

Tab 1:

**Improving Access to Mental Health Services for Children Through
Outcomes-Focused Advocacy**

Presenters

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An Advocate's Role

1. Does the child have an unmet mental health need?

What is Mental Health?

“A mental disorder results from the interaction of a child and her environment. Thus mental illness often does not lie with the child alone. [Conceptually] the mental disorder is an ‘emergent property’ of a transaction with the environment.”

Mental Health is Defined by Outcomes:

- Safe at home
- Success in school
- Avoided delinquency
- Progress towards self-sufficiency

2. What can you do about it?

Enforceable entitlement to adequate care.

- EPSDT--medically necessary care to correct or ameliorate mental illness
- IDEA--related services that are needed to benefit from Free Approp. Pub. Ed.

What does the child need?

- Screens, Assessments & Diagnoses
- Key Components: Evaluation and action/
Goals Driven

How can you get it?

- Team building
- Services tied to Outcomes
- Embrace the child's Entitlement
- More Specificity = more services

System Transformation

OLD MODEL

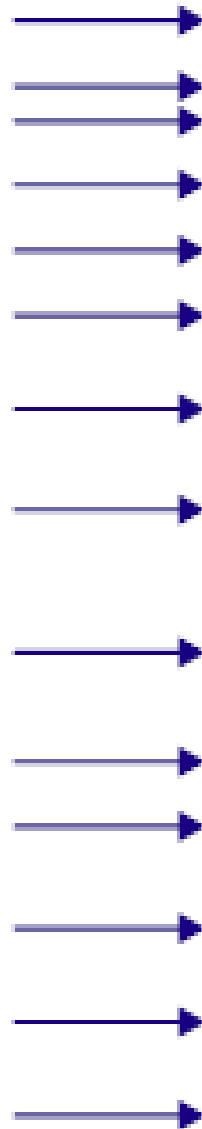
Focus on child
Emphasize child deficits and pathology
View parents as clients
See parents as cause of problem
Color and culture blind
Offer office-based services

Provide placement for child
Individual clinicians working with individual clients
Focus on conditional treatment

Focus on interventions
Categorical funding
Fragmented services

Advocacy

Isolation



CSOC

Focus on the family
Emphasize child and family strengths
View parents as partners
See parents as part of solution
Culturally competent
Offer office, in-home and community-based services

Try to prevent placement of child
Service team concept

Focus on long-term commitment, unconditional care, no eject/no reject policy
Outcome driven
Flexible funding
Collaborative integrated service development and delivery
Voice, ownership, access, quality and accountability
Community

EPSDT: Early, Periodic, Screening, Diagnosis & Treatment

- Periodic screens and diagnosis for physical, mental health, dental, hearing & vision
- Medically necessary treatment for discovered conditions for Medicaid-eligible individuals
- Outreach & informing, scheduling, transportation, case management, etc.
- Services array exceeds the scope of more limited adult care.

EPSDT Provisions

- **§1396a(a)(10)**: states must provide medical assistance to eligible individuals listed in §1396d
- **§1396a(a)(43)**: EPSDT requires informing, screening, and treatment
- **§1396d(a)(4)(B)**: EPSDT is a mandatory service
- **§1396d(r)**: EPSDT includes any medically necessary treatment to correct or ameliorate mental illness or condition

EPSDT: Comprehensive Federal Entitlement for Youth

EPSDT services include:

“such other necessary health care, diagnostic services, treatment, and other measures ... to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan.”

42 USC 1396d(r)

...With a Catch: California Eligibility Requirements

- (1) included diagnosis
- (1) a significant impairment or probable significant deterioration in an important area of life functioning or probability of developmental delay
- (1) service is expected to *significantly reduce* the impairment or *prevent significant deterioration*
- (1) not responsive to physical health care

9 CCR §§ 1830.205, 1830.210

Establishing Medical Necessity

- Find a therapist/ clinician to conduct an assessment or evaluation
- Work with clinician, child and family to identify specific behaviors that need to be addressed with treatment
- Work with/ encourage clinician to draft recommendations for treatment
 - More specificity means better services—ie. Encourage the clinician to link the service to the specific behavior. This makes it more difficult for the Mental Health Plan to contest the service.
 - Think outside the box—don't craft recommendations based on the services that exist in the community, but rather what the child/ family need
- **Once you have a recommendation in writing, this triggers the EPSDT medical necessity entitlement**

Individuals with Disabilities Education Act (IDEA)

- Schools must provide handicapped student with a free and appropriate public education (FAPE)
- FAPE includes “related services” which are support services that are required in order that a student may benefit from his special education program
- Related Services may include mental health treatment, including residential care
- In California, the related services entitlement under IDEA is administered through the **AB 3632 Program**

Special Education: AB 3632 Timeline

1. Student qualifies for special education and gets an IEP.
1. Mental health services available through school district are exhausted or deemed futile and IEP refers to CMH for AB3632 services.
 - If its obvious from preliminary special ed assessments that student will qualify for special ed and that AB3632 services will be required, a referral can be made even before student is officially found eligible for special education.
2. Parent signs consent for AB3632 referral.
1. Within **1 working day** of receiving consent from the parent for the referral, **the District must forward complete packet to CMH.**
2. Within **5 days** of receiving the referral for assessment for AB3632 services, **CMH must determine whether the assessment is necessary or appropriate.** If CMH deems assessment **unnecessary or inappropriate**, it must notify the school and parent within **1 working day** of making that determination. If referral is incomplete, CMH most notify the school within 1 working day.

Special Education: AB 3632 Timeline (con't)

5. If CMH agrees to assess, it must **create an assessment plan** and provide it to parent for **consent within 15 calendar days** of receipt of the referral.
5. As soon as the **parent returns the signed consent form**, CMH has **50 days** to complete the assessment.
5. Parent receives written assessment at least **2 days** prior to IEP.
6. IEP held to review assessment and determine eligibility for AB3632 services. N
 - The district CANNOT disagree with CMH if CMH determines that the child needs AB 3632 services.
5. If student found ineligible for AB3632 services, parent's recourse is to file for due process.

Some Examples of Intensive Home-Based Services

- **Wraparound Services**
 - **Referral Sources: Foster Care**
Probation
Special Education (AB 3632)
- **Therapeutic Behavioral Services (TBS)**
 - http://www.dmh.ca.gov/Services_and_Programs/Children_and_Youth/EPSDT.asp
- **Case Management**
 - **AB 3632 services include case management**
- **Crisis Intervention**
- **Crisis Stabilization**

Determining the Child's Needs

- **Strengths and Needs Focus**
 - Start From:
 - What Works Well Currently? What can be improved?
 - Keep list of current services and show how they are not adequate to meet needs of family.
 - What Does the Child/ Parent do Well?
 - What Resources Does the Family Already Have?
 - Parents as Part of the Solution, Not Part of the Problem
- **Goals-Oriented**
 - What are the Behaviors that Need to be Addressed?
 - What are the Parent and Child's Goals?
 - Exs: Stay at home, not out of home placement;
 - Graduate high school
- **Team Up with Therapist/ Clinician**

Case Study

JOSE:

- In Juvenile Hall because of suicide ideations and threats to kill mother and brother
- Schizoaffective disorder—severe paranoia, heard voices, issues around trust
- Very close to family, huge support network of extended family
- Mother was afraid for him to return home. Jose wanted to be at home and not in placement.
- Lawyers, Probation, Mental Health all agreed detention was not appropriate—needed intense MH services. Focused on out-of-home placement

JOSE (con't):

- Started evaluation process for Special Education/ AB 3632 to pay for placement
- Plan B: started working with mom and Jose to figure out what services would be needed in the home
- Discussed mom's fears—broke down to specific behaviors
 - Afraid to leave Jose alone—his mind would wander
 - Refusal to engage in new services
 - Unpredictability in behavior
- Worked with previous provider to come up with a plan for services
- Qualified for AB 3632 service. Jose sent to out of home placement—2.5 hours from home. Minimal family therapy.
- Jose AWOLed from placement during the holidays—ran to his home.

JOSE (con't):

- Clear that Jose wanted to be at home. Set plan with provider into play and proposed it to court. Worked with IEP team to write home-based services into IEP.
- Jose returned home with home-based therapy, medication management, family therapy and crisis intervention during business hours.
- Services not intensive enough for Jose's needs.
 - No support for family before 9am or after 5pm
 - Limited visits with therapists.
 - Needed TBS to address behaviors around taking medication and controlling anger
- Worked with provider to increase frequency of services. TBS referral made.
- In the end, Jose was receiving more services than any other child served by provider because of outcomes-focused advocacy.

JOSE (con't):

- Despite increase in services, they still did not meet needs of family
- Jose hospitalized several times for suicidal ideations and threats.
- Worked with mom to keep track of why services not intensive enough:
 - Still no support before or after hours and no real crisis plan in the event of emergency during those times
 - TBS limited to few times a week
 - Limited support and training for mom
 - Limited crisis intervention/ stabilization capability
- Called IEP meeting. Encouraged mom to voice struggles while reiterating that she wanted him to stay in the home.
- Requested wraparound services—laid out why the level of need was so high. Some apprehension about Jose's age (16.5) and acuity. Continued to advocate and make case for wraparound.

JOSE (con't):

- Wraparound approved while Jose was hospitalized. Developed transition plan and new provider attended IEPs and meetings in hospital.
- Jose returned home—Mom voiced fears about leaving him alone at night. Fears of another suicide attempt
 - Provider dispatched 2 staff members to sit with Jose at night—one from 10pm-2am and the other from 2am-6am.
 - Continued for a few weeks—mom became more comfortable and was able to tell them to reduce that service when no longer necessary
- Issues with waking up and going to school—provider began sending staff to help Jose get ready and provide therapy before school. Also had a TBS counselor in school with him, until no longer necessary.
- 24/7 support. Strong crisis plan that incorporated resources in community—extended family, church, etc.
- 1.5 years later, Jose still at home. No more hospitalizations. More stable than he has ever been. Working towards HS diploma. Provider continues to work with him, but at far lower intensity.

If you have questions or would like more information, please contact:

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