Systems of Care for Children: Prospectus for Change in Wyoming

The Mental Health Division of the Wyoming Department of Health exists to be a leader in providing high-quality behavioral services that anticipate and respond to the changing needs of persons served.

— Mental Health Division Website

The Child and Adolescent Service System Program (CASSP)

Core Values of the System of Care

Guiding Principles for Services to Children with Emotional Disturbances

1. Access to a comprehensive array of services that address their physical, emotional, social, and educational needs.
2. Individualized services based on unique needs of child and family.
3. Services in least restrictive, most normative environment that is clinically appropriate.
4. Families and surrogate families should be full participants in all aspects of planning delivery of services.
5. Integrated services with linkages among child-serving agencies for planning, developing, and coordinating services.

Guiding Principles for Services to Children with Emotional Disturbances

6. Case management to ensure coordinated and therapeutic services that address changing needs.
7. Early identification and intervention in order to enhance likelihood of positive outcomes.
8. Ensure smooth transition to adult services system.
9. Protection of the child’s rights, as well as advocacy efforts.
10. Service without regard to race, religion, national origin, sex, or physical disability. Sensitivity and responsiveness to special needs.

Contact information:
Wyoming Mental Health Division: 307.777.7094
WICHE Mental Health Program: 303.541.0257
1. **Strength-based approach** that evaluates family and cultural assets.

2. Family involvement, viewed as capable and knowledgeable and as the primary source of facilitating treatment.

3. Needs-based services: family is an active partner, whose assessment of child’s needs should be listened to and used to guide treatment.

4. Individualized service plans: medical to psychological to educational.

5. Outcome-focused approach: clear, agreed-upon goals continually evaluated and measured.

### Wide range of effective treatments:
- Prevention
- Crisis Response
- Assessment
- Other Emergency Services
- Outpatient Treatment
- Home-Based Therapy
- Mentoring
- Respite Care
- Case Management
- Day Treatment
- Independent Living
- Therapeutic Foster Care
- Treatment Group Home
- Residential Treatment
- Inpatient Hospitalization
- Residential Facility for Crisis Situations
- Family Support

### Interface between family and mental health systems:
1. Wraparound maximizes family involvement in service delivery.
2. Family’s perspective is included.
3. Families need to choose their own leadership.
4. Balance of local family support needs and statewide involvement.
5. System change requires family involvement.
6. Families should define functions of the family organization.
7. Clearly specify requirements.
8. Family organizations need assistance.

### A system of care should have a built-in evaluative component that answers:
- Who are we serving?
- What services are they receiving?
- Are services delivered in accord with model?
- What is the cost of service delivery?
- What are the outcomes?
- Are we serving the right children/families?
- Does fidelity to a model affect outcomes?
- Which services are most effective for which children?
- How are costs associated with service trajectory?

#### Key Components in a System of Care

1. **Wraparound Services**
2. **Evidence-based Services**
3. **Family Involvement**
4. **Evaluating the System of Care**
5. **Financing the System of Care**

### Financing the System of Care

1. State appropriations.
2. Federal or foundation grants.
3. Title IV E Waivers.
4. Use existing funds differently.
5. Matching opportunities.
6. Medicaid
   - Home and Community Based Waiver
   - Tax Equity and Fiscal Responsibility Act (TEFRA) (Katie Becket Option)
   - Health Insurance Flexibility and Accountability (HIFA)
Best practices may be defined differently by different people, but generally refer to those treatment interventions that are considered most effective on the basis of outcome research and/or community standards.

**Prevention and Early Intervention**

Prevention is not only common sense, it is common practice in other areas of healthcare.

- Expectant mothers learn about healthy pre-natal practices and/or eliminating harmful behaviors.
- People are immunized against harmful diseases at different points in life.

Prevention in mental health for children in high risk environments is designed to have similar results:

- Prevention means less money spent on treatment later.
- More importantly, prevention reduces unnecessary and unneeded suffering.
- Even when youths have begun having difficulties with the law, substance abuse, or other behavior problems, research indicates that early intervention produces favorable results.
  - An early home visitation program reduced arrests, substance use, running away from home, behavior problems, and sexual activity with multiple partners.
  - Parenting skills training reduced antisocial behavior in children.
  - Programs like Head Start facilitated better peer relations, less truancy, and less antisocial behavior.
  - Early intervention programs in child care settings have improved intellectual development and academic achievement.
  - Early screening programs in elementary schools improved academic achievement and adjustment.
  - Finally, targeted prevention efforts have shown reductions in suicide, alcohol and drug abuse, teenage pregnancy, and juvenile delinquency.

**Early Childhood System of Care**

Data indicates that young children (ages 1-6) receive a very low percentage of mental health treatment compared to older children and adolescents, despite an apparent need for such services. An early childhood system of care may be a useful way to address service deficits for these children.

Such a system seeks to achieve several goals:

1. Promotes emotional wellbeing of infants and young children.
2. Provides assistance to families.
3. Expands competencies of caregivers.
4. Ensures that young children with early-onset of symptoms have access to services.
5. Involves multiple community resources (e.g., Head Start, schools, healthcare).
BEST PRACTICES (continued)

Multidimensional Treatment Foster Care (MTFC)

1. Designed as an alternative for residential treatment for incarcerated youth with SED or seriously violent, antisocial, substance abusing behavior.
2. Emphasizes low child-to-caretaker ratios, with one to two children per foster home.
3. Involves intensive training and supervision, and an outcome-focused approach that utilizes daily behavioral measures.
4. Treatment lasts about six to nine months.

The goals of treatment are as follows:
1. Encourage normative and pro-social behaviors.
2. Provide close supervision.
3. Set specific, clear, and consistent limits.
4. When rules are violated, follow through with nonviolent consequences.
5. Encourage academic skill development.
6. Teach new skills for forming relationships with positive peers and for bonding with adult mentors and role models.
7. Limit access to negative/delinquent peers.
8. Support biological family members to increase the effectiveness of their parenting skills.
9. Decrease conflict among biological family members.

Multiple studies on the effectiveness of MTFC indicate the following results:
• Reduced re-offending rates, increased rates of successful reunification with families (Chamberlain & Reid, 1998);
• Increased program completion rates, decreased runaways, decreased incarceration rates (Chamberlain & Moore, 1998);
• Decreased disruptions in placement and problem behaviors than traditional foster care (Chamberlain, Moreland & Reid, 1992).

Multisystemic Therapy (MST)

A community-based, family-driven treatment for youths with antisocial/delinquent behavior.
• Focuses on “empowering” caregivers to solve current and future problems.
  The MST “client” is the entire ecology of the youth: family, peers, school, and neighborhood.
• MST is being used in more than 30 states in the U.S.
• It is a state-wide program in CT, CO, HI, OH, & NE.

MST - Home-based Services
Treatment Site ......................... In the field: home, school, neighborhood, and community.
Provider ............................... Single therapist (as part of, and supported by, a generalist team).
Treatment ............................... Total behavioral health care.
Case Management Function .... Service provider rather than broker of services.
Treatment Duration ................. 3 to 5 months in most cases.
Clinical Staff/Client Families ...... 1:4-6 (avg. 15 families/year/therapist).
Staff Availability ..................... 24 hr/7 day/wk team available.
Treatment Outcomes ............... Responsibility of staff & agency.
Expectations of Outcomes .......... Immediate, maximum effort by family and staff to attain goals.

Research on the effectiveness of MST indicates:
• Decreased re-arrest rates by 25% - 75%
• Decrease in out-of-home placement 47% - 64%.
• Improved family relations/functioning.
• Decrease in drug use.
• Decrease in aggression.
Data from the MST therapist adherence measure predicted:
• Decrease in criminal activity.
• Decreased incarceration.
• Decreased adolescent emotional distress.