

## Work Group II: Supports and Services for Children and Families

### **A. The children’s mental health system is significantly underfunded. Consequently, children (aged 0–18) with emotional and mental health issues are underserved due to the level and structure of funding for mental health services.**

Efforts to contain cost result in state and local policies and procedures that encourage inappropriate cost- and service-shifting among systems, including, but not limited to, mental health, juvenile justice, child welfare, substance abuse, and education.

The needs of many children with emotional and mental health issues are not being met, nor are we acting upon the increasing knowledge of the mental health field to identify the early antecedents of mental illness. The level and structure of the funding of mental health services is the most significant factor limiting the promotion of mental health in children, screening and assessment, and provision of services and supports.

Children who do not meet income or severity criteria for Medicaid have reduced access to the public mental health system. For those children who are covered by Medicaid, current funding levels are inadequate to meet their mental health needs. There is also uneven geographic access to services for children due to variations in funding among community mental health service programs.

#### *Proposed Options*

- II.1. Maximize use of Medicaid funding by identifying all bona fide sources for matching funds and identifying and removing legal and other barriers to Medicaid waivers.
- II.2. Pilot the creation of joint purchasing and alignment of mental health services among local CMHSPs, family courts, and local FIA offices that results in the development of a common provider network in three counties.
- II.3. Increase the amount of state general fund dollars appropriated for mental health so that CMHSPs can serve children who need services but do not meet current income or severity criteria.
- II.4. Eliminate disparities in allocation of funding (Medicaid and general fund) among and within CMHSPs to provide and fund a comparable array of services in each region.
- II.5. Support mental health parity legislation.
- II.6. Establish a single entity responsible for assessing and forecasting mental health treatment needs for Michigan children and families across departments and publicly funded programs. The needs assessment would assist the state of Michigan in developing a target for adequate funding for children’s services and a plan for reaching this target.

**B. Michigan lacks a comprehensive system of care for children’s mental health services: Stroul and Friedman define a system of care as “a comprehensive spectrum of mental health and other necessary services which are organized into a coordinated network to meet the multiple and changing needs of children and adolescents with severe emotional disturbances and their families.”**

There are many barriers to accessing children’s mental health services that must be eliminated in order to close the gap between the number of children who receive services and the number of children in need of services.

- The current service system lacks a uniform strategy for screening and early intervention.
- The current mental health system operates to limit access to services by virtue of its fragmentation.
- Many professionals who work with children lack the necessary knowledge and tools to screen and refer children for mental health services.
- Families are not consistently involved in planning the system of care for children.
- Limited capacity exists to treat and follow up with children who have been determined to need services.
- Services provided are often inappropriate to the needs of the child and family.
- Families become caught between systems when involved with mental health as well as child welfare, juvenile justice, education, or substance abuse. Fragmented funding can make it difficult or impossible to coordinate services and funding to address dual or multiple needs.
- Serious gaps exist in the current array of available services; for instance, prevention and early intervention, respite and crisis care, and residential treatment. Outpatient treatment restrictions force many children into higher levels of care than are necessary.

Creating a system of care involves the organization of public and private service components within the community into a comprehensive and interconnected network in order to accomplish better outcomes for children and families. It involves joint planning and shared funding to accomplish such interconnections as proactive screening, smoothly functioning access to assessment and appropriate service, coordinated service planning across systems, and shared information.

*Proposed Options*

- II.7. Establish and fund a system of care (see attached “System of Care Service Components”) and make available a comprehensive array of services within 60 minutes (one way) of every Michigan citizen.
- II.8. Select and implement a specific mental health screening instrument for EPSDT. Screen and refer for assessment at school entry, middle and high school transitions, first suspensions, removal from home by FIA, first court appearance. Coordinate with EPSDT.

- II.9. Explore more appropriate diagnostic tools such as the Zero to Three Diagnostic Classification tool for young children.
- II.10. Develop a comprehensive coordinated system of care for children aged 0–5 incorporating all state funded services. (See attached list “Components of Education, Prevention, and Early Intervention.”)
- II.11. Provide easy, consumer-friendly, timely access to public mental health services at multiple entry points (no wrong door). Establish and monitor a reporting system to track those who attempt to receive services but are denied treatment.
- II.12. Create an education campaign to inform stakeholders of the existence of information and disseminate information through state offices, professional associations, universities, and all organizations that have contact with child- and family-serving professionals.
- II.13. Increase the number of child and adolescent psychiatrists, social workers, psychologists and infant mental health specialists across the state by providing incentive programs to locate in Michigan, provide services to clients of the public system, and receive training and continuing education programs. Support the AACAP and the APA at state/national levels on workforce issues.
- II.14. Review alternatives to the 20 outpatient visit benefit within Medical Health Plans and promote MHPs contracting with CMHSPs or consolidate the outpatient benefit within CMHSPs to provide appropriate services for mildly and moderately emotionally disturbed Medicaid children. The capitation amount per child should be increased.
- II.15. Implement an interagency process to review prior interventions for appropriateness and effectiveness before considering out-of-home placement or change in placement.
- II.16. Explore court funding for treatment if a child referred to a CMHSP does not meet mental health criteria for services.
- II.17. Establish and disseminate fiscal and administrative policy and guidelines that provide for blended funding, screening, assessment, access, services, and sharing of information.
- II.18. Address issues of confidentiality in ways that respect a family’s right to privacy but encourage coordination among providers in different systems.
- II.19. Strengthen the resource capacity of schools to serve as a key link to a comprehensive, seamless system of school- and community-based identification, assessment, and treatment services.
- II.20. Mandate in-service training for teachers throughout Michigan to help them recognize mental health issues and provide them with the information they need to make the necessary referrals for care.

### **C. Children and families receiving public mental health services encounter inconsistent use of standards of care and best practices.**

There is variation across the state in the use of best practices by agencies (MH, FIA, schools, juvenile justice) providing mental health services to children and families. Barriers to addressing the variation in the consistent use of best practices include:

- Limited capacity to identify, disseminate, and apply increasing knowledge about the nature of emotional disorders in children to public and private screening, diagnostic, and treatment efforts, e.g., inadequate training programs to standardize care and assure the use of evidence-based practices
- Lack of consistent standards of care for children’s mental health services, e.g., lack of a clear definition of “family-centered practice,” which makes it difficult to require all public and private providers to include the child and family in all decisions about their care
- Insufficient efforts to offer culturally competent services that assure individualized care with regard to race, ethnicity, disability, gender, sexual orientation, socioeconomic status, geography, and the culture of families of children with serious emotional disorders
- Lack of strong connections between the mental health system and entities that could support the use of best practices, e.g., higher education
- Little public recognition of the connection between symptoms in childhood and adult mental illness

#### *Proposed Options*

- II.21. Specify use of evidence-based best practices, when available, in contracts (cf. Dr. Robert Friedman and Dr. Kay Hodges) and experiential based practices already proven and implemented in Michigan (e.g., intensive home-based services and wraparound services). Require adherence to values and principles of system of care (Stroul and Friedman, 1994).
- II.22. Convene a representative work group to explore use of evidence-based and experiential-based best practices for children involved in child welfare and juvenile justice leading to requiring feedback evaluation of experiential-based best practices as the first step in evaluating the impact of promising policies and programs.
- II.23. Enhance graduate training within colleges and universities regarding best practice methods for children and families.
- II.24. Assess current training options and determine the need for implementing a training institute for the state to provide training on best practices to a broad audience, including, but not limited to, staff of CMHSPs, FIA, and private child- and family-serving agencies. Link training institutions to be sure that information provided is consistent.

- II.25. Develop a clear consensus-based definition of, and guidelines for, “family-centered practice,” outlining implications and action items and revise MDCH policies on person-centered planning to specify *family-centered* practice when children are the identified consumer so that the child and family are included in any/all decisions about their care Include children in treatment planning by offering them direct information in developmentally appropriate ways about service options.
- II.26. Specify in MDCH contracts that representatives of families of children receiving services be included in governance bodies.
- II.27. Use family advocates, such as family members with prior experience, to assist families in interacting effectively with complicated service systems.
- II.28. Develop and require implementation of a formal mechanism to utilize service recipient and family feedback in an ongoing quality assurance process.
- II.29. Increase efforts to recruit and train minority providers.
- II.30. Review recipient rights policies for sensitivity to cultural competence issues.
- II.31. Licensing agencies and state agencies should require documentation of: policies/procedures, training, quality improvement, grievance process for individuals who have not had their rights respected.
- II.32. Adopt common community and individual indicators as measures of outcome.

## System of Care Service Components

1. An ideal service continuum includes:
  - Prevention services
  - Early detection and intervention for children from birth to age 18 who have, or are at risk for, SED
  - Infant mental health services to prevent SED by providing appropriate parent-infant assessment and intervention
  - Comprehensive assessment of care needs
  - Medication assessment, review, and management
  - Case management
  - Wraparound services (including systems and services coordination mechanisms for multiple needs children and adolescents)
  - Outpatient services
  - Family community support services (family advocacy)
  - Emergency services
  - Acute care hospital inpatient treatment
  - Residential treatment

- Transition services for older adolescents and young adults
- Therapeutic foster care
- Respite services
- Substance abuse services

2. Components of education, prevention, and early intervention include:

- Infant mental health services with an emphasis on enrollment during pregnancy or first months of infancy.
- Parent education
- Social emotional component within child care and schools
- School curriculum (Michigan Model)
- Proactive intervention in child care (MH services in Head Start); schools (bullying and other violence prevention); CMHSP (Integrated services making children part of service plan)
- Mental health services through school health clinics