CHILDREN'S MENTAL HEALTH SERVICES

CHARGE

The Children's Mental Health subcommittee focused its work on the following:

- Defining core mental health services for Iowa's children with a focus on crisis mental health services;
- Determining which of the services are the highest priority to initiate first;
- Recommending how the services selected would be governed; and
- Recommending how services would be funded

The following describes the results of the subcommittee's discussions.

CHILDREN'S MENTAL HEALTH SERVICES

The Children's Mental Health subcommittee developed a list of children's mental health services descriptions that should be available to Iowa children experiencing mental health challenges and their families. The list of services was derived from the Core Services described in the 2013 *Children's Disability Workgroup Final Report*. Subcommittee members also considered information in the draft *Statewide Call for Action: A Strategic Plan for a Children's Mental Health Redesign,* the comprehensive list of children's mental health services from the State of Minnesota, and service descriptions from other states. The subcommittee recommends children's mental health services are delivered using system of care principles and evidenced based practices whenever possible.

> **System of Care** *is defined as a child and family-driven, cross-system spectrum of effective, community-based services, supports, policies, and process for children birth to young adulthood, with or at risk for physical, emotional, intellectual, behavioral, developmental, and social challenges and their families that is organized into a flexible and coordinated network of resources, builds meaningful partnerships with families, children and young adults, and addresses their cultural and linguistic needs, in order for them to optimally live, learn, work, and recreate in their communities and throughout life.*
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> **Evidence based practices** *(EBP) are practices that have consistent scientific evidence showing they improve individual outcomes. EBPs have the following characteristics:*
> - *Transparency: Both the criteria and the process of review are subject to peer-review.*
> - *Research: Accumulated scientific evidence based on randomized controlled trials.*
> - *Standardization: The practice's essential elements are clearly defined.*
> - *Replication: More than one study and group of researchers have found positive effects.*
> - *Meaningful Outcomes: Consumers are shown to achieve meaningful outcomes.*

The subcommittee identified the following service descriptions that have been grouped using the categories of services from the 2013 Children's Disability Workgroup Report. Each service was listed once in a service category that fit it the best. More expansive definitions of some of these services are included in Appendix A of this report.

Category 1: Prevention, Early Identification, and Early Intervention

Behavioral health and substance use education

A statewide program that provides education regarding the signs, symptoms, and effective responses for behaviorally health and substance use disorder conditions in children and is intended to reduce stigma. Specifically designed education is provided to the following groups:

- Youth, especially youth with a severe emotional disturbance (SED)
- Parents and family
- Educators
- Other child care providers
- The community at large

Primary care screening for mental health and substance use disorder

- Training for primary care physicians regarding the signs, symptoms, and effective responses for behavioral health or substance use disorder conditions in children.
- Using a standard screening tool recommended to be used by primary care physicians in all well child visits.
- Adopt the principles of screening, brief Intervention, and referral to treatment as a statewide model of early intervention.

Category 2: Behavioral Health Treatment

Assessment and evaluation

A complete holistic health and behavioral health assessment that includes the social determinants of health done by a licensed mental health professional designed to identify issues as a basis for a treatment plan.

Medication prescribing and management

Medication prescribing means services provided by an appropriately licensed professional including, but not limited to, determining how the medication is affecting the individual; determining any drug interactions or adverse drug effects on the individual; determining the proper dosage level; and prescribing medication for the individual for the period of time before the individual is seen again.

Medication management means services provided by a licensed professional including, but not limited to, monitoring effectiveness of and compliance with a medication regimen; coordination with care

providers; investigating potentially abusive activities or misuse of medication pursuant to licensed prescriber orders.

Collaborative Psychiatric Consultation Service

Collaborative Psychiatric Consultation Services provides licensed prescribers access to a board certified child psychiatrist to consult with medication management and prescribing. Experts in the field will determine which medications and dose ranges would be eligible for psychiatric consultation. Calls for assistance will be triaged by a licensed mental health professional. If determined appropriate, the call will be referred to a project child psychiatrist for telephone consultation to the licensed prescriber. The service is free of charge to all callers.

Crisis intervention and stabilization

A crisis is when a child or the child's family is lacking immediate internal and external resources that place the child at risk of maintaining a healthy and safe environment. Children's mental health crisis response services are intensive face-to-face, short-term mental health services initiated during a crisis to help the child/youth return to their baseline level of functioning. Children's crisis response services must be provided by a crisis response team outside of urgent care, inpatient or outpatient hospital settings.

Crisis response providers must be experienced in mental health assessment, crisis intervention techniques, have emergency clinical decision-making abilities and knowledge of local services and resources. Services include:

- Crisis Screening
- Crisis Assessment
- Crisis Intervention
- Crisis Stabilization

A single statewide crisis telephone line should be available.

Individual, group, and family therapy

Individual, group and family therapy means a dynamic process in which the therapist uses professional skills, knowledge and training to enable children and their families to realize and mobilize their strengths and abilities, take charge of their lives, and resolve their issues and problems. Therapy services may be provided to individuals, groups, or families. Therapy will not be unnecessarily limited by site of service and includes in-home family therapy

Integrated Health Home Care Coordination

Integrated Health Home Care Coordination means activities designed to help children and their families locate, access, and coordinate a network of supports and services that will allow children to experience resilience and recovery and live a safe, healthy, successful, self-determined life in their home and community.

Intensive Evidenced Based Treatment

Intensive in-home services provide therapeutic interventions to children with an SED and their families that are at risk of inpatient treatment or out of home placement that is designed to prevent such placements. Intensive in-home services are designed by a team that includes the child and their family that combines individual, group and family therapy and behavioral interventions with the support of paraprofessionals.

The Youth Assertive Community Treatment (ACT) provides a menu of intensive mental health services provided in a comprehensive, coordinated team approach.

Residential or Inpatient Treatment

Acute inpatient psychiatric hospital treatment is defined as treatment in a hospital psychiatric unit that includes 24-hour nursing and daily active treatment under the direction of a psychiatrist and certified by The Joint Commission or the National Integrated Accreditation for Healthcare Organizations (NIAHO) as a hospital.

Psychiatric Medical Institution for Children is a non-hospital facility that provide inpatient services to individuals under 21 years of age and that is accredited by JC or any other accrediting organization with comparable standards recognized by the State that meets the standards set by the Centers for Medicare and Medicaid Services and is licensed and certified by the state.

Subacute mental health services are short-term, intensive, recovery-oriented services designed to stabilize an individual who is experiencing a decreased level of functioning due to a mental health condition.

Category 3: Recovery Supports

Family Support provides the training and support necessary to ensure engagement and active participation of the family in the treatment planning process and with the ongoing implementation and reinforcement of skills learned throughout the treatment process.

Youth Peer Support

Youth peer support is to assist youth experiencing an SED to learn from someone with a lived experience that recovery and resiliency is possible and to provide guidance, coaching and encouragement during the youth's recovery journey. Youth Peer Support provider is an individual in the youth's identifiable age group that has had lived experience of an SED and has been thoroughly trained as a peer support worker.

Respite Care provides temporary direct care and supervision for the child with an SED.

Attendant Care provides a child with an SED that would otherwise be placed in a more restrictive setting personal support and supervision services.

Family Resource Home provides short-term and intensive supportive out of home resources for the child with an SED and his/her family without the family needing to give up custody of their child.

Category 4: Community-Based Flexible Supports

Wraparound Services are designed to meet the goals set by the child and family team and to provide flexible support to the child and family. The services in a wraparound plan, also known as direct support services, differ from traditional mental health services and include the flexible use of funding to meet children and family needs.

SERVICE PRIORITY

The Children's Mental Health Services subcommittee recognizes that not all of the identified services can be developed at once. The subcommittee recommends a phased in approach that allows full development of all services over time. The subcommittee agreed that children's mental health crisis services are the highest priority service. Therefore, the subcommittee recommends that these be the first children's mental health services developed statewide. The subcommittee recommends mental health crisis services be developed based on the definitions in this report, be comprehensive in nature, and be accessible in all areas of the state to all Iowa children and their families that need them.

Once children's mental health crisis services are implemented statewide, the subcommittee recommends that process should begin to develop and make available the full array of mental health services described in this report. When these additional services are ready to be developed, the governance and funding recommendations described below will need to be re-evaluated.

GOVERNANCE

Once the service priority was agreed upon, the subcommittee discussed how to govern the development and delivery of children's mental health crisis services. It was agreed that governance includes, but is not limited to, the following:

- The establishment of statewide standards for the delivery of children's mental health crisis services
- The development of accessible children's mental health crisis services statewide
- An organized effort of funding from a wide variety of existing sources
- Identifying gaps in funding and developing funding requests to fill the gaps
- Monitoring the effectiveness of services that are provided
- Making adjustments in services and the service system to better meet the mental health crisis needs of children and their families

The subcommittee discussed a variety of approaches for governance. The consensus of the subcommittee was to not recommend adding this responsibility to the Mental Health and Disability Service (MHDS) Regions. They felt it was too early in the MHDS Regions' development of adult MHDS services to add another major responsibility. The subcommittee recommends that the governance entity be independent of existing children's service delivery systems that do not specialize in children's mental health services such as, but not limited to: education, child welfare, juvenile justice, early intervention, etc. The subcommittee felt that an entity independent from these service systems would be less encumbered by existing service delivery approaches and would more likely to develop quality, evidenced based mental health crisis services that are responsive to the needs of children and their families. However, the subcommittee was clear that children served in these other service systems need, and will likely be major users of, children's mental health crisis services. The subcommittee also noted that the governance entity would need to be administratively linked to a state agency to allow it to effectively carry out many of the responsibilities of governance listed above.

The subcommittee discussed the various challenges related to fulfilling the roles of governance listed above. The subcommittee concluded that they did not have sufficient knowledge regarding what it would take for such an entity to be successful. Therefore, the subcommittee recommends that a group of key state leaders meet to develop a mutually agreeable plan for designating a Children's Mental Health Crisis Services governance entity. The group of key state leaders should include, but not be limited to, the Directors of the Department of Human Services, Department of Public Health, Department of Inspections and Appeals, Department of Public Health, Department of Human Rights, and the Department of Education. Other interested entities should be added to the discussion as these Directors determine can be helpful to the process.

FUNDING

The subcommittee discussed the different funding sources for children's mental health crisis services. The subcommittee identified the following three funding sources as most likely the largest contributors to children's mental health crisis services funding:

- Medicaid
- Private health insurance
- MHDS Regions that serve children

The governance entity will be responsible to work collaboratively with those responsible for these funding streams to braid them together to maximize the impact of funding the needed mental health crisis services. In addition, the governance entity will be responsible to determine if there are more sources of existing funding. As noted above, the governance entity is then responsible for identifying the gap in funding to ensure a comprehensive children's mental health crisis system and to develop funding requests to fill those gaps.

TIMEFRAMES

The subcommittee recommends that the governance entity be established by the end of the 2016 legislative session. Initial service development with existing funding should be underway by December 2016. The governance entity should present a request to fill the funding gap for consideration by the Governor and the Legislature for the 2017 legislative session.

APPENDIX A
EXPANDED DEFINITIONS OF SELECTED CHILDREN'S MENTAL HEALTH SERVICES

Crisis intervention and stabilization

A crisis is when a child or the child's family is lacking immediate internal and external resources that place the child at risk of maintaining a healthy and safe environment.

Children's mental health crisis response services are intensive face-to-face, short-term mental health services initiated during a crisis to help the child/youth return to their baseline level of functioning. Children's crisis response services must be provided by a crisis response team outside of urgent care, inpatient or outpatient hospital settings.

Crisis response providers must be experienced in mental health assessment, crisis intervention techniques, have emergency clinical decision-making abilities and knowledge of local services and resources.

Crisis Screening

Prior to doing crisis assessment conduct a screening of the potential crisis situation. The screening must:

- Gather information using a standard screening guide;
- Use the screening guide to determine whether a crisis situation exists;
- Identify the parties involved; and
- Implement an appropriate response whether or not a crisis response is needed.

Crisis screening must be available 24 hours a day 7 days a week and may be done over the telephone

A single statewide crisis telephone line should be available.

Crisis Assessment

A standardized crisis assessment is an immediate, face-to-face evaluation by a physician, mental health professional or practitioner, to determine the recipient's presenting situation across all life domains, and identifying any immediate need for emergency services.

- Provide immediate intervention to provide relief of distress based on a determination that the child's behavior is a serious deviation from his/her baseline level of functioning;
- Evaluate in a culturally appropriate way and as time permits the child's:
    - Current life situation and sources of stress;
    - Symptoms, risk behaviors, mental health problems, and underlying co-occurring conditions;
    - Strengths and vulnerabilities;
    - Cultural considerations;
    - Support network;
    - Physical health; and
    - Functioning.

Conduct the crisis assessment anywhere that the individual and clinician determine is safe and appropriate including, but not limited to, the recipient's home, the home of a family member, or another community location. Determine the need for crisis intervention services or referrals to other resources based on the assessment.

Crisis Intervention

Crisis interventions are face-to-face, short-term intensive mental health services started during a mental health crisis or emergency to help the recipient:

- Cope with immediate stressors and lessen his/her suffering;
- Identify and use available resources and recipient's strengths;
- Avoid unnecessary hospitalization and loss of independent living;
- Include a family team meeting;
- Develop action plans including providing needed short term support and/or treatment outside the family home; and
- Begin to return to his/her baseline level of functioning.

Crisis intervention services must be:

- Available 24 hours per day, seven days per week, 365 days per year;
- Provided on-site by a mobile team in a community setting;
- Culturally appropriate; and
- Provided promptly.

Crisis Stabilization

Crisis stabilization services are mental health services provided to a recipient after crisis intervention to help the recipient obtain his/her functional level as it was before the crisis. Provide stabilization services in the community, based on the crisis assessment and crisis plan.

Consider the need for further assessment and referrals. Update the crisis stabilization treatment plan, supportive counseling, skills training, and collaboration with other service providers in the community. A transition plan from crisis services is written and implemented that includes a "warm hand-off" to on-going treatment services.

<u>The Youth ACT</u>

Provides the following services in a comprehensive, coordinated team approach:

- Individual, family, and group psychotherapy
- Individual, family, and group skills training
- Crisis assistance
- Medication management
- Mental health case management
- Medication education
- Care coordination with other care providers

- Psycho-education to, and consultation and coordination with, the recipient's support network (with or without recipient present)
- Clinical consultation to the recipient's employer or school
- Coordination with, or performance of, crisis intervention and stabilization services
- Assessment of recipient's treatment progress and effectiveness of services using outcome measurements
- Transition services
- Integrated dual disorders treatment
- Housing access support

Recipients and/or family members must receive at least three face-to-face contacts per week.

Family Support provides the training and support necessary to ensure engagement and active participation of the family in the treatment planning process and with the ongoing implementation and reinforcement of skills learned throughout the treatment process. Training is provided to family members to increase their ability to provide a safe and supportive environment in the home and community for a child with an SED. For the purposes of this service, "family" is defined as the persons who live with or provide care to a child with an SED, and may include a parent, spouse, children, relatives, grandparents, or foster parents. Services may be provided individually or in a group setting. Services must be recommended by a treatment team, are subject to prior approval, and must be intended to achieve the goals or objectives identified in the child's individualized plan of care.

This involves:

- Assisting the family in the acquisition of knowledge and skills necessary to understand and address
- The specific needs of the consumer in relation to their mental illness and treatment; development and enhancement of the families specific problem-solving skills, coping mechanisms, and strategies for the consumer's symptom/behavior management;
- Assisting the family in understanding various requirements of the waiver process, such as the crisis plan and plan of care process;
- Training on the child's medications or diagnoses; interpreting choice offered by service providers; and assisting with understanding policies, procedures and regulations that impact the consumer with mental illness while living in the community.

Family Support is provided by a family member of a child with an SED that has successfully completed Family Support training.

Respite Care provides temporary direct care and supervision for the child with an SED. The primary purpose is relief to families/caregivers of the child. The service is designed to help meet the needs of the primary caregiver as well as the identified child. Normal activities of daily living are considered content of the service when providing respite care, and these include: support in the home/after school/or at

night, transportation to and from school/medical appointments/or other community based activities, and/or any combination of the above. Transportation is included as a part of this service.

Respite Care can be provided in a child's home or place of residence or provided in other community settings. Other community settings include: Licensed Family Foster Home, Licensed Group Boarding Home, Licensed Attendant Care Facility, Licensed Emergency Shelter, Out-Of-Home Crisis Stabilization House/Unit/Bed.

Attendant Care provides a child with an SED that would otherwise be placed in a more restrictive setting due to significant functional impairments resulting from an identified mental illness. This service enables the child to accomplish tasks or engage in activities that he/she would normally do him/herself if the child did not have an SED. Assistance is in the form of direct support, supervision and/or cuing so that the child performs the task by him/her self. Such assistance most often relates to performance of Activities for Daily Living and Instrumental Activities for Daily Living and includes assistance with maintaining daily routines and/or engaging in activities critical to residing in his/her home and community. The majority of these contacts must occur in customary and usual community locations where the child lives, works, attend schools, and/or socializes. Services provided at a work site must not be job tasks oriented. Services provided in an educational setting must not be educational in purpose. Services furnished to an child that is an inpatient or resident of a hospital, nursing facility, intermediate care facility for persons with an intellectual disability, or institution for mental disease are not eligible.

Services must be recommended by a treatment team, are subject to prior approval, and must be intended to achieve the goals or objectives identified in the child's individualized plan of care. Transportation is provided between the participant's place of residence and other services sites or places in the community and the cost of transportation is part of this service.

Family Resource Home provides short-term and intensive supportive out of home resources for the child with an SED and his/her family without the family needing to give up custody of their child. The intent of this service is to provide out of home support for the family in order to avoid psychiatric inpatient and institutional treatment of the child by responding to potential crisis situations through the utilization of a co-parenting approach provided in surrogate family setting. The goal will be to support the youth and family in ways that will address current acute and/or chronic mental health needs and coordinate a successful return to the family setting at the earliest possible time. During the time the professional resource family is supporting the youth, there is regular contact with the family to prepare for the child's return and his/her ongoing needs as part of the family. It is expected that the child, family and the professional resource family are integral members of the child's individual treatment team. Transportation is provided between the child's place of residence and other services sites or places in the community and the cost of transportation is part of this service.

Wraparound Services are intensive, holistic services that engage the family and their children to meet the goals set by the child and family team and to provide flexible support to the child and family. The goal of wraparound services is to ensure the child lives successfully in the family, is successful in school

and is a participating member of the community. The services in a wraparound plan, also known as direct support services, differ from traditional mental health services because they:

- Are primarily provided in the homes of families and in settings in the community rather than in an office setting;
- Are available when families need them, including after-school, in the evenings or on the weekends instead of only during office hours;
- Emphasize treatment through participation in purposeful activities, giving children the opportunity to practice life skills and make positive choices through involvement in community activities, instead of focusing on treatment through talking about problems; and
- Are built around engaging the child and family in activities that interest them and meet their goals instead of just around a goal of stopping negative behaviors.