Maine Council of Child and Adolescent Psychiatry Input for
Children's Behavioral Health System Review and Planning Process

1. What's Going Well
    a. We have a wide service array in the MaineCare Benefits Manual; many states don't have that. Including, we have in-home services program.
    b. We are doing this review. There has been a 21 year drought for System Review and Planning--but that drought is over!
    c. The MaineCare Accountable Communities contracts with Accountable Care Organizations (ACO's) have the potential to improve accountability for effectiveness of services. MaineCare is considering making Children's Residential Treatment a service for which ACO's must be accountable. Currently, being accountable for this service is optional for ACO's; this actually gives the ACO's an incentive to move youth from the community into residential treatment. If accountability for residential treatment is made obligatory, however, ACO's would be incentivized to make sure their youth get excellent treatment and stay in their home and community.
2. What Needs Improvement, and Potential Solutions
    a. The Office of Child and Family Services (OCFS) must fully embrace its leadership role of organizing and administering the Children's Behavioral Health System of Care (CBH SOC)
        i. When OCFS was created in 2006, Children's Behavioral Health Services (CBHS) was one of 3 Divisions (Child Welfare and Early Childhood were the other two). CBHS was deconstructed around 2014. OCFS Director Jim Martin, to his great credit, reconstructed CBHS in 2015.
        ii. When CBHS was reconstructed, the Director of CBH was not made an Associate Director (AD); Child Welfare, Operations, and Early Intervention and Prevention are all led by AD's. The Director of CBH not on same salary level as the AD's; this is unexcusable and a statement that CBH is not as important as the other functions of OCFS. Administering the CBH SOC is an extremely difficult task and is clearly an AD level position.
        iii. Adult Mental Health has its entire own Office: the Office of (Adult) Substance Abuse and Mental Health Services. But CBHS is not even a full fledged Division within OCFS.
        iv. OCFS must fully embrace its leadership role in CBH SOC. One foundational change must be to make CBHS a full Division of OCFS and make the head of CBHS an AD. Continuing to not do so would be a structural statement that CBH is not a top tier function of OCFS.
    b. OCFS/DHHS must coordinate with the Department of Corrections Division of Juvenile Services (DOC DJS) on the treatment of youth who are aggressive or break the law. This is a key aspect of OCFS/DHHS's leadership role.
        i. One systemic strength is that a number of Behavioral Health Program Coordinators are co-located in the offices of Juvenile Community

Corrections Officers. This is a great boon to outpatient coordination of care.

ii. There is, however, no Department or Office level coordination with DOC DJS, despite the documented fact there is tremendous overlap[1] in the youth served by the two systems. This is a truly terrible abdication of a core state government function.

iii. There is no agreement, on the CBH service provider and JCCO level, of which youth should be served by DHHS and which by DOC. The two Departments have not worked together to give front line staff guidance on this key decision; this is a terrible evasion of responsibility.

iv. Although we are not sure, we believe that In most states, DJS and CBHS are in same Department.

1. Given the tremendous overlap in population served, this must be considered. Combining CBHS and DJS would be one way to solve the current problems of the two systems disagreeing on which should serve the most challenging youth.
2. DJS has a long history of using state (non-MaineCare) funds to incentivize quality and to ensure access to key services (e.g., MST). DJS also has had a robust strategic planning process. If CBHS and DJS are combined, it will be crucial for the strategic planning and the use of state funds for RFP's and contracts continue.
3. If CBHS and DJS are not combined, CBHS/OCFS must take a leadership role in making sure the behavioral health needs of all youth are being met.

c. CBHS must coordinate closely with DOE

i. Many CBH treatments occur in school. Day Treatment, in particular, is a very intense form of CBH service that occurs in schools

ii. CBH treatment in schools has been somewhat of an orphan; neither DHHS nor DOE has embraced responsibility for these programs. There are, to our knowledge, no QA/QI programs for Day Treatment

iii. On the youth specific level, there is usually very little coordination of CBH treatments occurring in and out of school (e.g., Day Treatment and Home and Community Treatment {HCT}).

d. Quality Assurance/Improvement

i. We are excited that this Review and Planning process is underway. We cannot, however, do this only once every 21 years; we need a regular Review and Planning process. Undertaking this process every 3 years would be appropriate.

ii. We know you will hear a lot about access issues, and those issues are critical. Quality and effectiveness of services is an equally critical issue.

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1 https://digitalmaine.com/cgi/viewcontent.cgi?referer=https://www.google.com/&httpsredir=1&article=1032&context=doc_docs

    iii. We are not aware of a QA/QI process for CBH SOC services.
        1. We know there is a consumer satisfaction survey, but few consumers complete this, and there is no way to know if completers are representative.
        2. There was an attempt to use the Child and Adolescent Needs and Strengths (CANS) for Quality Improvement for Targeted Case Management; we're not sure how this is going.
        3. OCFS should consider the experience of DOC DJS with Multisystemic Therapy (MST). MST, as an evidence based practice, has robust quality indicators. DJS uses non-MaineCare funds to incentivize high quality.
        4. All CBH services need a robust QA/QI program. We believe providers will be open to working on this in a collaborative manner. We estimate that Maine spends between $100-150 million on the total CBH SOC (when hospitals, residential treatment, etc., are included). To spend that much money without a QA/QI program is not effective governance.
    iv. We believe that some states outsource their CBH QA/QI.
        1. One example is CT: https://www.chdi.org/
        2. Perhaps this should be considered.

e. Almost total reliance on MaineCare funding
    i. We believe Maine is unusual in its almost complete reliance on Medicaid funding for its CBH SOC. (Mobile crisis funds and block grant funds are, to our knowledge, the only non-MaineCare funding.)
    ii. Reliance on MaineCare precludes, as mentioned above, contracts that incentivize quality improvement. As Dr. Andy Cook, the first OCFS Medical Director, used to say: "Bad treatment is the most expensive treatment of all." If we don't improve quality, we will continue to spend lots of money on treatment that may not be effective.
    iii. Reliance on MaineCare funding precludes strategic planning. Consider Psychiatric Residential Treatment Facilities (PRTF's). MCCAP was fully in support of adding PRTF's to the MaineCare Benefits Manual. Without an associated RFP for program development, however, DHHS has no idea how many PRTF beds it will get or how they will be distributed geographically. Without an associated RFP, DHHS is introducing an expensive (though needed) treatment program in a completely haphazard manner. This is not an effective way to implement a program.
    iv. Maximizing the federal match may, at first, seem fiscally prudent; in the end, though, it is penny wise and pound foolish. Our best guess is that Maine spends upwards of $100 million state funds; without active planning accomplished through RFP's, this money is not effectively spent.
    v. Does SAMHS have more state dollars for RFP's?
    vi. Speaking of the Mental Health Block Grant: is the MHBG allocation process public? Should it be?

f. Substance abuse treatment does not seem well integrated with mental health treatment
    i. There doesn't seem to be integration of services at the community level.
    ii. Although many youth who qualify for residential level of care have both mental health and substance abuse problems, we are not aware of residential programs that explicitly treat both.
    iii. Adolescent Substance Abuse treatment is administered by SAMHS. Is it a good idea to have youth Substance and Mental Health treatment in different Departments? Is there close Departmental coordination on this?
    iv. We are, of course, in the midst of a terrible opioid epidemic. Most young adults with Opioid Abuse Disorder had, as youth, both mental health and substance abuse (marijuana, alcohol, and/or tobacco) abuse problems. Having youth mental health and substance abuse treatment not be integrated is a big problem.

g. Wraparound Case Management
    i. We used to have this program.
    ii. It was not efficiently managed; but stopping the program entirely has left a large gap in our SOC.

h. What role should Peer Support play in our SOC?

i. The SOC for more aggressive kids is worthy of particular note
    i. When youth are stuck in ED's for long periods of time, it is almost always because their level of aggression made programs reluctant to serve them.
    ii. Unlike the adult system and many state systems for youth, there is no state psychiatric hospital for youth.
    iii. There is no hospital that can't say no. The only institution that can't say no is Long Creek; that's why youth with severe psychiatric problems are sometimes placed there.
    iv. Maine's capacity for hospitalizing aggressive youth is very small.
        1. St. Mary's and Northern Maine Medical Center don't take aggressive kids.
        2. Spring Harbor often can only take aggressive youth in a single room, and they only have 4 single rooms.
        3. Acadia typically limits the number of youth requiring one to one aides to a total of 5 youth.
        4. In total, we really only have capacity for about 9 very aggressive youth at any one time. Any additional youth will wait in ED's.
        5. We do not have secure residential treatment programs. The addition of PRTF's to the Benefits Manual is a promising start; but it is unclear if we will have any providers if there is not an RFP for program development.
        6. OCFS's SOC leadership responsibility includes responsibility for psychiatric hospitalization, secure residential treatment, and the overall treatment of aggressive youth. OCFS has not yet embraced this aspect of its leadership responsibility.

j. We need a real focus on Early Childhood SOC
    i. For disruptive behavior, the evidence based programs parenting skills program proposal for Section 65 is promising.
        1. We need to make sure those programs have effective QA/QI mechanisms to ensure they are delivered with fidelity.
        2. We will need to ensure good access to those programs when young children are identified by primary care practitioners, child care providers, and CDS.
    ii. For Autism Spectrum Disorder, the presence of Section 28 Specialized Services (Applied Behavior Analysis) is a great strength of our SOC
        1. Waiting lists, though, are much too long. When a child of 24 or 36 months is diagnosed with Autism, time is of the essence
        2. As for all of our programs, we need an effective QA/QI program. The Association for Maine Behavior Analysis has expressed a desire to work with OCFS on this. https://www.mainebehavioranalysis.org/
        3. The proposal to fund Board Certified Behavior Analysts is very promising.

k. We need evidence based prevention programs for both mental health and substance abuse
    i. SAMHS may do some of this now, but it is not coordinated with OCFS.
    ii. There may be some evidence based prevention programs administered by the Early Childhood and Prevention Division.
    iii. OCFS, as part of its leadership role in the CBH SOC, should conduct a review of evidence based prevention of mental health and substance abuse programs and implement the ones with the most evidence.

l. We need to expand our Cumberland/York program for First Episode Psychosis (FEP) statewide.
    i. NIMH has made Coordinated Specialty Care (CSC) for FEP a priority. https://www.nimh.nih.gov/health/topics/schizophrenia/raise/what-is-coordinated-specialty-care-csc.shtml
    ii. When DHHS turned back the last 2-3 years of a SAHMSA Now's The Time/Health Transitions grant, it committed to finding a funding mechanism for extending CSC teams statewide. Now is the time to fulfill that commitment.

m. Transition Age Youth: it will be important for OCFS/DHHS to monitor and implement evidence based programs for this population.

n. Home and Community Treatment (HCT) is worthy of particular note
    i. HCT is the lynchpin of our SOC. It is only through rapidly accessible and high quality HCT that we can decrease the institutionalization of our youth
    ii. The relationship between LCSW and Behavioral Health Professional (BHP) treatment has become unclear
        1. We had assumed that the LCSW was the primary provider, and that the BHP was a "therapy extender".

        2. BHP hours, however, often greatly exceed LCSW hours. Families sometimes refer to the LCSW as the “supervisor”, as if they weren’t there enough to be providing direct treatment.
    iii. Longer term, less intensive HCT may sometimes be necessary
        1. DHHS is said to be restricting Section 28 Treatment Services to youth with Developmental Disability. This may well be a positive development, as it was unclear what role BHP’s should play in in-home mental health treatment when not part of a team with an LCSW.
        2. Some youth with mental health problems, however, may need longer term in-home treatment than HCT currently provides.
    iv. We need to have rapid access to HCT for youth coming out of hospitals, crisis units, and emergency departments.
    v. HCT providers need to be able to compete effectively in the LCSW labor market.
        1. Working in-home and afterhours may not always be as attractive a work structure as office based or school based therapy.
        2. Working in-home, with our most challenging youth and families, requires our most skilled and talented therapists.
        3. Providers need to be able to offer salaries that will attract talented and experienced therapists.
    vi. HCT, like all service lines, needs an effective QA/QI program
o. Can we expand our use Telehealth better for access to rural areas?