Addendum to the

System of Care Report to the Montana Legislature

Report and Recommendations as Required by House Bill 243

Prepared By The

Montana System of Care Planning Committee

October 29, 2010

Children's Mental Health Bureau

Memo

To: **Representative Chuck Hunter;**

From: Bonnie Adee, Children's Mental Health Bureau Chief

CC: System of Care Planning Committee

Date: October 29, 2010

Re: Addendum to the Report Required by HB 243

Representative Hunter,

Thank you for your testimony on August 17, 2010 after the presentation of the System of Care Report required by House Bill 243. As result of it, the System of Care Planning Committee (SOC Committee) has produced the attached Addendum to the System of Care Report with the hope that it more fully addresses the requirements of your bill and assists the Legislature in evaluating Montana's experience with system of care development up to this point.

My role as Children's Mental Health Bureau (CMHB) Chief has been to facilitate discussion and collect comments and feedback from the SOC Committee and then to integrate and synthesize these comments to reflect the conclusions and recommendations of the SOC Committee in the Addendum. The contractor hired to write the report, Open Minds, did produce an Addendum as requested, but the SOC Committee did not think it sufficiently represented the recommendations of the members and chose to submit its own Addendum to the Open Minds report. The SOC Committee formed a workgroup, representing both of its subgroups (Statutory and Community) to rewrite the report. The Statutory Planning Committee is comprised primarily of administrators representing the state's child serving agencies, and the Community Planning Committee represents primarily family members, youth, and staff, providers and stakeholders involved with the KMAs. The workgroup began with the Open Minds Addendum but significantly revised it, using information from the members who chose to submit responses to the items required in the bill and who participated in the discussions.

The workgroup's Addendum was reviewed by the Statutory Committee and the group still did not think the Addendum accurately expressed the views of the full SOC Committee. The Statutory Committee members struggled with how to balance the input from Community Committee members, particularly those involved with and invested in KMAs,

with the reality that neither state nor federal funding is available to continue the KMA model.

The Statutory Committee members agree there are important and positive benefits from the state's experience with KMAs which should be sustained, including adopting many of the principles, values, practices and activities identified and implemented during the five year grant period. However, the Statutory Committee does not recommend the continuation of KMAs to the Legislature which makes the questions posed by the legislation more difficult to answer.

The entire SOC Committee agrees on two key points. The State needs to retain and increase the gains made to engage and empower family members and youth to participate in significant ways in the development of Montana's system of care, including in the development of their own individual plans. Second, high fidelity wraparound is the model state agencies will support to improve access to and effectiveness of community services for youth and families.

The Addendum will identify the recommendations which have support from all members of the SOC Committee who participated, and which are primarily from the Statutory Committee members without full consensus from the Community Committee members and other stakeholders. The content of the Addendum does not necessarily represent the opinion of the CMHB, nor any other single member, nor does it necessarily represent a consensus of all the System of Care Planning Committee members. This report reflects the opinions of multiple individuals that self-selected to contribute to the preparation of the document, provides a summary of important observations of individuals involved in the system of care development about lessons learned from the KMAs, and makes recommendations about opportunities to move forward.

Section 1.3(a); State whether and how kids management authorities (KMAs) or their equivalent should be structured, staffed and funded, including but limited to identifying the agencies to be involved, how their involvement could be encouraged or required, and how they could most effectively participate in the process.

SHOULD KMAs OR THEIR EQUIVALENT BE CONTINUED?

The Statutory Committee members of the System of Care (SOC) Planning Committee agree the KMA model implemented during the SAMHSA grant cannot be continued. Federal and state funding for KMAs ended on September 29, 2010, and the grant funded KMA model is not sustainable with local resources only. KMAs did not become the "building block" of a statewide system of care for children, although some communities do have local interagency teams developed only with local or non-government support, and these may continue. One of the grant funded KMAs will continue as a local interagency team (Billings) and one will continue as a provider of wraparound services (Helena).

Because of the recommendation to discontinue the KMA model, some of the remaining questions are difficult to answer. However, some of the members of the Community SOC Committee disagree with this recommendation and say that KMAs, as local interagency teams, are an important component of the system and should exist in conjunction with the use of wraparound facilitation to ensure a cohesive family driven service delivery system. Those members believe that even though funding is currently not available for local interagency teams, they are needed to plan for local service delivery for Montana's at risk children and families.

When KMAs existed, a great deal of effort went into defining them. Should the Legislature determine there is a need for local interagency teams, information and guidelines are available from the SOC Committee describing the role of those teams in planning for local service delivery at the community level.

WHAT WORKED WITH THE KMAs?

All member of the SOC Committee agree that KMAs increased family participation in the system of care. KMAs provided a single point of entry for families and supported meaningful participation by families (and sometimes youth) in service planning. KMAs helped families and youth navigate the system, connected them with necessary resources, advocated for them and provided them with access to family and youth support groups and peer to peer activities. At a broader community level, KMAs provided a forum for public and private stakeholders to discuss important issues including gaps in services and funding, and engage in activities to impact services within the community. Over time, KMAs became an important resource and point of access for families outside of the Medicaid system who lacked other benefits in addition to those with access to Medicaid. In some cases KMAs prevented these families

from entering the system and decreased their risk of out of home placement or involvement with juvenile justice or family services.

KMAs offered family driven and youth focused activities, including youth and family peer to peer groups. KMAs helped parents make informed decisions and helped them bring together the resources they needed or identified. More opportunities for agency cooperation were a result of participating agencies having a better understanding of each other's resources as well as limitations. The KMA was also a good forum to help families understand agency responsibilities, mandates and limitations. Youth and families have access to more support and information at the community level across the state today as a result of replicating some of the best practices initiated by KMAs, including creating a Montana chapter of Youth M.O.V.E.

The SAMHSA grant supported wraparound training for KMA staff, agencies, providers, families, other stakeholders, and community members. The core values and principles of wraparound were embraced by many in the KMA communities and provide an excellent foundation on which to develop statewide implementation of the wraparound model in the future.

KMAs helped bring family members and youth to the table to plan with the Statutory SOC Committee. The Statutory Committee members state clearly they value receiving recommendations and input from the Community SOC Committee members, now comprised of a majority of family/youth members and co-chaired by two family members. Holding joint meetings periodically has helped this model become more effective. All members recommend continuing and strengthening the System of Care Planning Committee's role by continuing to support regular meetings and communication among the members.

WHAT DID NOT WORK WITH THE KMAs?

When Montana received the SAMHSA grant, stakeholders expected there would be increased funding for services available as a result. For many, the initial support for the KMA diminished when stakeholders discovered the grant did not provide for a significant expansion of current services, increased financial resources, or an effective means of prevention. Providers and agencies came to the table looking for supplemental financial sources for Medicaid de-certified kids, room and board funding, or extended/additional and flexible benefits and were disappointed. Throughout the grant, access to services received low marks from families served by KMAs, in part because many families were not eligible for Medicaid.

The data collected from families served by the KMAs was massive on the one hand, but inconclusive on the other hand, and did not clearly demonstrate the positive outcomes anticipated. To change this in the future, the SOC Committee recommends identifying desired outcomes more clearly, developing a tracking system, and requiring data collection from all providers as well as family members across all child serving agencies. In addition, the services system must increase the use of evidence based practices such as wraparound.

There was lack of support and negative responses to the KMAs in some areas of the state, including in communities that were not selected to be grant recipients. Some stakeholders across the state had witnessed previous system wide service delivery projects started for at risk children but not continued for various reasons. Some believed the State would repeat this same pattern and not support sustainability for KMAs either. KMAs varied widely in the services provided and in their organizational

structures and supports. The KMA model could not be brought to scale and become available to all communities. The name "Kids Management Authority" also created angst among some stakeholders, given the fact that the KMAs did not have any real authority.

How should the KMAs/Local Interagency Teams be structured, staffed and funded?

While the SOC Committee does not recommend that local interagency teams be mandated, it recognizes their potential value where they exist. The Statutory SOC Committee recommends that local interagency teams be an option for communities able and willing to provide local funding.

Where they exist, they must be flexible enough to meet the unique characteristics of the communities they serve. Because of the rural nature of Montana, not every community or county needs or can support a local interagency team. The catchment area could be one city/town, one or several counties, or a region and could be housed within existing community agencies to be cost effective and efficient. Compatible agencies could include: Human Resource Development Councils, Community Health Centers, schools, public agencies, local government offices and providers. The Community SOC Committee recommends that legislators consult the December 2008 KMA Certification draft document developed by the SOC Committee for a working definition of a local interagency team. That document also provides recommendations about responsibilities, functions, and members of an interagency team. A sample of a county interagency agreement that articulates structure and requirements is available upon request to CMHB.

Where a local interagency team exists, the SOC Committee recognizes the value of an identified person to provide coordination and assist with planning. Members also recognize the value of the role of the parent coordinator in the KMA model to assist family members to participate in the planning process.

In lieu of interagency teams, some members support the model of a statewide coordinator or liaison between each child serving agency and the children's mental health system to increase understanding of and access to services for youth and families in those systems. One such position exists today. The CMHB and the Developmental Disabilities system share a person who identifies youth who are or may be dually eligible and assists both systems in developing appropriate services for them.

(b): Define a clear role for the Kids Management Authorities, including whether the Authorities should be involved in local coordination of services, encouraging family centered state agency practices, and providing advocacy and assistance to families in navigating the system.

While the SOC Committee does not see a clear role for Kids Management Authorities in the future, the state can learn from its experience with KMA. The following responses are provided for that purpose.

(i) Coordinating services at the local level

This was one of the primary functions of the KMA, in conjunction with supporting families and youth as they engaged in services.

(ii) Encouraging and ensuring that state agency practices are family centered

"Family and youth centered" is a transformative and foundational value for Montana's system of care. When families and youth are empowered to speak up, state agencies and providers benefit from understanding their perspective and experience of the system. Local interagency teams with family members can promote best practices with providers and with state agencies and can personalize the importance of these practices through sharing stories of parents and youth experiencing different parts of the Montana service delivery system.

(iii) Providing assistance and advocacy for families in navigating the array of state services for children.

In addition to coordinating services for individual children at the local level, KMAs prioritized supporting families. Families reported this was appreciated as a valuable KMA service.

(c) Identify how agency funding may be better blended to provide services to multi-agency children, including but not limited to an analysis of whether the state should seek waivers for use of Medicaid fund or funds provided through Title IV-E of the Social Security Act.

The Statutory SOC Committee does not recommend blended funding to serve children at this time. However, several members of the Community SOC Committee suggested the Legislature use the System of Care Account to create flexible funding to serve high risk multi-agency children whose needs cannot be addressed in the community otherwise.

The Statutory SOC Committee does recommend continuation of the current PRTF Demonstration Waiver Project as a Home and Community Based Waiver to serve Medicaid-eligible SED youth statewide who need or are at risk of needing Psychiatric Residential Treatment Facility (PRTF) level of care. The Statutory SOC Committee does not specifically support any other waiver opportunities.

(d) Provide a clear statement of which children and family populations should be served by the system of care.

Ideally any Montana family with a youth in need of mental health care will have access to effective treatment. Prevention and early identification and intervention strategies must be incorporated into the system in order to avoid or reduce the need for more intensive and expensive services later, and to improve the quality of life and functioning of the youth at home and in the community.

(e) Define how local governments may or should be involved in the system of care.

Local government has a planning responsibility for adequate access to mental health care for its residents. To meet this responsibility, local government could support the development of an interagency planning team, could house or provide the team's coordinator, and could fund some of the team's activities. One county in south central Montana recently passed a mental health safety mill levy which could support for a single point of entry to services for at risk children and families. If wraparound

delivery capacity is expanded to cover the entire state, local government may have a role to developing and sustaining the model locally.

(f) Define how and state whether the wraparound process of providing a unique set of services that are based on a child's and family's needs and strengths will be connected to the system of care, including recommendations.

It is the consensus of the SOC Committee to recommend high fidelity wraparound as an evidence-based practice that strengthens family involvement. It is a model for strategically supporting a family by organizing systems, people, services, supports, and interventions that allow them to experience different results that are meaningful in their everyday lives. It is a model that:

- provides new opportunities based on strengths, capacities, and interests while being respectful of culture, values, preferences and attitudes;
- supports teams by allowing them the opportunity to critically think through with youth and families more creative ways to problem solve, meet needs, and produce outcomes;
- acknowledges the mandates and expertise of various systems and people within those systems while holding the family system as the most influential toward outcome achievement.

High fidelity wraparound has achieved preliminary acceptance as a best practice by the Substance Abuse and Mental Health Services Administration (SAMHSA). There is a growing body of evidence and data that supports the conclusion that high fidelity wraparound produces better outcomes than many other traditional treatment models. In Montana, the wraparound model used by the KMAs when working with families produced evaluation results for agency involvement in services and in treatment planning and for emotional and behavioral problem improvement in the top 25th percentile when compared with national System of Care data.

The PRTF Waiver Demonstration project uses a high-fidelity wraparound model to offer community alternatives to residential care for youth. The project serves only Medicaid-eligible SED youth in need of or at risk of placement in Psychiatric Residential Treatment Facility (PRTF) level of care whose families agree to receive services within their own home, a much smaller and narrower population than was served by the KMAs. Thanks to grant funding, wraparound training has been offered in Montana since 2008.

(i) **How will the wraparound process be provided?**

The SOC recommends developing statewide capacity for high-fidelity wraparound facilitation. On behalf of the SOC Committee, the Children's Mental Health Bureau plans to submit this proposal to the Montana Mental Health Trust in November 2010.

High fidelity wraparound facilitation will be provided by certified facilitators who are supported by certified coaches. Other trained and coached individuals will include peer mentors for both families and youth. Youth and families will determine their own team and with the help of the facilitator, develop

their own plan. There is agreement among all of the SOC Committee members that there must be a single statewide consistent high fidelity model of wraparound that has been demonstrated to produce desired outcomes.

(ii)To whom will the wraparound process be provided?

Each payer and each child-serving agency will make the decision about which population it will offer wraparound to, within the purpose and limitations of its funding. Currently high fidelity wraparound is offered only to a limited number of families- primarily those with Medicaid and at risk of out of home placement eligible for the PRTF Demonstration Waiver. In the past, the KMAs were able to offer the wraparound process to families without Medicaid or other agency involvement. The SOC Committee recognizes that without access to the wraparound process and supports, these non-Medicaid eligible youth are at risk to migrate to state funded child serving agencies such as Child and Family Services and Juvenile Probation in order to receive assistance. Continued exploration of alternatives remains a goal of the SOC Committee.

For example, the wrap-around model is highly consistent with what CFSD is trying to do with Family Group Decision Making in reaching those families that have already crossed the threshold of needing an intervention involving the assistance of the court. Child Protective Services referrals to wrap-around providers, in cases with recognized risk factors but no court involvement, are expected to increase. The CPS system is beginning to make changes in placing primary emphasis on family engagement, resulting in professionals needing to re-evaluate their roles. When the courts, DPHHS, and attorneys for kids and parents team up to create a system of integrity that ensures speed, fairness, and accountability for all involved, parents benefit from the best the system has to offer and there is much greater satisfaction for all involved. Youth Court and Juvenile Probation is interested in offering wraparound to youth and families at risk of out of home placement and have begun exploring this use of wraparound with a pilot project in Billings.

(iii) Who should provide the wraparound process?

The SOC Committee recommends that wraparound facilitators are trained and coached through a credentialing process to ensure high fidelity and consistent outcomes. The credentialed wraparound facilitator can be any of the following: case manager, licensed professional, agency staff person, or a family member who has graduated from wraparound. Ideally, the wraparound facilitator is working with a family partner (peer) and a youth partner (peer). Wraparound facilitators can work for licensed providers, child serving agencies, or be individually licensed professionals. However, they must be trained, supervised and working with a coach in order to achieve consistent outcomes. There is also consideration of the need for an autonomous statewide coordinator.

Over the next tow years, the SOC Committee will encourage individual agencies to concurrently plan how best to provide wraparound services, working on threshold projects and experimenting with different approaches to implement wraparound.

(iv) How will it be funded?

Currently, the wraparound process is funded by Medicaid in the PRTF Waiver demonstration project, and with limited general fund resources in Children's Mental Health Bureau and Juvenile Probation. As the capacity to deliver the wraparound process grows, other state agencies may choose to pay for it with treatment funding or other resources. The SOC Committee recommends that DPHHS make wraparound facilitation and peer support a state plan Medicaid service. In addition, a pool of funding for the wraparound process could be developed for non-Medicaid eligible youth at risk for out of home placement in order to avoid the need for the family to seek access to treatment through child-serving agencies such as Child and Family Services and Juvenile Probation.

Each child-serving agency has the option to use wraparound facilitation to serve youth and their families. Agencies can develop facilitators in-house or use facilitators who work for other agencies or providers. Each agency can decide how to fund wraparound facilitation and services-either from existing flexible funds or by redirecting funds used for less effective interventions and work toward developing a pool of funding for non-Medicaid eligible youth.