

Child and Adolescent Behavioral Health Services

Children's Mental Health Division
Minnesota Department of Human Services
July 2014



Minnesota Department of **Human Services**

Legislative Report

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For more information contact:

Minnesota Department of Human Services
Children's Mental Health Division
P.O. Box 64985
St. Paul, MN 55164-0985
(651)431-2321

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Legislation

MN Session Laws 2013, section 108, article 4, section 29:

CHILD AND ADOLESCENT BEHAVIORAL HEALTH SERVICES.

The commissioner of human services shall, in consultation with children's mental health community providers, hospitals providing care to children, children's mental health advocates, and other interested parties, develop recommendations and legislation, if necessary, for the state-operated child and adolescent behavioral health services facility to ensure that:

- (1) the facility and the services provided meet the needs of children with serious emotional disturbances, autism spectrum disorders, reactive attachment disorder, PTSD, serious emotional disturbance co-occurring with a developmental disability, borderline personality disorder, schizophrenia, fetal alcohol spectrum disorders, brain injuries, violent tendencies, and complex medical issues;
- (2) qualified personnel and staff can be recruited who have specific expertise and training to treat the children in the facility; and
- (3) the treatment provided at the facility is high-quality, effective treatment

I. Introduction

The 2013 Minnesota State Legislature directed the Department of Human Services, Children's Mental Health Division, in consultation with –specific stakeholders to develop recommendations and legislation as necessary for the state-operated Child and Adolescent Behavioral Health Services (CABHS) facility. CABHS is operated by the Department of Human Service's Direct Care and Treatment Administration and located in Willmar, Minnesota. The CABHS work group met five times between November 2013 and March 2014. The work group included members from the CABHS facility, advocacy organizations, parents, residential treatment providers, community mental health providers, county social service agencies, hospital providers, managed care organizations, school representatives, and the Minnesota Department of Education.

Legislative reports produced by the Children's Mental Health Division for at least the past five years addressed recommendations for the Child and Adolescent Behavioral Health Services facility in Willmar. The Mental Health Acute Care Needs Report (March 2009) recommends that CABHS consider a metro location for the facility and develop programing for groups of children and adolescents with the following diagnoses:

- Autism Spectrum Disorders with self-injury or aggression
- Reactive Attachment Disorder/PTSD with aggression
- Co-Occurring disorder of MI/DD and Conduct Disorder
- Mental Illness with brain trauma (TBI, fetal alcohol)
- Mental Illness and complex medical issues
- Borderline Personality features and severe emotional dysregulation
- Schizophrenia

The Child and Adolescent Intensive Services Workgroup (CAISW), as a subgroup of the [Chemical and Mental Health Services Transformation Advisory Task Force: Recommendations on the Continuum of Services](#) (December 2010), addressed the need for a public safety net within Minnesota's system of care and recommended that the Child and Adolescent Behavioral Health Services facility, in combination with contracts with other hospitals, provide it. The report recommended using a portion of - state funding - for the CABHS program to be directed to contracted extended-stay beds within the metropolitan area and northern Minnesota and also psychiatric residential treatment facilities, as a new level of care, be investigated as alternative model of care throughout the state and at the CABHS facility in particular.

The CABHS work group focused not only on the legislative request, but conducted follow up to the previous legislative reports to determine if the recommendations were implemented or still applicable. The work group determined the target group of children with the most unmet needs in

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the state, recommended enhanced components in treatment, staffing needs, quality assurance monitoring and the need for a new level of care to serve these children within the State of Minnesota.

It is worth noting that the work group, led in particular by county representatives and children's residential service providers, introduced useful distinctions between the needs of youth who might be highly aggressive and self-harming but can be served in existing facilities when adequate supports and staffing are available, and those of youth with very serious illnesses which can manifest as unpredictable/disregulated and highly violent behavior, who clearly need a higher – typically hospital – level of care. Care will be taken in this report to utilize this distinction when important to differentiating needed levels of care in Minnesota's child-serving system.

In addition, the work group also analyzed whether the current CABHS program is providing services to the children within the identified target population as well as other aspects of service provision, staffing and outcome measurement.

The CABHS work group concluded their work by proposing short, medium and long term strategies to enhance services for the target population, including the appropriate type of facility, staffing and treatment for children experiencing violent, highly aggressive or self-harming behaviors in the state.

II. Child and Adolescent Behavioral Health Services Facility

Child and Adolescent Behavioral Health Services operated by the Direct Care and Treatment Administration of the Department of Human Services has two separate services—Community Services and an inpatient facility. CABHS’ community services focus on an interdisciplinary team providing comprehensive services to children living in state operated foster homes. However, the focus of this report is the inpatient facility the psychiatric hospital that receives referrals from other hospitals once the child has exceeded typical acute episode stabilization but still needs hospital level of care. The CABHS facility provides specialty mental health care which is eligible for third party reimbursement; all patients must meet medical necessity requirements for hospital level of care and be receiving active treatment.

As documented in the [CABHS Utilization Management Report](#) (July 2013), the CABHS facility admitted 121 youth and discharged 124 between January, 2012 and June, 2013. The average length of stay has been 35 days. CABHS reports the following average daily census numbers for the 16 licensed bed facility:

Year	Average Daily Census
2010	8.45
2011	8.81
2012	7.79
2013	7.68

In 2012, 52% of the 76 youth receiving care at CABHS were from Greater Minnesota; however Anoka, Dakota, Stearns, Ramsey and Hennepin were the home counties for 39 youth. While the total number of referrals made to CABHS is not reported, only 44% were accepted to the program with 68 of the accepted referrals came from other in-patient hospitals.

After the [Mental Health Acute Care Needs Report](#) in March 2009, CABHS redefined their target population to youth with neurobiological disorders (Autism spectrum, traumatic brain injury, fetal alcohol spectrum) and trauma (PTSD, severe emotional dysregulation disorders). The 2012 data demonstrates almost an equal distribution between the two populations.

The CABHS facility has a state appropriation of \$5,246,703 for state fiscal year 2014 with 43.15 budgeted full time equivalents. This includes 2FTEs of prescribing time (3 psychiatrists and one Advanced Practice Registered Nurse), 19 registered nurses, 2 social workers, one psychologist, 4 licensed practical nurses, and 20 human services technicians. The budget is based on a daily census of 14 patients with a per diem rate of \$1,678.

The physical plant of the facility impacts the patient census as well as patient supervision and care. The current CABHS facility is made up of three locked units that are separated by walls and/or by floors that hinder staff flow from unit to unit when there are crises. The physical

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structure is inefficient for consistent supervision of high needs youth as the facility has poor sight lines—nursing stations are recessed away from hallways, as opposed to protruding out into the hallways, thereby limiting staff ability to monitor children effectively. In order to accommodate the building issues, only three or four patients occupy each unit instead of being at capacity. Having children separated requires more hospital technicians to provide monitoring rather than leveraging staff members in an open setting and maximizing therapeutic staff and treatment time.

CABHS has attended to patient care quality, receiving Performance Honors in 2012 and 2013 in a row from the Joint Commission for the following indices:

- Continuing care plan created and transmitted to the discharge site
- Reduction in multiple antipsychotic/medication
- Reduced overall rate of multiple antipsychotic medication at discharge.

Besides participating in the Joint Commission quality performance reviews, CABHS has a patient and parent satisfaction survey that they conduct and record quarterly based on a 5 point rating scale. The [CABHS report](#) using CQI+ Outcomes Measurement System looks at CABHS performance in comparison with a National Aggregate Comparison while providing trending data within the program itself. Comparing CABHS with other programs is difficult because of the low numbers and the longer term hospital stay. Items which are measured: Patient outcomes in regards to change in Clinician Rated Symptoms and Behaviors (BPRS-C), Change in Clinician Rated Depression and Change in Overall Functioning and patient/parent satisfaction.

- Change in Symptoms and Behaviors: 60% of all programs fall below CABHS score
- Change in Overall Functioning: 25% of programs fall below CABHS score
- Overall Patient Satisfaction: 11% of all programs fall below CABHS score

III. Defining the Target Population's & Understanding Treatment Needs

Prior to determining if CABHS is meeting the needs of children experiencing the most complex mental health conditions, the work group tried to ascertain who these children are, their mental health treatment needs, and whether the mental health system of care can fully meet their complex needs..

Minnesota's mental health system for children has developed a robust service array over the past decade. Since 2003, the Minnesota system has evolved to include the following services:

- Outpatient psychotherapy
- Children's Therapeutic Services and Supports (rehabilitative skill training, crisis assistance, behavioral aide services, day treatment and psychotherapy services)
- Children's Mental Health Residential Treatment (rehabilitative skill training and psychotherapy service)
- Partial Hospitalization
- Inpatient Psychiatric Hospitals
- Children's Mental Health Targeted Case Management

Within the past 3 years, the DHS Children's Mental Health Division has developed or is in the process of developing new services for inclusion in the Minnesota Health Care Programs (MHCP) benefit set:

- Youth Assertive Community Treatment (rehabilitative service for youth 16-20 with serious mental illness or co-occurring mental illness and substance abuse disorder through a team approach)
- Intensive Treatment Services in Foster Care (clinical service to be provided 6 hours a week to the child in foster care, foster family, biological family, or anyone who is a part of the child's permanency plan)
- Family Psychoeducational Services
- Mental Health Clinical Care Consultation

The work group recognized that the development of the MHCP benefit set will substantially add to the infrastructure within the state, there remains a need for an added level of care that will treat youth who no longer require acute hospitalization but are not ready for rehabilitative services provided by a Youth ACT team or in a residential treatment setting.

The Center for Medicaid Services established a new category of Medicaid facility in 2001 called Psychiatric Residential Treatment Facility (PRTF) paid for through the inpatient psychiatric

facility or “psych under 21” benefit. PRTFs have an Institution of Mental Diseases exclusion, i.e., the prohibition of payment for facilities providing mental health treatment over 16 beds does not apply. Federal guidelines specify that a PRTF need to have the following:

- The facility needs to be a stand-alone entity that is a psychiatric hospital or inpatient psychiatric program (accredited by the Joint Commission on Accreditation of Health Care Organizations) or a non-hospital (that is accredited by Joint Commission, CARF or Council on Accreditation of Services for Families and Children).
- A certifying team (different than the treatment team) that determines eligibility for children that includes a physician and someone who knows the child
- A treatment team that includes a psychiatrist, or a physician and clinical psychologist, with at least one of the following: clinical social worker, registered nurse, occupational therapist, or master’s prepared psychologist
- Meet specific timeframes and expectations for individualized treatment and discharge plans

Children identified as having “the most complex needs” often require staffing that exceeds what a hospital or Children’s Mental Health Residential Treatment providers are able to provide, given scheduling and payment limitations. The creation of a psychiatric residential treatment benefit would allow the state to provide the appropriate level of staff and treatment that is contains best practices and is evidence based to the youth with the highest acuity of symptoms and functional impairment outside of a hospital.

A. Target Population

Members of the CABHS work group immediately agreed that the children with the highest unmet treatment needs included those with any of the diagnoses listed in the statute (autism spectrum disorders, reactive attachment disorders, PTSD, co-occurring mental health and developmental disability, borderline personality disorder, schizophrenia, fetal alcohol spectrum disorders, brain injuries, and complex medical issues) accompanied by a high level of aggression, violence, and/or continuous self-harm.

Youth who are experiencing symptoms of mental illness and high levels of unpredictable aggression and/or continuous self-harm were reported, by the work group, as not likely to be accepted into treatment or discharged early by hospitals and children’s residential treatment facilities due to their extreme behaviors, safety concerns for other children and staff, and liability issues. Counties reported having to call multiple facilities and foster placements trying to find appropriate treatment for children with these needs.

The Minnesota Association of County Social Services Administrators (MACSSA) and the Children’s Mental Health Division partnered to gather informal data on how many children fit this profile in the state within the past 2 years. Out of 87 counties, 53 including multi-county partnerships) responded that there were 339 children in 2012 whom they had difficulty placing and 385 with this level of need in 2013.

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Year	Aggressive Behavior	Self-Harm Issues	DD/MI	Sexualized Behaviors	Medically Fragile	CD/MI
2012	166	80	102	94	7	90
2013	204	245	80	106	11	59

*could report children in multiple categories

The Minnesota Council of Child Caring Agencies provided information from 7 programs regarding youth who were denied admission to programming because of behaviors within 2013.

	Aggressive	Low IQ	Sexualized behaviors	Self-Harm	MI/CD	Severe Mental Illness
Denied admission	143	25	12		12	14
Administrative Discharge	83	2		15		

***duplication in numbers likely

Children with high levels of aggression and self-harm behaviors are more likely to be denied admittance to programs and be discharged early from them. Currently these children drift from one placement to another or return to their families without treatment. The work group fully supported the need to create a facility that is staffed appropriately to treat and maintain them safely.

It is unclear whether the Child and Adolescent Behavioral Health facility admits and treats children within this population. While CABHS admits some of these youth who fit within the trauma and neurobiological disorder target populations, the facility clearly does not admit all or a sufficient number to attend to this problem.

B. Needed Components in Treatment

Minnesota Session Laws 2013, section 108, article 4 section 29 asks whether the CABHS facility is meeting the needs of the children within the identified population. The work group focused on identifying what would be the required treatment and ancillary components within a psychiatric residential treatment facility which would meet the needs of highly aggressive and/or self-harming youth who are experiencing a mental illness:

- Highly individualized treatment planning that is specific to diagnosis, development and family needs rather than a “program” that is operated by the facility

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- Maintain high amounts of family involvement through transportation, temporary housing, or technology resources
- Actively involve members of the child's permanency plan if involved in child protection or a ward of the state
- Discharge and transition planning needs to be determined at the point of intake with clear expectations embedded in treatment goals
- Recreational programming and access to exercise facilities to maintain healthy physical activity

C. Staffing Requirements and Qualifications

Children who are highly aggressive and actively self-harming require consistent and constant supervision. The CABHS work group asserted a need for these children to be housed in smaller units to decrease stimuli from other children and receive services and supervision from highly trained, experienced staff. There was a common sentiment that even line staff need to have a higher level of education and work experience than in typical current programs due to the intensive treatment needs of children in the target population. Children and adolescents identified by the work group require consistent access to responsive medication management and qualified, engaged, treating professionals who are available during non-business hours to accommodate families and make sure that treatment is consistently available every day.

Psychiatric residential treatment facility requirements through the Center of Medicaid Service for the treatment team include:

- A board-eligible or board certified psychiatrist;
- A clinical psychologist with a doctoral degree paired with a physician licensed to practice medicine; or
- A physician licensed to practice medicine with specialized training and experience in the diagnosis and treatment of mental diseases, and a psychologist who has a master's degree in clinical psychology or has been certified by the state.

The treatment team must also include one of the following:

- A psychiatric social worker;
- A registered nurse with specialized training or one year's experience in treating mentally ill individuals;
- An occupational therapist who is licensed and has specialized training or one year of experience in treating mentally ill individuals;

- A psychologist who has a master's degree in clinical psychology or who has been certified by the state.

The CABHS work group endorsed these requirements as the beginnings of an appropriate structure to treat children who are experiencing a mental illness and high level of unpredictable aggression and/or continual self-harm.

CABHS staff indicated that they have sufficient psychiatric staffing and availability to be able to provide this level of service. CABHS also has enough registered nurses and has found recruitment for human services technicians as well as licensed practical nurses to be relatively easy. The only staffing need they would have would be for a recreational therapist. The CABHS facility has two separate units, each with 8 beds which provides the opportunity for smaller units and relative containment of children and adolescents when there are intense behaviors on the unit.

D. Evaluating Treatment Quality and Efficacy

As Minnesota does not have a standardized treatment modality available for children who have a mental illness and high level of unpredictable aggression and/or constant self-harm, there is no basis for measurement of treatment quality and efficacy. This sub-population of children is often discharged from residential treatment due to their behaviors or is never admitted. Measuring progress in treatment is difficult due to treatment inconsistency.

Should the State of Minnesota create a specific level of care for these target populations, there are several viable methods for evaluating treatment quality and efficacy through both process and outcome measures.

Examples of measurement systems:

- Utilizing accreditation reviews from Joint Commission, CARF or the Council on Accreditation of Services for Families and Children
 - Example from Joint Commission: Hours of physical restraint use, hours of seclusion, multiple antipsychotic medications at discharge with appropriate justification, post discharge continuing care plan, post discharge continuing care plan transmitted
- Creating process measurement based on research studies that focus on (Kapp, Hahn & Rand, 2011):
 - Access: access to services, availability, follow up care
 - Process: participation in treatment, treatment plan completion, serious occurrences, use of restraint and seclusion
 - Client status outcome: Child and Adolescent Services Intensity Instrument, Strengths and Difficulties Questionnaire

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- Physical health markers:
 - Blood pressure
 - Heart rate
 - Metabolic parameters
 - Weight/Body Mass Index

- Minnesota process indicators:
 - Family involvement (engagement/outreach and attendance/involvement)
 - Transition planning/discharge planning
 - Discharge location
 - Recidivism to PRTF programming and hospitalization within 6 months

CABHS currently participates in Joint Commission reviews and other measurement processes. There is no available data to determine whether they measure or document level of family involvement, discharge location, recidivism, or physical health markers.

IV. Report Recommendations

The CABHS work group created immediate, intermediate and long-term goals to attend to and provide better services for children who experience a mental illness, have high levels of unpredictable aggression and/or are actively self-harming.

Immediate (2014)

The most immediate opportunity to address these unmet needs lies in changes to the existing CABHS program. As one workgroup member summarized, moving and changing the program could result in increased access for children to:

- Specialized behavioral health treatment services that exist nearby
- Specialized medical services that exist nearby
- Psychiatric providers
- A larger pool of skilled health care providers and staff members
- A wider array of recreational activities
- A wider array of psychological testing and diagnostic assessment options
- Family contact and family programming

For these and other reasons, the workgroup recommended:

1. The State operated Child and Adolescent Behavioral Health facility should expand their target population from neurobiological disorders and youth with trauma to include youth with mental illness who experience high levels of unpredictable aggression and/or self-harm behaviors and who are not able to be admitted to other facilities or services because of their behaviors.
2. The Child and Adolescent Behavioral Health facility should operate at full licensing census to meet the inpatient hospital level of care needs for the children of Minnesota so that there are fewer out-of-state hospitalizations.
3. As the current facility in Willmar has serious physical plant limitations which would impede accepting children whose complex needs include extreme aggression or active self-harm at fully licensed capacity, CABHS should move to a more appropriate location that can attend to these children while also providing greater access for family involvement during treatment. This location should have an open floor plan with good sight lines for staff, access to competent security, and be in or near the metropolitan area.
4. CABHS should document and track staffing and treatment needs for the identified target population for psychiatric residential treatment facility (PRTF) development purposes.

Intermediate (2014-2015)

1. DHS should propose within the Governor's 2015 legislative package a request to develop a psychiatric residential treatment benefit and begin a rule-making process for facility licensing standards.

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2. DHS should propose within the Governor's 2015 legislative package a request to develop contracted inpatient psychiatric beds in Greater Minnesota for circumstances when an extended stay is required for stabilization and to prevent placements far away from families.
3. Develop a longer-term hospital facility in the metropolitan area that could specialize with younger children (under 12) through partnerships among local hospitals, health plans, and DHS.
4. Facilitate conversations between counties and representatives from Minnesota Council of Child Caring Agencies to develop and determine how to pay for a secure residential treatment facility using existing funding sources in order to provide for the supervision and treatment needs of youth who are highly aggressive and engage in self-harm.

Long-Term (2015-2018)

1. Using the treatment component recommendations described above, DHS should develop facility licensing and treatment standards for psychiatric residential treatment facilities and create a contracting process to assure that there will be regional availability throughout the state.
2. DHS should convene a follow-up group of county, family, advocacy and provider groups to map the state's placement and intensive treatment needs and capacity, so that long-term program design and funding can be strategically planned.

V. Implementation Language

As CABHS facility staff were a part of the CABHS committee, discussions in regard to the recommendations were immediate. The CABHS facility and Children's Mental Health Division agree to report quarterly to the Children's Subcommittee of the Governor's State Mental Health Advisory Council on the progress for the recommendations, as well as summarizing progress within the biannual report to the Governor and Legislature.