NA	21	15 visits	--	--
Outpatient	1,156	**	29	**	251	NA

Source: Lifespan, 2020-2021 and Butler Hospital, 2020-2021. Programs can have overlapping enrollment. Number treated is based on the hospital census (i.e., the number of patients seen in any program during FFY 2021). The average length of stay is based on discharges. ** Only total number treated with outpatient services by the Lifespan Physician Group is available.

-- = Service not offered. NA = Data not available for this service.

- The two hospitals in Rhode Island that specialize in providing psychiatric care to children and youth are Bradley Hospital and Butler Hospital. Inpatient treatment at a psychiatric hospital is the most intensive type of mental health care. In FFY 2021, the most common diagnoses for youth treated in an inpatient setting at Bradley and Butler Hospitals were depressive disorders, anxiety disorders, adjustment disorders, schizophrenia, and bipolar disorders.[33,34]
- Bradley Hospital has a Developmental Disabilities Program that offers highly specialized inpatient and residential services to children and adolescents who show signs of serious emotional and behavioral problems in addition to developmental disabilities.[35]
- **In FFY 2021, there were 837 children and youth awaiting psychiatric inpatient admission (psychiatric boarding), almost double (a 92% increase) the number in FFY 2019 when there were 437 boarders.** The average wait time for psychiatric admission in FFY 2021 was 3.7 days, compared to 3.2 days in FFY 2020. In FFY 2021, an average of two children per day were ready to leave the psychiatric hospital but were unable due to a lack of step-down availability or no other safe placement (including at home).[36,37]

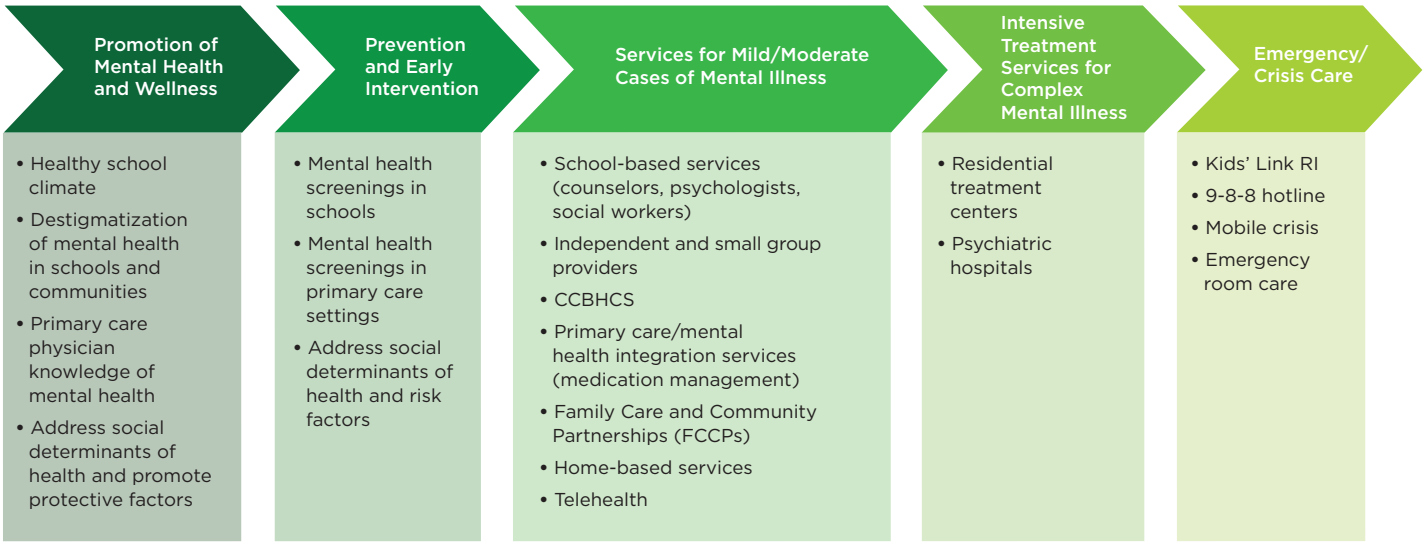
CHALLENGES IN RHODE ISLAND MENTAL HEALTH SYSTEM

- There is **limited mental health care capacity for children and youth**. Youth that need and want mental health services struggle to get adequate, timely, and affordable care. Inaccessibility is caused by insurance-related barriers, lack of clinicians, and extremely long waitlists. These challenges were exacerbated by the COVID-19 pandemic when some mental health programs closed temporarily.[38]
- An even more critical issue is the severity of the **ongoing workforce crisis** that has left low levels of staffing across service agencies. Key reasons for this shortage include chronic underfunding, low reimbursement rates for mental health services (especially through Medicaid), low wages, and high demand of workers, which can lead to worker burnout and high turnover rates. A related issue is the need for a more diverse workforce that reflects the population and that has the linguistic skills and cultural competence to meet the needs of Rhode Island children, youth, and their families.[39,40]

MENTAL HEALTH AS A GOAL: A CONTINUUM OF MENTAL HEALTH CARE FOR CHILDREN AND YOUTH

Mental health is an important part of physical health, and the continuum of care should focus on prevention and promotion of mental health and wellness strategies as well as the treatment of mental health diagnoses. Rhode Island needs a comprehensive continuum of mental health care for children and adolescents in Rhode Island that goes beyond high-end crisis/emergency room treatment and offers the right care at the right time in the right place.[41,42] Systems connected to youth mental health needs include primary care/pediatrician offices, schools, community organizations, child welfare programs, and child care centers.[43] Collaboration across these sectors is crucial to ensuring that children and adolescents have access to mental health care services and support when they need it.[44]

CONTINUUM OF CHILDREN'S MENTAL HEALTH CARE



PRIMARY CARE MENTAL HEALTH SUPPORT

Pediatricians and primary care providers are trusted by families and play a crucial role in addressing child and adolescent mental health needs, including promoting positive mental well-being. These providers are often the first point of contact between families and mental health services, help identify early signs of mental health, and provide direct care as well as referrals to other more specialized services.[45,46] For this reason, improving pediatric provider mental health competency is key to supporting and directing families to proper mental health promotion, prevention, and treatment.[47,48]

Integrating mental health needs into primary care is a key component of the patient-centered medical home (PCMH) model, an American Academy of Pediatrics designed model that expands primary care to a medical home that offers comprehensive and coordinated care including behavioral health care.[49] The Rhode Island model, **PCMH-Kids**, integrates behavioral health into participating practices, makes it a priority to address the mental health needs of children and their families and promotes screenings for social-emotional challenges and healthy competencies.[50]

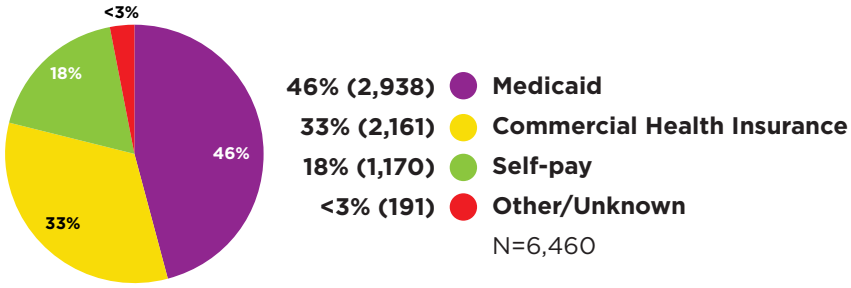
One of Rhode Island's Psychiatry Resource Networks (PRN), **PediPRN**, provides same-day clinical teleconsultation services and mental health referrals for primary care providers of children and adolescents. This program supports Rhode Island health care providers by offering same-day specialized clinical consultations and resource/referral services related to mental health — enabling health care providers to provide comprehensive care for their patients more promptly and avoid lengthy wait times for specialized care.[51]

- In FY 21, 359 providers in 68 practices were enrolled in PediPRN. Ninety-two providers utilized the teleconsultation service 312 times for 259 pediatric patients. The most common diagnoses were anxiety, depression, attention-deficit/hyperactivity disorder (ADHD), and autism spectrum disorder (ASD) and the most common reason for using PediPRN was for medication consultation.[52]

COMMUNITY-BASED MENTAL HEALTH CARE

Rhode Island has six community mental health organizations (CMHOs) that are the primary source of public mental health treatment services available in the state for children and adults.[53] During 2021, 6,460 children under age 18 were treated at CMHOs.[54]

CHILDREN TREATED AT COMMUNITY MENTAL HEALTH ORGANIZATIONS BY INSURANCE STATUS, RHODE ISLAND, 2021



Source: Rhode Island Department of Behavioral Health, Developmental Disabilities and Hospitals, Division of Behavioral Healthcare, 2021.

- In 2021, the most common primary diagnoses for children and youth treated at CMHOs in Rhode Island were anxiety, attention deficit/hyperactivity disorder (ADHD), depression disorders, and conduct disorders.[55]

CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINICS (CCBHCS)

CCBHCs are designed to provide a comprehensive range of mental health and substance use disorder services to vulnerable individuals and meet the needs of complex populations including children and adolescents.[56] The Rhode Island-specific program model is designed to provide comprehensive mental health and substance use disorder services to vulnerable individuals throughout the entire life cycle and to have a strong focus on ensuring equity and eliminating disparities. There are currently five organizations with federally-funded CCBHC grants in the state (Thrive Behavioral Health, Community Care Alliance, Newport Mental Health, East Bay Community Action Program, and Family Service of Rhode Island).[57]

CCBHCs should align with the existing behavioral health care resources for youth (e.g., Kids' Link and community mental health organizations) and strengthen resources, including addressing the current behavioral health workforce crisis. Without adequate funding, the CCBHC model cannot be fully and successfully implemented.

CHILDREN AND ADOLESCENTS WITH RITE CARE/MEDICAID

- Socioeconomically marginalized children and adolescents—for instance, those growing up in poverty—are two to three times more likely to develop mental health conditions than peers with higher socioeconomic status.[58] Low-income youth also were disproportionately impacted by the COVID-19 pandemic, facing more educational and social disruptions (e.g., longer periods of distance learning, housing instability, and parent job loss).[59]
- In State Fiscal Year (SFY) 2021, 29% (31,394) of children under age 19 enrolled in RIte Care/Medicaid had a mental health diagnosis. Of those children, 18% were ages five and under, 43% were ages six to 12, and 39% were ages 13 to 18, and 42% were females and 58% were males.[60]
- In SFY 2021, 1,096 children under age 19 enrolled in RIte Care/Medicaid were hospitalized due to a mental health-related condition (up from 1,030 in SFY 2020), and 2,246 children had a mental health-related emergency department visit (down from 2,288 in SFY 2020). Ninety percent of mental health-related emergency department visits for children with RIte Care/Medicaid did not result in a hospitalization.[61]
- In 2020, 53% percent of all emergency department visits for children under age 18 with a mental health primary diagnosis were made by children enrolled in RIte Care/Medicaid and 30% by children with commercial insurance.[62]

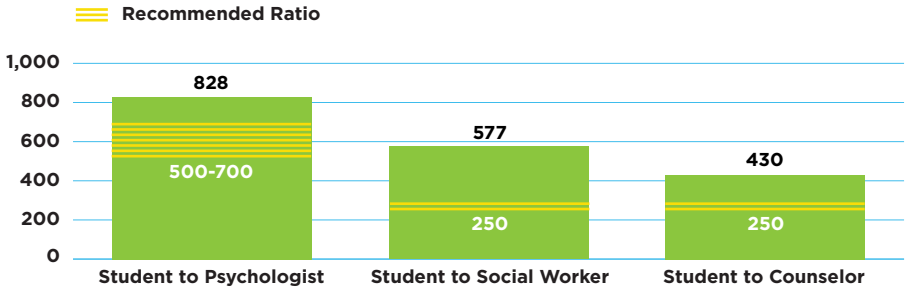
SCHOOL-BASED MENTAL HEALTH SUPPORT

Because children and youth spend a large part of their days in schools, their experiences during the school day can greatly impact their mental health.[63] A healthy school climate helps promote and protect youth mental well-being and school-based mental health resources, including school-based mental health professionals, play a vital role in creating and sustaining positive school experiences and can improve health outcomes for youth.[64]

- **Project AWARE** focuses on increasing the capacity of participating schools to create safe and secure environments that promote the mental health of school-aged youth. Project AWARE provides training for school personnel and other adults who interact with school-aged youth so they can better detect and respond to mental health issues and works to promote positive mental health among all students and connect students with severe emotional disturbance or serious mental illness to needed services.[65]
- **Universal Social, Emotional, Behavioral (SEB) Screening:** Universal screening is an evidence-based, proactive method for identifying the presence of protective factors and indicators of well-being and identifying and better serving students at risk of developing mental and behavioral health challenges and those exhibiting early signs of mental illness.[66]
- ***Trauma Informed Schools Act:*** The *Trauma-Informed Schools Act* creates a universal approach designed to help students who have experienced trauma; however, the strategies and practices will benefit all children by creating positive school climates. This legislation, passed during the 2022 session, requires that all administrators, teachers, and staff in every Rhode Island public school receive trauma-informed training. These trainings include restorative practices, social-emotional learning, and positive disciplinary practices -- effective approaches for addressing student trauma and helping to create positive student-teacher relationships, improve students' sense of belonging, build safe schools, and increase academic outcomes.[67,68]

Beyond promoting mental wellness for all students, schools can also provide intervention and treatment for students with additional mental health needs. School-based mental health services are delivered by trained mental health professionals who are employed by schools, such as school psychologists, school counselors, school social workers, and school nurses. Providing mental health services in schools removes access barriers for students (e.g., transportation, scheduling conflicts, and stigma). Schools can provide school-based services and refer youth to more intensive resources in the community when needed.[69]

STUDENT-TO-MENTAL HEALTH PROFESSIONAL RATIO IN SCHOOLS, RHODE ISLAND, 2017-2018



Source: U.S. Department of Education 2017-2018 Civil Rights Data Collection. Rhode Island Department of Education, Public school enrollment in preschool through grade 12 as of October 1, 2018.

- The National Association of School Psychologists recommends a ratio of 500 to 700 students per school psychologist.[70] The School Social Work Association of America recommends a ratio of 250 students per social worker.[71] The American School Counselor Association recommends a ratio of 250 students per school counselor.[72] Rhode Island is above the recommended ratio in all categories.
- During the 2020 school year, there were 67 counselors in the Providence Public School District, resulting in a 358-to-1 student to counselor ratio, well above the recommended 250-to 1 ratio.[73]

RISK FACTORS FOR MENTAL HEALTH CHALLENGES IN CHILDHOOD

Risk factors for childhood mental health conditions include environmental factors like prenatal exposure to toxins (including alcohol), physical or sexual abuse, adverse childhood experiences, toxic stress, genetic factors or a family history of mental health issues, involvement with juvenile justice and child welfare systems, and living in poverty.[74,75,76] In addition to genetic factors, mental health and well-being is impacted by the social, economic, and physical environments of youth and their families. To both prevent mental health conditions and promote mental wellness these factors must be acknowledged and addressed throughout all stages of life.[77] Exposure to risk factors for mental health disorders accumulate over time and contribute to social and economic inequities and consequently to inequitable mental and physical health outcomes.[78]

Adverse Childhood Experiences – Adversities faced during early childhood disrupt the development of the brain and biological systems and can result in short-term harm and long-term negative outcomes, such as depression, substance use disorders, suicide, and certain chronic diseases in adulthood.[79,80,81] Maltreatment -- child neglect or abuse -- is one example of adverse childhood experiences (ACEs). Other ACEs include poverty, domestic violence, neighborhood violence, parental mental illness, homelessness, parental substance use disorders, and other forms of trauma that occur in childhood.[82] Deficiencies in the built environment including a child's sense of safety, or lack of safety, is also considered an ACE. The cumulative effect of multiple adverse experiences in childhood can have devastating long-term consequences.[83] Children and youth who experience four or more ACEs are more likely to experience behavior problems, anxiety, and depression than those with no exposure to ACEs due to elevated toxic stress levels.[84] Children of Color are at an increased risk of elevated toxic stress that impacts long-term health due to pervasive, systemic racism. Racism's toxic legacy includes generational trauma and economic inequity. Creating culturally responsive family supports, preventing neighborhood violence, strengthening financial security at the household level, promoting family home visiting programs, and cultivating and sustaining afterschool programs are all evidence-based strategies for preventing ACEs and lessening their severity if they have already occurred.[85]

MENTAL WELLNESS FROM EARLY CHILDHOOD TO ADULTHOOD

Infant and Early Childhood Mental Wellness is the foundation for all future development and is necessary for the development of curiosity, persistence, motivation, and trust. It includes the capacity of infants and young children to experience, express and regulate emotions; form close, secure interpersonal relationships; and explore their environment and learn, in the context of family, community, and culture. Infants need to form secure attachments with at least one caregiver.[86] Infants who do not develop secure attachment are at risk for learning delays, relationship dysfunction, difficulty expressing emotions, and future mental health disorders. Babies and toddlers can and do suffer from mental health conditions caused by trauma, neglect, biological factors, or environmental conditions.[87]

Research shows that 16% to 18% of infants and young children experience mental health challenges, approximately the same rate as experienced by older children.[88] In Rhode Island, approximately 50% of infants and young children have Medicaid health coverage which covers screening, evaluation, diagnosis, and treatment for children's mental health needs starting at birth. Despite this available coverage, less than 8% of the Medicaid population under age six received any mental health services in 2018.[89,90] In 2022, the General Assembly passed the *Infant and Early Childhood Mental Wellness Act* that requires the state to create a plan to use Medicaid to help improve early identification and treatment of mental health challenges in young children. The Executive Office of Health and Human Services has created an Infant and Early Childhood Mental Health Task Force to develop this plan. Prevention and early identification and treatment of mental health challenges in young children could reduce expulsions from child care and preschool and suspensions in the early grades.[91]

Adolescence and Transition to Adult Mental Health System -- Children with mental health diagnoses often continue to have mental health needs as adults and require a transition into the adult behavioral health system. Ineffective transitions between the two systems can lead to poor outcomes during adolescence, an already vulnerable and sensitive time period. Poor transition planning can result in a disruption in mental health services, a lack of continuity of care, disengagement from services, and poorer clinical outcomes.[92] There is currently a lack of services to support this transition. Rhode Island's Healthy Transition Program provides services to youth and young adults ages 16 to 25 who are experiencing mental health conditions.[93]

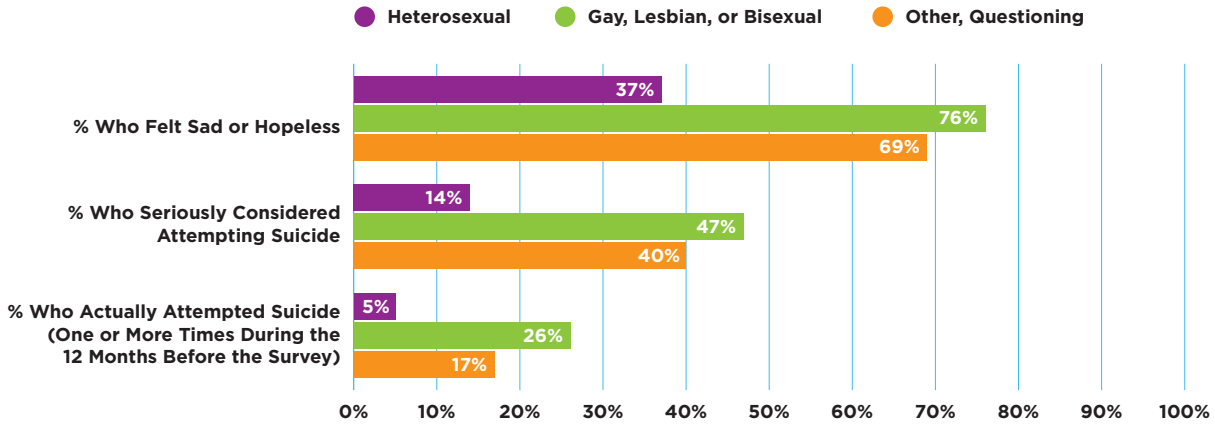
RACIAL AND ETHNIC DISPARITIES

- While rates of mental health treatment are low for all youth with mental health needs, Youth of Color are significantly less likely to receive treatment. When they do receive treatment, it is more likely to be inadequate due to the lack of a diverse and culturally and linguistically competent workforce.[94] Disparities in mental health treatment can be attributed to underlying determinants of mental health including poverty, ACEs, chronic stress, racism, and discrimination.[95]
- Youth of Color were also more likely to have their mental health impacted by the pandemic. These youth were more likely to face COVID-19 related stressors, such as household unemployment, loss of a loved one, and increased isolation.[96]

LGBTQ+ YOUTH

- LGBTQ+ youth are more likely to have mental health conditions and suicidal ideation than their peers.[97] LGBTQ+ youth were also disproportionately impacted by the COVID-19 pandemic. Nationally, 62% of Gay,Lesbian, or Bisexual Youth, 64% of Other or Questioning Youth reported that their mental health was not good most of the time or always during the COVID-19 pandemic, compared to 30% of heterosexual youth.[98]

MENTAL HEALTH STATUS OF YOUTH, BY SEXUAL ORIENTATION, 2021



Source: *Adolescent Behaviors and Experiences Survey*, 2021.

- Nationally, more than half (53%) of transgender and nonbinary youth seriously considered suicide in the past year compared to 33% of cisgender LGBTQ+ youth. Among transgender and nonbinary youth 93% report that they are worried about anti-trans legislation that would deny them access to gender affirming medical care.[99]
- LGBTQ+ youth who lost access to school-based services during the COVID-19 pandemic may have had increased youth mental health needs, due to lockdowns in environments where they might not have been supported or accepted.[100]

YOUTH IN THE JUVENILE JUSTICE SYSTEM

- Youth with mental health needs that go unaddressed often end up in the juvenile justice system due to lack of access to preventive community-based services and historic criminalization of mental health needs. The juvenile justice system is not always designed to meet mental health needs.[101]
- Fifty-eight percent (84) of the 144 youth who were at the Training School at some point during 2021 received mental health services for psychiatric diagnoses other than conduct and adjustment disorders, including 47% (9) of female youth and 60% (75) of male youth.[102]
- Since 2006, the Rhode Island Family Court has integrated the Mental Health Clinic (MHC) into the Family Court to better meet the needs of court-involved youth who are not at the Training School. The MHC provides a variety of evidence-based forensic assessments and consultation to judges and magistrates for court-involved youth, ages eight to 18, involved with juvenile justice or child welfare petitions. Each year, more than 150 youth receive in-house forensic, mental health and/or substance use assessments, consultation, and/or service referrals through the MHC.[103]

CHILDREN AND YOUTH IN THE CHILD WELFARE SYSTEM

- Children and youth in the child welfare system, and youth in foster care in particular, have very specific behavioral and mental health needs. Some youth require intensive services for mental health needs while in out-of-home placements and benefit from the care provided in a treatment foster care home. **Treatment or therapeutic foster care** is out-of-home care provided by a foster parent who has received specialized training in caring for children and youth with complex behavioral, emotional, and mental health needs. Treatment foster care is often more cost-effective than residential treatment homes and provides the structure and familiarity of a home environment.[104]
- In Rhode Island, low rates of reimbursement for agencies that provide therapeutic or treatment foster care (and provide specialized training for treatment foster parents) limit their ability to provide the services and supports these children and families need. All foster families need appropriate supports, including mental health services for children and teens, and respite services.[105,106,107]
- Infants under age one are the most likely age group to experience maltreatment, which can disrupt a child's ability to form positive attachments that are essential for the development of emotional security.[108,109]
- In 2017, the Rhode Island Family Court instituted the Safe and Secure Baby Court (SSBC) which was designed to support new biological parents who may have been in the child welfare system themselves and/or have a history of mental health conditions, domestic violence exposure, or substance use. SSBC improves collaboration between the RI Family Court, the child welfare system (including the infant's foster parents), pediatric and infant mental health providers, and other community resources to increase access to services designed to help parents build and maintain healthy relationships with their babies.[110,111]
- In 2018, Rhode Island established the **Voluntary Extension of Care (VEC)** program, allowing youth ages 18 to 21 who were in foster care the option of continuing to receive services from the Department of Children, Youth and Families (DCYF). VEC helps older youth in care transition to adulthood by supporting them in making life decisions and provides housing and other supports.[112] Youth in VEC need mental health supports as they transition to adulthood.
- The Community Services and Behavioral Health division of DCYF offers parents and legal guardians access to residential treatment for children diagnosed with an intellectual developmental disability or serious emotional disturbance without having to relinquish custody to the Department.[113]
- **Family Care Community Partnerships (FCCPs)** are DCYF's primary prevention resource for the state. FCCPs provide wraparound services at home and in the community to serve families that have children who have serious emotional, behavioral, or mental health challenges or who are at risk of involvement with DCYF. Families can be referred to FCCPs for a number of reasons including alcohol/drug use, mental health or behavioral concerns, stressful life events, developmental disability/delay and other needs, such as being at risk for maltreatment, parental and familial stressors and parental mental health. Families can access services through the FCCPs without being involved with DCYF.[114]

RECOMMENDATIONS

- Focus on mental health **promotion and prevention** in schools and communities.
- Provide families with the **economic and community supports** they need to thrive so children do not face homelessness, poverty, child neglect and abuse, community violence, and toxic stress that are often precursors to mental health problems.
- Advocate for **policies that support the secure attachment of infants and young children** to parents and caregivers including paid family leave, increased access to high-quality child care (by increasing rates and compensation for early educators), increased access to Early Intervention, and identify and treat parental mental health and/or physical health challenges, including maternal depression.
- Implement and invest in a **seamless and coordinated system of behavioral health care** that provides the right care, at the right time, in the right place and supports children as they grow and transition to adults.
- Fully fund and **prioritize comprehensive, community-based systems of care** that connect families in need of outpatient behavioral health services and supports for their children with evidence-based interventions in their home, community or school as well as follow-up with families to overcome any barriers to care.
- **Increase state funding, including Medicaid rates**, dedicated to ensuring that all families and children, from infancy through adolescence, can access evidence-based mental health screening, diagnosis, and treatment to appropriately address their mental health needs, with particular emphasis on meeting the needs of under-resourced populations.
- Address longstanding **workforce challenges** in child mental health, including innovative training programs developed collaboratively by Rhode Island's existing health care professional programs.
  - loan repayment and reduced/free tuition consistent with Rhode Island Promise grants
  - intensified efforts to recruit and retain underrepresented populations into mental health professions
  - training for workforce and others involved in children's lives.
- Advance policies that **ensure compliance with and enforcement of mental health parity laws**.
- Continue to **track the implementation of recently passed legislation** and policies to improve the mental health of children in Rhode Island (*Nathan Bruno Act, Trauma Informed Schools Act, Infant and Early Childhood Mental Wellness Act*).
- Improve the **oversight and administrative coordination** of children's behavioral health and coordination with the adult behavioral health system and transition.
- **Increase data collection efforts to track mental health needs** for children and youth (for example requiring ACEs screenings in primary care offices, including screening data to track if children and youth seen in the emergency room for mental health needs have had any prior mental health care/interventions and in what settings).
- Increase implementation and sustainable funding of effective models of **school-based mental health care** with clinical strategies, including a mental health "warmline" for school staff to access care comparable with the existing PediPRN model for pediatricians, and models for payment, such as PCMH-Kids (which co-locates mental health providers in pediatric practices).
- Incentivize adoption of effective and financially sustainable models of **integrated mental health care in primary care pediatrics**, including clinical strategies and models for payment.
- **Address the ongoing challenges of the acute care needs** of children and adolescents, including shortage of beds and emergency room boarding, by expanding access to short-stay stabilization units and community-based response teams.
- Address regulatory challenges and **improve access and availability of telemedicine** to provide mental health care to all populations.

REFERENCES

[1] Center for Disease Control and Prevention. (2021) What is children's mental health. Retrieved March 18, 2022, from www.cdc.gov

[2] Centers for Disease Control and Prevention. (2022). Mental health surveillance among children: United States, 2013-2019. *Morbidity and Mortality Weekly Report, 71*(Supp.2):1-36.

[3,75] Murphey, D., Barry, M., & Vaughn, B. (2013). *Adolescent health highlight: Mental health disorders.* (Publication No. 2013-1). Washington, DC: Child Trends.

[4] Suryavanshi, M.S. & Yang, Y. (2016). Clinical and economic burden of mental disorders among children with chronic physical conditions, Unites States, 2008-2013. *Preventing Chronic Disease.* (13).

[5] Kim, H. K., Viner-Brown, S. I., & Garcia, J. (2007). Children's mental health and family functioning in Rhode Island. *Pediatrics, 119* (Supp.1), S22- S28.

[6,17] 2021 Rhode Island Youth Risk Behavior Survey. (2022). Providence RI: Rhode Island Department of Health.

[7,8,95] The Annie E. Casey Foundation (2022). *2022 kids count data book: State trends in children well-being.*

[9,31,41,44,62,63,96,97,100] *Protecting youth mental health: The U.S. Surgeon General's Advisory.* (2021). U.S. Department of Health & Human Services, Office of the Surgeon General.

[10] *AAP-ACAP-CHA Declaration of a national emergency in child and adolescent mental health.* (2021). Retrieved October 11, 2022 from www.aap.org.

[11,12] Lifespan, 2019-2022.

[13,14] Tides Family Services, Thrive Behavioral Health, Community Care Alliance, & Newport Mental Health (2022). Children's Mobile Crisis Response: Overview of Mobile Crisis, Summary of Data from August 2020-April 2022. Rhode Island.

[15] Substance Abuse and Mental Health Services Administration, SAMHSA (2022). 988 Suicide and Crisis Lifeline. 988 Partner Toolkit. Retrieved October 11, 2022, from https://www.samhsa.gov/sites/default/files/988-factsheet.pdf

[16] Governor's Office, State of Rhode Island. Governor McKee Highlights New Budget, Legislative Investments in Rhode Island's Behavioral Health Care System (2022). Retrieved October 11, 2022, from https://governor.ri.gov/press-releases/governor-mckee-highlights-new-budget-legislative-investments-rhode-islands

[18,19] Rhode Island Department of Health, Center for Health Data and Analysis, Hospital Discharge Database, 2016-2020.

[20,22,24] Cancilliere, M. K., & Donise, K. (2022). A Comparison of Acute Mental Health Presentations to Emergency Services Before and During the COVID-19 Pandemic. *Rhode Island Medical Journal* (2013), 105(4), 9–15.

[21,62] Rhode Island Department of Health, Hospital Discharge Database, 2011-2020.

[23] Leff, R. A., Setzer, E., Cicero, M. X., & Auerbach, M. (2021). Changes in pediatric emergency department visits for mental health during the COVID-19 pandemic: A cross sectional study. *Clinical child psychology and psychiatry*, 26(1), 33–38.

[25] Hill, R. M., Rufino, K., Kurian, S., Saxena, J., Saxena, K., & Williams, L. (2021). Suicide Ideation and Attempts in a Pediatric Emergency Department Before and During COVID-19. *Pediatrics, 147*(3) , e2020029280.

[26] *Rhode Island behavioral health system of care plan for children and youth.* (2022). Providence, RI: Rhode Island Executive Office of Health and Human Services.

[27,46] Wissow, L., van Ginneken, N., Chandna, J., and Rahman, A. (2016). *Integrating children's mental health into primary care.* Baltimore, MD: Center for Mental Health in Pediatric Care, Johns Hopkins School of Public Health.

[28] *Mental health hearings: Findings and recommendations* (2017). Providence, RI: Rhode Island Senate Health and Human Services Committee.

[29,38,73,94] Mizerak, E., et al. (2022). (rep.). *The State of Behavioral Healthcare in Rhode Island: 2020 Report.* Mental Health Association of Rhode Island (MHARI) & Brown Initiative for Policy. Retrieved October 13, 2022, from https://assets-pbn-com.s3.amazonaws.com/2022/09/MHARI-SoS-Report_Final-9.01.22.pdf.

[30,43,49] Tobin Tyler, E., Hulkower, R., & Kaminski, J. (2017). Behavioral health integration in pediatric primary care: Considerations and opportunities for policymakers, planner, and providers. Milbank memorial Fund.

[32] Declaration of a Rhode Island State of Emergency in Child and Adolescent Mental Health. (2022). *Rhode Island medical journal*, 105(4), 74

[33,35,36,52] Lifespan, 2019-2021.

[34] Butler Hospital, 2017-2020.

[37] Abid, Z., Meltzer, A., Lazar, D., & Pines, J. (2014). Psychiatric boarding in U.S. Eds: A multifactorial problem that requires multidisciplinary solutions. *Center for Health Care Quality.* Paper 1.

[39] Barna, M. (2022). Mental health workforce taxed during COVID-19 pandemic: Worker shortage hinders access. *The Nation's Health Journal 51*(10) 1-14.

[40] Jennings, E., Singleton, M., Mizerak, E., (2021). *Network adequacy: A survey of Rhode Island's behavioral health provider network.* Mental Health Association of Rhode Island (MHARI). Retrieved October 13, 2022, from www.mhari.org

[42] Tolan, P. & Dodge, K. (2005). Children's mental health as a primary care and concern: A system for comprehensive support and service. *American Psychologist. 60(6)*, 601-614.

[45,48] Godoy, L., et al. (2019). Increasing mental health engagement from primary care: The potential role of family navigation. *Pediatrics. 143*(3):e20182418

[47,51] Rhode Island psychiatry resource network (PRN). (2022).*Teleconsultation programs for providers.* Rhode Island Department of Health.

[50] Flanagan, P., & Lange, E. (2018). A pediatric care transformation journey. *Rhode Island Medical Journal.* 101(10). 20-23.

[53] Rhode Island Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals. (2018). *What is a licensed community mental health center?* Retrieved October 13, 2022 from www.bhddh.ri.gov

[54,55] Rhode Island Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals, Division of Behavioral Healthcare, 2021.

[56] Substance Abuse and Mental Health Services Administration. (2022). *Certified Community Behavioral Health Clinics (CCBHCs).* Retrieved October 16, 2022, from www.samhsa.gov/certified-communitybehavioral- health-clinics

[57] The National Council for Mental Wellbeing. (2022). CCBHC Location List. Retrieved October 16, 2022, from https://www.thenationalcouncil.org/resources/ccbhc-location-list/

[58] Reiss F, Meyrose A-K, Otto C, Lampert T, Klasen F, Ravens-Sieberer U (2019)Socioeconomic status, stressful life situations and mental health problems in children and adolescents: Results of the German BELLA cohort study. *PLoS ONE* 14(3): e0213700

[60,61] Rhode Island Executive Office of Health and Human Services, MMIS Database, 2020-2021.

[64,67] *Policies and practice supporting student centered learning in Rhode Island: School climate (2020)*. Rhode Island Kids COUNT.

[65] Rhode Island Department of Elementary and Secondary Education. (2021). Rhode Island Project AWARE: Year 3 annual programmatic report.

[66] Brinz, S., Petrarca, K., & Reilly-Chammat, R. (2022). Social Emotional Behavioral Universal Screening. Rhode Island Department of Education.

[68] Rhode Island General Law 16.21.40-41. Enacted by the General Assembly as H-6667 Substitute B and S-2556 Substitute A in 2022.

[69] National Alliance on Mental Health (n.d.) *Mental health in schools*. Retrieved October 16, 2022, from www.nami.org/advocacy

[70] National Association of School Psychologists. (2013). *NASP recommendations for comprehensive school safety policies.* Retrieved September 16, 2022, from www.nasponline.org

[71] School Social Worker Association of America. (2012). *NASW standards for school social work services.* Retrieved October 16, 2022, from www.sswaa.org

[72] American School Counselors Association. (2021). *Student to-school-counselor ratio 2020-2021.* Retrieved September 16, 2022, from www.schoolcounselor.org

[74] Murphey, D., Vaughn, B., & Barry, M. (2013). *Adolescent health highlight: Access to mental health care.* (Publication No. 2013-2). Washington, DC: Child Trends.

[76] Murphey, D., et al. (2014). *Are the children well? A model and recommendations for promoting the mental wellness of the nation's young people.* Princeton, NJ: Robert Wood Johnson Foundation & Child Trends.

[77,78] World Health Organization and Calouste Gulbenkian Foundation. (2014). *Social determinants of mental health.* Geneva, World Health Organization.

[79] *Essentials for childhood: Steps to create safe, stable, nurturing relationships and environments.* (2021). Atlanta, GA: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control.

REFERENCES (CONTINUED)

[80,82,85] Centers for Disease Control and Prevention (2019). *Preventing adverse childhood experiences: Leveraging the best available evidence.* Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

[81] Hughes, K., et al. (2017). The effect of multiple adverse childhood experiences on health: a systematic review and meta-analysis. *Lancet Public Health* 2, e356–e366.

[83] Javier, J.R., Hoffman, L.R., Shah, S.I. et al. Making the case for ACEs: adverse childhood experiences, obesity, and long-term health. *Pediatric Research 86*, 420–422 (2019).

[84] Health Resources and Services Administration's Maternal and Child Health Bureau. (2020). *Adverse Childhood Experiences, NSCH Data Brief.* Retrieved October 13, 2022, from https://mchb.hrsa.gov/sites/default/files/mchb/data-research/nsch-ace-databrief.pdf

[86] Zero to Three. (2018). *The Integration of DC:0-5TM: Diagnostic classification of mental health and developmental disorders of infancy and early childhood: A briefing paper.* Retrieved April 14, 2022, from www.zerotothree.org/resources

[87] J Clinton, AF Feller, RC Williams. (2016). The importance of infant mental health. *Pediatric Child Health 2016, 21*(5):239-241.

[88] Klitzing, K. von., Doehnert, M., Kroll, M.,& Grube, M. (2015). *Mental health disorders in early childhood.* Dtsch Arztebl International, 112, 375-86.

[89] Rhode Island Executive Office of Health and Human Services 2018, 2020-2021.

[90] National Center for Children in Poverty (n.d.) Rhode Island Early Childhood Profile. Retrieved October 14, 2022, from www.nccp.org/early-childhood

[91] Rhode Island General Law 27-38.2. Enacted by the General Assembly as H-7801 & S-2614 in 2022.

[92] Broad, K., Sandhu, V., Sunderji, N., & Charach, A (2017). Youth experiences of transition from child mental health services to adult mental health services: A qualitative thematic synthesis. *BMC Psychiatry* 17:380

[93] Rhode Island Department of Behavioral Healthcare, Developmental Disabilities & Hospitals. (2021). *Take charge of your behavioral health: A behavioral health guide for transition aged youth (TAY) in Rhode Island.* Retrieved October 14, 2022 from www.bhddh.org

[98] Adolescent Behaviors and Experiences Survey, (2021).

[99] The Trevor Project. (2022). *2022 National Survey on LGBTQ Youth Mental Health.* Retrieved October 16, 2022, from www.thetrevorproject.org/surveys

[101] Hammond, S. (2007). *Mental health needs of juvenile offenders.* National Conference of State Legislatures: The Forum for America's Ideas, Washington, D.C. Retrieved October 13, 2022, from https://www.ncsl.org/print/health/Mental_health_needsojuvenileoffendres.pdf

[102] Rhode Island Department of Children, Youth and Families, Rhode Island Training School, Clinical Services, 2021.

[103] Rhode Island Family Court Correspondence (2022).

[104] Child Welfare Information Gateway. (n.d.). *Treatment foster care.* Treatment Foster Care - Child Welfare Information Gateway. Retrieved October 14, 2022, from https://www.childwelfare.gov/topics/outofhome/foster-care/treat-foster/

[105] Walsh, W. A., and Mattingly, M. J. (2011). *Long-term foster care—different needs, different outcomes.* Carsey Institute at the University of New Hampshire. Issue Brief No. 31. Retrieved October 14, 2022, from https://scholars.unh.edu/cgi/viewcontent.cgi?article=1138&context=carsey

[106] Craft, C. (2022). *How respite foster care works.* Verywell Family. Retrieved October 14, 2022, from https://www.verywellfamily.com/what-is-respite-foster-care-26300.

[107] American Academy of Pediatrics. (2021). *Health care standards*. Retrieved October 14, 2022, from https://www.aap.org/en/patient-care/foster-care/health-care-standards/.

[108] Rhode Island Department of Children, Youth and Families, Rhode Island Children's Information System (RICHIST), 2021.

[109] Cole, P., Gebhard, B., & Ullrich, R. (2017). *The child welfare system: A critical support for infants, toddlers, and families.* Washington, DC: Zero to Three and CLASP. Retrieved March 24, 2022, from www.clasp.org

[110] Rhode Island Family Court. (2020). *Safe and Secure Baby Court.*

[111] Rhode Island Association for Infant Mental Health. (n.d.). *Initiatives - Safe and Secure Baby Court.* RIAIMH. Retrieved October 19, 2022, from https://riaimh.org/Initiatives

[112] Rhode Island Department of Children, Youth and Families. (n.d.). Youth Development Services and Voluntary Extension of Care Program. Retrieved April 19, 2022, from www.dcyf.ri.gov

[113,114] Rhode Island Department of Children, Youth & Families Correspondence (2022).

ACKNOWLEDGEMENTS

Rhode Island KIDS COUNT would like to thank Laurie-Marie Piscoitta, Mental Health Association of RI; Susan Orban, Washington County Coalition for Children; Susan Dickstein, RI Association for Infant Mental Health; Samantha Brinz, Kristen Petrarca, RI Department of Education; Marti Rosenberg, Ellie Rosen, Rebecca Lebeau, RI Executive Office of Health and Human Services; Kayla Rosen, RI Governor's Office; Beth Bixby, Tides Family Services; Ben Lessing, Community Care Alliance; Tanja Kubas-Meyer, RI Coalition for Children and Families; Andrea Chu, Hassenfeld Child Health Innovation Institute; Henry Sachs, Kathleen Donise, Bradley Hospital; Colleen Caron, Jane Pellegren, RI Department of Children, Youth & Families; Kathleen Kemp, Rhode Island Family Court; Karine Monteiro, RI Department of Health for their support of this Children's Mental Health publication.

Rhode Island kids count

CVSHealth

We'd like to thank CVS Health for its support of this Issue Brief.