Mental Health and Disability Services in Iowa

PRESENTED BY: JULIE GIBBONS, POLK COUNTY HEALTH SERVICES, RACHEL CECIL, COUNTY RURAL OFFICES OF SOCIAL SERVICES, MAE HINGTGEN, MH/DS OF THE EAST CENTRAL REGION

Iowa Department of Public Health

Bureau of Family Health Conference 10.28.20

AGENDA

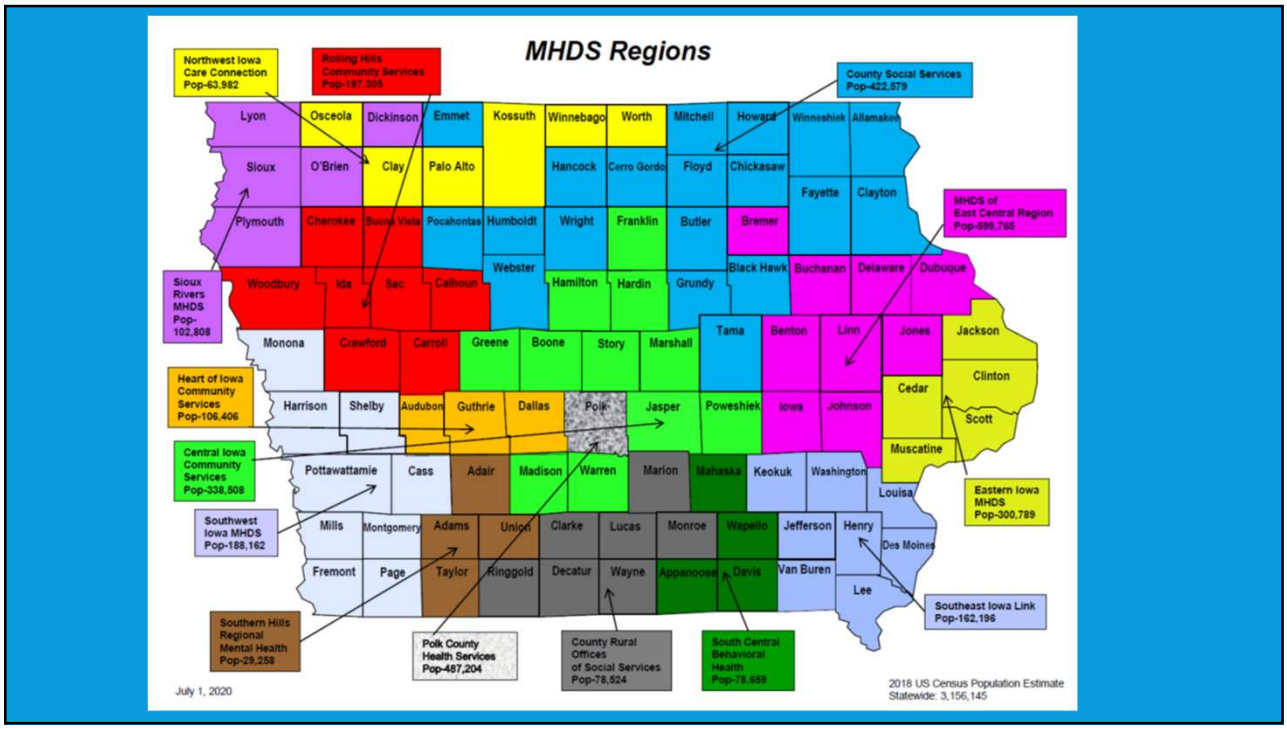
- Introductions
- History of MH/DS Regions
- Key legislation
- Children's Behavioral Health services
- Alignment with Child and Adolescent health

HISTORY OF MHDS SERVICES IN IOWA

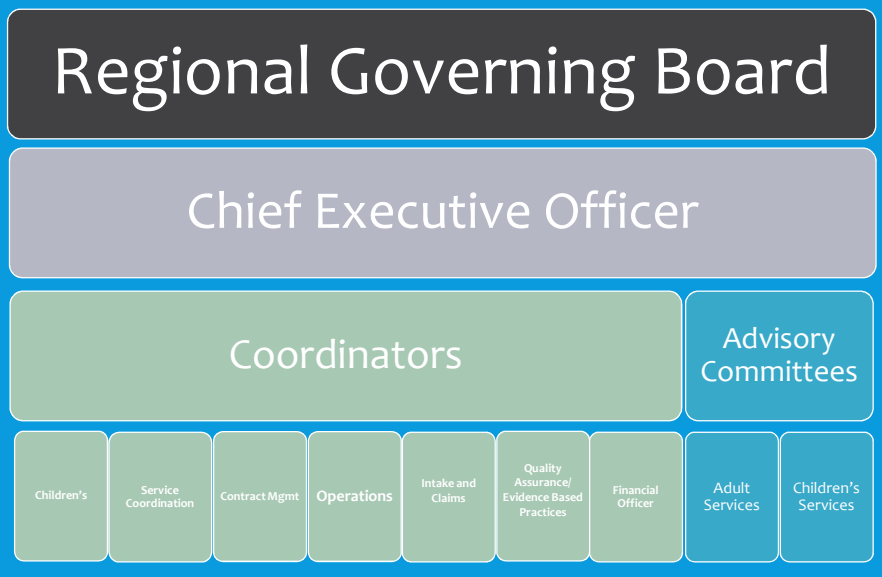
- 1995 – Senate File 69 passed
  - Established county MHDS fund aka "Fund 10"
  - Fund 10 was capped
  - Law was billed as property tax relief
  - County property taxes paid the non-federal share of all MHDS services for adults
  - Established county administration and management of MHDS services with a Central Point of Coordination
  - 99 counties in Iowa, so 99 different systems

HISTORY CONTINUED

- 2013- Senate File 2315 passed
  - Billed as MHDS Re-design
  - Established MHDS Regions and regional administration
  - 14 regions created across Iowa
  - Regions formed through 28E governmental agreements
  - Total county property tax rates were capped then divided out dependent on how regions were formed
  - Each region has a max Per Capita that individual counties must contribute to the overall Region budget
  - Services are centrally administered but more evenly distributed across regions



REGIONAL GOVERNANCE STRUCTURE



REGIONAL GOVERNING BOARD

- a. The governing board shall include the following voting members:
  - (1) At least one board of supervisor member from each county comprising the region or their designees.
  - (2) One adult person who utilizes mental health and disability services or is an actively involved relative of an adult who utilizes such services, designated by the regional adult mental health and disability services advisory committee.
  - (3) Members designated by the regional children's behavioral health services advisory committee as follows:
    - One member representing the education system in the region.
    - One member who is a parent of a child who utilizes children's behavioral health services or is an actively involved relative of a child who utilizes such services.
- b. The governing board shall include the following nonvoting members in an ex officio capacity:
  - (1) One member representing an adult service provider in the region, designated by the regional adult mental health and disability services advisory committee.
  - (2) One member representing a children's behavioral health service provider in the region, designated by the regional children's behavioral health services advisory committee

COLLABORATION AND PARTNERSHIP

- Regional Children's Advisory Committee
  - (1) A parent of a child who utilizes services or an actively involved relative of such child.
  - (2) A member of the education system.
  - (3) An early childhood advocate.
  - (4) A child welfare advocate.
  - (5) A children's behavioral health service provider.
  - (6) A member of the juvenile court.
  - (7) A pediatrician.
  - (8) A child care provider.
  - (9) A local law enforcement representative.
  - (10) A regional governing board member.

RECENT LEGISLATIVE CHANGES

Complex Needs and Children's Services

CURRENT REALITY

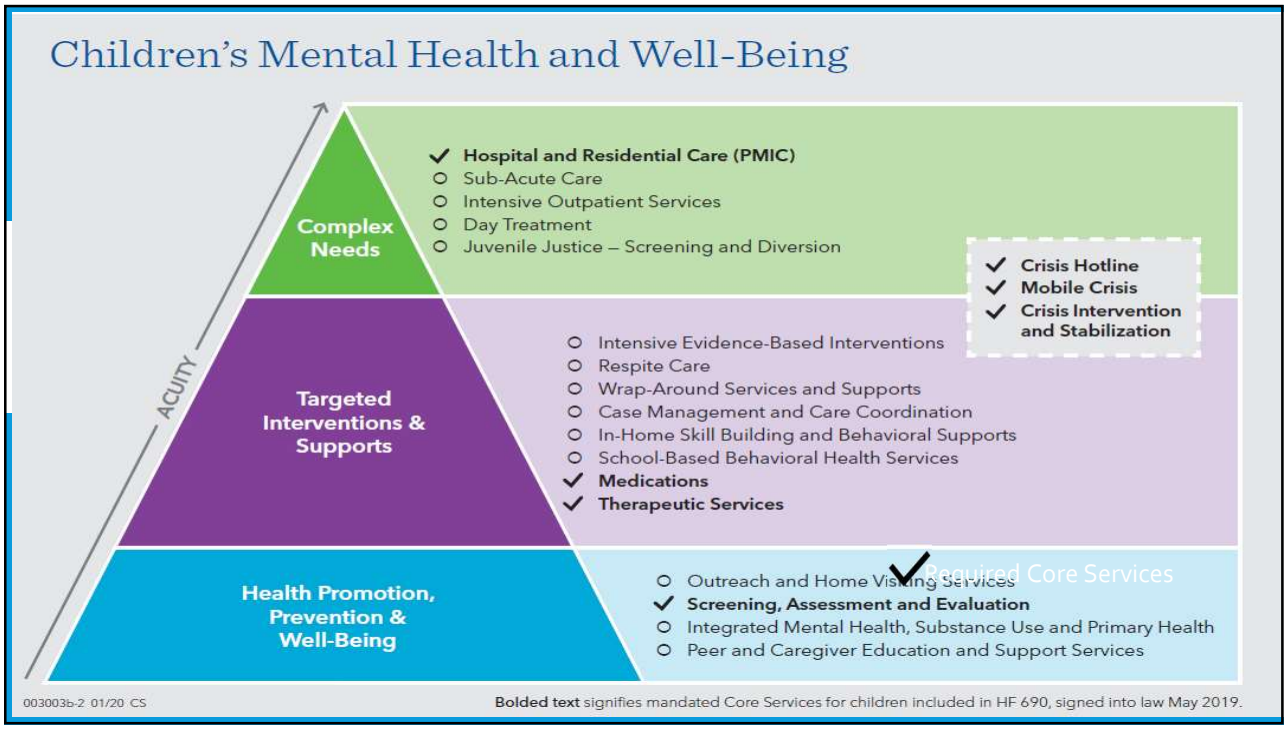
- 2018 Senate File 2456 "Complex Needs" bill
  - Required regions to add more services to address needs of people with co-occurring, complex needs
- 2019 – House File 690
  - Established regional responsibility for children's behavioral health services effective 7/1/20
  - Two tiers of children's services to be phased in by 2021
  - No additional funding allocated
  - Requires regions to hire an additional Coordinator for Children's services
- COVID-19 reality has created financial and workforce instability = challenge to region and providers ability to implement

CHILDREN'S BEHAVIORAL HEALTH

- Services to be implemented 7/1/20
  - Assessment and evaluation for eligibility
  - Outpatient psychotherapeutic treatment
  - Medication prescription and management
  - Prevention
  - Education
- Services to be implemented 7/1/21
  - Behavioral health inpatient treatment
  - Crisis stabilization community-based services
  - Crisis stabilization residential services
  - Mobile response
  - Early identification
  - Early intervention

THESE LAWS IMPACT POLICY

- Management Plan – Policies and Procedures
  - Eligibility
  - Intake/Authorizations
  - Governing structure
  - Financing and delivery of services
- Annual Service Plan
  - Summary of planning and needs
  - List services offered
  - Provider network
- Annual Budget
- Annual Report
  - Outcomes and results



Criteria for Eligibility Based Services

- Under the Age of 18
- Legal Resident of the Region (County)
- Family Income at or below 500% of Poverty
- No resource limit
- No other insurance
- SED Diagnosis

SERIOUS EMOTIONAL DISTURBANCE

- Diagnostic Criteria for an eligibility based service
- DSM 5—
  - Children with Severe Emotional Disturbance (SED) are persons who are under the age of 18, who have had a diagnosable mental, behavioral or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-V, that resulted in functional impairment which substantially interferes with or limits the child's role or functioning in family, school or community activities.

ELIGIBILITY BASED

- Medication prescribing and management - determining how the medication is affecting the individual; determining any drug interactions or adverse drug effects on the individual; determining the proper dosage level; and prescribing medication for the individual for the period of time before the individual is seen again.
- Behavioral health outpatient therapy - evaluation and treatment services provided on an ambulatory basis for the target population. Outpatient services include psychiatric evaluations, and individual, family, and group therapy. Outpatient services shall provide elements of diagnosis, treatment, and appropriate follow-up.
- Crisis Stabilization Community Based Services - Crisis stabilization community-based services (CSCBS) short-term services designed to de-escalate a crisis situation and stabilize an individual experiencing a mental health crisis, provided where the individual lives, works or recreates. Services are expected to be less than 5 days
- Crisis Stabilization Residential Services - Crisis stabilization residential services (CSRS) are short-term services designed to de-escalate a crisis situation and stabilize an individual experiencing a mental health crisis.
  - CSRS is provided in facility-based settings of no more than 16 beds.
  - The goal of CSRS is to stabilize and reintegrate the individual back into the community.
  - Crisis stabilization residential services can be for youth aged 18 and younger or adults aged 18 and older. Youth and adults cannot be housed in the same facility setting.
  - Service is intended for no more than 5 days.
- Behavioral Health Inpatient Treatment - Inpatient treatment incurred at a state mental health institute or a unit in a community-based hospital designed to treat mental disorders.

NON ELIGIBILITY BASED

- Prevention –Efforts to deter the occurrence of disease and promote health
- Education
  - Public – Activities provided to increase awareness and understanding of the causes and nature of the conditions or situations which effects a persons functioning in society
  - Provider – training related to provider competency in delivering co-occurring, integrated services, trauma informed services, and evidence based practices
- Early Identification
- Early Intervention – efforts to reduce the risk factors and increase protective factors in a child life
- Mobile Response – a service which provides on-site, face-to-face mental health crisis services
- Assessment and Evaluation – Screening, diagnosis and assessments of individual and family functioning, needs, abilities and disabilities and determining current status of functioning, recommendations for services and need of further evaluation

NON CORE SERVICES

- Regions have used discretion to implement:
  - School-based services
  - Collateral time
  - BHIS
  - Respite
  - Tier 2 services
  - Transition services
  - Service Coordination between physical health and primary care

ALIGNMENT WITH NATIONAL PERFORMANCE MEASURES

- NPM 10: Percent of Adolescents, ages 12 through 17, with a preventive visit in the past year.
- 2018 CMS 416 data
  - 51% of 14-16 year olds
  - 45% of 15-17 year olds
  - 23% of 19-20 year olds

ALIGNMENT WITH STATE PERFORMANCE MEASURES

- SPM 4: Percent of adolescents who report that during the past 12 months they have felt so sad or hopeless almost every day for 2 weeks or more in a row that they stopped doing some usual activities.
  - 1 in 5 adolescents 13-18 year old will have a serious mental illness
  - 50% of lifetime mental illness start by age 14
  - 70% of youth in local and state juvenile systems have a mental illness (Source CDC)

CREATING LINKAGES

- Whole Person Assessment
- Referral Process

COLLABORATION AND PARTNERSHIP

- Prevention & Education

MENTAL HEALTH FIRST AID® USA

COLLABORATION AND PARTNERSHIP

- Early intervention & Early Identification
- Universal Screening Panel Recommendations
  - Modified Checklist for Autism (M-CHAT)
  - Survey of Wellbeing of Young Children (SWYC)
  - Patient Health Questionnaire (PHQ)
  - Ages and Stages Questionnaires (ASQ)
  - Strengths and Difficulties Questionnaire (SDQ)
  - Social Academic Emotional Behavior Risk Screener (SAEBERS)
  - CRAFFT (Car, Relax, Alone, Forget, Friends, Trouble)

UNIVERSAL SCREENING

- Developmental screening (note this includes screening for Autism): 9, 18, 30, and 36 months
- Yearly developmental monitoring until age 21
- Annual screening of substance use and depression screening beginning (minimally) age 12
- Educational setting: Minimally an annual screening with attention to the following vulnerable times in a child's life:
  - School entry: Kindergarten or 1st grade
  - 4th grade
  - 6th grade
  - 9th grade

COMMENTS FROM A FEW SCHOOL DISTRICTS:

- We piloted SAEBRS last year at the elementary, but only used it in the winter and were unable to administer it in the spring. We have decided not to use it this year as it asks for the teacher to rate the student and this can cause some concerns with parents as they are able to see the teachers ratings of the student. If parents are not in agreement with the ratings, then this could prevent the parent and teacher from having a good relationship.
- We require parents to actively consent (meaning that they have to give permission, whereas some schools use passive consent, which they have to contact the school if they want to opt out).
- In our middle school, we are using a survey that students complete that may alert staff to concerns that need addressed. I am not super familiar with this survey, but I do know that it is being used.
- We are working hard district wide to develop an early warning system that collects data on student attendance, behavior, and grades to alert staff if there is an issue so they can begin providing interventions for the student (this might include interventions with their teacher, a school counselor, success coach, or our school social worker). We also use situational information that we has been provided to us (divorce, death, etc) as a way to determine if the student needs an intervention.
- I have piloted SAEBRS for the past two years (both SAEBRS and mySAEBRS). I use that information to form small groups for social skill instruction as well as check in with anyone who might have troubling answers. If an area affects a large number of students in a grade, I will create guidance lessons focused on that. Every student was screened fall and spring (except last spring due to COVID closure). I'm not sure if we will continue to use the SAEBRS and expand its use to other buildings or if we will look at another screener

QUESTIONS?

THANK YOU!

Rachel Cecil
Chief Executive Officer
CROSS MHDS
2003 N. Lincoln St.
Knoxville, IA 50138
Phone: 641-828-2238 ext 3870
www.crossmentalhealth.org

Julie Gibbons
Children's Program Planner
Polk County Health Services
2309 Euclid Avenue
Des Moines, IA 50310
515.243.4545
PCHSIA.ORG

Mae Hingtgen
Chief Executive Officer
MH/DS of the East Central Region
210 Jones Street
Suite 203
Dubuque, Iowa 52001
563.239.0013
mae.hingtgen@dubuquecounty.us