

# Oregon Children's Mental Health System Reform

Children's System Change Initiative and Beyond

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A stylized silhouette of a mountain range in shades of teal, located in the bottom right corner of the slide.

# Children's System Change Initiative

Overarching goals are to keep kids:

- ◆ At home
- ◆ In school
- ◆ Out of trouble
- ◆ With friends



# Evolution of Delivery Systems

- ◆ in attitudes towards families
- ◆ in location of services from office to community & family-based settings
- ◆ in types of services from office-based to flexible, community-based supports

# Prior System Structure

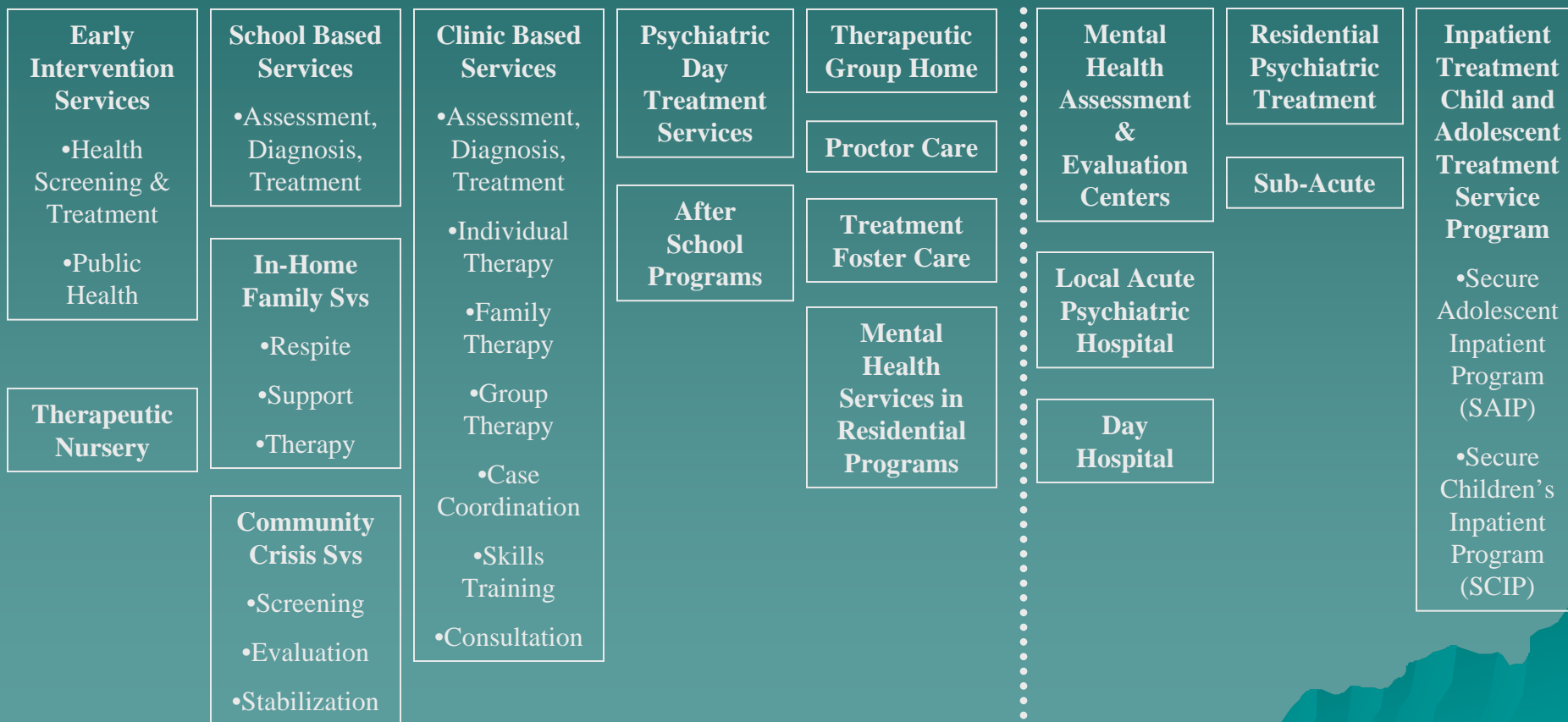
- ◆ Prior to October 1, 2005, children's funding and responsibility was separate and uncoordinated. The system was fragmented and duplicative. Cost and outcome data were not linked, and public policy making was not well informed.
- ◆ Acute care and outpatient services were administered through Mental Health Organizations and Community Mental Health Programs.
- ◆ Psychiatric Day Treatment Services and Psychiatric Residential Treatment Services were administered through direct state contracts outside the local system structure.
- ◆ Families had little voice/choice in treatment options or system design and oversight. There were no peer delivered services.

# Children's Mental Health System of Care

← LEAST RESTRICTIVE → MOST RESTRICTIVE

## Community Based Care

## Inpatient Based Care



# System Reform

## FROM

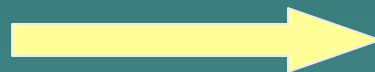
## TO

Fragmented service delivery



Coordinated service delivery

Categorical programs/funding



Blended resources

Limited services



Comprehensive service array

Reactive, crisis-oriented



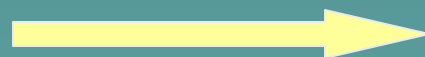
Focus on prevention/intervention

Focus on “deep end,” restrictive



Least restrictive settings

Children/youth out-of-home



Children/youth within families

Centralized authority



Community-based ownership

Creation of “dependency”



Creation of “self-help”

# Legislative Directive

In 2003 a legislative directive required DHS/AMH to “substantially increase the availability and quality (breadth, depth, and intensity) of individualized, intensive, and culturally competent home- and community-based services so that children are served in the most natural environment possible and so that the use of institutional care is minimized.”

# Children's System Change Initiative

Designed to create a standardized method of determining a child and a family's level of service need, assure care coordination, increase service flexibility and interagency collaboration, and increase accountability at a local and state level.

## 6 CSCI Policy Statements

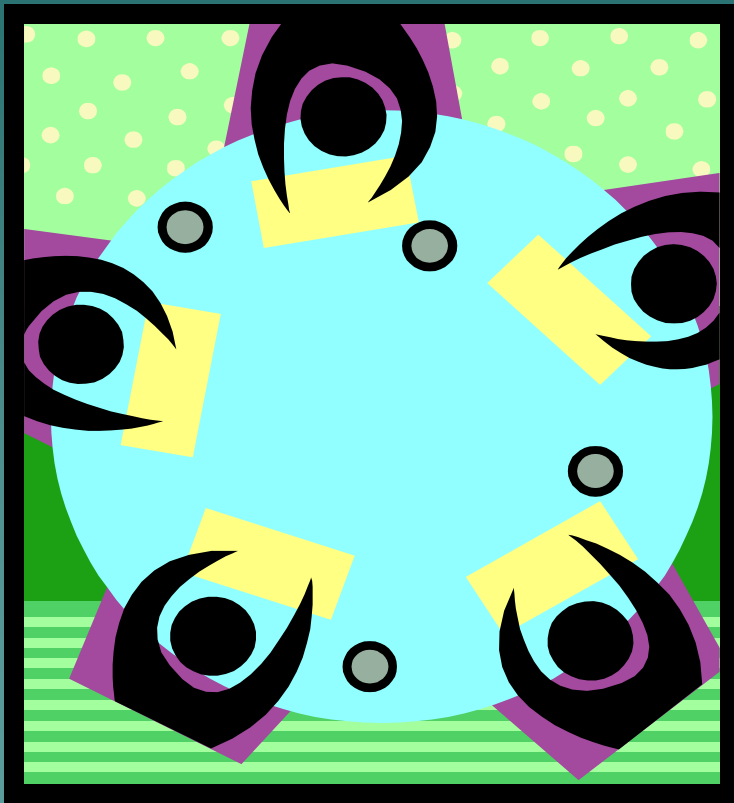
- ◆ Level of Need Determination
- ◆ System Structure and Function
- ◆ Family Involvement
- ◆ Cultural Competency
- ◆ Outcomes
- ◆ Financing

<http://www.oregon.gov/DHS/mentalhealth/child-mh-soc-in-plan-grp/main.shtml>

# Level of Need Determination

- ◆ Multiple points of referral
- ◆ Administration of Child & Adolescent Service Intensity Instrument (CASII)
- ◆ Consideration of other risk factors

# Continuous Care Coordination

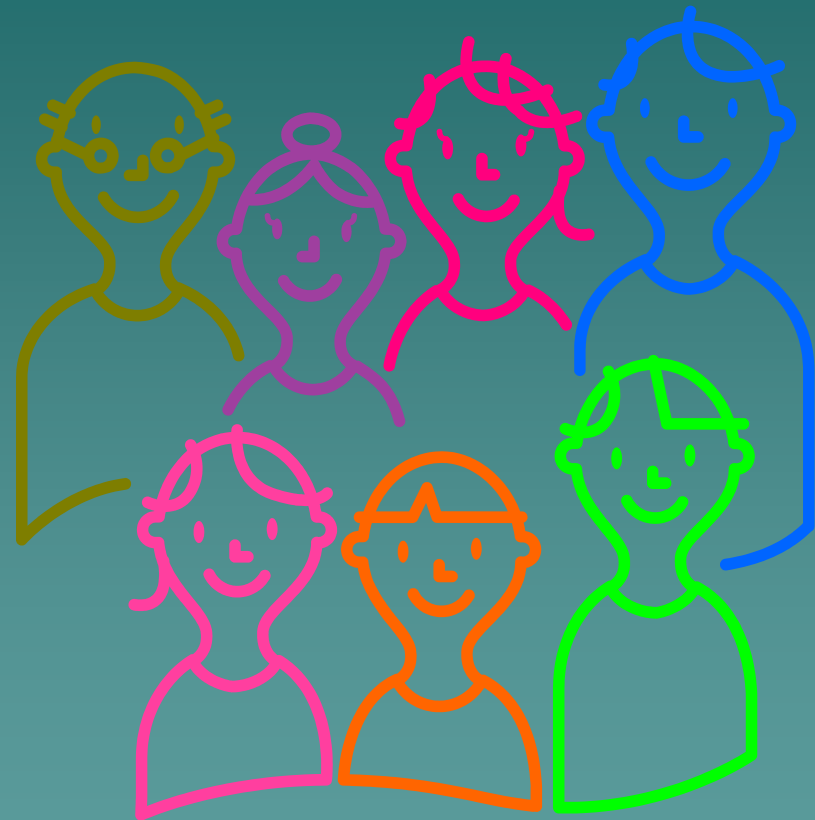


Care Coordinator and team plan, implement, and review Individualized Services and Supports Plan.

Coordinator develops a supportive relationship with family & facilitates communication between team members.

# Child & Family Team

- The Child & Family Team is comprised of the family, care coordinator, involved child-serving agencies & informal and natural supports.



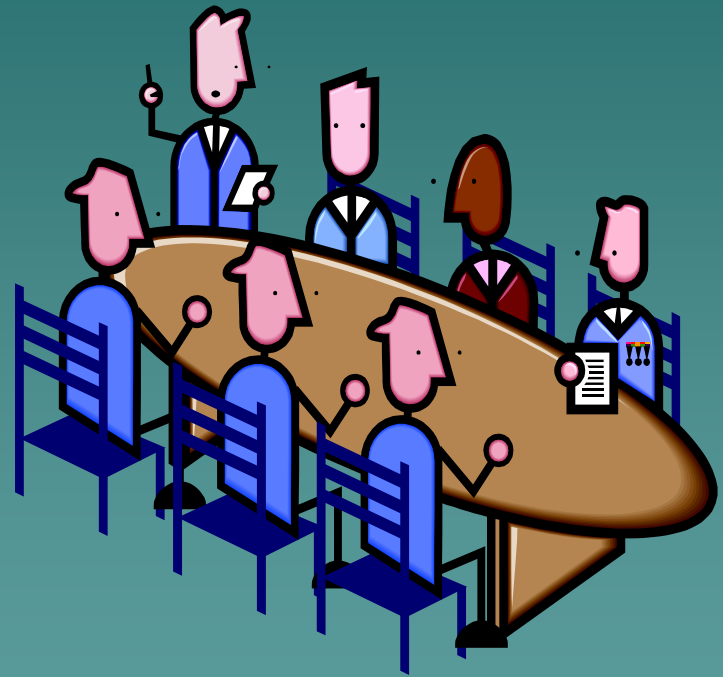
# Service Coordination Plan



The Service Coordination Plan identifies strengths, needs, and goals across life domains. It organizes and supports related planning.

# Community Care Coordination Committee

Membership of this committee will represent the local system of care and will provide practice-level consultation and problem solving for involved parties.



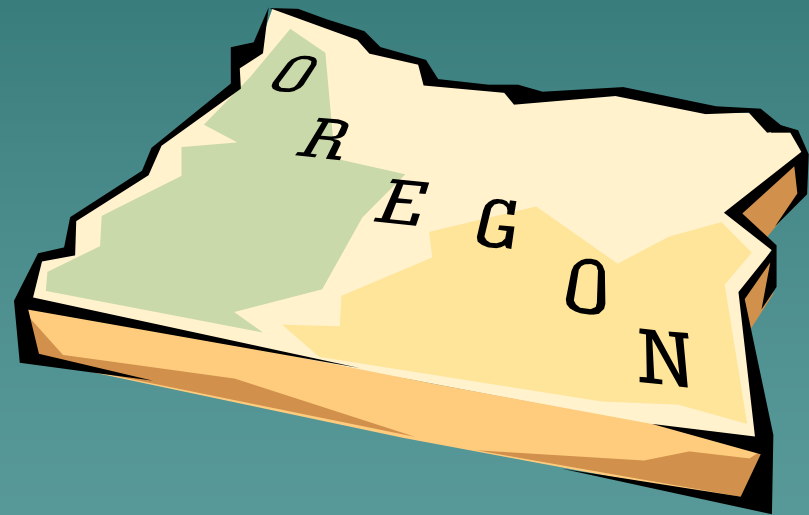
# Local/Regional Advisory Council



Formed by the MHO, this council will be comprised of at least 51% family members and will provide oversight for the system, providing recommendations for improvement to the MHOs and LMHAs

# State Advisory Committee

- ◆ This committee is composed of 51% family members and provides statewide oversight of the children's mental health system, mental health policies and programs.
- ◆ It is linked to the AMH Planning and Management Advisory Council.



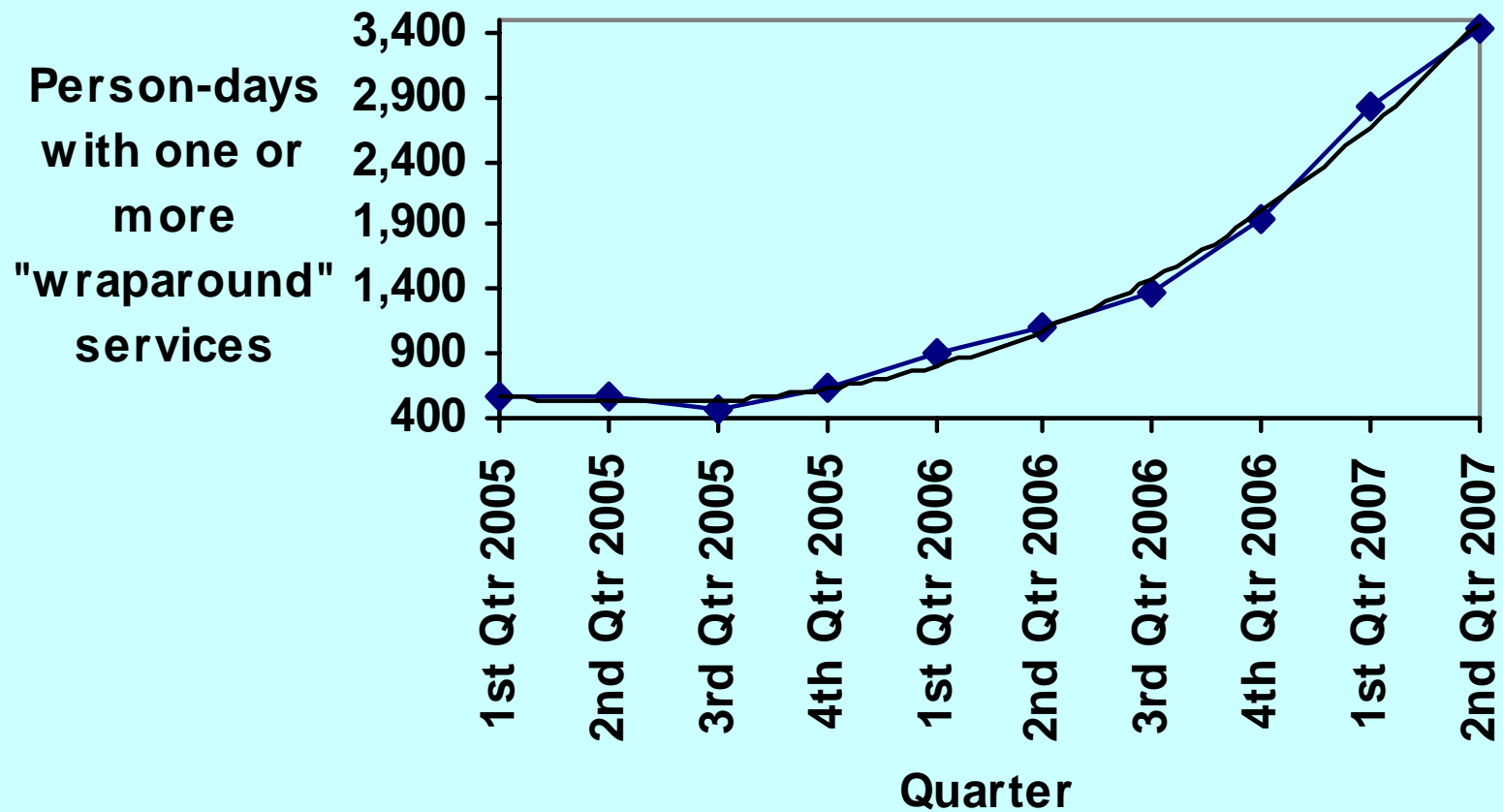
# CSCI Results

- ◆ Requires a broad range of service components individually tailored and coordinated to meet the complex needs of children with severe mental or emotional disorders
- ◆ Standardized needs determination (level of service intensity) process
- ◆ All children with mental health needs who went through the screening process received a dramatic increase in the range, type and frequency of community-based mental health services. 88 percent of children screened were approved for services\*
- ◆ Of the children treated through CSCI:
  - 58 percent were treated in community-based settings\*
  - 42 percent were treated in facility-based care\*

*Prior to CSCI, nearly all of these children were treated in facility-based care*

\*PAE Data 2007

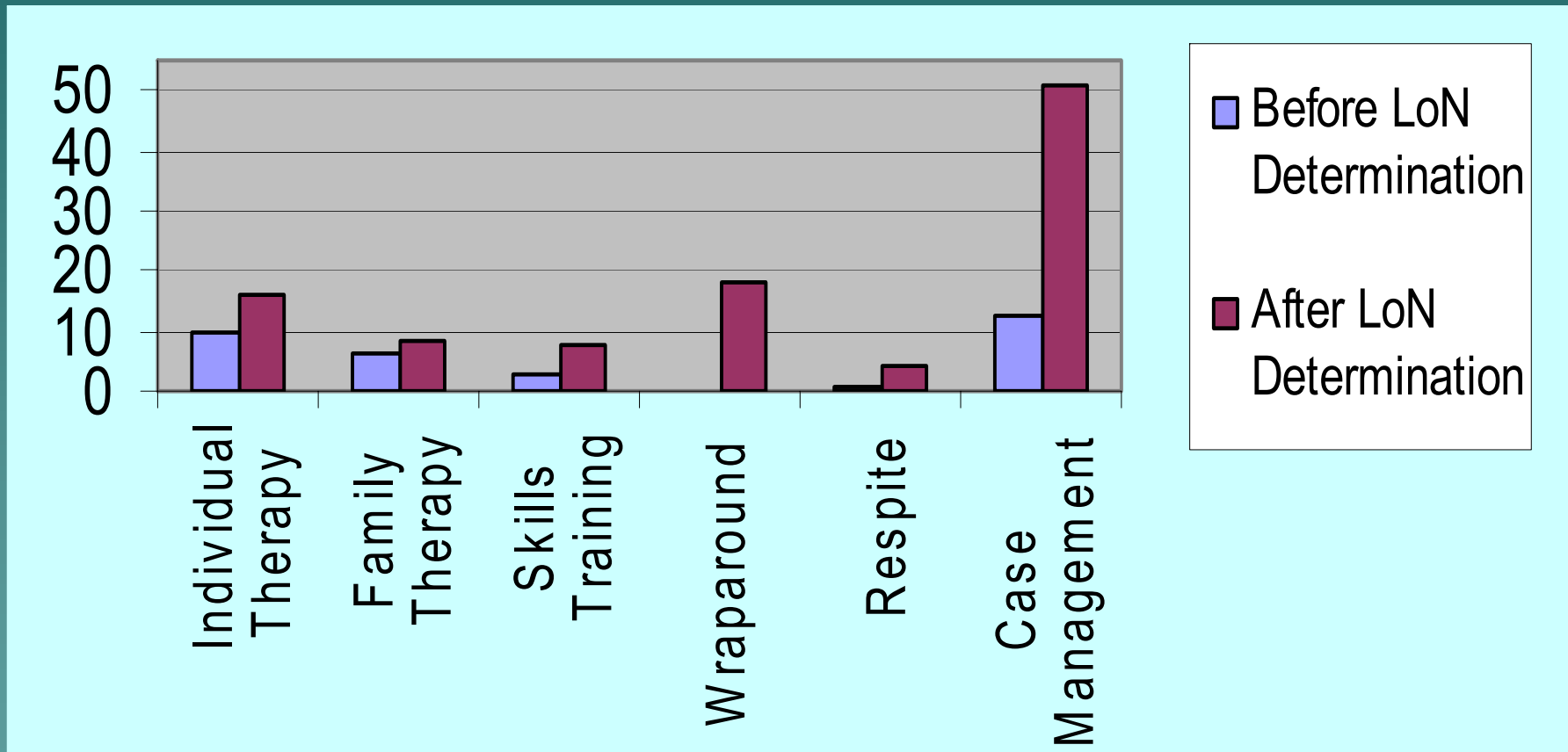
# Person-Days with One or More MHO- Provided "Wraparound" Services, By Quarter: 1/2005 - 6/2007



Data source: MMIS

## Community-Based Services

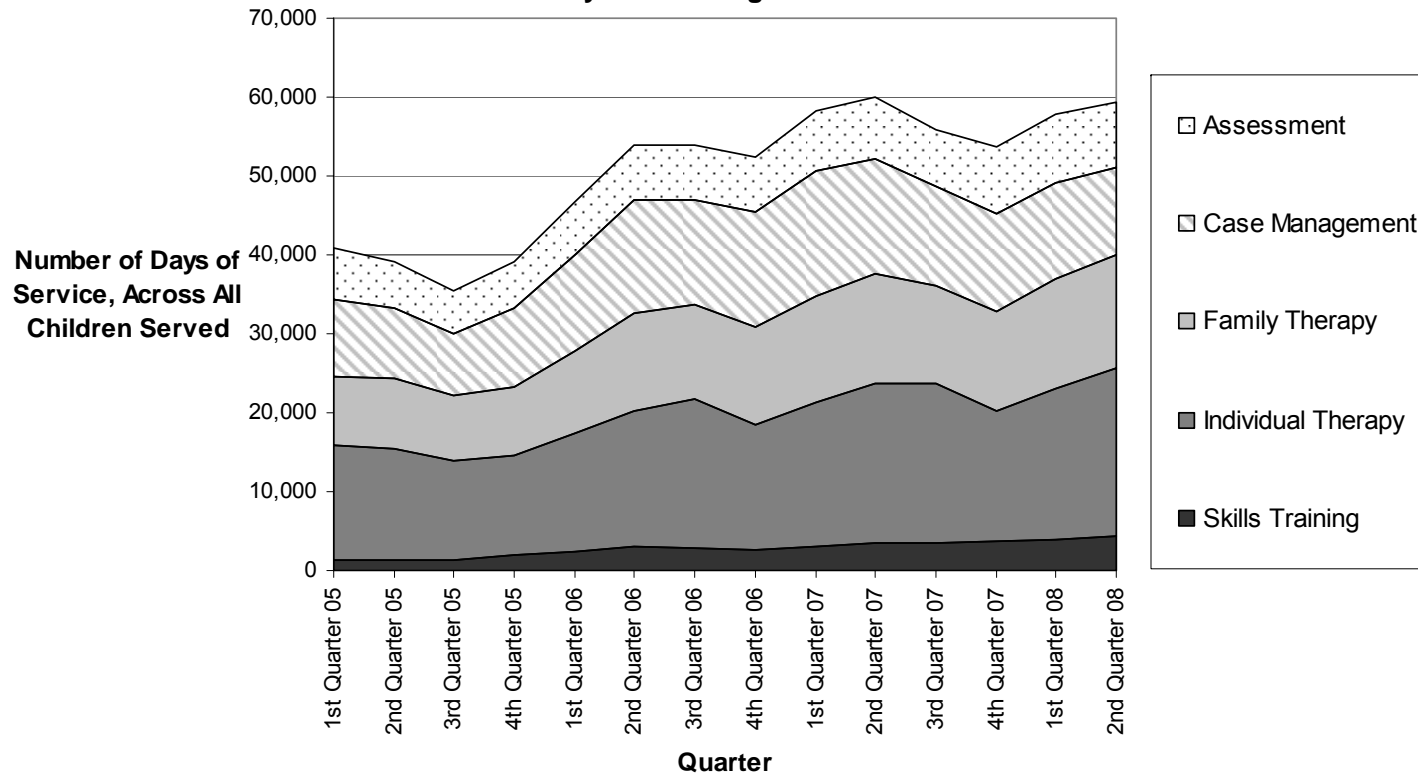
Services increased for all children after the Level of Need Determination process



Days with Service in Service Category, Per 1,000 Person-Days of Eligibility for Service: Before Vs. After Level of Need Determination. PAE Data from 2008

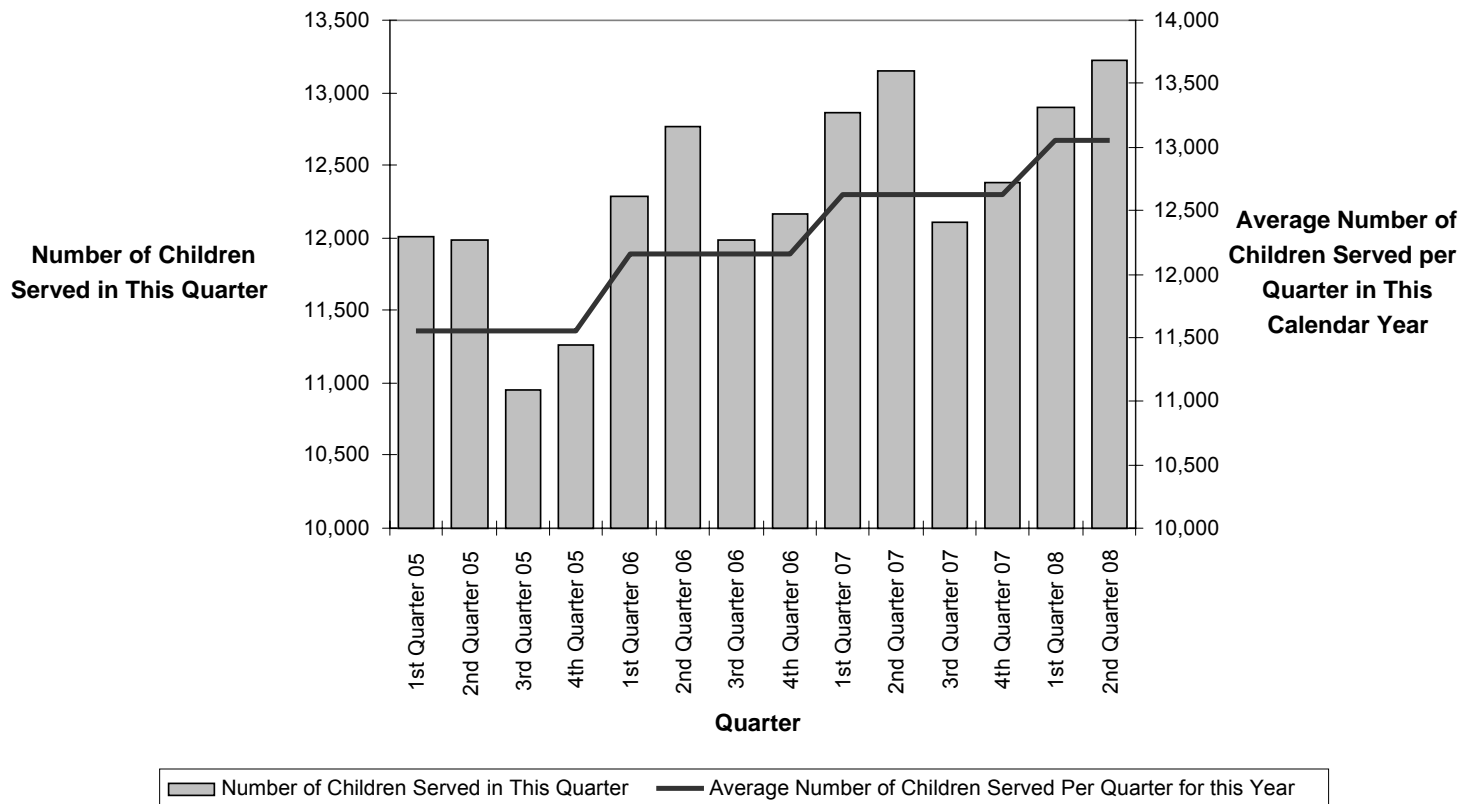
# Increased Array of Outpatient Mental Health Services

Figure 2. Trends in Provision of Children's Outpatient Mental Health Services by MHOs: January 2005 through June 2008



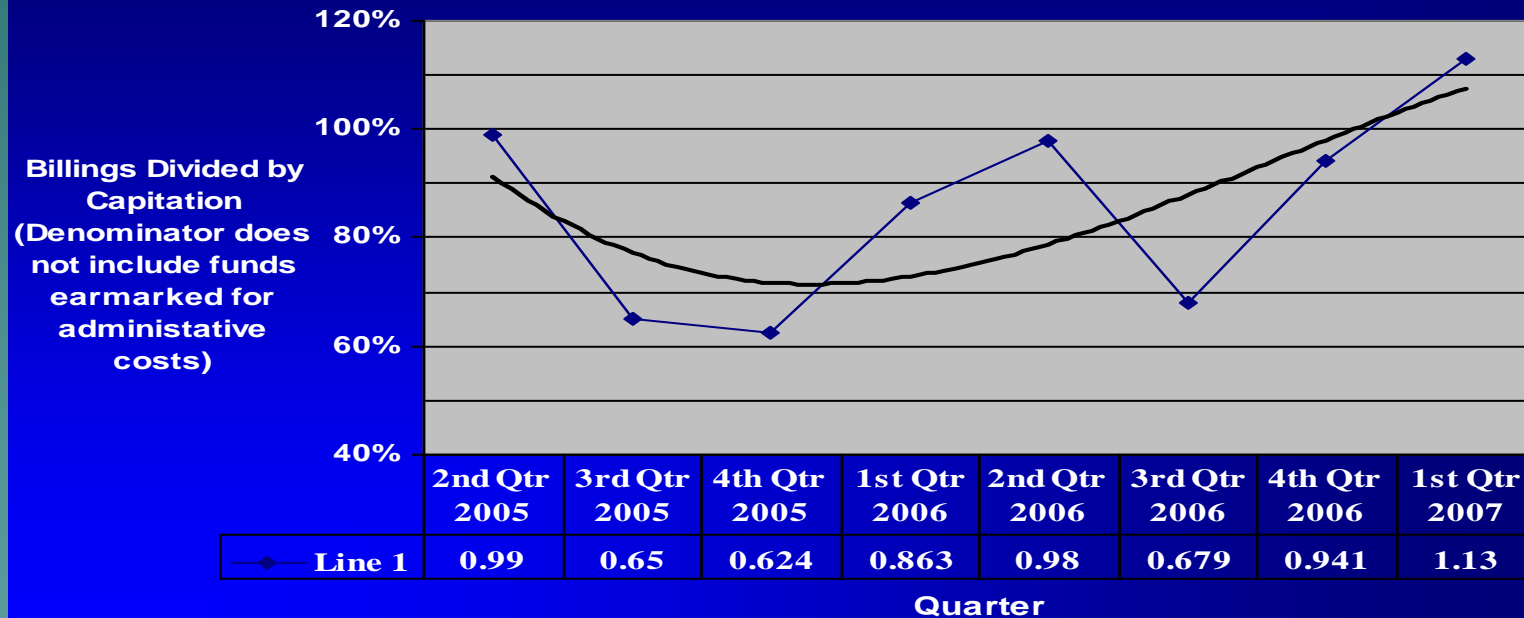
# More Children are Receiving Services

Figure 1. Trend in Number of Children Receiving MHO-Provided Mental Health Services: First Quarter of 2005 through Second Quarter of 2008



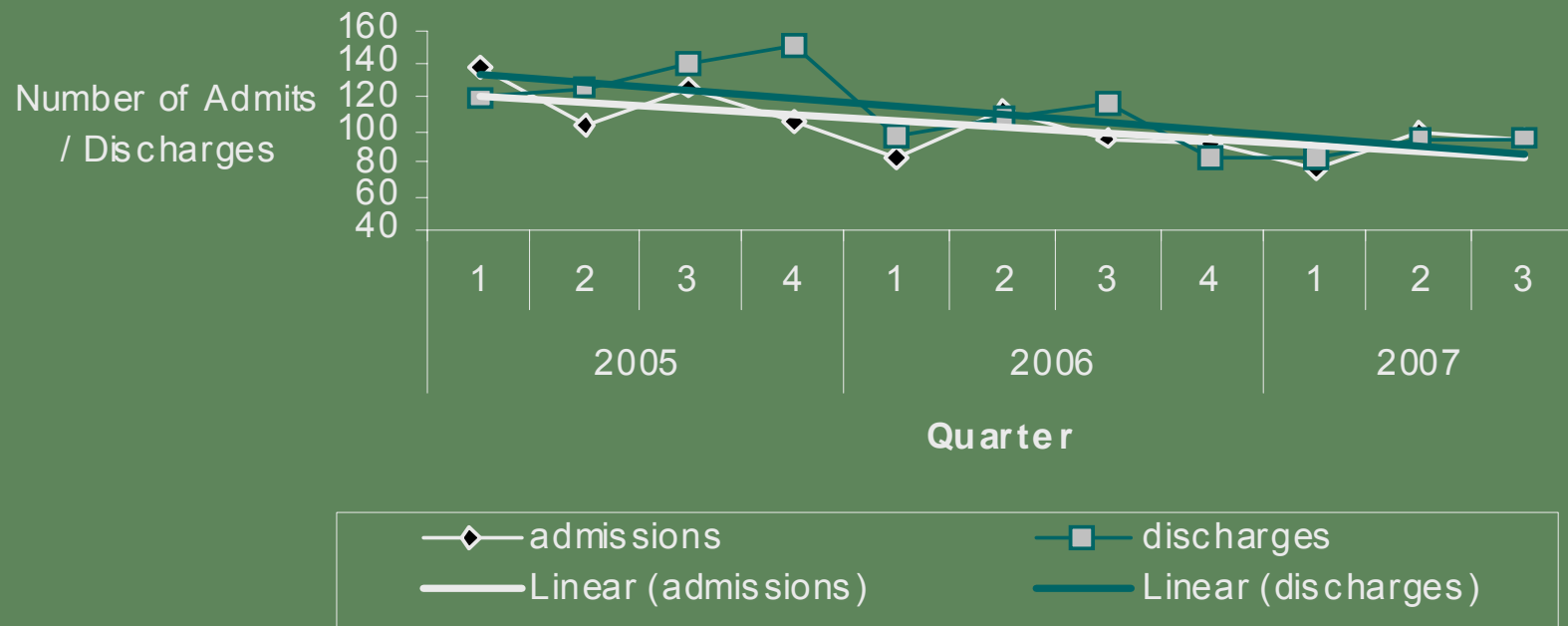
# Money earmarked for children is being spent on them

**Figure 3. Billings for Children's MH Services as a Percentage of Capitation for Children's MH Services, By Quarter that Billings were Submitted: 4/2005 - 3/2007**



# Fewer children are being served in residential treatment

Figure 15. Number of Admissions to and Number of Discharges from Non A&E Residential, By Quarter: 1/2005 - 9/2007

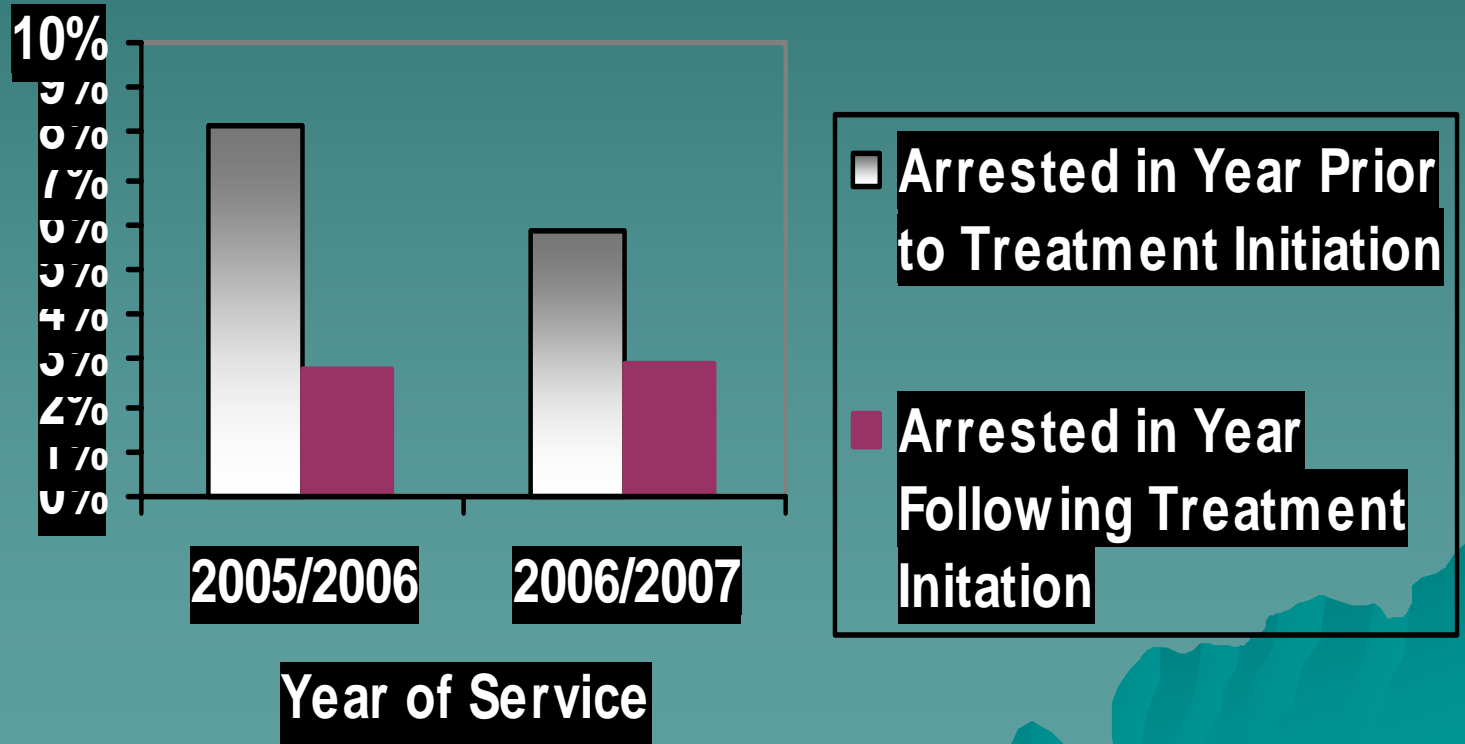


Note: "Linear" refers to linear distribution describing a line that best fits the data  
Data source: CPMS

# ...and fewer are arrested.

**Figure 47. Percent of Children Arrested, Year Before Treatment vs. Year Following Treatment: By Year of Service**

**Percent of Respondents Indicating Child was Arrested in the 365 Days Preceding / Following**



# CSCI Results

- Children with mental health issues are served in their local communities
- CSCI fundamentally changed the services children and their families receive:
  - 90 percent of the children were served in a community setting
  - The number of children admitted to psychiatric day treatment settings *decreased* by 25 percent
  - The number of children admitted to psychiatric residential treatment settings *decreased* by 34 percent
  - The number of Medicaid-eligible children receiving services *increased* from an average of 11,500 per quarter in 2005 to an average of 13,056 per quarter in 2008
  - The number and types of community mental health services increased\*

\*data from 2008, Program Analysis & Evaluation Unit, AMH

# Lessons Learned

- ◆ Troubleshoot enrollment and eligibility issues
- ◆ Leverage flexibility of the Oregon Health Plan
- ◆ Use creative planning to insure workforce development
- ◆ Identify early the indicators and outcomes: data reporting mechanisms and requirements
- ◆ Consider mechanisms for expansion of system and ways to insure caseload size for care coordinators
- ◆ System experts at MHO level; join with other MHOs to share as they go
- ◆ Communicate goal and successes to system partners early and frequently

# Unintended Positive Consequences

- ◆ Improved organization, emphasis on planning and trouble shooting
- ◆ Development of services for specific populations with high need: early childhood, young adults in transition
- ◆ Expansion of efforts to reduce high end services enhanced development of specific community based EBPs such as Collaborative Problem Solving and Parent Child Interaction Therapy

# Challenges

- ◆ Secure buy-in and agreement for focus of project; be mindful of administrative layering (“burden”)
- ◆ Blending needs of multiple stakeholder groups who may be at varying degrees of readiness
- ◆ Resource issues at state and local levels
- ◆ Support providers to manage change and develop a broadening array of services & supports

# Statewide Wraparound Initiative Goals

- ◆ Family and youth-driven system
- ◆ Integration of all child-serving systems
- ◆ Combined funding
- ◆ Culturally competent planning, services and oversight
- ◆ Ensuring that children and adolescents are “at home, in school, out of trouble and with friends”

# Initiative Tasks and Structures

- ◆ Project Site Implementation
- ◆ Outcomes and Indicators
- ◆ Workforce Development
- ◆ Information System
- ◆ Finance
- ◆ Federal Policy
- ◆ Cross Agency, Department, and Division Transformation Team
- ◆ Interagency Steering Team
- ◆ Statewide Wraparound Initiative Advisory Committee

# Identified Population

Youth who have or are at risk of developing emotional, behavioral or substance use related needs, and who are involved in two or more systems of care.

# Statewide Children's Wraparound Initiative Target Population

## Phase 1

- ◆ children in the custody of DHS for more than one year and who have had at least 4 placements,
- ◆ or children who have behavioral, emotional and/or mental health conditions severe enough to warrant direct entry into the service system at a high level of care.

# Project Components

- ◆ Local and State governance
- ◆ Local single point of accountability
- ◆ High Fidelity Wraparound
- ◆ Care Coordination
- ◆ Focus on youth and family outcomes and system effectiveness

# Project Outcomes and Indicators

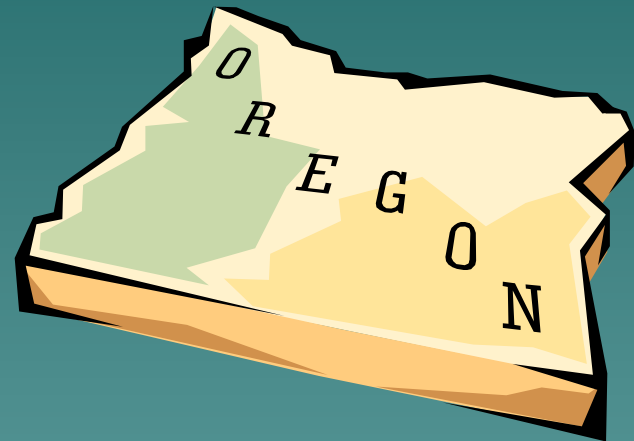
- ◆ Collected at entry and every 90 days
- ◆ Current residences and any changes
- ◆ Academic performance
- ◆ Risk of harm to self and others
- ◆ Risk or history of running away
- ◆ Risk or history for delinquency
- ◆ Substance use
- ◆ Care giver supports
- ◆ Estimate of progress
- ◆ Behavioral and Emotional Rating Scale (BERS-2)

# Three Project Demonstration Sites

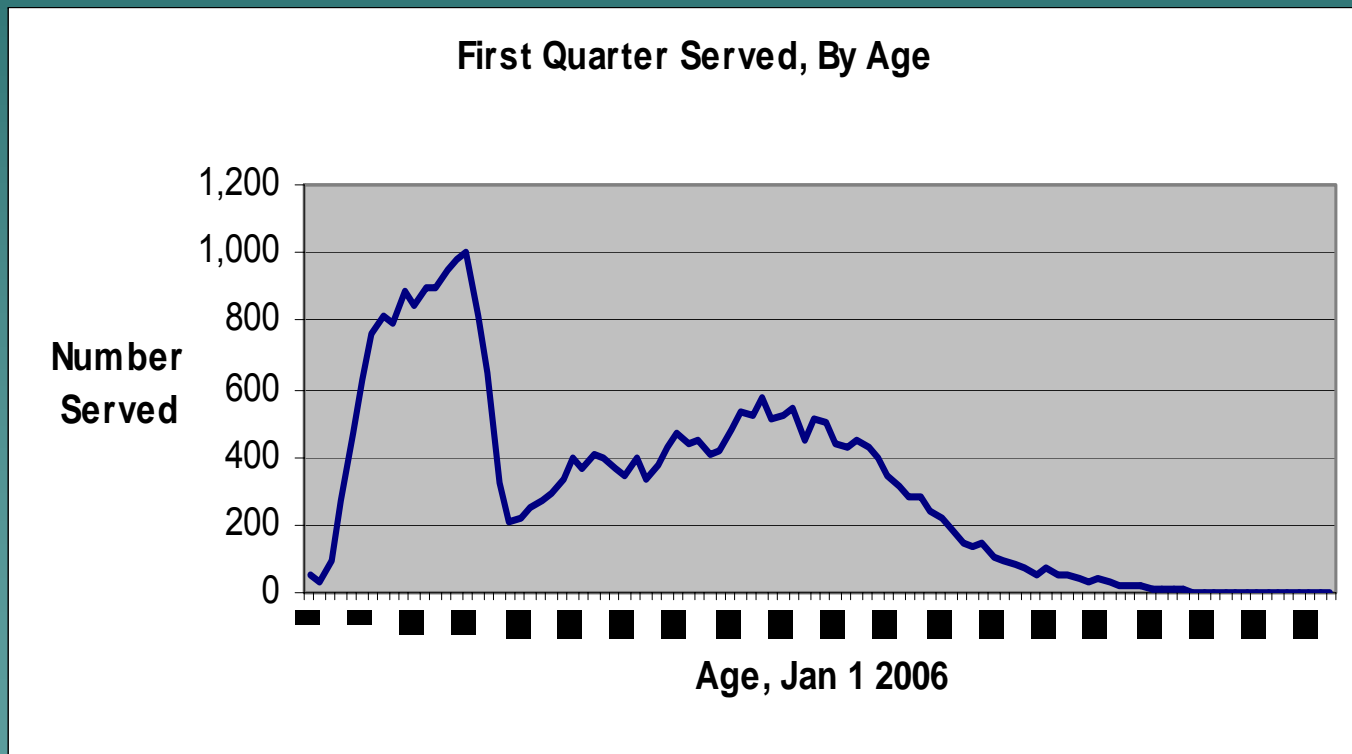
- ◆ Washington County Wraparound: 60 youth increasing to 150 youth
- ◆ Mid-Valley WRAP: Marion, Linn, Polk, Tillamook and Yamhill counties: 140 youth increasing to 180 youth
- ◆ Rogue Valley Wraparound Collaborative: Jackson and Josephine counties: 100 youth

# Oregon will have

- ◆ Single point of contact
- ◆ Family and youth voice and choice
- ◆ Least restrictive placement
- ◆ Coordinated services
- ◆ Blended resources
- ◆ Infrastructure in place
- ◆ Agencies and organizations that are accountable for outcomes
- ◆ Local accountability and responsibility



# Young Adults in Transition Quickly Lost from Treatment



Data from Addictions & Mental Health Division,  
Program Analysis & Evaluation Unit, 2006

# Young Adults In Transition

- ◆ Young Adults in Transition are young people who have encountered trouble in their early lives and who “age out” of a system of care or dependence.
- ◆ Nationally, only 50% of youth with serious emotional and behavioral disorders obtain a high school diploma vs. 81% of general population
- ◆ 73% of those unable to complete high school are arrested 3-5 years after leaving school
- ◆ 70% of young adults in Juvenile Justice system have a mental disorder
- ◆ Gay, lesbian ,bisexual, transgendered and young adults with diagnosed co-occurring disorders are at increased risk
- ◆ Homelessness/lack of appropriate housing is one of the most significant barriers
- ◆ In Oregon 80% less likely than other mental health populations to receive services

# Additional Questions???

