Chapter Five

Access to Appropriate Care

Screening, Assessing and Treating the Mental Health Needs of Children in Child Welfare: A Cross System Initiative

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Introduction

The Indiana statewide implementation of a routine process to screen, assess, and treat children in the child welfare system with mental health needs and their families is a collaborative model of planning, service implementation, and quality improvement. Systems serving children and families in Indiana have planned and are implementing this initiative. Monitoring and quality improvement includes sharing of data across three systems: child welfare, Medicaid, and mental health, with analysis by Indiana University. This summary describes progress to date on implementation of the initiative.

Need

Children in the child welfare system are at high risk for mental health problems. As many as 76% of children in foster care have developmental, emotional, or behavioral problems (Farmer et al., 2001). Using data from the National Survey of Child and Adolescent Well-being (NSCAW), Oct 1999 - December 2000, Burns and associates (2004) found nearly half (47.9%) of children in the child welfare sample, aged 2 to 14, (*N* = 3,803) had clinically significant emotional or behavioral problems. For all children, less than 25% of those with serious emotional disturbances have recently received mental health care (Costello, Messer, Bird, Cohen, & Reinherz, 1998). Burns and associates (2004) found that only 15.8% of children in the child welfare study received any mental health services in the previous 12 months; one fourth of children with evidence of the highest level of need received any mental health services.

Also using NSCAW data, Hurlburt and associates (2004) found that the level of collaboration between child welfare and mental health is associated with improvements in children's mental health symptoms. Cross-system collaboration is also linked with decreased disparities in mental health service use between African-American and White children.

National child welfare and mental health policy are converging, providing catalysts for change. The New Freedom Commission for Mental Health (2003) includes early identification and intervention as one of six goals to transform the public mental health system. The Child and Family Services Review (CFSR) of state child welfare systems found that 69.9% of reviewed cases across all states were in substantial conformity with Well Being Outcome 3; that children receive services to meet their physical and mental health needs (USDHHS, 2005). For states not in substantial compliance with standards, a program improvement plan (PIP) is required. PIPs address systemic changes that impact day-to-day practice. To address deficits in child and family wellbeing, Indiana's PIP applies elements of cross system collaboration, planning, training, and monitoring.

The Initiative

A cross-system team has developed and is implementing the initiative as a model of effective services for children. Partners include the Indiana Family and Social Services Administration's Division of Mental Health and Addiction, Department of Child Services (DCS), Medicaid, Federation of Families, Department of Correction, Department of Education/Division of Exceptional Learners, the Juvenile Justice Quality Improvement Committee, and the State Budget Agency. Support from other stakeholders has been sustained through quarterly public meetings.

The initiative involves screening each child who is placed into substitute care or who becomes adjudicated as a Child in Need of Services (CHINS) for mental health risks or needs using the Mental Health Screening Tool (MHST; California Institute for Mental Health, 2002). The screening is completed by child welfare's family case managers. Children with identified needs are referred to a mental health professional for assessment and recommendations. The resulting reports inform the decisions of child welfare staff and children's families.

The cross system team focused on the child welfare mental health initiative with the intention of demonstrating that effective collaboration can more effectively meet the needs of children and their families. The theory of change was made explicit using a logic model (Hernandez & Hodges, 2003). The population of concern was identified, desired outcomes were clarified, common values were endorsed, an action plan with specific strategies was developed and an evaluation/quality improvement process was designed.

A curriculum was developed to train child welfare family case managers and supervisors to use the screening tool. In June, 2004, training for the Phase I sites began, including invitations to local mental health providers. Statewide implementation was scheduled to be complete in December 2004. Local plans were developed in each of 92 counties, identifying timelines, contacts, mental health providers, referral and report content, and payment for services. Most assessment services are being billed to Medicaid.

Methods

No one database contains the information needed to monitor and evaluate the implementation of the process and its effectiveness in better addressing children's wellbeing. The child welfare system has data regarding demographics; abuse and neglect; children placed in substitute care or who are CHINS; completion of the mental health screening; findings of the screening; and changes in placements. The mental health database includes diagnosis, substance use, a functional assessment (Newman et al., 2002) and the Restrictiveness of Living Environment Scale (ROLES; Hawkins, Ameida, Fabry, & Reitz, 1992). The database is limited to children enrolled by contractual providers of the public mental health system. Medicaid claims data include behavioral health diagnosis, type of provider, specialty of provider, services provided (including assessment and treatment), and costs. Claims data will report assessment activities and treatment by a wide range of providers. Shared, this data can follow the screening, assessment, and treatment process for children in the child welfare system. Patterns of services can be followed in the short term. Predictors of failed placements and permanency may be identified. The effectiveness of the early identification and intervention initiative can be studied. Sharing data across systems has not previously been used to study Indiana's child services.

The initial evaluation plan calls for the development of a benchmark from SFY2004 data, using an unique identifier created by Integrity software across systems, and sending data to Indiana University for matching and analysis. As there will be a six month delay in availability of data due to matching and quality concerns, evaluation outcomes such as changes in functioning, service utilization, and cost will be completed in the future. Initial reports will focus on implementation of the initiative, using the information for feedback and quality improvement. A qualitative review of local implementation plans and comments from the field supplement this database. Data from Department of Child Services regarding the screening process, number of children eligible for screening, actually screened, and screening results are reported monthly to local child welfare agencies and shared with stakeholders quarterly.

Results

Cross-system Training. The training focused on the use of the screening instrument and completing the screening tool in ICWIS (Indiana's SACWA system). Over 30 training sessions were held statewide. Anecdotal feedback from stakeholders indicated that some local child welfare and mental health staff traveled to the training together, strengthening their relationships. To others, the purpose of the screening initiative, and how it could help improve the child's well being, was not always clear. Local child welfare staff were not always aware of the local plan. Training about child development, especially early childhood developmental and mental health issues is needed. Child welfare staff, after using the screening tool, with its built in prompts to aide decisions, have requested similar prompts for other assessments. Some mental health and child welfare staff did not see any need for the training.

County Implementation Plans. Based on 41% of plans (38 of 92 counties), referral methods, anticipated volume of referrals for assessment and source of payment were analyzed (Wright & Lawson, 2005). Local communities expected to be making 10 to 240 referrals per month for assessment by a mental health provider with a mean of 86. The process for initiating referrals includes use of fax (59%), e-mail (8%), phone or mail (2%), and no explicit referral process for 24% of the plans. Medicaid was mentioned as the source of payment for assessment by 89% of the communities. There was little mention of the source of state match.

Early Implementation. As the process was implemented between July and December 2005, critical issues emerged, identified in Table 1. The initiative was implemented statewide January 2005. Table 2 summarizes January – March, 2005 screening data from Indiana's Department of Child Services. Sixty-six percent of children who were screened had identified mental health risks.

Table 1
Emerging Critical Issues: Continuous Quality Improvement

Issues	*Responses*	*Successes & Challenges*
General Issues	Monthly Team Meetings Quarterly Stakeholder Meetings Questions & Answers Applied for juvenile justice grant for Qi & coordinator	Problem Solving Questions continue to come to members of team and child welfare or mental health staff. Grant renewed
Should mental health assessments be standardized?	Assessment Committee	Preliminary Standards: principles recommended. Considering cross-system standard tools/processes
Involvement of biological parents and caretakers in assessment?	Reviewed shared values: Child & family centered	Part of recommendations.
Timely connection to assessment, treatment and support?	Part of CW QA Review Process Monitor with evaluation of shared data Encourage regular local cross-system meetings.	Mental health centers report slower than expected level of assessment referrals.
Early Childhood Assessment and Services?	Consultation from Child Development Center, Riley, and Infant & Toddler Mental Health Association.	Part of new grant with small training/consultation planned for child welfare trainers, foster parents, and providers
What if child is already in treatment?	Ask provider for update; new assessment can be requested by child welfare.	

Table 2
Summary Screening Report (January – March, 2005)
Indiana Department of Child Services

Screening Status	*Number of Children*	*% of Children*
Not Screened	427	25.2
Rescreen*	438	25.9
No identified mental health risk	280	16.5
Identified Mental Health Risk – Refer	130	7.7
Identified Mental Health Risk – Urgent	419	24.7
Total	1694	100.0

*Rescreen in 30 days, insufficient information to screen

Discussion

The short time frame requires change in both the child welfare and mental health systems. Full implementation of the early identification and intervention initiative will involve routine screening, getting children with identified mental health needs assessed, and accessing timely, effective treatment for children and their families. Early implementation data suggest a high level of compliance in the screening process and documents a high level of mental health needs. The initiative's progress and challenges support the need for collaboration and leadership from the child welfare and mental health systems to achieve cross-system changes to improve the quality of services which focus on the wellbeing of children who have been abused or neglected.

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"You Had Me at 'Hello'" Characteristics of Culturally Proficient Initial Engagement Practices

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Introduction

There is a large gap between need and capacity for children's services throughout the United States. Yet even when help is available, professionals are consistently challenged in engaging families and delivering care for children with mental illness. This challenge increases when poverty, cultural and language barriers are present; in such cases, families frequently do not appear for appointments and are lost to follow-up.

In a study aimed at examining the special access barriers faced by children in poverty, results showed that 39% of children scheduled for intake appointments at a clinic serving low-income and minority children were no-shows (McKay, McCadam, & Gonzales, 1996). A key factor in getting and keeping children and their families in treatment is recognizing the challenges families face in seeking services (Staudt, 2003). However, even when ecological and total service delivery approaches are used, the drop-out rates range between 26%-29% (Staudt, 2003). This suggests that even when appropriate resources are available, some families may need additional clinical strategies in the form of sustained but respectful outreach in order to use them.

The Massachusetts Mental Health Services Program for Youth (MHSPY) provides home and community based clinical and wraparound services for children with serious emotional disturbances who are at risk of out of home placement in an original and replication site (Grimes, 2004). MHSPY is a voluntary, strengths-based, model of care coordination that is family-driven and strives for cultural proficiency. This paper examines the relationship between innovative engagement techniques with diverse, Medicaid enrolled families and chances for success in program retention.

Method

Eligibility for referral to the MHSPY program includes Medicaid enrolled youth between the ages of three to 18 years. These youth are identified by juvenile justice, mental health and child welfare agencies or school personnel and referred from within the five target cities in Massachusetts. Many of the youth and caregivers referred to the program have long histories of previous attempts at service provision, often without success, and the charts carry indications of "non-compliance" with traditional patterns of care delivery. Seventy-nine percent of all youth enrolled in MHSPY have services from two or more additional state agencies, in addition to Medicaid. Historically, over 80% receive Special Education services. Sixty-eight percent (68%) of the program participants are males and fifty percent (50%) are children of color. The average age is fourteen and the average CAFAS (Hodges, 1998) score at entry is 116, well within the clinical range anticipated to need intensive services, possibly out of home.

A MHSPY stakeholder agency (child welfare, schools, juvenile justice, mental health) initiates contact with a family and introduces the idea of a referral to MHSPY. This is the first of several exchanges regarding the needs of the youth and the possibility of help for the family. Next, if the family agrees to have a consultation about program participation and benefits, the MHSPY Enrollment Manager, a licensed social worker, schedules an appointment with the caregiver for an initial interview. In addition, the caregiver and youth are sent a reminder letter and are called the day of the appointment. The program is entirely voluntary and a series of consents must be signed for participation. The program is exceptionally sensitive to the family's capacity to engage in the referral process. The Enrollment Manager makes accommodations to facilitate the engagement process by making multiple appointments, if necessary; reading or speaking at a level that facilititates understanding of the materials; being flexible in scheduling meeting times, and addressing individual needs as necessary (such as bringing food or refreshment if family is in need of it). Family contracting, over the purpose of the referral as well as the process, is a key component to the initial engagement phase and represents the second of the conversations identifying needs and offering hope. The Enrollment Manager also speaks in detail with the referring agency staff member, working to align the hopes of the agency with those of the family within the scope of the MHSPY process.

The program uses a number of measures to assess level of functional impairment, social competencies, and social support. Each caregiver and youth age 11 or older is interviewed at enrollment, and every six months thereafter, in order to complete standard functional measures and other program evaluation instruments. The Enrollment Manager also requests permission to collect all treatment and school records. Explanations to families and caregivers as to the purpose behind accessing these records (to allow for a broader understanding of the range of services the youth has received, facilitate collaboration with current providers, and inform our practice) serve to further establish mutual respect and trust.

Decisions about prioritized entry into the program are made by the community-based team of stakeholders based on need as reported by the caregiver and the referring agency. At times, capacity exceeds demand and referrals are required to wait to enter the program. While the youth and family wait for enrollment, the Enrollment Manager remains in contact with both the family and the referring agency. Each is encouraged to continue to update the program on any changes in the youth's status.

Once the youth is enrolled, the family is visited by a Parent Partner to extend a welcome from someone who has "walked in the family's shoes." This exchange adds still another layer of relationship-building for caregivers and process explication about what to expect. Finally, all of this is followed by the initial and follow-up meetings with the MHSPY Care Manager. The Care Manager, a social worker experienced in working with youth and families, acts as a team coordinator and process facilitator. At this stage, the needs and strengths identification begun by the Enrollment Manager is picked up and taken forward by the assigned Care Manager in an interactive care planning process of discovery and mutual empowerment. Each family's unique culture informs and guides the individualized care plan created by the care planning team of people the family invites to participate (professionals and natural supports) so that goals and interventions are expressed in language that can be "owned" and endorsed within the home. The enrollment and care planning procedures are intentionally interwoven so that the family never feels dropped or abandoned in the process and there are a series of "re-contracting" steps throughout.

Results

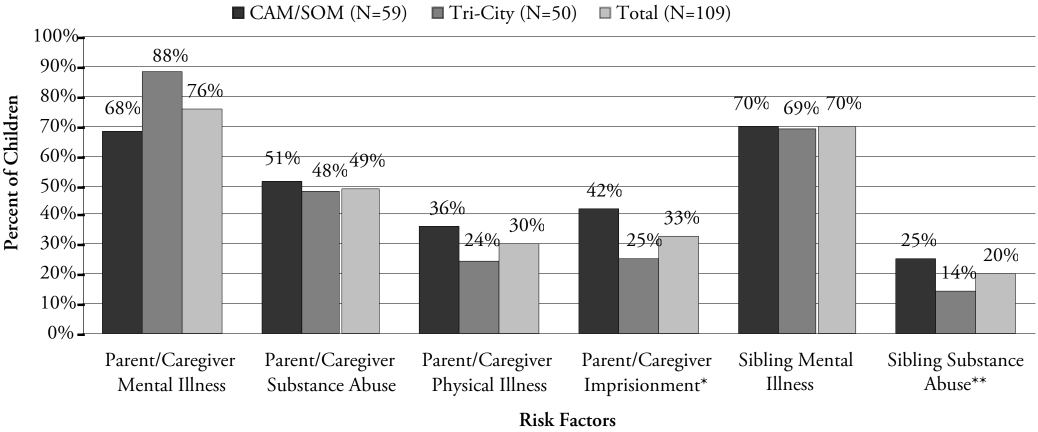
A record review for youth enrolled between 2003 and 2004 revealed that 77% of MHSPY youth had caregivers who suffered from mental illness, 50% of the caregivers reported problems with substance abuse, and 57% of caregivers had experienced domestic violence (see Figure 1). Yet, in contrast to the typical drop-out rates of over 50% for such highly burdened families, MHSPY has consistently experienced a 3% drop-out rate and an average length of enrollment of 21 months (see Figure 2).

Discussion

The Massachusetts Mental Health Services Program for Youth (MHSPY) is a system of care that serves vulnerable youth ages 3-18 from diverse backgrounds who face multiple medical, mental health, educational and other needs which put them at-risk of out of home placement. Funded through a unique collaboration of state agencies, MHSPY is given flexibility to work individually with youth and families in cultivating sustainable, community based support systems for each child and family. The first step in creating sustainable support is to engage and support caregivers in the process, so they can direct their children's care.

The initial visit(s) to the home are by the MHSPY Enrollment Manager who focuses on getting to know the youth in the context of the family, school and community. These visits also (a) clarify expectations and address concerns about the process and procedures, (b) establish a collaborative relationship, (c) focus on immediate and practical concerns, and (d) address barriers to help-seeking (McKay, Stoewe, McCadam & Gonzales, 1998).

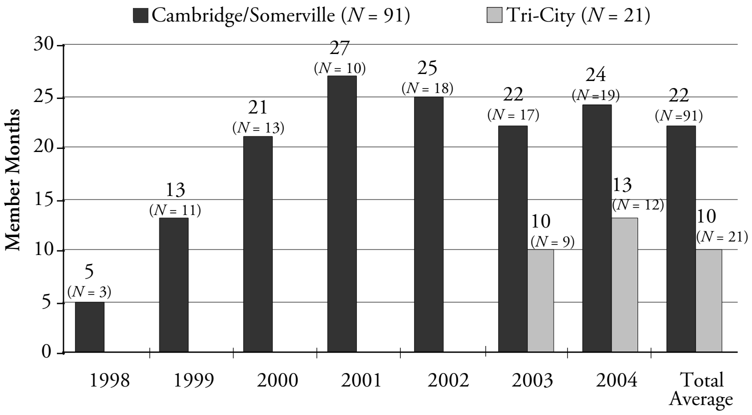
Figure 1
Family Risk Factors for MHSPY Members July 2003 – December 2004



*Data collection for this category of risk began 7/1/04. (Total N=15)

**Based on data collected between 7/1/04 - 12/31/04, approximately 50% of teenage siblings use alcohol or other drugs.

Figure 2
MHSPY Annual Mean Length of Enrollment in Member Months by Disenrollment and Site
March 1998 – December 2004



The shared process of completing the many forms for eligibility determination and the protocols for baseline data collection strengthens the connection between the clinical program representative (the MHSPY Enrollment Manager) and the family, and establishes a contractual relationship. The forms are completed at entry by the caregivers, youth, teachers or counselors, in part based on motivational concepts that demonstrate a level of shared commitment to the process (Deane, 1991). Furthermore, the forms serve to facilitate conversation about needs and experiences of the youth and family and help lay the foundation for the subsequent definition of the family mission for the child.

The initial engagement phase is shaped by social exchange theory, which proposes that power, equity, and the creation of commitment are fundamental in human interaction and integral to the bargaining processes. Appointments are always scheduled in the family home or a public place of their choosing with sensitivity to power dynamics, mistrust of service providers, and the possible family or cultural belief that services will not help. In addition, home-based engagement responds to transportation, time, and childcare barriers. Furthermore, it allows the family to "tell their story" in their natural environment and native language and to conduct ethnographic observations of the family system, including gathering information about family strengths.

The persistent, non-judgmental outreach by the Enrollment Manager, with the emphasis on responding to and understanding the family-defined need is viewed as a critical first step in the development of engagement in care. The intentional gathering of information, in the family's words, regarding reason for referral, history of previous care received, persons who are currently experienced as resources, and hopes for the child at the heart of the referral, deepens the family engagement. The joint processes and rituals around completion of forms and the accomplishment of repeated meetings carry the family past the threshold of most attempts at clinical care delivery. Should there be a waiting list, the Enrollment Manager takes responsibility to maintain and foster the newly established relationship with both the family and referring agency during the waiting period. Throughout the process of enrollment, the community-based team continues to assess the needs of the youth. When a youth is enrolled the program makes every attempt to match the competencies and interests of the Care Manager, who acts as the process facilitator, with those of the youth and family. The caregiver is also offered the opportunity to partner with a Parent Partner through the process. Ultimately, 98% of the families who enter the MHSPY program, most of whom are referred based on great difficulty reaching them and/or providing services to their children, establish a connection and continue to participate for the duration of the process. This is a testimony to the engagement opportunities available in strengths-based systems of care.

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Comparing Needs and Strengths of Crisis and Elective Admissions to Children's Acute Care Inpatient Services

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Introduction

This study was part of a comprehensive outcome evaluation of psychiatric and mental health inpatient services at the Children's Hospital of Eastern Ontario (CHEO). CHEO is a tertiary care, pediatric teaching hospital in Ottawa, Ontario, Canada, that serves Eastern Ontario, Western Quebec, and Baffin Island. This represents a catchment area of approximately 600,000 children ages 18 years and under. In 1997, provincial directives placed CHEO in the lead for delivering specialized psychiatric and mental health services to children and youth. This led to an overall increase in the number of beds for inpatient services at CHEO and specific funding to create a new 10-bed inpatient unit for children aged 12 and under, which opened in September 2003. Prior to this, children's psychiatric inpatient services were offered at the local psychiatric hospital in the form of a six to eight week treatment program. The creation of the Child Inpatient Unit at CHEO represented a dramatic shift both in philosophy and model of care, as inpatient services were now focused on providing crisis stabilization and comprehensive, interdisciplinary assessment.

The goal of the Child Inpatient Unit is to reduce, not eliminate, level of risk and symptoms, and to facilitate reintegration of the child into his or her family and community environment for ongoing care. To this end, the target average length of stay is 14 days. In addition to stabilization and assessment, the services provided include diagnostic clarification and formulation, medication review and/or adjustment, and treatment planning. Children are not admitted for a first-line assessment or diagnosis, or when the sole purpose is to provide respite to parents or caregivers or for court-ordered or custody and access assessments.

This new model of inpatient service also provided an opportunity to adopt a clinical outcomes management approach by placing central importance on the clinical information about the children, youth and families served to inform and manage decision-making at different levels of the system (Lyons, 2004). This approach was operationalized by fully integrating program evaluation activities within the clinical service, and using the clinical information for assessment and treatment planning and for informing the service at all levels.

The objectives of the current study are to review the first 15 months of data from a new psychiatric inpatient service for children, and to identify the similarities and differences between children admitted to the unit following an acute crisis versus those admitted by way of a planned, elective admission. These data will help determine whether the newly designed unit is serving its mandated population of children with acute, severe, and complex needs who are experiencing difficulty functioning in a less restrictive setting, and will inform the system of the role of appropriate hospitalization within the system of care.

Method

Participants were drawn from 122 children (age 5 to 13 years) consecutively admitted for crisis stabilization and/or assessment to the Children's Inpatient Unit between September 2003 and December 2004. After excluding readmissions, parents or guardians of 104 children gave informed consent for the use of clinical information for research purposes, for a 98% consent rate. Twenty-four children (23%) were admitted following a crisis presentation to the Emergency Department, whereas 80 children (77%) were admitted directly to the unit on an elective basis. As part of routine patient care, demographic and treatment history data were collected, and standardized measures of emotional and behavioral functioning, family functioning, and parenting stress were completed at admission by the children (age and ability taken into consideration) and their parents or caregivers. Members of the unit staff completed the Child and Adolescent Needs and Strengths-Mental Health (CANS-MH; Lyons, 1999) and Childhood Acuity of Psychiatric Illness scale (CAPI; Lyons, 1998) for each child at admission. The CAPI is a 20-item outcome measure designed to monitor change in acute care settings, and serves as the primary outcome measure. It can be used repeatedly over brief time intervals and takes 5 to 10 minutes to complete. The CAPI yields a Total score and four subscale scores: Risk Factors, Symptoms, Functioning, and Systems Support. CAPI ratings are based on the previous 24-hour period (i.e., prior to admission or prior to discharge/transfer).

Results

Overall, the crisis and elective groups were more similar than different. However, there were several noteworthy differences between the groups. Compared to elective children, children admitted in crisis were older (10.5 vs. 9.3 years), $F(1,102) = 6.12, p < .015$, more likely to be admitted with no clear diagnosis (33% vs. 11%) or with a primary diagnosis of depression (21% vs. 1%), and less likely to have a primary admission diagnosis of behavior disorder (13% vs. 58%), $\chi^2_{(Dx)} = 41.91, p < .001$. The crisis group was also more likely than those admitted electively to present with suicidal ideation at admission (92% vs. 61%), $\chi^2 = 7.89, p < .005$. Significantly higher ratings were observed on the CAPI for the crisis group on items measuring acute risk behaviors, $F(1,101) = 23.08, p < .001$, and symptoms, $F(1,101) = 9.13, p < .005$. In contrast, children admitted electively were more likely to have had chronic and persistent mental health difficulties. History of community-based mental health treatment was significantly more frequent for the elective group compared to the crisis group (98% vs. 79%), $\chi^2 = 9.88$, $p < .005$, although the majority of children in each group had received community-based services.

Length of stay differed significantly between the groups. Children admitted in crisis were discharged after an average of 10.5 days, whereas average length of stay for elective admissions was 16.9 days, $F(1,102) = 30.98, p < .001$. Discharge diagnoses also varied significantly according to type of admission, $\chi^2_{(Dx)} = 21.86, p < .005$. Children admitted in crisis were more likely to be discharged with a primary diagnosis of depression (13% vs. 3%) or adjustment disorder (21% vs. 3%) than children admitted electively, who were more likely to have a diagnosis of behavior disorder (60% vs. 33%) or anxiety disorder (10% vs. 0%).

Despite these differences, the groups were much more similar than different overall. No differences were observed for gender distribution (majority male), living situation or guardianship (one or both parents), school placement (some level of special education support), or discharge destination (same living situation). Both groups of children had moderate to severe difficulties with functioning at home, school, and with peers, as evidenced by high ratings on the CAPI and CANS-MH measures. Furthermore, average ratings for each group did not differ along any dimension of functioning. Both groups also had moderate treatment needs, primarily due to the use of daily medication. There were no group differences in the profile of current involvement by various professionals (e.g. family physician, psychiatrist, psychologist, social worker or other counselor) or in history of hospital-based mental health services. No differences between the crisis and elective groups were noted on dimensions of caregiver needs and strengths on the CANS-MH. Modal ratings for both groups noted mild deficits for the caregiver's provision of appropriate supervision, involvement with the child's treatment, and knowledge of the child's needs and strengths. Similarly, no differences were observed for the strengths items, with both groups showing evidence of stable relationships over time, adequate interpersonal skills, and optimism. Finally, no differences were observed at discharge on the CAPI, with all mean ratings on risk behaviors and symptom items less than 1 (*mild*).

Discussion

Children access acute care inpatient services by two different routes. Data from the first 15 months of a new Children's Inpatient Unit support the presence of different needs that are in keeping with the child's initial presentation to the unit. For example, children presenting in crisis are more likely to require stabilization of suicidal ideation and behavior and symptoms of depression or psychosis. However, the data also suggest that both children in crisis and children admitted electively to the unit have longstanding difficulties with functioning at home and school and have had extensive contact with mental health professionals prior to coming to the hospital. Profiles of caregiver needs are also highly similar.

The data lend support to the notion that these two groups of children are actually from the same population of children with acute, severe, and complex needs for which the inpatient service was designed. Thus, the unit is meeting its mandate as a tertiary care hospital setting within the broader system of care. The data suggest that the children admitted electively and their families may in fact be at high risk for future crisis situations, and that this may be prevented by admitting the child before the situation escalates. Thus, the unit can respond to children's urgent versus emergent needs and provide stabilization or comprehensive assessment. Furthermore, understanding the clinical needs of the children and families served leads to the development of evidence-based approaches on the unit. Therefore, the data inform the inpatient team about the shared and unique needs of the children who access the service through different pathways and guide the future development of the service. This ultimately leads to better service that is individualized to accommodate children's specific needs.

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