An Assessment and Study of the

Mississippi System of Care

Executive Summary

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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.

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.