

# An Assessment and Study of the Mississippi System of Care

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**Table of Contents**

Introduction .....1

An Overview of the Findings of the Assessment and Study  
of Mississippi’s System of Care.....3

Methodology.....6

System of Care Elements.....8

Summary and Discussion of Existing Statute.....12

Findings.....17

    Parents/Families/Youth .....17

    Statutory System of Care .....18

    Context: System of Care Partners.....22

Recommendations .....29

Appendix A: MS Mental Health System Organization and Operation .....36

Appendix B: Collaborative Application of the System of Care.....40

Appendix C: Medicaid .....44

## Introduction

This Assessment and Study of Mississippi's System of Care is provided first and foremost to the children, adolescents, young adults, and families of Mississippi who have struggled, and who will yet struggle, with behavioral health needs. The saddest part of this work is that those struggles are sometimes so incredibly painful and difficult; the happiest part of this work is making system changes that better enable families to raise their own children successfully to adulthood, maybe even with a little less struggle.

This Assessment and Study is provided to the Center for Mississippi Health Policy which provided funding and support for the study. The Center views behavioral health care of children as an important element of a healthy Mississippi and is seeking to ensure continuation of the development of the system of care.

Information and support for this Assessment and Study have been provided by many persons and organizations. First among them, Sandra Parks, Director of the Division of Children and Youth Services at the Department of Mental Health, provided a steady flow of data and answers to questions and orchestrated two highly-structured and successful Site Visits.

Deep respect is also offered to Brenda Scafidi, previous Director of DCYS at DMH, and Tessie Schweitzer, retiring and founding Director of MS FAA, who worked together over several decades to produce the climate that currently exists in Mississippi, a climate that allows the current system of care to touch real lives and prepares that system of care to grow to touch more real lives. The families of Mississippi thank both for their dedicated service.

This Assessment and Study is limited by the data available to inform the process. Quantitative data about system functioning are very limited. Public systems do not utilize sophisticated or well-developed Management Information Systems (MIS), and the outcomes expected from services are not defined or tracked. Quality improvement systems are not in evidence at any level. Much of this study is based on impressions.

This Assessment and Study report is organized as follows:

An Overview of Findings is provided first. Those who prefer the quick summary will appreciate this overview, although details in other sections are important.

A Methodology section is provided to explain the process that led to this report. This section is followed by a discussion of System of Care Elements to explain the standard applied in this Assessment and Study.

A Summary and Discussion of Existing Statute is then provided, as the System of Care statute drives development in Mississippi and is the focus of this study.

Findings from this Assessment and Study are offered next, organized as follows:

- Parents/Families/Youth – their experiences and reports
- Statutory System of Care – the three statutory components
- Context: system of care partners – surrounding context

Recommendations follow, with the single goal of improving the lives of Mississippi children and their families. The order in which recommendations are presented generally attempts to follow the findings outline, but no priority should be implied by anything beyond the language of each recommendation. It is emphasized that all of the recommendations are designed to work in concert, working synergistically to build effective systems of care across Mississippi.

At the end of the report are three appendices with detailed information and analysis in the following relevant areas:

Appendix A – MS Mental Health System Organization and Operation

Appendix B – Collaborative Application of the System of Care

Appendix C – Medicaid

Errors of any kind in this report belong solely to the author.

## **An Overview of the Findings of the Assessment and Study of Mississippi's System of Care**

A careful study of the past several decades shows that Mississippi has steadily created components of a functional system of care, even while resources were not available to fully implement those components. Recommendations have been provided by a succession of groups. Mississippi leaders have employed national experts and blended that knowledge with in-state expertise about Mississippi children and families to determine next step recommendations on numerous occasions (see, for instance, the Joint Legislative Committee on Performance Evaluation and Expenditure Review (PEER) report, June 2008 ; Planning for the Future of Mississippi MAP Teams, Behar and Hydaker, 2007; Findings of the Joint Legislative Committee Hearings, December 2000; or the Impact Study Baseline Report, C.A. Heflinger et al, 2000). System of care development in Mississippi is a story of slow steps forward, interspersed with reality checks; improvements are visible, yet great unmet needs still exist.

§43-14-1 of the MS statute defines the MS System of Care to include three primary components, also defining membership and functioning requirements for each. The Interagency Coordinating Council for Children and Youth (ICCCY) and the Interagency System of Care Council (ISCC) are both established as state level entities intended to promote collaboration across separate state systems, and local Multidisciplinary Assessment and Planning (MAP) Teams/Adolescent ("A") Teams ("A" Teams were added in the Juvenile Justice Reform Act of 2005) create collaboration across those same systems for the benefit of individual children, youth, and families at the community level.

All evidence provided for this Assessment and Study suggests that state-level collaboration is being nurtured and developed, primarily by the ISCC but with explicit support from the ICCCY. Examples of deliberate alignment of system policies and practices through interagency partnerships are in evidence and individual participants in the ISCC express commitment to the shared purposes of that group, most with excitement.

Evidence also suggests three important findings about the local MAP and "A" Teams:

- 1) The 1,266 children and families directly served last year (FY08) by 36 MAP Teams generally got good help, and family anecdotal information strongly supports the positive impact of MAP Team processes on this small group of Mississippi children and youth.
- 2) The MAP Teams have unquestionably decreased overall system costs for the group of children and youth served, although data to prove that assertion are not available. Relevant and convincing data are available through the MYPAC project, a parallel, grant-supported effort to divert children and youth from institutional settings to intensive, community-based care using Medicaid tools.
- 3) It is reasonable to assume, based on the most conservative parameters for estimation of the population of need, that up to ten times as many children, youth, and families in Mississippi could appropriately and successfully be served by the MAP Teams, but the raw capacity to handle that number of children, youth, and families is not currently present.

The three statutory System of Care entities operate within the broader context of publicly-funded child- and family-serving systems, which collectively expend substantial resources to identify and address behavioral health needs of children and adolescents. MAP Teams succeed through better, more creative, application of existing resources from existing community entities, including schools, courts, child protection and advocacy agencies, health and human service providers, and others. MAP and “A” Teams create community opportunities to problem-solve, bringing together diverse knowledge and resources and offering solutions to the problems faced by families in the community. At present, the capacity of the teams is simply limited.

It is interesting to note that Mississippi stands at a unique moment in history when three major child-serving systems are striving to address behavioral health needs among the children and youth those systems serve, in addition to the ongoing work of the behavioral health care system. [See Appendix B for a detailed discussion of these law suits.]

- The education system is implementing, as a result of the Mattie T. Consent Decree, reforms in special education to improve identification and care of students with emotional/behavioral disorders that negatively impact their ability to benefit from education. Mattie T. includes goals for more accurate identification of special needs among students who are African-American, reversing a long-standing trend of disproportionately identifying students in this group as “mentally retarded”.
- The child welfare system is implementing the Olivia Y. Settlement Agreement, which includes, among others, a requirement that children entering state custody receive an assessment to identify potential treatment needs within a short time after entering custody. If behavioral health or other needs are identified, the agreement describes parameters about addressing them.
- The juvenile justice system is resolving a federal law suit through strategies that include substantial changes in behavioral health care for youth committed to the Oakley School, especially in identifying behavioral health needs, assuring access to relevant and effective treatments, and minimizing suicide risks.

Each of these systems would benefit from an expanded system of care that enables the application of common MAP team-like community processes to the populations of need identified within each system. As a result, the families of Mississippi would benefit through increased ability to successfully raise their own children. Although children, adolescents, and young adults with mental illness and/or substance use disorders are identified through different systems, the treatment and support needs of such youth are fairly consistent, regardless of the system in which they are identified. More important, behavioral health disorders are treatable!

Behavioral health disorders are successfully addressed through individualized, flexible, goal-oriented, and self-correcting community processes supported by regulatory and funding structures. Earlier identification and response to those needs lessens both their immediate impact and their eventual cost to the child, family, and community. The combined resources and capabilities of all of the child- and family-serving systems are necessary for the creation and maintenance of those processes, as is input from families and youth, particularly if earlier identification and care are to be effective. Each public service system stands to gain a great deal through committed involvement in system of care development.

The broader public mental health system that surrounds the MAP teams is doing some good work, with some CMHC regions demonstrating significantly more effort and success in working with children and youth than others, but the help offered is not necessarily well-aligned with the needs of those children and youth or with best practices in the field. Service capacity is a substantial issue in the primary treatment system for children and youth with behavioral health needs, especially in the lack of intensive, community based services.

On the basis of reported numbers, MS Community Mental Health Centers (CMHC) in 15 regions are serving a substantial number of children and adolescents identified as having a serious emotional disturbance (SED). However, the public system process established to identify children and youth with SED is directly linked to access to services that will be paid for by Medicaid. Without the label, only more limited services can be accessed. Therefore, the substantial whole of children and adolescents reported to be served by the primary mental health system and paid for by Medicaid are identified as SED. However, the average number and types of services provided to each individual recipient suggest that, in spite of their “serious” emotional disturbance, most children and youth received infrequent and/or short-duration services from the system, which in turn suggests that 1) their needs were not that serious, and/or 2) the system did not respond adequately to their needs.

The MYPAC initiative is demonstrating that community-based, team-based, and family-driven care can effectively address child, youth, and family needs and simultaneously save tax dollars. MYPAC is based on identical principles to those outlined in the System of Care statute and its outcomes suggest the possibilities of bringing the system of care to scale statewide. The children and youth served in MYPAC have serious and complex needs, and the type of care they require is sometimes more intense than what most community agencies have traditionally provided. The use of more intensive therapeutic options at the community level decreases the number of children who need to go to hospitals or residential treatment agencies, thus saving the costs of unnecessary placements. More importantly, community-based care allows children and youth in distress to maintain contact with their family and community, important resources in their long-term management of their behavioral disorders.

Children, youth, and young adults in MS suffer from serious emotional disorders, and those disorders are largely treatable. The best care for such children and youth is provided within the child’s community and family. Only a small portion of the MS children, youth, and young adults with those disorders are getting access to the most effective care infrastructure – the MAP and “A” Teams. Components to provide effective care have been developed and are at work in pockets across the state, but broad portions of the MS population lack access to that care. The current system of care infrastructure requires significant support and development to address the unmet behavioral health needs of Mississippi children and their families.

## **Methodology**

This Assessment and Study was driven by the following Goal Statement:

To gather information, data, and stakeholder input about the Mississippi System of Care, focused on the work of the Multidisciplinary Assessment and Planning (MAP) teams, the Interagency Coordinating Council for Children and Youth (ICCCY), and the Interagency System of Care Council (ISCC) and targeting the children and youth (up to 21) with serious emotional disorders (including behavioral disorders, conduct disorders or mental illness) who are at risk of school suspension or expulsion, or placement in a treatment facility; and to present a written report that includes system assessment findings and recommendations for improving the functioning and effectiveness of the Mississippi System of Care.

Substantial information was provided for this Assessment and Study by Sandra Parks, DMH, and Tessie Schweitzer and Laura Smith, MS FAA. Additional information was provided by other members of the Interagency System of Care Council. Relevant information was obtained through state agency websites and other Internet sites. Information was reviewed to answer three critical questions:

1. What are the experiences of Mississippi children and adolescents with serious emotional disturbances and their families?
2. How is the statutory system of care functioning for this population of children and adolescents?
3. How are the public service systems that surround the system of care functioning with respect to this population of children and adolescents?

Two site visits were conducted to gather relevant information and stakeholder input. A state system site visit in Jackson occurred in mid-July, during which the author met with the full ISCC, individually with each ISCC member, individually with four ICCCY members, and with a large group of parents and family members from across the state, organized for this purpose by MS FAA. A local system site visit in early September enabled the author to meet with five separate MAP teams (in Forrest, Hancock, Harrison, Rankin, and Warren Counties), with a large group of parents and family members along the Gulf Coast, and with all of the state's MAP Team Coordinators in a day-long meeting. These visits were invaluable in gathering information and gaining understanding of Mississippi realities.

An assessment that includes child and family outcomes, multiple system entities functioning at multiple levels, and collaboration between public systems must have a yardstick against which to measure, but no easy yardstick exists. Negotiations at the onset of this project established a listing of system elements to be reviewed, as follows:

Organization and Financing of the System  
Data Production and Use  
Collaboration among Agencies, Service Providers, and Families  
System Planning and Governance  
Quality Assurance  
Accountability



Unmet Needs and Disparities  
Workforce Development

To this list, the author added Evidence-Based Practices. A brief section outlining the meaning of these elements in a system of care, based on the author's experiences, follows this Methodology section and offers a proxy for the yardstick used in this Assessment and Study. It should be noted that the discussions covering Organization and Financing of the system and Collaboration are more highly developed because those shared elements lie at the heart of all system of care infrastructure.

## **System of Care Elements**

The following brief discussion, based on system of care literature and the author's extensive experience, is offered to frame the author's views that were used to formulate the findings and recommendations of this report.

### Organization and Financing

The system of care does not need to build a new or separate entity to fulfill the principles that guide SOC development. A true system of care, of necessity, engages all public helping systems through heightened organization and improved alignment of policies, practices, goals, financing, and accountability. The key in a system of care is that helping systems are better organized to provide the services and supports that individual children, youth, and families need, in effective and cost-effective ways.

Policy professionals argue that policy must drive financing but in the real world financing tends to drive policy, just as a family decides their spending priorities based on the amount of money available. Therefore, the financing structures and approaches employed in public services are critical to an effective SOC.

A simple model for understanding the management of helping systems includes three components: 1) planning; 2) implementation; and 3) evaluation.

“What do we want to do?” “What do we do?” “How did we do?”

A system of care is organized so that these three components are aligned across all helping systems and entities, alignment that cannot happen without deliberate activities.

All planning by one system or entity recognizes and influences planning in partner systems. Key stakeholders take part in all planning activities, for each service system. Leaders of each system inform each other about planning processes and outcomes, seeking opportunities to link work together. Budget requests are not developed and submitted competitively; rather, system leaders seek strategies that enable multiple systems to support priorities across systems, promoting public investment in the most critical areas.

Implementation by each system is deliberately designed to include relationships with all other systems. Eligibility requirements for access to individual services are designed to leave few gaps between services. Service definitions utilize similar language and formatting. Provider requirements and expectations are aligned across systems so that individual community providers can simultaneously deliver services across categorical systems. Funding priorities and mechanisms are aligned across systems, employing similar language, concepts, approaches, and forms. Entities receiving public funds through one system are explicitly expected to cooperate with other community helping entities.

Evaluation cannot take place in a vacuum – the context of outcomes is significantly important. Each system gathers evaluation data about its specific mission and evaluation results are linked across systems and entities. Systems utilize similar terms and definitions, gather data in related formats, and include each other's expertise in interpreting results.

System of care leaders create mechanisms and processes that allow all of these activities to be aligned across systems. The ICCCY, ISCC, and local MAP teams are excellent examples of deliberate mechanisms and processes for this type of alignment.

## Data Production and Use

Effective systems are data-driven; decision-makers at all levels, but especially at the highest system levels, know the system's current state and target the changes/improvements they wish to achieve by examining data. Those same, or better, data are then used to determine if the changes/improvements were effective. Gathered data are directly related to system/entity mission, goals, and objectives. Data are examined and reported regularly in public processes and system stakeholders are engaged in analysis and reporting.

Information system architecture is deliberately chosen to fit each system's structure, with an emphasis on creating data systems that can "talk to each other". Front-line staff who gather data are trained and supported in effective practices. Data directly related to each helping entity's mission is collected, analyzed, and utilized. Stakeholder groups are established and supported to examine data and find consensus about the meaning of the data. Feedback channels and mechanisms between systems are established and maintained to ensure that relevant data are considered in decision-making processes.

## Collaboration Among Agencies, Service Providers, and Families

Collaboration among stakeholders on behalf of the children, youth, and families in need of services and supports is the most important quality of systems of care. In effect, the working partnerships among helpers, advocates, families, and youth, at the community, state, and federal levels, are the system of care, with a shared commitment to the values enacted through these partnerships.

Two distinct types of partnerships are necessary in a system of care, both of which require retraining of system staff (top to bottom) and public education.

First, service system staff must learn how to work in teams, including attitude adjustments and the development of specific skills to make teams more effective. This need is as strong for a system executive director as it is of every front-line staff person, irrespective of their role. Specific skills are needed to work collaboratively in decision-making processes, and those skills are not frequently included or emphasized in professional training programs.

Second, partnerships between helpers and the youth and families they help are essential but not easy. Many professionals have been trained to "fix" problems, and the general operational guidelines of most public systems support that "expert" mentality. At the same time, the general public has been educated to expect "fixes" from professionals, and thus many families come to care asking for their child to be "fixed". Parallel efforts in staff retraining and public education, coordinated across all public systems, will lead to the type of partnerships that actually help children and adolescents achieve success in managing their mental illness and moving toward productive adulthood.

The development of these partnerships leads to new types of decision-making as policy, management, and funding actions are taken by system of care leaders, no matter the chair they occupy.

## System Planning and Governance

“Governance” refers to the ways in which authority and resources are wielded. System of care governance requires authority and meaningful resources to be shared, with decisions that impact significant numbers of people and/or amounts of money coming through consensus built among many different perspectives. Planning simply implies that leaders are looking forward, determining ways to use past experience to improve the impact of all services.

At the state level system of care, publicly funded system leaders come to a common table with other stakeholders and work towards alignment of rules, regulations, and funding requirements within and across the systems. The attitude of shared governance starts at the top, with leaders symbolically demonstrating commitment to this process by relinquishing solitary control of certain processes and resources. At the regional/community level, system of care leaders and stakeholders also join together to actually implement those aligned rules, regulations, and funding requirements in ways that best meet the needs and priorities of the local community.

## Evidence Based Practices

All system organization, all governance and collaboration, all administrative activities are jointly aimed at what happens at the front lines, the places where system agents interact with real people. It is imperative that current knowledge about how to treat childhood behavioral health disorders reaches the front lines, and that can only happen in an organized system of care, where separate systems, with distinct qualification, training, and certification strategies, work deliberately to develop and align those strategies. System investments are needed to develop initial capacities for evidence-based practice implementation. Once those capacities are established, the need for resource investments will decrease over time as the treatment system decreases use of the more traditional and expensive interventions, especially institutionally-based care.

## Quality Assurance

The original System of Care articulation (Stroul & Friedman, 1996, 2<sup>nd</sup> ed.) left out the importance of quality management and assurance, but subsequent system development has demonstrated the necessity of active quality improvement systems in effective systems of care. Goals and expected outcomes are clearly stated and accepted across multiple perspectives. Feedback loops are deliberate, constant, and focused on the primary missions of helping systems, with stakeholder input and child outcomes the primary sources of feedback. Every person connected to the system plays a role in quality assurance, with a particular emphasis on the staff and volunteers closest to service recipients. QA data are regularly reported to the public and utilized within systems to improve child outcomes.

## Accountability

System of care accountability must satisfy two primary audiences: 1) taxpayers who support public services, and 2) persons/families for whom services are provided. Strong ethical standards are jointly implemented across all systems, documentation is maintained and accessible (except personal care information), and systems regularly report to the taxpayers in a well-functioning system of care. Persons receiving services are respected and their

experiences stand at the center of accountability. Consumer (children and their families) experiences and outcomes, defined within the missions of public agencies, are the primary source of understanding about the effectiveness of public care. Cost-effective care is a goal shared by all system participants. In a system of care, accountability must satisfy both audiences to an equal degree.

### Unmet Needs and Disparities

Systems of care evolved through the recognition of a specific population of children and adolescents who were being “thrown away” by public systems that were unable to respond effectively to their needs. The system of care approach is explicitly designed to identify unmet needs, of any type, and respond through system adjustments and improvements. Disparities in care that emerge across definable populations in the community are recognized and addressed, when possible. Such adjustments can only be made in partnerships built across public systems.

### Workforce Development

Prior to the system of care approach, systems focused first on filling positions, with less attention (and resources) given to training and supervision of the people who implement the mission. Research on many fronts is demonstrating best practices, but research also shows that new knowledge takes 15 years to penetrate front-line practice. A system of care deliberately supports competency development, following aligned processes and curricula, and aligns certification and regulation processes to those key competencies. Payors include, in compensation formulas, resources to support supervision and training, and community providers practice effective supervision and training. Parents, other family members, and young persons previously served by the system are recognized as valuable workforce assets within the system of care.

## **Summary and Discussion of Existing Statute**

Mississippi Statute 43-14-1. is titled, “Interagency Coordinating Council for Children and Youth,” and is the primary focus of this Assessment and Study. The first sentence in section (1) of this statute provides a statement of purpose: “to provide for the development and implementation of a coordinated interagency system of necessary services and care,” which the statute later names a “System of Care”.

The words “coordinated interagency system of necessary services and care” hold deep meaning and provide the standard for this Assessment and Study.

“Coordinated” requires a set of ongoing activities to **link together** the actions of the community’s helpers. Those ongoing activities are needed at the front lines, in state administrative offices, and at every system level in between. Coordination is deliberate, planned, regular, and documented. Coordination does not happen accidentally.

“Interagency” seems similar to “coordinated” but this word **defines the agencies** that must participate in coordination of care. “Interagency” is a broad and inclusive term, generally implying the full range of a community’s helping entities and the systems that fund and oversee those entities. “Interagency” means that all of the relevant, publicly-funded agencies participate, minimizing shadings of importance or dominance.

“System” means that everyone, every entity involved in the helping process, is viewed **within their appropriate context**, which is in relationship to each other, to the community, and to the persons served. A “system” exists when the relationships of all of the corporate parts are recognized and positively managed.

“Necessary services and care” speaks to the quality of care provided by this system. “Necessary” services can only be determined when a family and child have a) access routes into the helping system and b) access to effective screening and assessment processes. Once the appropriateness and necessity of services have been determined, the quality of the system is indicated when effective services are provided in a way that reflects the community’s caring for the child. It is not simply “giving services” – it is caring for the child by providing the needed services, seeking outcomes that are best for the child over a lifetime.

This opening statement of this statute clearly sets a legislative expectation that all of the publicly-funded helping agencies in Mississippi will deliberately coordinate their work together, developing and managing policies and practices to achieve coordination, so that Mississippi children and youth are cared for.

That same first sentence in the statute next describes a specific population of children and youth for whom coordinated, interagency care is to be provided: “Children and youth up to age twenty-one with serious emotional/behavioral disorders . . . who require services from a multiple services and multiple programs system, and who can be successfully diverted from inappropriate institutional placement.” Again, these words convey complex and important meanings.

“Children and youth up to age 21” clearly excludes no children on the basis of age. “Children” is a term that applies from birth, so young children are included in this system. The word “youth” deliberately recognizes the common emergence of emotional/behavioral

disorders as children approach and pass through puberty; “youth” is commonly used to describe an adolescent. Also important is “up to age 21.” Young persons with emotional/behavioral disorders tend to mature more slowly than “normal”, with many reaching the legal age of 18 without adequate maturity to manage their lives. The language of the statute recognizes that need by ensuring care within the system of care that continues long enough to successfully shepherd them to maturity.

“Serious emotional/behavioral disorders” is a complex term with a rich history, but it generally refers to the expression of a disability through a child or youth’s behaviors in one or more environments and that interferes with “normal” functioning. Normal functioning for a child means growing, learning, participating in the community, finding self-identity and roles, etc. Emotional/behavioral disorders frequently interfere with a child or youth’s functioning at home or at school, the places where children spend most of their time, and for some children in other community locations.

It is especially important to note that serious emotional/behavioral disorders are now known to be primarily rooted in biology and genetics, with environmental factors providing a trigger for the emergence of some disorders. Both nature and nurture matter in the development of mental illnesses, with poverty being an influential variable in the risk for disorders among children. A person (a child or youth) experiencing an emotional/behavioral disorder does not choose such a disorder, and disorders do not reflect moral failings of the individual or their family. Harmful experiences during childhood can and do increase the risk for disorders, and most parents make mistakes while raising their children, but most emotional/behavioral disorders among children and adolescents have clear physiological roots that require appropriate assessment and intervention. Families need to be part of the care process and children and youth are best served by remaining in positive relationship with their families.

The inclusion of the word “behavioral” in the statute broadens the more common term, “serious emotional disorders”. “Behavioral disorder” is a more modern term, reflecting growing knowledge that “mental illness”, “emotional disorders”, and “substance abuse disorders” are all related, tending to afflict overlapping groups of people and requiring integrated, coordinated interventions.

In the final words of the statute’s first sentence, “who can be successfully diverted from inappropriate institutional placement,” the priorities are set for the work of building a system of care. These words indicate that the system must first and foremost work with those children and youth whose needs are so serious that they are at risk of having their lives irrevocably changed by a week or a month or a year or more in an institutional setting. The system of care priority is to stop such placements through “diversion” to alternative care, most especially to community-based, non-institutional care. It should be noted that such children can be very young in age, with behaviors hard to manage in traditional community child care settings; such children can have their placement risks identified in a wide range of agencies and systems, each using different standards and decision-making processes regarding such placements; and many children with untreated or unsuccessfully treated behavioral needs eventually enter the juvenile justice system, in which institutional placement is a primary tool.

The children and adolescents named within this statute do not comprise a narrow, insignificant group of Mississippi citizens. National research generally shows that between 5% and 9% of all children and youth have emotional disorders serious enough to negatively impact their functioning. Epidemiological studies have also shown that higher levels of

poverty drive these percentages higher, leading to a prediction that 7% to 11% of all Mississippi children and youth are likely to experience negative impact from an SED. That means at least 53,000 persons under 18 (Census data do not include persons 18-20 as a discrete group) in Mississippi are experiencing negative impact from serious emotional disorders, and the number may be as high as 83,000. Only a portion of these children and youth would present for treatment in any given year.

Leaders and experts across all types of service sectors believe strongly that preventing such disorders and identifying and treating disorders earlier in their development would lead to healthier children and lower long-term care needs. Increasing the ability of public systems to identify needs and intervene earlier means that the number of Mississippi children and youth who might need help from the system of care could really be significantly more than 83,000, and getting to them earlier is good for every stakeholder of the system.

Why a long introductory discussion about a handful of words? This Assessment and Study is focused on this particular statute, and the words in the first sentence provide the standards against which the Mississippi System of Care must be studied. Is there coordination? Is there effective interagency involvement? Are broad ranges of children and youth impacted by emotional/behavioral disorders being identified and treated? Are services necessary? What services are being given? Is Mississippi keeping children and youth from entering inappropriate institutional care? What is happening to the children and youth who are touched by the Mississippi System of Care?

To be sure, the statute says much more (discussed below), offering principles to guide the system of care, further defining groups of children to be included, and describing administrative and service processes to make it happen. The opening sentence in section (1) of this statute provides a detailed and meaningful description of what is expected from the Mississippi System of Care, and this Assessment and Study attempts to articulate the manner and degree to which those expectations are being met, with a hope of future improvements in the MS System of Care.

The remaining portion of section (1) in the statute emphasizes the importance of operating in the most cost efficient manner possible, based on individualized plans of care. The statute names specific programs and services that should be coordinated within the system of care, including: Early Intervention (E.I.), Early and Periodic Screening, Diagnosis and Treatment (EPSDT), waiver programming for developmentally disabled persons and children with special needs, Individuals with Disabilities Education Act programming (Special Education), the MS Children's Health Insurance Program (CHIP), and waiver programs for children with serious emotional disturbance.

A significant component of this statute is the definition of outcomes expected to be achieved through the system of care, including:

- to reduce the number of inappropriate out-of-home placements, including out-of-state placements; and
- to reduce the number of inappropriate school suspensions and expulsions for children with emotional/behavioral disorders.

A "system of care" is then defined in the statute as, "a coordinated network of agencies and providers working as a team to make a full range of mental health and other necessary services available as needed by children with mental health problems and their families." The primary values that guide the system of care are listed as: (a) child centered, family



focused, and family driven; (b) community based; and (c) culturally competent and responsive.

The statute goes on to indicate that a system of care responsive to these values would provide for: (i) service coordination or case management; (ii) prevention and early identification and intervention; (iii) smooth transitions among agencies, providers, and to the adult service system; (iv) human rights protection and advocacy; (v) nondiscrimination in access to services; (vi) a comprehensive array of services; (vii) individualized service planning; (viii) services in the least restrictive environment; (ix) family participation in all aspects of planning, service delivery and evaluation; and (x) integrated services with coordinated planning across child-serving agencies.

Section (2) of §43-14-1 establishes the Interagency Coordinating Council for Children and Youth (ICCCY) and names seven mandatory members, including six publicly funded service system executives (education, mental health, health, human services, Medicaid, and vocational rehabilitation) and one family advocacy representative. The remainder of section (2) describes operational parameters for the ICCCY (selecting a chair, meeting frequency, organizational procedures, etc.).

Section (3) of §43-14-1 establishes the Interagency System of Care Council (ISCC) as the “state management team for the ICCCY.” The ISCC responsibilities are listed as:

- collecting and analyzing data and funding strategies, with recommendations made to the ICCCY and the Legislature concerning such strategies,
- coordinating local Multidisciplinary Assessment and Planning (MAP) Teams,
- applying for grants from public and private sources necessary to carry out its responsibilities.

Section (3) names mandatory members of the ISCC, including representatives from the same six publicly funded service systems mandated to the ICCCY, a family member representing a family education and support organization, two special education organization representatives, and a family member appointed by MS Families as Allies.

Section (4) establishes the statewide system of local MAP teams. MAP Team members are named to represent five public services systems (education, human services, health, mental health, and rehabilitative services), with the possibility of including three additional members, one of whom may represent a family education/support organization with statewide recognition. The two possible remaining members could represent any significant community level stakeholders with resources that can benefit the identified population of children and youth.

Section (4) goes on to establish “A” teams (Adolescent teams), to work in concert with MAP teams, to focus particularly on nonviolent youthful offenders who have an SED, and names the specific minimum membership of those teams (school counselor, mental health professional, child welfare professional, youth court counselor, and a parent who had a child who committed a non-violent offense and entered the juvenile justice system).

Section (5) of §43-14-1 gives the ICCCY authority to provide input regarding how each member agency utilizes its federal and state statutes, policy requirements, and funding streams to identify and serve children and youth in this population group. This is an important system of care authority that emphasizes the alignment of statute, policy, and funding across public systems.

Section (6) enables the creation of a pool of state funds, with contributions from each ICCCY member agency, to be used to increase present funding levels by matching Medicaid funds to increase the overall resources available to the system of care.

Section (7) of §43-14-1 emphasizes that it is the local coordinating MAP team that develops individualized system of care programs for the identified population of children and youth.

Section (8) defines each local MAP team as the “single point of entry” to ensure comprehensive diagnosis and assessment and to coordinate needed services. This section also establishes that children in crisis have the first priority for access to MAP teams.

Section (9) names the ICCCY as responsible for monitoring the performance of local MAP teams.

Section (10) of §43-14-1 requires the establishment of a binding interagency agreement between the mandatory members of the ICCCY regarding the oversight of the system of care established in this statute, an agreement that must be renewed by July 1 of each year.

Section (11) mandates that this entire statute be repealed on July 1, 2010.

§43-14-3 further explicates the powers and responsibilities of the ICCCY to include:

- (a) to serve in an advisory capacity, to provide state leadership, and to provide oversight to system of care programs, and
- (b) to insure the creation of a state pool of funds to support systems of care and a process for utilization of those funds.

## **Findings**

The findings from this Assessment and Study are organized as follows: the most important voice is the experience of children and their families, so that voice is presented first. The second portion of the findings discusses the three statutory components of the MS system of care. Finally, the context of the statutory system of care is explored through findings from the surrounding systems that also touch this population of children and youth and their families. It must be restated here that data to fully describe the functioning of these surrounding systems were very limited and non-existent for several systems.

### **Parents/Families/Youth**

\* Parents and family representatives at all levels were interviewed for this Assessment and Study, including those serving as members of the ISCC, staff at Mississippi Families As Allies, members of local MAP Teams, members of several parent support groups across the state, and individual family members who chose to contribute their input to this Assessment and Study during visits to local communities. The overall findings from this broad set of parents and family representatives may be summarized in two important points:

- When families/youth are able to access the system of care, more often than not good outcomes follow. Most of those served by the system of care voice appreciation for both the efforts and the outcomes, many, though not all, repeating the term “life-saving”. Where children and youth with significant needs and their families can come together with local service staff in a shared quest to address those needs, good things can happen.
- Too few families know about and access the system of care, and involvement most commonly comes late in the child’s development of an SED, after inordinate challenge, stress, and struggle by the youth and family. Many, many families and children remain unidentified and unserved. There are more family stories of pain and distress than of success and hope.

Note: Data describing mental health-provided and/or Medicaid-paid services for children and their families can be found in Appendices A & C.

\* Too many parents and family members feel isolated and unsupported as they struggle to address the challenging behavioral health needs presented by their children. They might describe system leaders as “mean-spirited,” or local staff as “uncaring,” because systems have been unable or unwilling to respond to the needs of their children. Parents report that they are frequently blamed for the behavioral health problems of their children, in spite of current knowledge that most such problems are biologically based. These feelings are often the backdrop to the feelings of relief when parents are finally put in contact with the local MAP Team and progress begins to take place.

\* Parents are uniformly critical of schools and how the needs of their children are handled by schools. These complaints reflect family perceptions and certainly demonstrate that school is the consistent early context where the behavioral health care needs of their children are identified or raised, perhaps even before they are named as “behavioral health care needs.”

\* Parents and family members express a desire to be heard, while telling many stories of not being heard. Parents feel marginalized when blame for their children's behaviors is placed on them and speak frequently of engaging many, many professionals, in many systems, before perhaps finding someone who seems to understand.

\* Family advocacy is strong in Mississippi and parents and other family members who have knowledge of MS FAA express extraordinarily strong support for the organization and its work. MS FAA is known across the country as a leading state-level advocacy voice for children and families struggling to address behavioral health care needs. MS FAA is also playing a substantial direct care role, supporting individual families and local support groups around the state. Services and supports from an advocacy group are important, but they are NOT a substitute for a system of care among the publicly funded systems. MS FAA direct services appear to be heavily used, with some regions counting on MS FAA staff to provide a parent voice at MAP team and other meetings. The primary advocacy role is to identify and raise unaddressed needs and populations, integrating stakeholder voices in efforts to address them, and MS FAA has steadily accomplished this role throughout its existence. Direct services are also delivered by MS FAA because the unmet need for those services is so strong, which reflects service issues that need to be addressed by the public systems.

## **Statutory System of Care**

### ICCCY

\* Persons interviewed during this Assessment and Study report that the ICCCY is not very active, a perception shared by some members of the ICCCY. The group meets twice each year, receives presentations from the ISCC and other groups, and primarily affirms decisions and recommendations that have been worked out through the ISCC.

It should be noted that only four members of the ICCCY were interviewed for this Assessment and Study, two only briefly. Those who made themselves available for interviews were strongly supportive of the collaborative process and of their respective staff who serve on or work with the ISCC. Among these four, there is some recognition that politics play a significant role in decisions made at their level, whereas the system of care approach seeks community based, apolitical solutions. Underlying this message is the suggestion that community based collaborative work might best succeed when most issues are not decided at this highest level (i.e., through politics), but rather are worked out closer to the community level.

\* ISCC members report that the mandatory members of the ICCCY tend to be involved in too many boards and groups, limiting their involvement and attention to any specific group. Further, the ISCC members recognize their own roles in problem-solving and system improvement and see it as their responsibility to keep as much as possible from rising to the attention of department heads, whenever possible.

\* A variety of respondents indicate that many members of the ICCCY do not fully understand the system of care approach, particularly the importance of shared, interagency program planning, implementation, and monitoring.

\* An Interagency Agreement is required by the statute to be signed among the members of the ICCCY and such an agreement exists. The current agreement reaffirms the

requirements of the system of care statute and binds most of the signers to little beyond “normal”, current practices. It is in this agreement that DMH commits the participation on local MAP teams by local Community Mental Health Centers, a necessary source of consistency for local teams. Interestingly, the agreement lays out a list of quality management targets (MAP team service utilization rates; recidivism rates for inpatient and residential treatment settings; utilization of those settings; plans of care; team design and methodology; local level collaboration; cost efficiency; and consumer/family satisfaction) that would be the ideal basis of ongoing performance management, but no action appears to have been taken recently to implement this portion of the agreement. No such data were offered for this study.

## ISCC

\* ISCC members report that valuable information is gained through participation on this body, particularly regarding specific events, opportunities, and functions of partner systems. Members likewise describe gains made through increased understanding of specific requirements and/or limitations experienced within partner systems; the increased understanding makes the partnership more functional.

\* ISCC members identify numerous instances where their involvement has led to increased alignment between partner systems. A simple example was given by DMH and DYS around the Adolescent Offender Program (AOP), where a conflict was discovered between the requirements of the two respective partners that forced local AOP programs into non-compliance with one or the other. Once discovered during an ISCC meeting discussion, each was able to make adjustments internally to resolve the conflict for local programs.

\* The ISCC, in partnership with the DMH, has developed good operational guidelines for MAP and “A” Teams. The population of children to be served by the MAP Teams is well-defined in program guidance, with a priority emphasis given to reducing the number of children placed unnecessarily into expensive, institutionally-based care. The operational model is well-defined (Map; Connect; Wrap) and MAP Teams appear to generally operate in compliance with the model.

\* ISCC members share a collective concern about the extent to which the values that make the ISCC successful are practiced among leaders above them and by front-line staff who actually serve children and families. Although the members share a commitment to the system of care values, they commonly describe feeling like lone voices within their own systems.

\* Individual interviews with each of the ISCC members confirm the strength of their commitment to the interagency approach and a willingness to do even more to make that approach work. At the same time, members describe receiving varying levels of support for this work from their immediate and/or ultimate bosses.

\* ISCC members uniformly believe that the system of care would be useful to much larger numbers of children than the 1,266 served in FY08. In particular, members identify a need to reach out to children and families in more rural, isolated portions of the state, to younger children, and to children earlier in their development of disorders. Each member is able to see ways in which such an expansion would be helpful to their individual system’s mission.

\* ISCC members see a strong need for increased interagency programming that targets children and adolescents with dual diagnoses (mental health and development disability). The numbers of these children being referred to the ISCC for help have steadily increased, and none of the individual systems is comprehensively skilled at identifying and addressing the needs of this specific sub-population of children and adolescents.

## MAP and “A” Teams

\* MAP and “A” Teams, where they function, are clearly meeting the intention of the statute. The children and adolescents served are unquestionably within the intended population. Every MAP team tells poignant stories about challenging children and adolescents whose needs were finally addressed due to MAP team involvement.

\* Families with children or adolescents with complex emotional needs sing the praises of most MAP teams when they get access to them. Every meeting with parents and family members during Assessment and Study Site Visits included both families who had used MAP teams and families who had not. Many of the latter learned about MAP teams during these meetings and, after listening to the experiences of the former, immediately wanted to know how to access the Teams for their children.

\* Families tell powerful stories about the impact of MAP teams in the lives of their children. These stories affirm both the severity of needs of the children presenting to Teams and the extraordinary lengths to which individual MAP teams go to address those needs.

\* The majority of work by MAP teams happens in response to a crisis – in crisis, emotions are high and representatives feel pressure to find quick solutions. Teams are finding good solutions, but the crisis process raises stress on all team members. Team members express a desire to know about the problems and find solutions before the crisis happens.

\* Local MAP team members consistently emphasized the importance of decision-making by persons who know the child and family. In particular, the ability for a MAP team to recognize when a “critical moment” has emerged for a child or family and take advantage of that moment with an effective intervention is key to MAP team success. Child, adolescent, and parental motivation and/or readiness for change can only be assessed by persons in contact with them.

\* Not all MAP teams are equal. MAP team annual data show clearly that certain teams perform more effectively, for a broader group of children and adolescents, than others. Site visits with a representative sample of local MAP teams (5) affirmed differences between teams.

\* At the same time, the MAP teams visited during this Assessment and Study all appear to conduct business in relatively consistent ways: for individual children, they gather information; report to the Team; problem-solve and brainstorm solutions; apply flexible dollars, when useful; and follow-up in future meetings to assess outcomes.

\* The mental health system is largely in the lead at the local level. Some MAP teams are comprised almost exclusively of mental health system personnel, though even those Team members value regular opportunities to collectively figure out how to help individual children and adolescents. Broad, consistent multi-system involvement in MAP or “A” teams is not common across the entire state.

\* Some MAP teams reflect effective partnerships among the major child-serving systems, especially involving mental health, schools, and/or juvenile justice. Data show that Teams reflecting those partnerships perform well and touch higher numbers of youth. In some areas, the partnerships just involve two partners.

\* MAP teams consistently lack support and involvement from the child protection system, with a few exceptions. This system is a critical system of care partner, particularly when a child's disturbance develops to the point that they may require or be considered for out of home placement. It is well-documented that children traumatized by abuse or neglect are at much higher risk for behavioral health disorders. The Division of Family and Children's Services (DFCS) would bring much-needed expertise to local teams, while benefiting from involvement around children in their custody with the most complex needs.

\* The MAP teams succeed on the basis of relationships. Site visits with local MAP teams revealed groups of persons in single communities who: 1) know and respect each other; 2) work well together, even on difficult issues; 3) share a commitment to addressing the needs of children and their families; 4) share a history of success, building trust in each other; and 5) experience obstacles within all of the formal systems. Every MAP team visited emphasized the importance of members knowing each other and learning to rely on each other for different things. Most MAP team members appear to look forward to the meetings.

\* MAP teams largely conduct their activities without the families or children under discussion in the meetings. Family presence varies across Teams, with some Teams not even trying to include them, but even those Teams that promote family participation reported that families are in the room less than 50% of the time. The case manager or primary therapist working with the family generally serves to bring the family's perspectives to the meeting and then to report outcomes back to the family after meetings.

\* MAP Team Coordinators are commonly individuals within the local service community who hold strong passion about care of children. They vary in experience and system knowledge, but they share a solid commitment to problem-solving and system improvement. Some primarily focus on managing the MAP team, but most have other responsibilities, often many others. Unquestionably, Coordinators with more experience and local respect succeed the best.

\* It appears that children and adolescents who do not live within the county hosting the MAP team (most MAP Teams serve multiple counties/communities) are not accessing this resource. The majority of children considered by the Teams live within the county where the Team meets (and MAP teams have been most strongly promoted in population centers). But not all Mississippi children and adolescents who could benefit from MAP and "A" Team involvement are able to access Teams.

\* MAP teams have utilized flexible dollars to which they have access to purchase a wide range of non-traditional interventions for children and adolescents and their families, including such items as specialized lessons (e.g., art, music, martial arts), memberships (camps, scouts), family necessities (education/training, childcare, household items, uniforms, daily living items), targeted treatment interventions (respite, psychological evaluations, medication, mentoring), and other items that enable youth to remain in their home and/or community. Generally speaking, these items are commonly purchased for children who are

not eligible for Medicaid coverage, but non-traditional (non-covered) items might also be purchased on behalf of Medicaid-eligible children when they reflect the child's needs.

\* In 2007 (most recent year for which these data were available), MAP teams purchased case management for 818 youth, day treatment for 573, outpatient therapy for 935, and family support service for 47.

\* In 2008, 36 MAP Teams served a total of 1,266 youth. Two-thirds (65%) of those youth were African-American, one-third Caucasian, with a negligible number of youth from other racial/ethnic groups. Fifty-four percent were male. The largest age cohort served was 6-12 (48%), followed by 13-17 (39%), 18-21 (7%), and 5 and under (6%).

- These data are consistent with Medicaid data, showing approximately the same breakdown of involvement between African-American and Caucasian children and youth.
- The age data reflect strong involvement with younger and prepubescent children, although adolescents continue to be served by the Teams.
- With the exception of the racial/ethnic breakdown, these data are relatively similar to other states using community teams in similar ways.

\* There is clear evidence of functional differences between MAP Teams in different areas. For example, the MAP Teams operating in Regions 1, 5, & 6 touched substantially higher numbers of children and youth than would be expected by population size, and teams in Regions 1, 6, 10, & 12 provided specific mental health services to substantially more children and youth than would be predicted by population. On the other hand, teams in Regions 2, 9, 11, & 14 touched far fewer children and youth than would be predicted by population, and Regions 2, 7, 9, & 11 provided almost no specific services through MAP Team activities, even though those regions are home to more than 31% of Mississippi's children and youth.

Explanations for such variations are many; persons working within the respective regions would be likely to immediately understand certain reasons for these variations. Unfortunately, adequate data are not available to identify and isolate the variables that lead to higher MAP Team performance. In truth, systems of care are not built for volume, but rather for individualized care of specific children and youth. Irrespective of the overall numbers, individual children and youth are being helped, and that is important.

## **Context: System of Care Partners**

### **Mental Health System**

\* The Mississippi Department of Mental Health holds primary responsibility for the State's mental health system in all aspects (described in detail in Appendix A), and it cannot do that job alone. Therefore, the DMH philosophy of collaboration is essential. DMH is not directly responsible to the Governor of Mississippi, a common arrangement in other states, but rather to a State Board of Mental Health, the members of which are appointed by the Governor and confirmed through the Senate.

\* Community Mental Health Centers (CMHC) are the primary tool through which DMH is able to implement its mission to "plan and develop community mental health services, set



minimum standards for ... services, and monitor compliance with those standards.” An effective and positive partnership between DMH and CMHCs is essential to system success.

\* CMHCs vary widely in their development of effective child and youth serving systems. Information gathered from many perspectives during this Assessment and Study suggested that some CMHCs work strongly towards effective child and youth care, in partnership within the local community, while others have focused more strongly on developing adult mental health services. Not surprisingly, there is a clear data correlation between effective, productive CMHC child/adolescent services and effective or high-performing MAP Teams.

\* Where effective MAP and “A” Teams operate, local members give much credit to leadership provided from the local CMHC, as well as to long-standing partnerships within the community. It appears that DMH has created an environment within which service providers with a commitment to children, youth, and their families can move local systems forward, but the motivation to do so must come from the community leadership.

\* CommUNITY Cares is a national grant program (funded through the Substance Abuse and Mental Health Services Administration – SAMHSA) to support system of care development being implemented in the Pine Belt Area (Forrest, Lamar, and Marion Counties). This six-year grant was awarded in 2006 to build effective care for adolescents (10-18) experiencing emotional disturbances and substance use problems. The primary approach being developed through this project is team-based: wraparound team planning and monitoring for individual youth and their families; task groups built around system components that bring together multiple stakeholders to plan and implement improvements; and state level interagency partnerships (including the ICCCY and ISCC) to create an environment within which the improvements can be implemented. CommUNITY Cares is already demonstrating the effectiveness of the system of care approach, based on data presented on the project website that show:

- decreased numbers of school expulsions, suspensions, and detentions among participants,
- improved academic performance and attendance,
- decreased number of youth experiencing a succession of multiple out-of-home placements,
- reduced caregiver stress, and
- diverted youth from the juvenile justice system.

The CommUNITY Cares accomplishments demonstrate the efficacy of the service approach codified in the system of care statute when it is applied to a significant number of youth with serious emotional disturbances in a single community.

It should be noted that during the writing of this report the State of Mississippi was awarded a new grant under the same federal program, creating more opportunities for system development.

\* Mississippi Youth Programs Around the Clock (MYPAC) is a 1915(c) Medicaid waiver program specifically aimed at finding and implementing alternatives to residentially-based care for children and youth with serious emotional disturbances. Beginning in October, 2007, the waiver allows Medicaid resources to be used to prevent placements by offering Intensive Case Management, Wraparound Services, and Respite Services for eligible children and youth, with the goal of keeping them in their home and community, when possible. Two

statewide providers implement MYPAC, Youth Villages and Mississippi Children's Home Services. Data provided by Youth Villages demonstrate extraordinary successes. Follow-up surveys reveal that:

- 82% of MYPAC children and adolescents remained at home or in a home-like environment
- 83% reported no problems with law enforcement or juvenile justice
- 81% were experiencing success in school

These are significant findings that, again, demonstrate the efficacy of the service approach codified in the system of care statute, although here it is applied to a relatively small group of children and adolescents. Medicaid data showed that 107 youth were served by the program in FY08 at an average cost of \$17,151 and an average length of stay in the program of 137 days. FY09 data, though incomplete at the time of this Assessment and Study, appear to continue these trends, although per-child spending in FY09 appears somewhat higher. These data reflect a financial gain for the state. If these youth were instead placed in residential treatment facilities at \$200/day the cost for 137 days would be over \$27,000, and there is no reason to believe their lengths of stay would have been limited to this number of days. If these youth were placed in an acute psychiatric hospital setting at approximately \$500 per day, this amount of money (\$17,151) would have paid for just 34 days, with no assurance of any follow-up care in the community.

\* National data indicate that Mississippi has dedicated a higher proportion of resources to institutionally-based mental health care, over a longer period of time, than most other states. The most recent data provided for this Assessment and Study reflect FY05 and do not provide child/adolescent-specific data, but those data indicate that MS committed 55% of its total resources to institutions, while the national average reported in 05 was 27%. Nationally, 70% of state mental health authority controlled dollars was committed to community based care in 2005, while Mississippi's percentage rose to 44% that year. The MS State Hospital at Whitfield is known to be the largest state psychiatric hospital in the country. Unfortunately, no data were provided for this Assessment and Study that would allow assessment or analysis of institutional spending specific to children and youth.

\* Total public spending for Mississippi children's mental health is difficult to discern. Medicaid is the primary funding source for MS public mental health services and those data show slightly over \$81M in FFY09 expenditures for services to children and youth. The DMH DCYS FY10 budget adds another \$5M in discretionary funds to support specific priorities. Together (though across different fiscal years), that represents \$86M in dollars directed to the MS child mental health system. There is believed to be additional spending for institutional care of persons under the age of 21 (the FY08 CMHC-reported data indicate that 715 children, adolescents, and young adults were placed in a state psychiatric hospital, 29 in other psychiatric inpatient settings, and 103 in state-operated residential treatment facilities). No further data were provided for this Assessment and Study.

\* Other systems are spending public resources for behavioral health care services. Those resources are currently unrecognized in most systems, although all systems recognize a need to improve identification and care of behavioral health needs among the children and adolescents they serve. No useful data were provided regarding the amount of spending in partner systems for mental health care of children and adolescents.

\* The only identifiable intensive, community based service currently supported within the MS system is day treatment. This is an important and potentially effective treatment resource,

but, by itself, it is inadequate to create community based care that can defer most placements for treatment reasons. The partnerships between CMHCs and local school districts that currently support day treatment programming are exemplary of the types of local partnerships that need to be expanded within a system of care.

\* The DMH DCYS has organized a system of crisis intervention programs for youth with behavioral disorders in crisis and at risk for out-of-home placement that is accessible within about half of the fifteen state regions, encompassing approximately half of the state's population. Half of those programs are implemented by agency staff with other full-time clinical responsibilities. Medicaid payment data and CMHC-reported service data do not report crisis-specific services, so no conclusions about the amount or volume of crisis services can be provided in this analysis.

## **Alcohol/Drug Treatment System**

\* National research has demonstrated that there is a high degree of overlap between populations of young persons with serious emotional disturbances and those with substance abuse treatment needs. Nonetheless, the two systems and types of expertise tend to be separated, with much less treatment capacity on the substance abuse side. Where it exists, substance abuse treatment capacity is largely implemented through the CMHCs, the primary treatment vehicle for mental health care. However, it was suggested that the CMHC representatives on local MAP teams tend not to have substance abuse expertise.

\* Data regarding substance abuse treatment provided for this Assessment and Study could not be broken out to discretely identify services provided to persons under age 21, so no analysis is possible.

\* Current programming for substance abuse treatment includes some day treatment programming, intensive outpatient programs, and individual/group therapies. Additionally, DMH and the juvenile justice system have coordinated the creation of several adolescent outpatient treatment programs, integrating mental health and substance abuse treatment for adolescents, and these programs are generally viewed very positively. However, detoxification programming for adolescents, an important first step in effective treatment for substance abuse disorders, is unavailable in Mississippi.

## **Education System**

\* The Mattie T. Consent Decree is currently driving changes in Mississippi's special education system (see Appendix B) that emphasize improved identification of behavioral health needs that interfere with students' abilities to learn and appropriate interventions when the needs are identified. Recent Monitor's reports show that progress is being made, even if the improvement targets are extremely conservative.

\* At least half of Mississippi's local school districts are reported to be implementing some level of Positive Behavioral Interventions and Supports (PBIS) and the DOE is preparing to provide technical support and training to promote PBIS during this current school year. PBIS is a method for creating a culture within a school building that sees needs before they become extreme and works collaboratively and creatively to address such needs. This culture is highly aligned with the system of care approach; both cultures will reinforce each

other. It is important to note that, nationally, only 40% of students with SED are formally served within the special education system, so a school-wide cultural approach focused on behavioral management and support would be a fertile environment within which to address the needs of students not served within special education.

\* Irrespective of positive progress made by Mississippi school districts in identifying students with emotional/behavioral disorders, the overall state identification rate remains substantially below the national average. The Office of Special Education has implemented a variety of strategies to improve education about and understanding of emotional/behavioral disorders among school personnel and those activities should continue. A strong combination of professional development, targeted technical assistance, and monitoring have already led to improvements and will continue to bear fruit.

\* Past collaborative work between DOE and DMH have led to many functional partnerships between local school districts and CMHCs to create in-school service capacity. More than 5,000 students (FY08) received day treatment services, which often reflect a defined partnership at the local level, sometimes encompassing multiple school districts.

\* As one aspect of responding to the Mattie T. requirements, DOE has added an Office of Parent Outreach, focused on support for and collaboration with parents and families. This development creates a substantial opportunity to align system of care efforts to improve family engagement across systems, creating synergy.

## **Child Protection System**

\* The Olivia Y. Settlement Agreement is strongly driving current changes in the MS child protection system (see Appendix B). It appears that the primary focus of this agreement was a deliberate restructuring of the administrative philosophy within DFCS, an attempt to change the culture of the organization as a whole. Substantial changes in system administration were reported, along with frequent reports of disarray at the front-lines. The reality in this Assessment and Study is that representatives of the child protection system are mostly absent from system of care development efforts, both locally and statewide, and no data to describe the current system were provided.

\* DHS put a new leadership team in place over child protection during the period immediately preceding this Assessment and Study. Overwhelming system demands forced that team to remain focused on internal system development tasks, to the neglect of interagency relationships. There is intent by the new leadership team to tend to those relationships in the near future.

\* The restructured administrative philosophy includes a commitment to family-centered practice, which mirrors developments nationally within this system. This creates a strong opportunity for alignment with the system of care approach and the child protection system would benefit from linking the two together. It was reported that new system practice guidelines were to be developed over this past summer and that the primary consultant helping the state with those guidelines is a professional familiar with and committed to the basic system of care values.

## **Juvenile Justice System**

\* DYS recently settled a Department of Justice law suit regarding the care of youth at the Oakley Training School and information provided for this Assessment and Study suggests the Division has moved aggressively to resolve the problems and create an effective system (see Appendix B). At the state level, this system appears to be fully committed to a collaborative, family-centered, best practice care system.

\* Clear efforts to address suicide prevention, mental illness assessment, and treatment for identified needs are documented in the monitor's report. Substantial numbers of youth entering care at Oakley have diagnosed disorders, including 67 last year (FY08) who were receiving psychotropic medication. When indicated, behavioral health screenings are now occurring with 24 hours of admission in the overwhelming majority of cases, a reported improvement over past practices. Progress in mental health issues lags behind progress in most other areas, according to the August 5, 2009 Monitor's Report.

\* Youth service counselors in this system are reported to be active participants on many local MAP teams, although that participation varies from county-to-county. Those system staff are reported to be highly satisfied with MAP team accomplishments, particularly because they create alternatives to punitive confinement. It was reported that a number of judges are strong supporters of the system of care and MAP teams, but no information from or about judges was provided for this Assessment and Study.

\* Mental health and juvenile justice systems have demonstrated collaborative skills through the establishment of Adolescent Offender Programs, structured treatment programs that address the behavioral health needs of the population served by local courts. Anecdotal reports about these programs were very positive, although no data were provided for this study.

## **Vocational Rehabilitation System**

\* The Vocational Rehabilitation system is not directly involved in the care of most children and adolescents, but it does have responsibilities for youth with disabilities beginning in the 11<sup>th</sup> grade. It is reported that youth with mental illness make up a small but growing portion of the voc rehab system population, but no data were provided for this Assessment and Study.

\* Job preparation, training, support, and placement are important components of transitional care for youth approaching adulthood with behavioral disabilities. The Department of Rehabilitation Services is a mandated member of the ICCCY and local staff are named in the statute as members of MAP teams. Anecdotal evidence gathered for this study indicate that voc rehab staff are significantly involved in a few MAP teams, marginally involved in several others, and absent in many. Given that more than half of the children served by MAP teams are age 11 or younger (FY07), with another substantial proportion of children served at ages 12-16, voc rehab staff are likely to be helpful in only a small portion of cases considered by MAP teams.

\* The Department of Rehabilitation Services was recently funded by the Legislature to add a substantial number of transition counselors with a focus on this age-group, and those staff have begun working with school districts and other agencies to build capacity. In addition,

the DRS Director has been a member of the ICCCY since its inception and strongly supports the collaborative approach established in the system of care statute. These are assets that can be used to strengthen the system of care.

## **Health System**

\* There is high alignment between the system of care and public health models, creating a strong potential for partnership. The statutory connection between the system of care and the SED designation has made it difficult for this partnership to develop because the SED designation appears to link those children and youth exclusively to the mental health system. As one result, representatives of local health systems participate actively in a few of the local MAP teams but most teams lack health representation. Anecdotal information gathered in this study suggests that, where present, the health representatives are valued members of those teams.

\* The public health system holds the responsibility for implementing the Early Intervention (EI) program (0-3), and, for children with identified delays and disabilities, this includes transitioning responsibility for care to local school districts at the child's third birthday. The current EI system does not gather data about the type of disability or delay, so analysis of young children with behavioral health needs is impossible.

## **Attorney General**

\* A representative of the Attorney General's office is a regular participant on the ISCC and is viewed by other members as a strong contributor. The AG's office has strong relationships with youth court judges, county prosecutors, and CASA representatives and those relationships would be invaluable in the development of local systems of care.

## **Recommendations**

The following set of recommendations is offered to further the development of Mississippi's System of Care for children and adolescents with emotional/behavioral disturbances and their families. The key recommendation for each is underlined, calling attention to the actions that are recommended. Additional discussion is offered for each recommendation to place the key actions in an appropriate context.

**Recommendation 1:** The current system of care statute, set to sunset on June 30, 2010, should be reauthorized with minor language changes described in several of the following recommendations. The statute is already strong, with clear guidance for how a system of care should function. The primary hindrance to an effective system of care in Mississippi is not the language of the statute – it is, instead, the inability to implement what the statute describes at a scale that serves the needs of those children and families who could benefit from the system.

**Recommendation 2:** Empower the ICCCY by giving it authority to impact policy and funding decisions across all public service sectors touching children and adolescents and adding relevant and necessary voices.

Although the ICCCY does not now stand in the way of well-developed recommendations that come through the ISCC, and the ISCC, as a whole, feels supported by the ICCCY and empowered to develop and promote recommendations in priority areas for the system of care, certain changes are needed to elevate the importance of state level leadership in improving the alignment and functioning of the major child- and family-serving systems. Such changes could lead to improvements in policy, practice, management, funding, and monitoring of those systems. And, as noted in Appendix A, the MS System of Care statute does not give sole authority to DMH to create the system of care; statutory responsibility is given to the entire membership of the ICCCY.

The MAP Teams work. Where they exist and when families get to them, MAP teams have accomplished good outcomes for a small number of children and families, in part, because individual local system representatives have been able to step outside inflexible, parochial practice models and negotiate partnerships that cross the grain of individual system protocols. State agencies would make the work of local MAP teams extraordinarily easier by negotiating those types of partnerships at the state level, changing practices within major systems to more strongly support collaborative, team-based work. Mid-management negotiation (e.g., the ISCC) alone provides inadequate support for this type of practice change, although design and implementation support would certainly come from this level. Negotiated practice improvements that align across systems require executive decision-makers to work at the collaborative table with their peers in good faith, and with input from other stakeholders.

Additional voices in the discussion would broaden the shared responsibilities for system-building across interested stakeholders. All currently-named agencies/systems need to remain involved as important members of a empowered state council, commission, or board. The family voice, currently represented by MSFA, must remain, and it is important to bring other family voices to the table as well, including individuals whose families have been served in public systems. The youth/young adult voice must be added to this table, and much support is available nationally to develop the mechanisms that provide this voice. The

Office of the Attorney General of Mississippi participates positively in the system of care and should be added to the mandated members. Representatives of local systems of care are essential to ensure that the ICCCY makes decisions with input from the realities of service implementation. Professional representation (e.g., psychiatrist, probation officer, special education director, early childhood expert), recommended by professional organizations and appointed by the State, would help ensure that decisions reflect best practices in many related fields. It would be valuable to include representatives of private philanthropy, business, and higher education, especially professional training programs relevant to this population. The statute could be further strengthened by requiring that any designee of an ICCCY member bring the member's full decision-making authority in order to serve as a designee.

A simple way to strengthen authority for the empowered ICCCY would be to mandate that any MS child about to be placed in out-of-home care, for reasons other than parental abuse/neglect (the mandate of child protection), or in alternative education environments be served first by the system of care led by the ICCCY, with three goals: 1) preventing restrictive placements if possible, 2) making least restrictive placements when placement is necessary, and 3) reintegrating the child/adolescent back into the community and home (or home-like environment, if necessary) as soon as possible through local monitoring and management. Establishing this authority at the ICCCY would require systems that currently hold statutory power to assume custody of children and adolescents to demonstrate to an interagency group that no alternatives to placement exist. Said differently, an interagency group in the community would get the chance to find alternatives that might work for the child and family.

Finally, the ICCCY should negotiate a meaningful Interagency Agreement that lays out system responsibilities in the many operational areas referenced in these recommendations (e.g., actions to ensure system representation on local MAP teams; funding support for necessary training; system commitment to refer all children and youth at risk for placement to the MAP teams before placements are made). The state level agreement should include accountability mechanisms and serve as a template for the nature and content of local agreements around specific programming.

**Recommendation 3:** Much more organization and support for the local MAP and “A” Teams is needed, as described in the following set of specific recommendations:

**Recommendation 3A:** Existing MAP and “A” Teams need support and development. It is recommended that the ICCCY offer an annual Team Policy Academy to bring together all MAP and “A” Team members from across the state to learn together and plan for the future. Policy academies are an opportunity to structure the work of teams in an environment that supports the exchange of information/experience across many different groups. Team skills are promoted and developed, new team members gain valuable information and connection, and teams work together to address local needs. The managed development of relationships among team members will pay large dividends to system managers over time.

Policy academies should be planned and implemented through interagency partnerships. ISCC members would play prominent roles in designing academy goals, selecting training content, and ensuring that full teams, representing all systems, participate from each community.



**Recommendation 3B:** The statute allows a representative of the family advocacy group to sit on local MAP teams, but fulfilling that opportunity is challenging in many communities. Systems are not comfortable identifying and supporting advocacy voices and the high level of personal commitment is not easily found in local citizens. The state system, as a whole (with involvement of all interagency partners), must become much more proactive in identifying and supporting family and youth voices to be part of the MAP team process. Entities such as MS FAA can be instrumental in supporting family members who serve on MAP teams, but it cannot take sole responsibility for recruiting, preparing, and supporting family members who choose to play a MAP team role. System infrastructure must be developed to support and sustain family and youth voices.

The ISCC should define specific expectations for intersystem recruitment, preparation, and support for both family and youth voices in MAP team processes. DMH should consider assignment of staff resources to coordinate implementation of this recommendation. Recruitment should take place across systems, through interagency planning/implementation, and a recruitment coordinator in DCYS could organize ongoing processes to train and support persons representing service recipients. The DOE Office of Parent Outreach should be asked to play an organizing role in this effort. It is obvious that turnover in the family and youth voices on MAP teams will be constant, so the system should be designed to constantly recruit and prepare new representatives. It is the VOICE that is important, not necessarily the individual who brings that voice to the table. Also see Recommendation 4.

**Recommendation 3C:** Currently, MAP Teams receive annual monetary awards from DMH that lump together the possibility of support for a portion of the MAP team Coordinator position, funding of some operational activities (e.g., stipends, transportation, certain types of training), and services/supports to address the needs of families and children presented to the team. It is recommended that these dollars be separated out and awarded as three defined funds to accomplish three separate goals:

- 1) MAP Team Coordinator – This position requires substantial time and work. MAP teams do not function well without a strong coordinator, but in too many circumstances the local Coordinator also has other full-time responsibilities. One model used in other states is for the state to provide a specific amount of dollars to support a full-time coordinator, requiring a percentage local match for the position. The activities of the Coordinator could be expanded to include community education about the MAP team, relationship-building with local partners, community resource development, evaluation data gathering and reporting, and broader management of interagency partnerships.
- 2) Flexible funds for services/supports – Current practices appear to be relatively clear and require no substantial changes.
- 3) Operational expenses – Pragmatic expenses for the system of care must be addressed, including transportation, stipends for persons who are not paid to participate, and training in system of care practices. This category could also include some level of support for local family and youth support/advocacy groups.

It is important to give local MAP teams separate management control of these distinct resources. The *coordinator position* support enables the community to have a MAP team

coordinator. A fixed funding mechanism should be established to give all communities equal opportunities to utilize these funds. *Flexible resources* for services and supports are essential to MAP team functioning but need not be extravagantly large. This resource should be budgeted year-by-year so local leaders can effectively manage it. *Operational expenses* can be standardized across the state (recognizing regional variations in transportation costs) to create a standard level of support for non-professional voices in operational processes.

With regard to MAP team coordinator positions: The State should offer equitable opportunities to each county to support the MAP team Coordinator.

Option 1: Offer a set amount (e.g., \$20,000), require a local match (e.g. \$12,000), and define the responsibilities of the position. Counties might self-select to band together to take advantage of this offer.

Option 2: Allow local communities to set the salary and responsibilities but offer 65% of the cost, up to a dollar limit appropriate to the position, with a mandatory 35% cash match from local collaborative sources.

**Recommendation 3D:** In addition, State agencies must accomplish two important goals:

- 1) Ensure representation of all key partners on local MAP Teams through state-level requirements that local entities participate fully, with training support to develop the needed skills and knowledge.
- 2) Establish MAP Teams accessible to families in every Mississippi county. Distance from a team cannot remain as a barrier to appropriate child, youth, and family care.

Implementation of this recommendation can only occur through interagency planning and implementation. Each state agency represented on the ICCCY must establish internal policies that require participation on local MAP teams by local agents and monitoring mechanisms to ensure such participation. Ideally, those policies and monitoring mechanisms would be established conjointly, aligning expectations for local entities. MAP teams need to be local to work effectively, so additional MAP teams must be developed to serve currently-unserved counties. Current MAP teams could fill some of this need through aggressive outreach to under-served counties, and new MAP teams will need to be formed in some areas, with support from the major systems.

**Recommendation 4:** Mississippi has benefited from the existence of a strong family advocacy organization, Mississippi Families as Allies. MS FAA has, since 2002, supported the development of the youth voice in MS. Two local Youth MOVE chapters are established with more in process, and several communities support youth leadership development programming, enabling many youth to actively participate in advocacy, workshops, and conferences. This work provides the foundation for the development of a statewide youth/young adult advocacy group to deepen that voice in system decision-making. Such groups are emerging under multiple models in many states and Mississippi is poised to take such a step, which will lead to the development of more local groups. It is recommended that the ICCCY and ISCC establish a framework to provide intersystem support, both resources and dedicated recruitment through local agencies, for a statewide advocacy group for this population. Note that this recommendation is directly linked to Recommendation 3B.

**Recommendation 5:** Separate from, and parallel to, the recommended MAP Team Policy Academies, the ICCCY and ISCC should work to develop and implement a “System of Care” training curriculum to be utilized across all public service systems. The curriculum should emphasize the system of care values base, teamwork and collaboration skills, partnerships with families and youth, and quality management. The curriculum could be implemented as standalone training events for mixed stakeholder audiences and it could be used to guide pre-service and in-service training within individual systems. A cadre of in-state, system trainers could be prepared to deliver such a curriculum in large numbers.

**Recommendation 6:** The mental health system must take the lead, employing functional partnerships with other systems, to establish more community based, intensive care alternatives. The existing partnerships between CMHCs and local schools, required by DMH, offer a template for additional local agreements to create capacity in a broader range of services than currently exists. A full range of intensive care options are necessary to respond to the types of needs that force local service entities to promote institutional placements, including *mobile crisis, crisis stabilization, intensive outpatient, day treatment, therapeutic foster care, and intensive case management.* These are the types of interventions that the CommUNITY Cares (Pine Belt Area) and MYPAC (statewide) programs are using to successfully address challenging behavioral health care needs in the community at a lower cost than placement in an acute hospital or residential treatment environment.

*Mobile crisis:* Children and adolescents who enter into expensive, intensive, bed-based care do so through crisis, with few exceptions. The ability to respond to such crises with interveners with knowledge of mental health conditions and treatment increases the ability to keep families in tact and minimize out-of-community placements, decreasing the collective care burden on all of the community helping systems. Psychiatric nurses, social workers, therapists, and case managers can all bring that knowledge. Crisis teams can form across service system boundaries, jointly responding to child safety, community safety, and treatment needs presented by children and adolescents, to cost-effectively implement crisis response teams.

*Crisis stabilization:* Children and youth with behavioral health care needs have crises, and many are predictable. Stabilization is most commonly accomplished in psychiatric hospitals, and that level of care is occasionally necessary. More often, children can be stabilized and returned to their normative environment within 24 hours of a crisis while maintaining or improving the treatment plan and avoiding placement. Crisis stabilization requires safe space, appropriately qualified staff, and close links to all child- and family-serving systems.

*Intensive outpatient:* Children and adolescents are responsive to programming that meets them where they are and moves them towards new, more effective skills. Fifty-minute counseling sessions, while historically popular, rarely lead to progress with young people. Behavioral improvements depend more on consistent programming over periods of time. Intensive outpatient programs are structured to address behavioral issues by bundling together therapy, case management, and behavioral change expertise in structured programming that is linked to families and parenting education.

*Day treatment:* DMH Service Standards dictate space, length of service, and partnership requirements but lack quality care standards. Day treatment that is targeted to narrow populations can return most students to normative learning environments, having identified

the types of supports needed to maintain student progress, within a semester. Any specific community is likely to need a set of focused day treatment programs, targeted by age, abilities, and needs, to successfully address behavioral health needs that interfere with education. Rural school districts with lower incidence of such intense needs will need to partner with neighboring districts, or through regional programming, to create access to such programming.

*Therapeutic foster care:* Children and youth with serious emotional disturbances are sometimes unable to remain with their families, for a wide range of reasons. Such children sometimes come into substitute care for abuse/neglect and/or public safety reasons. Irrespective of the route to substitute care, children and youth with serious emotional disturbances need specialized care that includes: foster parents who are trained to understand and address behavioral health challenges; clinical training and support from a community service entity; and immediate access to crisis resources. Partnerships between child welfare, mental health, and juvenile court staff are generally necessary to make TFC work.

*Intensive case management:* This is not targeted case management. Intensive case management is implemented for families with children who have serious and complex needs, with a long-term goal of developing family advocacy and care management skills. Intensive case managers carry low caseloads (8-12), provide a therapeutic service, coordinate services and supports from multiple and diverse providers, and work to remove themselves from the role as quickly as feasible.

**Recommendation 7:** Anecdotal evidence provided during this Assessment and Study suggests that child- and adolescent-trained psychiatry is in short supply in Mississippi. This expertise is essential to effective, community based care of children and adolescents with serious disorders. DMH must strengthen work in partnership with the UMC Department of Psychiatry to develop additional child/adolescent psychiatric capacity. It would also be useful for DMH to expand work underway in limited areas to utilize other trained professionals (e.g., nurse practitioners, psychiatric nurses) to address ongoing medication management needs through physician-supervised relationships. All options for the expansion of current telemedicine capacities should be explored.

**Recommendation 8:** Data provided for this Assessment and Study describe children and adolescents who are identified as having an SED, but the relative intensity of services purchased by Medicaid on behalf of those children make the SED identification process somewhat suspect. The official MS SED definition is currently aligned with the federal definition (SAMHSA) and no benefit would be gained through a definition revision. However, it is recommended that DMH re-examine the purpose of the SED designation and determine the extent to which current processes support that purpose.

Most persons who provided input for this Assessment and Study are in agreement that everyone (children, taxpayers, families, workers) would be better served if children and adolescents on a path to a serious emotional disturbance could be identified and served before their difficulties ever reach official SED status. This would be an important system long-range goal, but at this time it appears that youth already recognized with an SED should be the primary beneficiaries of a strengthened system of care.

**Recommendation 9A:** There are currently too many unknowns in Mississippi systems, making long-term recommendations challenging:

- No data were provided about care of children from child welfare, alcohol/drug treatment, health, or non-special education school activities for this Assessment and Study, although requests were made;
- DMH service data from CMHCs remain largely based on paper-pencil reporting techniques;
- DMH service data from CMHCs only partially align with Medicaid purchase-of-service data; and
- No outcome/performance data exist anywhere, except in small, focused projects.

The State, across all service agencies, needs to invest in the development and operation of basic management information systems that provide real-time management data, for both planning and day-to-day operational purposes, and align data across information systems. System managers need access to data that link together the numbers and types of services delivered, service costs across products and regions, and consumer outcomes, and those data need to come to a collaborative table where system leaders use them to better align performance on behalf of the persons served. This recommendation has little to do specifically with the system of care, but the system of care, aimed especially at those children with more challenging and complex needs, requires this broader data-driven management style to function most effectively.

**Recommendation 9B:** It does not appear that Mississippi public systems currently utilize quality improvement and/or management information systems that feed performance data into all decision-making. Data regarding mental health service provision are not available to managers in real time, inhibiting data-driven management. No outcome or performance data are collected, and system service standards do not link certification to outcomes or quality performance. It is highly recommended that DMH develop and utilize a simple, straight-forward quality management system that links the outcomes and experience of children and their families to the provision of service. Those data should be used to strengthen what works and change what does not.

**Recommendation 10:** The data available to this Assessment and Study were incomplete, revealing only portions of the broad picture of public service in Mississippi. However, there are several types of data that suggest that the public service systems respond differentially and somewhat disproportionately to children and adolescents who are African-American. Medicaid pays more mental health service claims for African-American children than all other groups added together; African-American children and youth receive, on average, more than 50% more service units than are provided to Caucasian children and youth, although there are no clinical reasons to explain such a difference; school special education systems have over identified retardation among African-American students and under identify their emotional/behavioral needs and learning disabilities; and African-American youth are over-represented in institutional populations. Adequate data were not provided to discern causes of these care disparities, so the only recommendation possible is that the ICCCY study these and similar data to determine causes and recommend changes. It is particularly important that all systems examine these data together to determine larger system practices that may lead to differential identification and treatment of needs.

## **Appendix A – Mississippi Mental Health System Serving Children and Adolescents**

The structure, organization, and operation of Mississippi's public mental health system is highly relevant to this Assessment and Study, as public care of children and adolescents with serious emotional disturbances is primarily identified with that system. (In fact, as argued elsewhere in this report, the children and adolescents who are experiencing SED are certainly involved with all other publicly funded systems, and all other systems have some investment in the provision of mental health services.) The Mississippi mental health system is described here, using language taken from the State Mental Health Plan for FY09, prepared by the Mississippi Department of Mental Health.

“The public mental health system in Mississippi is administered by the Mississippi Department of Mental Health, which was created in 1974 by an act of the Mississippi Legislature, Regular Session. The statute placed into one agency mental health, alcohol/drug abuse, and mental retardation programs, which had previously been managed under multiple entities. The creation, organization, and duties of the Mississippi Department of Mental Health are defined in the annotated Mississippi Code of 1972 under Sections 41-4-1 through 41-4-23. The network of services comprising the public mental health service system includes three major service delivery components: regional community mental health/mental retardation centers, state-operated facilities, and other nonprofit service agencies/organizations.

“The Department of Mental Health provides leadership in coordinating mental health services within the broader system through both structural and functional mechanisms. The Mississippi Department of Mental Health (DMH) is governed by the State Board of Mental Health, whose nine members are appointed by the Governor of Mississippi and confirmed by the State Senate. By statute, the Board is composed of a physician, a psychiatrist, a clinical psychologist, a social worker with experience in the field of mental health, and citizen representatives from each of Mississippi's five congressional districts (as existed in 1974). Members' seven-year terms are staggered to ensure continuity of quality care and professional oversight of services.

“The Department of Mental Health has seven major bureaus: the Bureau of Administration, the Bureau of Mental Health (oversees six DMH-operated facilities and seven state crisis centers), the Bureau of Community Mental Health Services (includes community mental health for adults and children, and Alzheimer's Disease/other dementia services), the Bureau of Alcohol and Drug Abuse, the Bureau of Intellectual and Developmental Disabilities, Bureau of Interdisciplinary Programs, and the Bureau of Workforce Planning and Development.”

Only certain of the DMH bureaus and divisions are directly involved in planning and implementing mental health care of children and adolescents, as described here.

“The Bureau of Community Mental Health Services has the primary responsibility for the development and implementation of community-based services to meet the needs of adults with serious mental illness and children with serious emotional disturbance, as well as to assist with the care and treatment of persons with Alzheimer's Disease/other dementia. The Bureau of Community Mental Health Services provides a variety of services through the multiple divisions.

“The Division of Children and Youth Services is responsible for determining the mental health service needs for children and youth in Mississippi and for planning and developing programs to meet those identified needs. The staff of the division direct, supervise, and coordinate the implementation of Department-funded children and youth mental health programs operated by community service providers in the state. The division develops and supervises evaluation procedures for these programs to ensure their quality and oversees the enforcement of certain governmental program regulations, including DMH guidelines and standards for services. Community mental health services for children are currently provided through the 15 regional community mental health centers and a number of other nonprofit agencies/organizations funded through the Department of Mental Health. Additionally, the Division develops and conducts training in the areas determined to require new or ongoing training/staff development.

“The Division of Community Mental Health Services for Adults, the Division of Children and Youth Services, and the Division of Alzheimer’s Disease/Other Dementia work with the Division of Accreditation and Licensure, the Bureau of Interdisciplinary Programs and the Bureau of Administration to develop and monitor implementation of Department of Mental Health minimum standards and guidelines for community mental health services.

“The Bureau of Mental Health oversees the state psychiatric facilities, which include public inpatient services for individuals with mental illness and/or alcohol/drug abuse services and the state crisis centers, as well as the Central Mississippi Residential Center and the Specialized Treatment Facility, a specialized treatment facility for youth with emotional disturbances whose behavior requires specialized treatment.”

The DMH, at the state level, holds key planning and development responsibilities that impact the approach and impact of mental health care for children and adolescents, again presented here as described in the State Mental Health Plan for FY09.

“The major responsibilities of the state are to plan and develop community mental health services, to set minimum standards for the operation of those services it funds, and to monitor compliance with those minimum standards. Provision of community mental health services is accomplished by contracting to support community services provided by regional commissions and/or by other community public or private nonprofit agencies. The MS Department of Mental Health is an active participant in various interagency efforts and initiatives at the state level to improve and expand mental health services. The DMH also supports, participates in and/or facilitates numerous avenues for ongoing communication with consumers, family members and services providers, such as the MS State Mental Health Planning and Advisory Council; the Regional Commissions Group, members of which include the governing boards or commissions of community mental health centers; and, various task forces and committees that engage in ongoing efforts to improve the service system.

“The DMH administers and grants to local providers funding from the federal CMHS block grant and the Substance Abuse Prevention and Treatment (SAPT) block grant, as well as special federal program grants (such as the PATH program). The DMH also applies to the MS Department of Human Services for a portion of Mississippi’s federal Social Services Block Grant (SSBG) funds for mental health, substance abuse and developmental disabilities services; DMH subsequently administers and grants these SSBG funds to local providers. The DMH also requests and administers through its service budget state

matching funds for Medicaid reimbursable community mental health services provided by the regional community mental health centers.

“Agencies or organizations submit to the Department for review proposals to address needs in their local communities. The decision-making process for selection of proposals to be funded are based on the applicant's fulfillment of the requirements set forth in the RFP, funds available for existing programs, funds available for new programs, and funding priorities set by state and/or federal funding sources or regulations and the State Board of Mental Health.”

The relationships between DMH and other public service systems are critical to the development of an effective system of care. It should be noted that in § 43-14-1 all responsibility for developing and implementing the system of care is given jointly to multiple system partners – the DMH is not, in any way, singled out to lead or drive the system of care efforts – those efforts are statutorily designed to be shared across agencies. In the State Mental Health Plan, DMH describes its relationships with other agencies as follows:

“The MS Department of Mental Health is under separate governance by the State Board of Mental Health, but oversees mental health, intellectual/developmental disabilities, and substance abuse services, as well as limited services for persons with Alzheimer's disease/other dementia. The DMH has no direct authority over other state agencies, except as provided for in its state certification and monitoring role; however, it has maintained a long-term philosophy of interagency collaboration with the Office of the Governor and other state and local entities that provide services to individuals with disabilities.”

Reflecting that philosophy, DMH requirements over the operation of Community Mental Health Centers, the primary and dominant providers of publicly-funded children's mental health services, include clear leadership expectations about developing and managing the MAP and “A” Teams, the local component of the statutory system of care. The following requirements come directly from the Minimum Standards for Community Mental Health/Mental Retardation Services, effective July 1, 2002.

“1500.4 All providers certified as community mental health centers (DMH-C) must make available or participate in at least one Making a Plan (MAP) Team in each community mental health region. MAP Teams address the needs of children, up to age 21 years, with serious emotional/behavioral disorders, including, but not limited to, conduct disorders, or mental illness, who require services from multiple agencies and multiple program systems, and who can be successfully diverted from inappropriate institutional placement. Each MAP Team must be comprised of, at least, one child behavioral health representative employed by the Regional CMHC with a Bachelor's degree meeting Minimum Standard 20.5 f., at a minimum. Additionally there must be one representative, at a minimum, from each of the following:

- a. Each local school district in a county;
- b. County Family and Children's Services Division of the State Department of Human Services;
- c. County or Regional Youth Services Division of the State Department of Human Services; and,
- d. County or Regional Office of the State Department of Rehabilitation Services.



Three additional members may be added to each team, one of which may be a representative of a family education/support 501(c)3 organization with statewide recognition and specifically established for the population of children addressed by the MAP Team (described above). The remaining two members will be representatives of significant community-level stakeholders with resources that can benefit the children with serious emotional disturbance.

- “1500.5 The community mental health center (DMH-C) must maintain a current written agreement from agencies participating in the MAP team that identifies the primary functions of the team, including, at a minimum, the following functions:
- a. Review of cases of children/youth, ages up to 21 years, when appropriate, who have a serious emotional disturbance and who are at risk for inappropriate out-of-home placement due to lack of access to or availability of needed services in the home and community.
  - b. Identification of community-based services that may divert children/youth (described in a.) from out-of-home placement.
  - c. Facilitation of the provision and coordination of services across agencies/entities for the target population (described in a.).
  - d. Facilitation of continuity of care for children/adolescents with serious emotional disturbance; and,
  - e. Facilitation of support for children/youth with serious emotional disturbances and their families.”

Although the system of care statute does not place responsibility for developing or managing system of care components exclusively on the DMH or the mental health system, the DMH clearly places leadership responsibilities on local mental health system entities (mostly CMHCs).

Data that describe the actual work of the mental health system were obtained for this Assessment and Study through two primary sources:

- 1) Medicaid payment data for mental health services provided within the system; and
- 2) Data submitted by CMHCs in response to an annual data survey.

It must be noted that the second source creates data tables through individual data reporting from each CMHC, primarily a paper-pencil data reporting system. There is no universal MH management information system (MIS) within which data about services, recipients, and costs are maintained and used for management decision-making.

At some points, the data from these two sources are aligned; at other points, data from these two sources are different. Some of those differences may be embedded in the findings of this report.

## **Appendix B – Collaborative Application of the System of Care**

The timing of the renewal of this statute is highly beneficial to the State of Mississippi. The system of care statute is aimed at establishing a system to serve children and adolescents who experience serious emotional disturbances (SED) and their families, enabling them to remain in school, in home, and in the community, when at all possible. While the SED designation is commonly connected with the mental health system (DMH and CMHCs), the children and adolescents referenced in this statute may commonly be identified through:

- the special education portion of schools, and the broader school community,
- the child welfare system, as children come into state custody,
- the juvenile justice institutional system as earlier treatment in other systems fails.

Each of these public systems is currently working to meet the requirements of lawsuit settlements that include issues related to children with serious emotional disturbances, also known as mental illness or behavioral health disorders.

Updating this statute and seeking broader compliance with its requirements could begin to address further unmet needs among Mississippi's children and adolescents, control public spending on institutionally-based care, and simultaneously help meet requirements agreed to in each of the separate settlements.

The following summaries highlight the connections between certain requirements within each of these system settlement agreements, each subject to court-ordered monitoring, and the development of an effective, community based system of care. Only portions of the settlements relevant to behavioral health needs are discussed here, but the settlements include many other requirements.

### **Mattie T.**

The Mattie T. Consent Degree, initiated decades ago and re-settled in 2003, requires education system improvements in the areas of Child Find, Least Restrictive Environment, and Nondiscriminatory Assessment of Minority Students for Special Education, according to the website of the Southern Poverty Law Center. The settlement agreement includes specific requirements addressing individual behavioral health needs among students in each of these three major areas.

Under the area of Child Find, Mattie T. requires that school districts, individually and collectively, bring levels of identification of children with SED (the Emotional/Behavioral Disturbance category) up to 75 percent of the national average identification, which is 75% of the national average of 0.74%, or 0.56% of all students, and maintain that compliance through a full school year. The 2008-2009 identification percentage was 0.37% of all students, representing a substantial improvement in identification over the baseline of 0.08% (2008) but still short of the goal. Over the past 6 school years, Mississippi school districts have steadily raised the level of identification of students with these needs, but most have not yet reached the minimal standard. Out of 152 regular school districts, 108 reported 2007-2008 identification rates below that standard, including large and small, urban and rural, and northern and southern districts equally distributed among those falling short of the requirement.

Under the area of Least Restrictive Environment, Mattie T. requires an increase in the percentage of students with disabilities who participate in Regular Educational Class Settings and a decrease in the percentage of students with disabilities served in Self-Contained Class Settings (isolated away from the general population, brief to all-day). Over the past 6 school years, Mississippi school districts have steadily raised the percentage of special education students participating in regular education, exceeding the targets for the past four years. Likewise, the percentage of special education students in self-contained classes has decreased for the past four years, exceeding the targets set in 2003 for the past three years. Only 28 districts (out of 152) failed to meet the targets for the number of children in self-contained environments in the 2007-2008 school year.

Under Nondiscriminatory Assessment of Minority Students for Special Education, Mattie T. requires districts to redress disparities, such as the over-representation of African-American students in the educable mentally retarded and specific learning disability categories, which can be inferred to reflect a concomitant under-representation of those students in other, perhaps more appropriate, categories, such as emotional/behavioral disability. Over recent years, Mississippi has reduced the number of districts with a disproportionate number of students who are Black classified as EMR, while also reducing the differential between students who are Black and classified with EMR and students of other racial/ethnic groups to 0.59. This differential is lower than the Mattie T. Consent Decree requirement of 1.15. Overall, Mississippi has reduced the identification of students with EMR to 0.72%. Only 17 of the 152 regular districts remained outside the targets for the 2007-2008 school year, suggesting broad success in increasing the accuracy of student need identification by schools. System performance is not as strong in reducing over-representation in the Learning Disability category, although improvement has occurred steadily, but targets have not been met overall, or by most individual districts. This category is important because children with serious emotional disturbances have often been identified only under the Learning Disability category, which sets limits on the amount of intervention needed.

The simple identification of students who are experiencing emotional/behavioral disorders is challenging, based on these data. The education system and individual school districts have made demonstrable progress in formally recognizing these disorders, but overall progress falls short of the very conservative targets set in the settlement agreement (75% of the national average). Second, school districts have clearly made great progress in increasing the interactions between students with special needs and their peers during the educational process. The integration of peers, however-abled, into the educational process benefits everyone involved, including those with special needs, other students, school staff, families, and systems. Unfortunately, there is no way to know the number of youth with behavioral health needs included in this progress. Third, skin color and/or cultural background can be allowed to play no role in identifying behavioral health needs, unless competent research shows the role they play; historic data suggest that skin color and/or cultural background may have played such a role. An increased focus on accurate identification of more important factors and better interpretation of those factors will put the statistical data where they belong.

Each of these areas can be addressed within the context of a developing system of care at the community level, in all Mississippi communities. Organizing partnerships between schools, families, mental health experts, and other community partners can lead to: 1) ever-improving assessment and identification of needs; 2) implementation of individualized care plans, including evidence-based practices and informal supports that keep students in the least restrictive educational environment possible through school-wide support processes; 3)

appropriate identification and labeling of needs, based on functional abilities and family support, instead of cultural assumptions or stereotypes; and 4) shared responsibility for successful programming across multiple agencies or systems.

Olivia Y.

The most recent Court Monitor's Report, Grace Lopes (06/05/09), is organized to identify each of the specific requirements within the settlement agreement and then report progress on each. The majority of requirements reflect administrative and organizational needs or child abuse/neglect needs, which are the purview of that system. Two specific settlement agreement requirements relevant to children and adolescents with serious emotional disturbances are described as showing no progress since previous assessments:

Period 1 IP §II.7 II. Foster Care Services Assessment and Implementation Steps

7. Physical and Mental Health Care

Defendants shall, in consultation with state Medicaid and mental health officials, develop and begin implementing specific and focused regional plans to recruit and develop service providers in areas identified in the needs assessment as having gaps in required services.

Period 1 IP §II.8. Educational Services

DFCS shall develop and implement a protocol for conducting a general and special education screen of children entering foster care.

DFCS shall develop and begin implementing a plan for providing, either directly or through contract, the following educational services in each county: tutoring, preparation for a general equivalency diploma (GED), and college preparation.

The first requirement above recognizes that there is inadequate service capacity in some areas of the state to identify, assess, and treat mental health needs. The first portion of the second requirement emphasizes developing and implementing protocols to assure that all children and adolescents entering foster care are screened for existing needs. National data show that significant numbers of children and adolescents coming into state custody have behavioral health needs, whether or not related to the placement; screening of behavioral health needs upon entrance to state custody will require organized actions at the state and community levels, such as can be developed within a system of care.

### Oakley Training School

The 11<sup>th</sup> Monitor's Report (08/05/09) for Civil Action No. 3:03-cv-1354WSu, United States v. State of Mississippi, includes reporting on requirements in two major sections that are highly important for adolescents with behavioral health needs.

Nineteen provisions were included in the Protection From Harm section of the settlement agreement (2005), and in this monitoring period 28% (5) provisions were satisfied, partial compliance was achieved in 17% (3), and beginning compliance in 56% (10). The report lists major tasks that remain necessary, especially including:

- Continue the development of a comprehensive, behavior management system and train staff in behavior management and de-escalation techniques.

- Ensure mental health professionals, social workers, juvenile correction workers and school staff are involved in treatment planning.
- Incident reports should not be used as behavioral management tools for isolation or disciplinary sanctions. The reports shall be used to detail the incident as it occurred.

Intense strategies have been created and implemented to address these behavioral health provisions and some progress was made prior to this Monitor's Report. Substantial work remains. These significant challenges – 1) creating a comprehensive behavior management system, 2) creating cross-system teams to plan, implement, and monitor treatment and care, as needed, and 3) separating the therapeutic interventions (behavior management) from operational procedures (incident reports) – could all be addressed in an interagency system of care.

Instituting a comprehensive behavior management system is a complex undertaking, requiring goal-oriented training for staff and strong development of connections to the community. Local MAP and "A" Teams could review and provide information about individual youth committed to Oakley by the court. Community care systems need to link to the in-house treatment program and lay groundwork for return of each youth to the community at some future date. The system of care is ideally designed for these roles.

Nine provisions were included in the Suicide Prevention section of the settlement agreement, and in this monitoring period 55% (5) showed substantial compliance, with the remaining 45% (4) in partial compliance. Major tasks listed by the report included:

- Documenting the daily assessment of suicidal youth in a detailed progress note that provides adequate justification for the decision. Continuing to improve staff understanding and usage of SOAP format.
- Developing and maintaining individualized treatment plans designed to reduce suicidal ideation and threats, self-injurious behavior, and suicidal threats perceived to be based upon attention-seeking behavior.
- Ensuring a formalized schedule of follow-up for youth discharged from suicide precautions.
- Assembling a Morbidity-Mortality Review Team and conducting another morbidity review (without the oversight from the Monitor).
- Demonstrating the initiation of quality assurance for suicide prevention.

In total and separately, each of these tasks would have the best chance to achieve success within a system of care context, wherein children and youth with suicidal tendencies or histories coming to the facility could be identified, with information provided about past care, served through team-based care planning, discharged after long-term planning that leads to direct links with community services, and served by a program and system with a focus on quality improvement in all systems, at all times.

## Appendix C - Medicaid

The Mississippi System of Care statute links together children and youth with serious emotional disturbances and the three collaborative mechanisms empowered by the statute. Those mechanisms (ICCCY, ISCC, and MAP/A Teams) touched the lives of 1,266 children, youth, and their families in FY08. Medicaid funding for public services to children and youth with serious emotional disturbances is linked directly to the SED designation; the 29,269 (08) children and youth identified as having SED by the Community Mental Health Centers (CMHC) across Mississippi get access to higher levels of service. Medicaid data show that, across all ages birth to 21, children and adolescents receiving any behavioral health care funded through Medicaid are receiving an average of \$547.09 (FFY09) worth of services in a year (down from \$552.28 in FFY08).

Several conclusions can be drawn from this set of facts:

A relatively small group of Mississippi children and adolescents with serious emotional disturbances is receiving intensive care through MAP Teams.

CMHCs are identifying lots of children and adolescents with serious emotional disturbances (to access higher service levels), but there is no way to validate the identification process as anything other than accessing a fund stream.

Irrespective of the accuracy of identification of children and adolescents with SED, the statutory SOC mechanisms touched 4.3% of the Mississippi children and adolescents identified as having SED.

The small amount of per-youth spending identified through Medicaid, the system's primary payor, suggests that the system's average response to children and adolescents identified as having SED is inadequate, at best.

More inferences can be drawn about the mental health service system for Mississippi children and adolescents by examining the data across several sets of categories.

### Age-related data

It is instructive to examine data across age categories with regard to cost:

<b>FY08 data</b>	<b>Units/child</b>	<b>Cost/unit</b>	<b>Cost/child</b>
0-1	3.1	49.20	153.36
2-4	61.4	31.73	1,949.78
5-11	19.1	27.84	530.99
12-17	15.9	25.57	406.14
18-20	36.3	11.30	410.22
<b>Totals</b>	<b>21.2</b>	<b>26.04</b>	<b>552.28</b>

<b>FY09 data</b>	<b>Units/child</b>	<b>Cost/unit</b>	<b>Cost/child</b>
0-1	1.4	75.90	108.20
2-4	62.6	31.72	1987.32
5-11	17.9	28.81	514.46
12-17	15.1	26.88	406.44
18-20	43.0	9.67	415.96
<b>Totals</b>	<b>20.8</b>	<b>26.34</b>	<b>547.09</b>

Generally speaking, there is strong consistency across the two years covered by these data, suggesting that yearly fluctuations are not strongly influencing these numbers. A clear trend

emerges of a decrease in the cost per service unit as age increases, which is intuitively counter to the reality that, as children with SED age, the intensity of their treatment needs tends to increase, especially when untreated at an earlier age.

The data from two specific age cohorts suggest that:

- 1) Medicaid is supporting some form of specialized programming for children aged 2-4 (including 8,516 individual children in FY09), as both the units per child and the cost per child are completely out of line with the remaining age cohort data, while the cost per unit in this age group fits the larger trend. Generally speaking, traditional mental health centers do not serve many children in this age range, which implies specialized programming.
- 2) Most of the programming purchased for 18-20 years olds (including 8,935 young adults in FY09) must be offered primarily in a group format, as the cost per unit is extraordinarily low for any other service format.

If the cohort of 2-4 is removed from the data, the overall average cost per child is even substantially lower than the \$547.09 average already cited above as small. With the exception of the 2-4 age category, average children and adolescents are not receiving intensive mental health services

#### Gender-related data

Generally speaking, higher numbers of males are identified during childhood and adolescence as having a serious emotional disturbance. Whether the incidence is actually higher among males, or males manifest more readily-identifiable signs and symptoms, has not fully been determined. Mississippi data show the following.

<b>FY08</b>	<b>Recipients</b>	<b>Units/recipient</b>	<b>Cost/unit</b>	<b>Cost/recipient</b>
Female	53,762	21.5	26.55	570.13
Male	87,043	21.2	26.24	555.04
Blank or unknown	560	3.4	56.81	195.37

<b>FY09</b>	<b>Recipients</b>	<b>Units/recipient</b>	<b>Cost/unit</b>	<b>Cost/recipient</b>
Female	55,924	21.6	26.50	571.30
Male	92,292	20.3	26.22	532.96
Blank or unknown	140	2.7	69.25	188.45

These data show that males comprise 61.6% (08) to 62.2% (09) of the Mississippi children and youth who received some amount of mental health care paid for by Medicaid. These figures are reasonably consistent with national data about recipients of mental health services. Across both years, the units per recipient, cost per unit, and cost per recipient are relatively consistent for both genders, although males dropped a bit in units per recipient and cost per recipient in FY09. These data do not suggest any gender-based discrepancies in mental health care of children and youth.

#### Race/ethnicity-related data

Race and ethnicity have been important components of mental health care in Mississippi, and the following charts show key race/ethnic breakdowns for the 0-21 population served by Medicaid:

<b>FY08</b>	<b>Recipients</b>	<b>Units/recipient</b>	<b>Cost/unit</b>	<b>Cost/recipient</b>
African-American	80,236	25.0	26.19	655.18
Caucasian	47,534	14.5	27.85	402.66
Hispanic	914	21.1	25.55	538.37
Race unknown	12,321	22.8	24.12	549.71

NOTE: Several racial/ethnic categories are missing in these charts due to small numbers.

<b>FY09</b>	<b>Recipients</b>	<b>Units/recipient</b>	<b>Cost/unit</b>	<b>Cost/recipient</b>
African-American	80,822	24.4	26.37	643.41
Caucasian	47,554	14.2	28.33	402.14
Hispanic	1,027	12.3	29.51	362.79
Race unknown	18,641	22.4	22.83	512.58

NOTE: Several racial/ethnic categories are missing in these charts due to small numbers.

These data suggest many differences/disparities in mental health care for children and adolescents:

- 1) Although the African-American population of Mississippi comprises 27.2% of the state's total, the number of African-American children and adolescents receiving Medicaid-funded mental health services is substantially more than all other racial and ethnic categories added together.
- 2) The cost per unit of care for all groups is substantially the same, suggesting that the intensity of services received is even across groups.
- 3) The average units per recipient and cost per recipient for Caucasian children and adolescents are less than two-thirds the cost per unit and cost per recipient for African-American children and adolescents. This raises questions about the diagnostic assessment process and the perceptions of what services are needed by or offered to different racial/ethnic groups.
- 4) The "race unknown" category is substantial, increasing by 50% from FY08 to FY09. The units per recipient and cost per recipient figures for this category suggest that this group is more like the two minority groups (African-American and Hispanic) than the Caucasian group. This raises the possibility that families and/or workers see some danger in identifying some Hispanic children and youth (the possibility they are "illegal") and choose the "other" or "unknown" categories.

The disparities described touching African-American children and adolescents (1 & 3) are generally in line with disparities recently identified in law suits regarding children and adolescents served by the juvenile justice and special education systems and the subject of fixes now underway. It is not reasonable to believe that African-American children and adolescents suffer from such a substantially higher incidence of SED than Caucasian children and adolescents, except to the extent that higher levels of poverty can be linked to African-American families (poverty being the single factor research links directly to the incidence of SEDs among children and adolescents).

### Service utilization

The following charts list information about mental health services for children and adolescents for which Medicaid spent at least \$1M in either year.

The first set of charts (08 & 09) shows the number of recipients, number of units, and total cost of that service, from highest cost down. The second set shows the units per recipient,



cost per unit, and cost per recipient for the same services, in the same order. [Please note: three services change order in both sets from 08 to 09.]

<b>08 Service</b>	<b>Number of recipients</b>	<b>Number of units</b>	<b>Total paid</b>
Day Treatment	5,248	1,095,325	\$35,040,790
Targeted Case mngt	16,527	1,158,285	\$17,238,666
Office therapy 45-50	18,223	112,037	\$8,518,423
Family psychotherapy	11,382	36,657	\$2,940,261
Office therapy 75-80	5,083	20,453	\$2,143,735
Community spprt srvc	7,005	105,173	\$1,940,307
Medication mngt	13,729	38,677	\$1,690,566
Nursing service	9,145	75,316	\$1,386,567
Family therapy w/o kid	6,036	17,707	\$1,320,912

<b>09 Service</b>	<b>Number of recipients</b>	<b>Number of units</b>	<b>Total paid</b>
Day Treatment	5,517	1,144,843	\$36,629,470
Targeted Case mngt	15,891	1,119,589	\$16,542,553
Office therapy 45-50	19,084	122,729	\$9,182,665
Family psychotherapy	12,327	36,960	\$3,194,653
Community spprt srvc	6,958	98,776	\$1,822,084
Medication mngt	13,745	37,780	\$1,643,828
Office therapy 75-80	4,944	14,506	\$1,567,645
Nursing service	9,749	73,261	\$1,350,361
Family therapy w/o kid	6,632	18,006	\$1,311,997
Office therapy – 20-30	8,734	24,082	\$1,185,838
Diagnostic interview	7,027	8,823	\$1,079,219

<b>08 Service</b>	<b>Units per recipient</b>	<b>Cost per unit</b>	<b>Cost per child</b>
Day Treatment	208.7	\$31.99	\$6,676.98
Targeted Case mngt	70.1	14.88	1,043.06
Office therapy 45-50	6.1	76.03	467.45
Family psychotherapy	3.2	80.21	258.33
Office therapy 75-80	4.0	104.81	421.75
Community spprt srvc	15.0	18.45	276.99
Medication mngt	2.8	43.71	123.14
Nursing service	8.2	18.41	151.62
Family therapy w/o kid	2.9	74.60	218.84

<b>09 Service</b>	<b>Units per recipient</b>	<b>Cost per unit</b>	<b>Cost per child</b>
Day Treatment	207.5	\$32.00	\$6,639.38
Targeted Case mngt	70.5	14.78	1,041.00
Office therapy 45-50	6.4	74.82	481.17
Family psychotherapy	3.0	86.44	259.16
Community spprt srvc	14.2	18.45	261.87
Medication mngt	2.7	43.51	119.59
Office therapy 75-80	2.9	108.07	317.08
Nursing service	7.5	18.43	138.51
Family therapy w/o kid	2.7	72.86	197.83
Office therapy 20-30	2.8	49.24	135.77
Diagnostic interview	1.3	122.32	153.58

The most obvious finding from these data is that Mississippi children and youth are being offered one intensive service in the community – day treatment – and a host of non-intensive services, at least as defined by unit cost or number of units provided.

Day Treatment service is the highest total cost service and is provided to over 5,000 youth each year. Based on the intensity of this service, these youth are likely to be experiencing SED and are thus appropriate candidates for intensive care.

It is interesting to note that in both years the average units per recipient are 4 per week (208 per year) and the DMH Service Standards state that “Each youth must receive day treatment services at a minimum of two (2) hours per day, two (2) days per week up to a maximum of five (5) hours per day, five (5) days per week.” This service is important in system of care efforts to keep children and youth and their community and avoid inappropriate placements, but it is hard to gauge the quality or impact of this service. The consistently low cost per unit suggests that the staff-to-youth ratios are consistently set at the minimum acceptable level.

The second most expensive service – Targeted Case Management – is actually the service most-provided (in units) for FY08. The cost per unit of this service suggests that a unit is either very brief or delivered in group settings. In either circumstance, it is not an intensive, relationship-based service. The annual average number of units per child (70, in both years) raises the possibility that these are brief, weekly phone calls – checking in, not treatment.

Office-based psychotherapy remains a frequently provided service. In the service data shown above, three separate entries are all office-based psychotherapy, although for different lengths of time. When added together, this service remains the third highest cost to the system (\$11.6M in FY08, \$11.9M in FY09) with a notably lower cost per child (\$355.10 in FY08, \$364.33 in FY09) than two of the separate categories shown above.

The broad constellation of services purchased by Medicaid for Mississippi children and adolescents suggests that in one year:

- about 5,000 get access to an intensive, community based service of unknown value;
- about 16,000 get access to a short-term case management service that appears to lack intensity;
- a group of up to 19,000 get access to an average of 6 50-minute counseling sessions, while another 12,000 (probably some duplication) get access to 3 family counseling sessions; and
- smaller numbers of children and adolescents get other services in limited durations.

These numbers indicate that, while 29,269 Mississippi children and adolescents are being identified with serious emotional disturbances, the majority of those youth are not receiving substantial and intensive services. These numbers suggest that either the children and adolescents served with Medicaid-purchased services are not in serious need or the system response to the children and adolescents with SED is inadequate.

It should be noted that the DMH Service Standards include a set of minimum services that MUST be provided by CMHCs within their respective regions, and that set of services is identical to the services funded through Medicaid (minimum required services for children and adolescents: day treatment; outpatient therapy; case management; psychiatric services; intake/functional assessment; emergency services; and pre-evaluation screening for civil commitment). Day treatment programming must be linked to schools and these data reveal

strong success in forging local relationships that allow such intensive community treatment to take place. However, data describing the specific children served in day treatment programming are non-existent and nothing is known about outcomes.

In fact, it is noted that the DMH Service Standards do not include any requirements linked to quality improvement or quality management programs, with no definition of service outcomes. Assessment of quality is carried out through peer-to-peer and bi-annual state reviews that focus primarily on providing technical assistance and encouragement/support for improvement.