Minnesota Association of County Social Service Administrators

Position Statement

2021

Possible Revisions to MN Stat. 260D

Proposal

Issue:

The advent of new requirements under Family First Prevention Services Act (FFPSA) for accessing Qualified Residential Treatment Programs (QRTP) has led to discussion with stakeholders to modify Minnesota's process to access residential treatment settings in light of the QRTP requirements. This discussion may not have incorporated the range of situations in families seeking residential treatment through counties, and have considered changes that may limit the interests of children/youth while potentially ruling out access to the partial federal reimbursements that remain for residential treatment.

Implementation Strategy:

MACSSA supports the continuation *of the current intent of MN Stat. 260D, incorporating the requirements of QRTP*. This allows counties to respond to requests for children's mental health and/or developmental or intellectual disability services by considering the best interests of the child, examining the treatment options best suited to the needs of the child, and does not rely on all county funding for services. It provides planned discharge from placement and ongoing services. Recognizing that different views of what a child needs may emerge between parents/caregivers, mental health or other health professionals, and county agencies, retaining a structure that provides oversight and impartial decisions regarding any differences is important to serving the best interests of the child. MACSSA welcomes discussion with NAMI-MN and AspireMN to seek a shared approach to addressing concerns about QRTP implementation within MN Stat. 260D.

Systemic Priority Alignment (check all that apply and explain why)

☑ Equity ☑ Service Integration ☑ Fiscal Framework

Comments: Equity: The current requirements of 260D include a process for children age 12 and older to have a guardian ad litem and counsel if they disagree with their placement for treatment. Parents have the right to a fair hearing if they disagree with a voluntary placement ending. The court provides oversight to determine best interests and compelling reasons for treatment placements. Those individual protections could be lost in the approach being discussed. Service Integration: County case management regularly includes assessment for broader services to the family, coordinating health care program access in particular. This coordination role could end with the approach being discussed. Fiscal Framework: The approach being discussed is unlikely to be eligible for Title IV-E funding, so reimbursement would be lost. It would not ensure community-based services are utilized as alternatives to placement, or to move from placement to community as soon as a child's needs indicate placement is not necessary, so there is the potential for more use of expensive, restrictive treatment approaches.

Operational Priority Alignment (check all that apply and explain why)

☑ Behavioral Health ☑ Case Management ☑ Child Well Being ☐ Community Based Settings & Services

☐ Health Care ☐ Housing & Transportation ☐ Modernization ☐ Self Sufficiency

Comments: This is specifically about treatment placements for children in the purview of behavioral health, although it may also impact placement of children for treatment of other disabilities. The discussion is about whether or not to have counties involved in coordination of services based on assessed needs, so would impact the range of children's mental health case management performed by counties or their contracted providers. The discussion has placed emphasis on eliminating the screening as well as court oversight of treatment placements as they continue, setting aside structure that has been intended to ensure treatment placements are in the child's best interests and that if they continue, they have compelling reasons to do so. The curtailing of protections could impact child wellbeing.

Rationale/Background:

Minnesota Statutes, section 260D—Child in Voluntary Foster Care for Treatment—establishes that the paramount consideration in all proceedings concerning a child in voluntary foster care for treatment is the safety, health, and the best interests of the child. The purpose of the chapter is to ensure services necessary to treat a child's symptoms while preserving the child's family ties whenever possible and in the child's best interests, approving the child's placement away from the child's parents only when the child's need for care or treatment requires it and the child cannot be maintained in the home of the parent, the child's parent retaining legal custody during the placement. Parents are responsible for visiting the child, planning together with the agency for the child's treatment needs, and being available and accessible to the agency to make treatment decisions as well as to obtain necessary medical, dental, and other care for the child. The placement in care for treatment is made when the child's parent and the agency agree that the child's treatment needs require foster care based on the level of care determination by the agency's screening team which includes the parent as a required member, taking into account the diagnostic and functional assessment for the child. The agency is required to obtain judicial review of the child's voluntary placement within 165 days of placement to determine whether the placement is in the child's best interests, if the parent and agency are appropriately planning for the child, and—if the child is at least 12 years old and disagrees with the placement—whether counsel and a guardian ad litem should be appointed for the child. If a child remains in placement for 13 months from the date of the voluntary foster care agreement, or has been in placement for 15 of the last 22 months, the agency must end the voluntary placement and send the child home or request that the court finds whether there are compelling reasons to continue the voluntary foster care arrangement, and if the court does not find compelling reasons, a termination of parental rights petition would be filed. Parents have the right to a fair hearing to appeal a termination of a voluntary placement agreement.

In addition to the requirements of MN Stat. 260D, counties are also held to the Minnesota Comprehensive Children's Mental Health Act (MN Stat. 245.487 to 245.4889). This Act establishes that the county board in each county is responsible for using all available resources to develop and coordinate a system of locally available and affordable children's mental health services.

Those conditions of 260D seek to ensure that children are only away from their homes and families when it is in their best interests and there is need for the treatment to occur in a placement setting rather than at home. The elements that create this balance—county screening team decisions and eventual court oversight that could ultimately include a petition to terminate parental rights if a child is in placement without compelling reasons—create uncertainty for parents who worry if their children will function well enough at home and in the community. In the discussions of changes needed to placements for treatment that would comply with FFPSA's Qualified Residential Treatment Programs, the worries of some parents and advocacy organizations have led to proposals that would end county screening team decisions and eventual court oversight. Because the federal requirements for QRTPs have similar language to child protection requirements, there is concern that they will be received as punitive to parents. At the same time, the discussion has not drawn forward the instances of placements found by courts not to be in children's best interests. There is opportunity for robust conversation among stakeholders about how the requirements could be implemented in a different manner from the assumptions, building both formal and informal supports into case planning for the child or youth and strengthening the role of parent voice in the juvenile screening team process. There is more nuance to this issue that underscores both the means for parents to have an active role in service planning for their children and the benefit of having the interests of children and youth reviewed when placement continues and the appropriate level of care is in question.

The current status of QRTP implementation in Minnesota has provided for the QRTP requirements to be met for treatment placements that are accessed through the child welfare system under 260C. This is untenable, as when QRTP is implemented on October 1, 2021, it creates a path for federal IV-E reimbursement for eligible children and youth in treatment placements if the court finds through petition that the child is in need of protection or services or neglected in foster care. Counties currently experience movement between 260C and 260D petitions in court. For example, a child protection court file may be largely resolved, parents having completed changes needed to ensure safety of their children and children returning to parents with the exception of a sibling with disabilities who remains in placement with additional treatment needs. Changing the child's petition for placement to a 260D petition allows the parents to regain custody while the child remains in a needed treatment placement. Similarly, there are situations where a child is in a treatment placements and parents have declined to provide consent for care, do not participate in family therapy, do not visit nor allow visits home, and decline to participate in discharge planning, expressing the intent not to have the child discharge. These situations may eventually move to a 260C petition to allow planning to begin with a relative placement or other permanency planning. This current discrepancy in IV-E reimbursement availability for eligible children is likely to raise concerns alleging financial motivations for 260C petitions in circumstances that already can be difficult to navigate when parents feel strongly about not wanting a child to be discharged from placement for treatment. The ability to align the type of petition to the child's circumstances is vital to case work.

The discussion of modifying the county role in placement approval and required inclusion of eventual court oversight has implications for the current county role developing and coordinating mental health services and ensuring children receive the appropriate level of service. Some questions that have arisen include:

- If counties do not review diagnostic and functional assessment information to determine an appropriate level of care, would counties also be relieved of locating placement settings, currently a challenging, time-consuming task?
- Placement for treatment is not a stand-alone service, as children typically receive community-based services prior to placement and post-discharge. Will counties be coordinating those services while separated from placement decisions?
- Will there be a process to determine whether placement is in the child's best interests, matched to their treatment need?
- Would there be a process to allow a child to have their disagreement with placement heard and considered when it is in conflict with the view of their parents?
- Would children still have access to counsel or guardians ad litem for any dispute process that might be developed as an alternative to court oversight?
- Since changes away from the QRTP structure likely would not meet federal IV-E requirements, would counties be expected to pay placement costs without access to IV-E reimbursement?
- If counties do not to have a role in screening for placement or in assessing if placement is in a child's best interests, and if the court will not have oversight responsibilities, can placement for treatment be moved in its entirety to the MN Department of Human Services to administer and fund?

National Alliance on Mental Illness Minnesota (NAMI-MN) and AspireMN are key stakeholders in this issue. In the First Special Session of 2020, the Department of Human Services was directed by the Legislature to confer with counties, tribes, NAMI-MN, AspireMN, and other stakeholders on recommendations regarding payment for the cost of treatment and care for residential treatment services, including community-based group care, for children currently served under Minnesota Statutes, chapter 260D (see Laws of MN 2020, First Special Session, Ch. 2, Art. 5, Sec. 96). The recommendations must address cost of care that would no longer be eligible for federal Title IV-E reimbursement for this population, the impact on youth currently served both in access to medical assistance and nonresidential services, and the impact on equity for overrepresented populations in the child protection and child welfare systems in Minnesota. DHS has consulted with counties, providing information on their recommendations and allowing for feedback and direct input to attach to the DHS letter that is due to the Legislature by January 15, 2021. The process was not able to include direct discussions among the key stakeholders to seek agreement on potential solutions to the concerns, but NAMI-MN has expressed interest in a third path to accessing treatment placement that relies on medical necessity and does not include county involvement. In this way, families' concerns about some of the 260D regulations could be avoided, and populations with distrust of public systems—especially African American, American Indian, and other Communities of Color—would have access to needed mental health services without requesting county services.

An option exists for people under age 21 years to access medically necessary mental health treatment in a residential setting without county involvement at Psychiatric Residential Treatment Facilities (PRTFs) as established in MN Statutes 256B.0941. These health care services do not need county involvement for room and board costs, and are not subject to counties assessing whether they are the appropriate level or duration of care: eligibility and coverage occurs through health coverage. The Department of Human Services leads the development and licensure of PRTFs. While Minnesota PRTF's offer only one level of care, other states have opted to create additional tiers of care within PRTFs to respond to a slightly wider range of the continuum of care needed by children and youth. There are currently drawbacks of PRTFs in Minnesota including the lack of discharge transition planning to community-based supports, the frequent unavailability of openings in PRTFs, and difficulty in gaining the right focus of interventions to a patient's needs. It bears noting, however, that it is difficult to find timely availability in the current residential treatment centers in Minnesota, and programs often determine that children or youth are not a good match to a program. County staff often spend an inordinate amount of time seeking placements in residential treatment. These are issues in our continuum of care, and not reasons to rule out PRTFs as an option for those with medical necessity for residential treatment and a desire to avoid county involvement. Emphasis could be placed on enhancing Minnesota's PRTF options rather than removing residential treatment from the service array in 260D or foregoing the QRTP requirements and IV-E reimbursement.

MACSSA welcomes discussion with NAMI-MN, AspireMN and other stakeholders on how to address concerns regarding QRTP implementation within 260D placements. Potential areas to explore include supporting enhancement of PRTFs in Minnesota, taking steps that amplify parent voice and support in the current county system, including requirements about staging kinship involvement, supporting resources for programs to transition to QRTPs or PRTFs or other ideas that are congruent with the county interest in maintaining a process for appropriate level and duration of care with protection for children's best interests and utilize available funding streams for services.

Summary statement: Continue the structure of MN Stat. 260D in determining need and providing oversight of placements for children's mental health treatment, accommodating the elements required under federal Title IV-E for Qualified Residential Treatment Programs. Support residential treatment programs and group home settings that provide treatment placements in transitioning to meet QRTP requirements. Alternately, if the structure of 260D for treatment placements is eliminated and QRTP requirements excluded, treatment placements should be administered and funded at the state level

rather than by counties. This would transfer responsibility for locating placements and managing the public costs of the treatment placements to the state rather than leaving them at counties without oversight on appropriateness or duration of placements.

Additional Information:

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Approved on: [insert date position was approved]