# Developing a Comprehensive Acute Mental Health Care Plan for Children

**Prepared by**

**Associated Provider Network**

**In Collaboration with**

**NorthSound Regional Support Network**
**DCFS Region 3**

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## Introduction

Associated Provider Network (APN), with the collaborative support of the NorthSound Regional Support Network (NSRSN) and Region 3 Division of Child and Family Services (DCFS), competed for and received a planning grant from the Washington State Department of Health to engage in a five county planning process regarding children's acute care services. The project specifically targeted development of best practices for delivering acute care services to children and families within the five county area, which includes small city, suburban, and rural segments and has no immediate access to a children's inpatient unit. The context for the planning project:

- APN has worked collaboratively in the last several years with NSRSN and Snohomish County in a Snohomish County planning process for children's acute care services that resulted in the creation of a children's crisis team and other acute care alternatives.
- NSRSN and APN are now at risk for inpatient Medicaid costs; savings in acute care can be applied to new program development.
- In 1998, children accounted for 34% of NSRSN Medicaid inpatient days, with an average length of stay of 15.5 days.
- All NSRSN inpatient stays for children were out of region, principally at Fairfax, Children's Hospital and Medical Center and Overlake. The average charge was $401/day or $6216 per admission.

A Planning Committee was convened with representation from APN, NSRSN, DCFS, families, substance abuse services, developmental disabilities services, and schools. This committee met regularly to oversee the project and its multiple information gathering aspects:

- Development of best practice information from state and national sites
- Review of stakeholder feedback from the five county area
- Case review of a sample of high need cases served by NSRSN and DCFS in FY98/99; four case review teams used a case conference method to look at the sample of cases. Each team was comprised of an APN clinical director/supervisor, a NSRSN children's resource coordinator and a DCFS staff worker.
- Data collection and analysis regarding users of inpatient services and out of home care and their overall use of system resources

The following report summarizes the information gathered, the system learnings that were identified and the priority actions recommended by the Planning Committee.

## Vision and Values

### *Vision*

Children and adolescents who are thriving in least restrictive environments with "parent people" who are committed to them over time (forever).

This means:

- Preservation of families
- Prevention of out-of-home placements and/or placement disruptions due to mental health symptoms
- Empowered children and families who do their own problem solving and decrease their reliance on formal systems
- Increased availability of in-home services to support parents
- Reduced psychiatric hospitalizations, lengths of stay and recidivism
- Improved outcomes from psychiatric hospitalizations
- Increased availability of intensive, community-based treatment options
- Increased skill levels for parents and providers
- Timely access to psychiatric services
- Services that are culturally competent
- Access to substance abuse services as well as mental health services
- A region-wide system of crisis response services designed to meet the specialized needs of children
- A continuous effort to decrease the stigma experienced by children and families, especially when receiving services in other systems such as education or healthcare

### *Values*

- We value families
  - Consumers and families shall, at all times, be treated with dignity, respect, courtesy and fairness
  - Consumer and family voice is a core value
  - Consumer and family satisfaction is a core value
  - People with mental illness are best served by people who care about them
- We believe in the strengths of families and the power of the family to change'
- We believe that children belong in families, not institutions
  - Community based care is better care
  - The right service at the right time produces the best outcome with the least emotional and financial expense
  - Stable nurturing placement is key to health child development and a necessary component in the healing of mental/emotional disturbance in children
  - Over reliance on facility-based care undermines our investment in the development of community based services
- We believe that individualized and tailored care is better care
- We believe that consumers, families and communities must be safe
- We believe that collaboration improves care and that the best systems of care for children are seamless within and across various child-serving systems

## Best Practices Nationally and in Washington State

### *Background*

The development of best practices in serving severely emotionally disturbed (SED) children and youth had its beginnings in the mid 1980s when the National Institute of Mental Health (NIMH) created the Child and Adolescent Service System Program (CASSP) with the purpose of assisting state and local groups in the development of comprehensive systems of care.

A milestone in the development of the system of care concept was the release of a monograph produced by Beth Stroul and Robert Friedman under the auspices of the CASSP Technical Assistance Center at Georgetown University and the Florida Research and Training Center for Improved Services for Seriously Emotionally Disturbed Children at the University of South Florida. The monograph, A System of Care for Severely Emotionally Disturbed Children and Youth[i] took the first steps in describing a system of care framework. This framework described seven key components [mental health services, social services, educational services, health services, vocational services, recreational services, operational services] that should be available. Appendix A contains a diagram of a System of Care and a listing of the types of services that should be available in each of the seven components.

Dr. Friedman subsequently proposed a "balanced system" for SED children based upon research in South Carolina, Florida, and Vermont. This work was utilized by the State of Washington Mental Health Division (MHD) in the development of a statewide action plan, Our Children Our Future.[ii] This document described the model for a balanced system of care and projected Friedman's model across Washington State's child and youth population. Appendix B contains a segment of the MHD plan with Friedman's model as well as the data projected at the time for the NSRSN relating to service volumes and potential demand for services. This Appendix also contains an updated version of Friedman's model applied to the current population of the NSRSN five county area.

At the time Dr Friedman developed these estimates, he was working from a body of research that estimated prevalence of "clinical maladjustment" at 11.8% of the population, and SED at 5% of the population. In the MHD document, it is estimated that the public mental health system should plan on delivering services to 6.7% of the population under the age of 18.

Children with serious emotional disturbance may also be eligible for special education and related services under the individuals with Disabilities Education Act (IDEA); however, researchers estimate that nationally, only 1% of students are identified and referred for necessary services.

According to a newly released NAMI study, Families on the Brink[iii], a 1999 NIMH report states "one in ten children and adolescents suffers from a mental illness severe enough to cause impairment". The NAMI report goes on to state that "the most recent statistics

available show suicide to be the third-leading cause of death among youth aged 15 to 19 years and the second-leading cause of death among youth 19 to 24 years of age….these rates have tripled since 1960.”

The NAMI study, which focused on the experience of families and children in their attempts to obtain adequate and appropriate services, makes the following recommendations:

- Increased research on the prevalence, nature and effective treatment of serious mental illness in children and adolescents to better guide clinical care and public policy;
- A campaign to educate health and school professionals about serious mental illness in children and adolescents so we can improve early detection of these brain disorders and provide proper care and services and supports for children and their families;
- An end to health insurance discrimination against serious mental illnesses in children and adults at the national level;
- The passage of national requirements to improve access to and quality of care in managed care systems—the passage of a managed care bill of rights;
- An end to the requirement that caring families relinquish custody of their children with serious mental illnesses solely to gain access to needed care;
- Needed training of juvenile justice officials about the screening for and appropriate treatment of youth with serious mental illnesses who enter this system;
- High standards for the application of restrain and seclusion to children in the treatment system to eliminate the risk of harm to these young people with serious mental illnesses while they are in the hospital or residential treatment facilities; and
- A national campaign focused on ending the stigma and discrimination that surround serious mental illness in children.

### *Systems of Care*

How have communities gone about trying to address these issues? The national focus over the last ten years has been on the development of systems of care (SOCs), and the “best practice” literature that has emerged from this work is rich with the learnings of communities and their accomplishments.

The SOC approach is, first of all, a philosophy: that children’s needs are best served when care is integrated and coordinated across providers and when that care is child centered and family-sensitive.[iv] Services are provided along a “continuum of care”, in which children are placed in the least restrictive setting possible. An explicit goal of most SOC efforts has been to reduce inpatient and residential treatment utilization, but to do so requires the development of sufficient alternatives. The key to system development has been collaboration among all stakeholders, including families.

The 1997 Comprehensive Community Mental Health Services for Children and their Families Program, sponsored by the Child, Adolescent and Family Branch of the Federal Center for Mental Health Services, has supported system development through the work of 22 grantees in 31 communities. This effort has been documented in Systems of Care: Promising Practices, a series of seven monographs about these communities.[v] In the monograph on lessons learned, the submissions from the sites fell into five areas:

**Family Involvement/Family Empowerment**

- Involve families from the very beginning of system design and development
- Multi-level family involvement, at both the individual case level and the system level, ensures that family involvement is not "tokenism'
- Family members can plan key roles as trainers, data collectors and direct service providers
- Include parent advocates on the service provider team
- Trust is necessary to build and maintain positive relationships among new partners
- Integration of a family perspective in all training and technical assistance activities is important
- Hiring parents is not enough, it needs to be coupled with a commitment to change practice

**Cultural Competence**

- Cultural competence is not just a training session, but a roadmap for how our work should be conducted as we build and implement systems of care
- Be aware of federal rules, especially Medicaid, when beginning a project in a culture that has a different language and different cultural beliefs from Western culture

**Systems of Care**

- Systems of care must be folded into the community's existing governance and infrastructure
- A sustainable approach to working with local systems is to contract with them for services to the target population as an alternative to costly residential treatment
- Stationing a mental health worker in each of the juvenile court offices to serve as a liaison is an example of how partnerships can be developed
- A Mobile Community Support Service that brings the needed services directly to the schools build successful partnerships
- Comprehensive training for staff and families at all levels is necessary
- Working with a wide array of providers including domestic violence programs, child-care centers, and youth service bureaus, builds a true community response to the system of care
- Involving the non-traditional mental health providers, such as the police can build strong community based partnerships for the system of care

**Evaluation**

- Evaluation must be an integral part of the system of care
- Data from integrated systems of care evaluation can be an effective navigational tool for systems change

**Managed Care**

- Incorporating system of care values into the managed care goals can bring greater effectiveness and "humanness" to the overall service delivery system
- Merging of system of care values with the need to contain costs in a managed care environment can be a daunting task.

## *The Role of Families*

The monograph on family involvement[vi] as a promising practice looked beyond the ways families have been participating in SOCs:

- Families as collaborators
- Families as advisers and advocates
- Families supporting one another
- Families providing community based services

The focus was to identify new roles, using the following criteria: a paid position with SOC funds, operational for at least a year, impacting directly on the implementation of

the SOC, and not a role/function that family-run organizations have historically provided. They found two models (provided under a variety of job titles in multiple sites):

- Families as system of care facilitators. These family members use their own experience as well as specific training regarding the system to help families become familiar with the system of care, effectively participate in it and gain access to quality services. [Rhode Island, Kansas, Illinois, Maine]. The lessons for success that were identified included:
  - ✓ Willingness to work with families as equals must be genuine
  - ✓ Expectation should be clear and specific
  - ✓ Support from families and agencies is required
  - ✓ Policies and procedures have to value the way families live and work
  - ✓ Compensation should be based on level of responsibility, not a degree
  - ✓ Training and supervision are essential
- Families as faculty. These family members are engaged in training providers in the community and future providers in a university setting. [Hawaii, North Carolina, Maine]. The lessons for success in these settings included:
  - ✓ SOC philosophy needs to be taught in colleges and universities
  - ✓ Patient and persistent leadership from the top is essential
  - ✓ Key supports facilitate the role of family as faculty
  - ✓ Evaluation of outcomes improves teaching and gains support for family as faculty.

### *Collaboration*

"True collaboration", as distinct from rules, mandates and agreements on paper, or coordination of services or cooperation between individual agencies, is described[vii] as a "revolution in consciousness and a revolution in practice", having the following characteristics [East Baltimore, MD, Kansas, Lane County, OR, North Carolina, Rhode Island, San Mateo and Ventura County, CA, Vermont, Stark County, OH]:

- Role clarity for families and service providers
- Interdependence and shared responsibility among collaborating partners
- Striving for vision-driven solutions; and
- A focus on the whole child in the context of the child's family and community.

Collaboration in SOCs is defined as "the process of bringing together those who have a stake in children's mental health for the purpose of interdependent problem solving that focuses on improving services to children and families". The process of building collaboration has led to the following key learnings:

- Collaboration must occur at multiple administrative levels within a child-serving agency and across the multiple agencies that provide services for children and families.
- Building collaboration is a developmental process that takes time and considerable effort.
- The emergence of families as full partners in systems of care is the key to true and lasting collaboration.

The components of successful collaboration are:

- Shared goal or vision
- Speaking the same language
- Trust and commitment
- Maintaining autonomy
- Respect for diversity
- Clear roles and responsibilities
- Governing structure
- Personal choice
- Evaluation

In support of the development of collaboration, the Robert Wood Johnson Foundation (RWJ) established the Mental Health Services Program for Youth, granting resources to communities to support collaborative efforts and blended funding models. A study that focused on Multnomah County, Oregon, looked at what happened when the RWJ funds terminated, specifically to the network of relationships.[viii] The study identified that the level of information exchange was somewhat lower one year after the RWJ funds were terminated. However, it found that information exchange was still quite extensive and hypothesized that the reported problems of fragmentation may be at another level than the system level. It was suggested that there is a need to concentrate more on "the pragmatics of ongoing coordination, such as joint agency training, the appointment of liaisons between agencies, and standardized referral and information exchange procedures….most importantly, if workers are given neither the time nor incentives to become involved in interagency coordination it cannot be expected to happen".

### *Wraparound*

"Wraparound is a philosophy of care that includes a definable planning process involving the child and family that results in a unique set of community services and natural supports individualized for that child and family to achieve a positive set of outcomes."[ix]

The practice requirements associated with wraparound include:

- Community collaborative structure
- Administrative and management organization
- Referral mechanisms
- Resource coordinators to facilitate the process
- Strengths and needs assessment
- Formation of the child and family team
- Interactive team process and formation of a partnership to develop individualized plan
- Development of a crisis/safety plan
- Measurable outcomes monitored on a regular basis
- Review of plans by the community collaborative structure

For example, in Wrapround Milwaukee [which actually enrolled over 175 children], the "25 Kid Project" focused on the population of children that were of greatest concern to

stakeholders: those placed in residential treatment centers at a cost of $50,000 or more per placement. The goal was to "develop a pilot project for up to 25 youth, enroll them in Wraparound with a case manager, identify services needed by the families, access those services through the various agencies in the provider network, have a pool of flexible funding available for services not available in the network, and offer the availability of the mobile crisis team to deal with crisis needs."[x] The results were documented at intervals of six months, one year, and two years. At the end of one year, 22 youth had moved back into the community, of which 3 needed to be placed back in an institutional setting. Of the 19 remaining in the community, 12 returned to home or that of a relative, 7 were in foster care. All but one child was attending school on a regular basis, and only four committed new delinquent acts. The average cost of community placements was $1564 per month versus $4,700 per month in residential treatment costs.

Appendix C summarizes the elements essential to the wraparound process [if it isn't happening, it's not wraparound].

### *Impact on Utilization of Intensive Services*

The sites associated with SOC development have been part of a rigorously evaluated process in order to understand the impact of the changes they have made. In California, eight counties have been involved in implementing a federal SOC grant. The materials in Appendix D provides a snapshot of the change process for several different counties:

- San Mateo County has a population of 715,400, close to the population base of the NSRSN. Consequently, its utilization data is of interest. However, it is a dense suburban county just south of San Francisco, not reflecting the mix of urban, suburban and rural settings found in the NSRSN. A complete copy of the San Mateo 96-97 report is included.
- Riverside County has a population of 1,441,200. However, it stretches from Orange County to the Arizona border with significant rural and desert areas. A summary of the major 97-98 accomplishments is included, along with a graph comparing Riverside's group home placements to the California average.
- Sonoma County has a population of 437,100, and is located north of the Bay Area, with a significant rural and suburban population and one city, Santa Rosa. A graph of youth hospitalizations by month, and a summary of data regarding these hospitalizations are included.
- Santa Cruz County has a population of 250,200. It is south of the Bay Area, between the ocean and the coastal range, also with both rural and suburban populations. A summary discussion of Medicaid funded acute inpatient utilization and state hospital utilization is included.

### *Washington State Practices*

As is apparent from the MHD Our Children Our Future report, there has been a conversation about implementing SOC concepts in Washington State for over ten years. For example, Appendix B contains a suggested referral protocol to be utilized by a cross-system collaborative body. Each RSN was required to create and submit a children's plan in the early 90s. In some communities, the collaborative process that was reflected in the plan still seems to be at work.

**King County**

King County's collaborative planning process of the early 90s resulted in the creation of regional Interagency Staffing Teams with access to a blended funding pool. They also created a multi-system policy group that included family representation, institutionalizing the ability to problem solve at the system level as well as at the individual family level. Another component of this collaboration was joint interagency training in which each system provides information to new staff entering any of the key systems.

King County has a population of 1.6 million. King County RSN uses a case rate payment system that enables flexibility on the part of MH agencies; it is a stratified rate, based on the level of care that is authorized. Case rates range from approximately $ 307/year to $8595/year for exceptional care services to children. In 1998, approximately 600 children received exceptional care services.

The basic elements from the original children's plan remain in place almost ten years later, having weathered the managed care transition. Having received a federal SOC grant, King County is now in the process of "fine tuning" its structures and processes. They key elements of the system are:

- ***The Regional Policy Team***. This group is made up of senior leaders from the systems serving children in King County. Families are also represented on this group. The group is charged with addressing the overarching policy issues affecting services to children. For example, they provided the structure and leadership to plan for management of inpatient services, the impact of the Becca Bill, and submission of the SOC grant.
- ***The Community Teams***. There are three regional teams (Central, East and South King County), made up of mid management representatives from child serving systems. There is a staff person to support each community team, jointly funded by MH and DCFS. The teams manage a shared pool of flex funds (MH and DCFS funded) and respond to requests from child and family teams for use of these funds. They also serve as the CLIP decision-making group for the region. These teams are also being used to respond to Becca Bill requests.
- ***Child and Family Teams***. These teams are the ones focused on the individual child and family. The teams are supported and facilitated by the regional staff person, who convenes the meetings and supports the families in the process. The focus is on problem solving, and development of natural supports.

- ***Interagency Training***. This training is provided every other month to any new staff person in any part of the system(s). The training is always overbooked. It regularly has staff from MH and DCFS, but has also included trainees from public health, juvenile justice, police and education. There are 12 presenters who review the basic facts regarding their programs. The training is being retooled to create a curriculum that is less "silo" driven and focuses on the shared processes of the SOC.
- ***Blended Funding Project***. This project was developed in the context of having the other components outlined above in place and functioning. The project currently is funded for 50 children/adolescents; the goal is to serve 90. It is grounded in managed care and in the delivery of nontraditional services. There is a Steering Committee [MH, DCFA, ESD, family representative] that reviews all applications for inclusion in the project. The Steering Committee is staffed by the Project Director. The Project itself is administered by ESD 121, which was selected as a governmental entity that all participants could transfer funds to for the purposes of creating a joint funding pool. The funding pool includes MH tier payments, DCFS group care payments and some JRA and school funds (DD is considering joining). When a child has been accepted, the child and family team creates a plan and draws down the funds to purchase the services needed, usually nontraditional services. Criteria for inclusion in the Project are: child has been served in the last 2 years by the traditional system and is not responding; the child is a current client in DCFS and either is now a MH client or meets MH criteria [most are at level 3b]. Referrals come through the system, via the regional interagency team coordinators, group care administrators, or other system's staff. The Federation of Families is evaluating the project, with one key outcome being the shift to a natural support team. The Steering Committee reports monthly to the Regional Policy Team.
- ***New Initiatives***. With the SOC grant, King County is working on improvements to the systems and processes above. In addition, it is planning to expand respite and parent support provided by families for families, and it is focusing on creating the transition bridge for 18 to 21 year olds.

**Pierce County**

Pierce County's collaborative planning process also created a multisystem policy group that has guided a number of initiatives over the years. One key to development of the Pierce County system has been the stability of leadership in the various systems over the last ten years.

Pierce County has a population of around 687,000. Pierce County RSN uses a case rate payment system that enables flexibility on the part of MH agencies; currently the RSN pays $530/month for services to children and $3300/month for homebuilders and CHAP services. They estimate that they have about 200 high risk/need children in their systems, and average about 8 admissions/month to inpatient services. A recent trend has been the emergence of referrals from CHAMPUS Tricare, non-Medicaid, families; they have exhausted their Tricare residential treatment benefits, usually in a setting distant from the family, and then turn to the public system to continue support of an out of home placement.

The RSN has about a 3% penetration rate for Medicaid children, but no turnaways and no wait lists, leading them to believe that needs are being met. This may be attributed to the efforts within Pierce County over the years to develop considerable early intervention services for families, including family support centers, ready to learn centers, and intensive home visiting for newborns in families at risk.

The RSN and DCFS have historically contracted with the same child serving agencies, which made split funding of individual plans easy to do. The current structure of DCFS group care purchasing has required adjustments, because of issues regarding the use of Title XIX funds in both systems. They adjusted to this by dividing up who would support which child, with each organization increasing funding per child. They are still putting in the same amount of funding for the same number of children, but it is no longer blended. Key elements of the Pierce County model include:

- ***Steering Committee.*** The formal collaborative process is now embodied in the Steering Committee, which includes MH, DCFS, parents, schools, and, as needed, DD and Juvenile Justice. This Committee reviews referrals for CLIP, CHAP, Homebuilders, and some group care requests.
- ***Shared Staff Coordinator.*** The Steering Committee is staffed by a person referred to as the "glue" of the collaboration: a position that is an employee of both the RSN and DCFS; it is jointly funded. This person works out of the DCFS office (where she works with the group care coordinator and has child placing ability) and the RSN (where she has the ability to commit resources above those already available in the community). Another key to success is the skills set of the specific individual and the respect and trust that has developed with all of the systems. The position responsibilities include:
  - ✓ Staff the Screening Committee
  - ✓ Act as a care manager and provide technical assistance and facilitation for child and family teams that are "stuck"
  - ✓ Train parents and collaborate with the parent organization, as well as support their work with families, schools, juvenile justice, child welfare and mental health
  - ✓ Make things happen (if it makes sense, do it) through use of DCFS exceptional cost system and/or RSN system
- ***Parent Advocacy Organization***. Another aspect of the Pierce County system is the parent advocacy organization, funded with a startup grant from the RSN and now staffed by 12 part time parent advocates and budgeted at $250,000. The organization provides training and support for parents and advocacy for parents in their interactions with the various systems. They recruit parent advocates through the school districts, where they identify potential candidates from those whose children have been in the IEP process. They train them and use advocates to do outreach to families that have been difficult to engage; as these relationships are built, the advocates stay with the families. The philosophical basis of their work is that parents are ultimately going to be responsible for their children, not the system and that natural supports and building on their own strengths must be a part of the process.
- ***Crisis Triage Center***. The creation of the Pierce County Crisis Triage Center three years ago also served an unplanned function for the system: as a diagnostic unit for the entire mental health system. Based on experience in emergency rooms, where not

many children or youth were being seen, the Triage Center didn't really plan to serve them. However, children under 18 represent slightly over 10% of the population served by the Center. The youngest child they have seen was four. It is the police who bring in these youngsters in crisis. The "swing" rooms are used for children, who are often coming from chaotic situations. If they are already being served by the system and have case aides, the aides are asked to accompany them; if they are under the age of 12, parents are asked to accompany them. While they frequently "deflate" within a few hours of arrival, at the time of the crisis, they cannot be handled in crisis foster homes or respite.

- ***Respite Foster Homes***. There are three foster homes, one for each mental health service area, each capable of serving 1-2 children for respite. These are used for planned respite, as a safety net, and sometimes for crisis respite. These are mental health funded services ($36,000/year per home plus $300/month administrative fee for group care administration to the agency managing the program). Stays are for a day or two, and the utilization averages between 60-70% occupancy.
- ***Crisis Services Expansion***. Present plans are to add to the system in a way that maintains the integrity of what has already been created.
  - ✓ ***Family Assessment and Stabilization Team (FAST).*** This would be a 24/7 team with 2 people on duty at all times except the graveyard shift. The team would have a pool of on-call family support specialists available and would respond immediately (within 3 hours) to crises in foster homes and family homes. It would be jointly funded by DCFS (using FRS funds) and the RSN.
  - ✓ ***Staffed Crisis Facility.*** This would be a staffed 6-bed facility that is able to provide a more intensive clinical response to children who cannot be served in respite or crisis foster care.

**Spokane County**

The Spokane DCFS staff have been engaged in a negotiation process with the RSN staff regarding joint support of a project that will be a part of the IV-E Waiver process. The focus is on children who are at risk of out of home care and the use of treatment foster care rather than group care. In the context of the new contractual relationships the RSN has created for mental health services, Lutheran Social Services is a child-placing agency and also has a contract for providing treatment services.

The program will have 80 slots in total, 40 will go into the treatment foster care program, 40 will be assigned to the control group and provided services in the present manner. The treatment foster care program will require Lutheran Social Services to develop foster homes and provide individualized and tailored care through a child and family team. DCFS will contribute $2500/month for the foster care services (currently out of home care can range up to $3500/month). It is assumed that treatment costs will average $1500/month; the RSN will reimburse the agency for these costs. Planning estimates are that length of stay will decline from 18 to 12 months.

**Clark County**
Clark County is in year two of a five year SAMHSA System of Care grant ($6.5 million over 5 years). Prior to the grant, the system had been utilizing the principles of Individualized and Tailored Care (ITC) and had an Interagency Board that staffed difficult cases using a multidisciplinary team approach.

The grant provided the impetus to expand ITC and truly develop wraparound approaches and a family driven system. The intent is to work at a systems level to get organizations to focus differently on what they do, rather than using the funds to expand current services. These efforts are targeted to SED children/youth (multisystem involved and at risk of placement) as well as their families. There is a local and national research component associated with the grant, and the goals are to reduce inpatient and out of home placements and to increase in-school time.

The grant recipient is the Clark County Department of Community Services, which oversees the grant itself. Several structures have been created to drive the refocusing process. The Policy Council overarches all child-serving systems in the county. It has 51% parent/family representation and is open to all organizations that wish to participate. Currently about 50-75 people are part of the Council.

The Board of Trustees serves as an executive committee. It has four mandated and four elected members plus the Department director. Members include two parents, MH, DCFS, Juvenile Court, Schools (1 superintendent selected to represent all seven districts), and business representatives. Their charge is to review systems issues and problem solve in a public forum that provides the opportunity for public input and observation of the decision making process.

The day-to-day component of the grant is the virtual team. Five key systems (MH, DCFS, Juvenile Court, Schools, Department of Community Services) have designated staff and transferred their FTEs to the grant. Grant funds are then being used to backfill their positions. The team is to serve as the system change agent. It is led by the Department staff person and is made up of people who are knowledgeable about each system, close to the realities of service delivery (they were directly providing service until assigned to the grant), and committed to have no caseload during their service on the team. The team may staff difficult cases at the request of the caseworker. Blended funding is accomplished on a case-by-case negotiation process. Among the team goals are to increase family involvement at all levels, and to have one service plan, with components for each system (note that if they can develop this model to meet each system's requirements, it will benefit all; each RSN could then work from this template).

The intent is to go slow, to create the capacity to think and act differently, and to develop service alternatives than aren't really treatment (moving more to individual case management). They have not yet identified any new services needed. In the context of the IV-E waiver planning, they have discussed establishment of a Children's Trust Fund, in which each system would put dollars into a fund to be used to address system wide needs. Other ideas include: Family Resource Center, Flexible Funds and Advocacy.

## Data Collection Regarding Children/Families and their Services in the NSRSN Region

### *The Current System and Experience in NSRSN: Stakeholder Interviews*

**Method**

Members of the Planning Committee contacted stakeholders in each of the counties to gather data on their perceptions of the acute care system.

- A standard interview guide was developed for use with all interviewees. Interviewers were APN, NSRSN and DCFS staff.
- Interviewers gathered feedback from people representing the following perspectives: parent (4), private mental health practitioner (4), schools (8), probation/police (4), pediatrician (3), substance abuse services (7), APN provider (9), system planner/manager (5), inpatient unit (2), and outreach worker (2). Stakeholders were representative of all five counties in the RSN: Island (6), San Juan (2), Skagit (11), Snohomish (12), and Whatcom (17).
- Altogether, a total of 48 individuals participated in completion of the interview guide.
- These individuals were asked to consider the following questions:
  - ✓ What are the top three reasons that children and families require intensive crisis intervention?
  - ✓ Do you see differences in these reasons between people living in rural areas versus the more urban areas of the North Sound region?
  - ✓ If you could have had any additional resource locally in the last year to support children and families in crisis, what would it have been?
  - ✓ What has been your experience in working with inpatient facilities/crisis respite regarding discharge planning and coordination with local resources?
  - ✓ What services and supports have been most useful in working with children and their families in crisis?
  - ✓ What services have you been dissatisfied with in crisis situations? Why?
  - ✓ What else should the committee know from your experiences?

**Findings**

The following table summarizes the observations of the stakeholders regarding the factors that contribute to the need for acute care services; those in bold are the most frequently mentioned; the issues vary by age group.

| Reasons for Crisis (all mentions) | Child 0-12 | Child 13-18 |
|---|---|---|
| ✓ Dysfunctional, chaotic families, including parental MH/SA issues | **29** | **8** |
| ✓ Child out of control /harm self or other/safety | **19** | **24** |
| ✓ Domestic violence in family | **13** | **10** |
| ✓ Physical/sexual abuse/neglect | **11** | 6 |
| ✓ Family unable to get early needed supports | **9** | 6 |
| ✓ Lack of parenting skills | **9** | 3 |
| ✓ Need for more intensive services | 6 | 5 |
| ✓ Poverty, mobility, health issues | 5 | 2 |
| ✓ Child substance abuse issues | 4 | **15** |
| ✓ Brain disorders/mental illness appearing | 4 | **19** |

| | | |
|---|---|---|
| ✓ Lack appropriate residential care | 2 | 3 |
| ✓ Acute, traumatic change in child | 2 | 2 |
| ✓ School unable to cope w/ hi needs | 2 | 1 |
| ✓ Conflict w/ parents, runaway | 1 | **9** |
| ✓ Family isolation, lack supports | 1 | 1 |
| ✓ Learning problems | 1 | |
| ✓ Attachment disorder | 1 | |
| ✓ Developmental disorder/delay | 1 | |
| ✓ Need mature mentor, life skills | | 2 |
| ✓ Adjustment disorders, borderline | | 1 |
| ✓ Eating disorder | | 1 |
| ✓ High stress of school for teens | | 1 |
| ✓ No investment in services/need mandate | | 1 |
| ✓ Feeling rejected by others | | 1 |
| ✓ Negative peer pressure in schools/community | | 1 |
| ✓ Repeated inpatient hospitalizations | | 1 |
| ✓ Desire for immediate results | | 1 |
| ✓ Pregnant teen | | 1 |
| ✓ Court referred for respite | | 1 |
| ✓ Difficulty in sorting out what is normal/not | | 1 |

In looking at the perceived reasons children and families may require crisis services, an important but difficult question to answer is that of the frequency or prevalence of need. As one indicator, an article in the January 24, 2000 issue of the Seattle Times reports on a telephone survey sponsored by the Snohomish Health District for the purposes of assessing health issues in the population. The survey reports, "***one in six Snohomish County residents, married or living with someone, has at some time been the victim of domestic violence from her or his partner".***

There was general agreement among stakeholders that there was minimal difference in needs between rural children/families and those in more urban settings. However, there was common acknowledgement of the rural difficulty in accessing services (caused by fewer available services, distance and lack of transportation to services, more low income families, lack of child care, lack of community assets/supports/appropriate places for youth to congregate and lack of knowledge about services).

One observer noted that many rural parents commute for work and have much less time at home to supervise children. It was suggested that some rural families might choose isolation, especially where there is domestic violence or physical/sexual abuse (e.g., keeping the victim isolated), and that the prevalence of substance abuse is higher. Of note is an article in the January 26, 2000 issue of the Seattle Times that reports on a study by the National Center on Addiction and Substance Abuse at Columbia University, which concluded "***eighth-graders in rural areas are 104 percent more likely than those in urban centers to use amphetamines, including methamphetamines, and 50 percent more likely to use cocaine,..83 percent more likely to use crack cocaine, and 34 percent likelier to smoke marijuana than eighth-graders in urban centers".***

Urban areas were viewed as having more crises (on the other hand, it was noted that those in the most urban area of the NSRSN have access to the Children's' Crisis Team), having a population more likely to engage in counseling and therapy, ignoring problems

that would draw attention in rural areas, and the place that rural kids go anyway to "hang out".

The most important additional resources "wish listed" for acute situations included:

***Facility Based Services***

- Staffed group care for high need youth that is between foster care and residential treatment, for up to 90 days (8)
- An E&T like facility for children 10 and up, to provide stabilization and emphasis on treating co-occurring disorders/local inpatient alternative/a facility with high level of security (4)
- Facility that deals with substance abuse and severe mental health issues (3)
- Local transitional care facility for pre or post hospitalization for those who need more than crisis respite/quality crisis beds (2)
- Transitional living for immature, inadequate youth 18 and not ready for emancipation (2)
- A viable residential facility for those who have been through multiple assessments and settings, but still need a place to live (1)
- Emergency respite beds available anytime of the day or night and money to pay for them (1)
- Housing of all types (1)
- A facility for residential treatment of whole family (1)
- Detox for youth (1)

***Acute Outreach and Outpatient Services***

- More respite services of high quality (available to a larger group of families, not just CHAP; planned, not just emergent; in home and in foster families; R&R respite; in all parts of the NSRSN) (11)
- Treatment aides/a pool of skilled staff and volunteer natural helpers with supervision (5)
- Child psychiatry, medication management, PCP consults/good communication, access for youth in substance abuse services (4)
- CHAP for all who need it, and CHAP aftercare/ CHAP like, intensive foster care (4)
- Early intervention and immediate counseling (3)
- Parenting skills and support groups for parents of high need children/youth (3)
- Ongoing case management for children/youth, with life skills training (3)
- Focus on working with the whole family, with highest skilled staff available (2)
- More MH evaluation for juvenile justice system, with designated liaison rather than on call system (2)
- After school and evening services, 3-11, after-school activities for behaviorally challenged (2)
- Outreach at home when families ask for it/improved CDMHP services with 24 hour availability and collaborative working approach (2)

- Short term (30 day) treatment foster care combined with intensive parenting, followed by 90 day intensive follow up with access via pager, parenting support/skills, individual and family treatment (1)
- More expedient comprehensive system to get in for evaluation, get a diagnosis and treatment plan and share it with all involved, and assure follow through
- Crisis nursery (1)
- Better crisis planning and coordination between MH and pediatricians (1)
- More attention for Native American youth and families (1)
- Bilingual, bicultural outreach services (1)
- Satellite services, with less distance to travel (1)
- Male clinicians (1)

***Community Based Services***
- A School Resource Officer (police outreach) in every school (1)
- Parent support groups that meet on a regular basis, community based in neighborhoods and run by parents (1)
- Mentoring and co-parenting programs (1)
- Flexible funding to address service gaps (1)
- Communication between social service agencies (1)
- Social worker active with schools (1)
- A safe place to live with a coaching model (1)
- Child care for families to access treatment (1)
- More teen centers (1)
- Accessible, affordable housing opportunities (1)
- Shared housing/apartments for families so they could support one another (2)
- Equal access and universal coverage for comprehensive MH services that are seamless regardless of funding sources (1)

Most of the stakeholders experienced with local crisis respite services and CCS Martin Center reported a very good working relationship with these facilities. There were mixed reviews regarding inpatient facilities, with a few positive statements, mostly regarding CHMC. Those who had good experience felt that once the inpatient facilities knew the community providers, they were conscientious and helpful, and that the emphasis on using teams to plan discharges had been very positive. From the inpatient perspective, the issues revolve around the need for rapid medication services, confusion regarding access to APN evaluation, and DCFS staff that seemed overwhelmed by their resource limitations.

Those who were quite discouraged about collaboration with inpatient facilities noted that it is now hard to get very difficult youth into care, MH must take the lead in coordination, there is frequently very little information transmitted following an inpatient stay, discharge planning is unrealistic, and discharge plans are very slow to appear. They saw the inpatient stay as providing little help with long term planning and stabilization, with discharge planning being last minute and not well thought out; referrals were in the

(delayed) discharge plan and follow up appointments for medications were not consistently set up.

Several observers were concerned about the lack of follow up with discharge plans, however, it was not clear whether they believed that was a problem with the inpatient team or the community team. Finally, a private therapist noted that it is difficult to work with mental health agencies and access case management services when needed for children because the agencies didn't want to work with private therapists.

In regard to crisis services, many noted that crisis outreach services have improved, and are more responsive, but that they are hampered by lack of resources for follow up, including lack of home based or other respite, therapeutic foster care, crisis beds, or a local transitional facility. CDMHPs were mentioned as either looking only at commitment criteria or not following the protocol, not getting a child or youth into appropriate care or not collaborating with the agency serving the child and not timely in response. CLIP services were mentioned as not responsive enough, with too long a waiting list, and not enough beds. Other specific frustrations mentioned had to do with the lack of effective legal jurisdiction to manage runaways (e.g. Youth At Risk petition has no teeth), the lack of crisis services for Navy dependents (e.g., inpatient and family service center), mental health and chemical dependency services that keep people in a victim mode, and the lack of transportation services which may require families to transport their children when that creates a lack of safety for all concerned.

The most useful services presently available in the system were identified as:

- Revamped crisis services/CDMHPs/Childrens' Crisis Team/crisis line (16)
- CHAP and its 24 hour support/in home intensive services/IFPS (10)
- Crisis respite foster care/emergency support in or out of home (10)
- APN access and mental health providers (6)
- Staff who know how to work with complex families; who understand issues related to children with disabilities or special health care needs; who are willing and have skills to try to work through the crisis in the home (4)
- DCFS, better communication, FPS (4)
- Other collaborative providers [NW Youth Services, Big Brother/Sister, Friendship House, Community Action Agency] (3)
- Safe home (2)
- Coordination with other providers/wrap around planning w/ interagency team of providers (2)
- Best children's resource management in the state/CHARC consultations (2)
- Schools (2)
- Crisis beds (that were available at Sun) (1)
- Medication services and medication monitoring (1)
- Stabilization aides (1)
- Adolescent case managers (1)
- New 1-800 telephone service (1)
- Fax machines improve rapid communication (1)

- Having a caring community (1)
- Funding for transportation (1)
- Juvenile courts (1)
- Sundown in Yakima (10
- Police intervention (1)
- When family can decided on a plan and intervention and follow through on it (1)
- Martin Center (1)

Finally, there were wrap up comments regarding the importance of good collaboration and communication among all the parties (e.g., MH, DCFS, substance abuse services, schools, juvenile justice, MDs). Communication with the substance abuse system was described as difficult and needing improvement, as does communication between mental health and medical providers and between public and private sector mental health providers.

Interviewees reiterated their support for: flexible and blended funding; easy access to and updated knowledge about a continuum of services including crisis respite, bilingual and bicultural outreach services, a safe secure local facility for those not detainable but at high risk in home or foster home, CHAP, a local transitional/triage facility that is interim between inpatient and CLIP beds, good discharge planning, faster access to medication management, and attention to caseload size that may make it easier to provide sufficiently intensive services.

In the larger environment, it was noted that managed care constraints have made multiproblem families drastically underserved (in the private sector), needing more resources and options for care in the community. It was also suggested that the age for voluntary consent be raised; there has been a change over the last twenty years, and the children now been seen often exceed people's capabilities to both manage and serve them.

Finally, returning to the needs of families, stakeholders noted that while many families are hard to keep in service for exactly the reasons they need services, the system should become more family oriented, with biological and foster families involved in the team and more opportunity to be in charge. There should be more focus on foster children, with groups and other supports for them, and attention to the needs of families so children are not placed back in settings with lots of unresolved issues.

## *Quantifiable Data Regarding Current Experience: Case Reviews*

### Method

The Planning Committee designed and implemented a case review methodology that would assist in understanding how the system might improve acute care services. Cases were selected using the following methodology:

- A list of all children with an NSRSN paid inpatient stay during FY98-99 was generated (210 names, 245 admissions).

- The list was matched against DCFS data to identify those who also had an out of home placement during the same time period. These names (a subset of the first list, 39 names) were then reviewed for selection of cases.
- The basis for selecting cases for case review included:
  - ✓ Geographic distribution across the five county region
  - ✓ Age distribution
  - ✓ Served in MH system prior to admission/not served in MH system prior to admission
  - ✓ Multiple admissions/single admissions/subsequent crisis bed users
  - ✓ Received CHAP type services
- A minimum of 1 case per county or at least 20% of each county's subset of the 39 yielded a final sample of 15 reviewed cases (3 of 4 Skagit, 3 of 5 Whatcom, 1 of 5 Island [3 selected, 1 reviewed], 8 of 24 Snohomish, 1 of 1 San Juan [selected, not reviewed]).
- Four case review teams used a case conference method to look at these cases, with staff from the north counties of the region reviewing cases in the south portion of the region and vice-versa. Each team had an APN clinical supervisor, a NSRSN children's resource coordinator and a DCFS caseworker.
- They attempted to interview, for each case, the DCFS caseworker, the APN clinician, and a family representative. In some instances, they had input from DDD, schools, or group home staff.
- Family representatives were interviewed separately from the providers. In nine of the cases, family representatives had been located and agreed to an interview; of these, six were actually interviewed.
- The method was to ask the same questions of all interviewees and document their responses; following the round of interviews, the team then debriefed their observations. The questions were:
  - ✓ At your earliest point of contact with the child/family, what was needed? (Not limited to what was available.)
  - ✓ Was it available? If so, was it timely? If not, why not?
  - ✓ What was done? What happened?
  - ✓ In regard to goals, service expectations, strategies, and styles, was there agreement among all the players involved? (Issue of "fit")
  - ✓ As you look back on the working relationships, what do you feel was most helpful? What do you feel was least helpful?
  - ✓ What worked the best and was the most useful? (E.g. team, services, interventions, natural supports, family resources, hospitalization?)
  - ✓ What did not work and was the least useful?
  - ✓ What barriers or gaps have there been in serving the child/family?
  - ✓ What is happening now?
  - ✓ What is needed now?
  - ✓ Is it available? If not, why not?

## Findings

The following table provides demographic information on the sample of cases reviewed compared to available data on the group of cases having both an inpatient and DCFS stay during FY 98/99.

| | Case Review Sample | All Potential Cases |
|---|---|---|
| **Gender** | | |
| ✓ Male | 10 | 26 |
| ✓ Female | 5 | 13 |
| **Age** | | |
| ✓ O-6 | 0 | 1 |
| ✓ 7-9 | 0 | 5 |
| ✓ 10-12 | 8 | 13 |
| ✓ 13-18 | 7 | 19 |
| ✓ Not noted | 0 | 1 |
| **Ethnicity** | | |
| ✓ Caucasian | 8 | 30 |
| ✓ Hispanic | 2 | 4 |
| ✓ Native American | 1 | 2 |
| ✓ Black | 0 | 3 |
| ✓ Asian/PI | 0 | 0 |
| ✓ Other/Not noted | 4 | 1 |

Other characteristics noted in the sample cases included living setting, whether enrolled in RSN services prior to the inpatient admission, and primary/secondary diagnosis.

| Living Setting | At Admission | At Review |
|---|---|---|
| ✓ One parent | 8 | 3 |
| ✓ Both parents | 2 | 1 |
| ✓ One parent plus step | 1 | 0 |
| ✓ Grandparent(s)/relatives | 2 | 2 |
| ✓ Foster care | 1 | 1 |
| ✓ Group/residential care | 1 | 2 |
| ✓ Child Study and Treatment | 0 | 3 |
| ✓ Hospital | 0 | 2 |
| ✓ Independent (was at CSTC) | 0 | 1 |

In addition to the three youth now at Child Study and Treatment, it is noted that another three of the cases reviewed were in the process of completing a CLIP application for long-term residential treatment.

| Enrolled in RSN services at time of 98/99 admission | Yes | No |
|---|---|---|
| | 8 | 7 |
| If yes, level of care authorized | | |
| ✓ 3 | 6 | |
| ✓ Not noted | 2 | |

| Diagnosis | Primary | Secondary/Rule Out |
|---|---|---|
| ✓ Attention-deficit/hyperactivity dis | 1 | 4 |
| ✓ Oppositional defiant dis | 3 | 5 |
| ✓ Adjustment dis | 2 | |
| ✓ Attachment dis | 2 | 1 |
| ✓ Obsessive compulsive dis | 1 | |
| ✓ Post traumatic stress dis | 1 | 3 |

| | | |
|---|---|---|
| ✓ Major depressive dis | 2 | |
| ✓ Depressive dis NOS | 1 | |
| ✓ Bipolar dis | 1 | 3 |
| ✓ Mixed | 1 | 1 |
| ✓ Learning disabilities | | 1 |
| ✓ Amphetamine abuse | | 1 |

The case situations themselves represented a range of needs and issues to be addressed. To establish a framework for understanding how to improve the acute care system from these cases, the analysis begins with the conclusions drawn by the case review teams. The case review teams were asked to assess whether there appeared to be shared goals, whether there appeared to be agreement on ways to achieve the goals, whether there appeared to be a trusting relationship among the parties, and the system lesson to be learned from each situation.

| **Shared Goals?** | |
|---|---|
| ✓ Yes | 5 |
| ✓ Yes, although it took time to get family "on board" | 1 |
| ✓ Yes, among professionals, but not with family | 8 |
| ✓ No team communication | 1 |
| **Shared Strategies?** | |
| ✓ Yes | 4 |
| ✓ Yes, among professionals, but not with family | 10 |
| ✓ No team communication | 1 |
| **Trusting Relationship?** | |
| ✓ Yes | 6 |
| ✓ Yes, among professionals, but not with family | 8 |
| ✓ No team communication | 1 |

## System Lessons Learned

As the case review teams debriefed each situation, they identified the following system lessons; the frequency of mentions follows in parenthesis.

- Creating solid community/provider/family teamwork and shared understanding of needs is critical. The best teaming doesn't work if the family has different goals. There should be a clearer assessment at the beginning of the commitment to the child. Foster parents must be fully informed and supported in regard to all of a child's needs. (5)
- The specific type and level of out of home placement is frequently not available, when and as requested, for those with severe behavioral issues. Using a variety of other approaches (group care, crisis respite, Mediplex, inpatient [Fairfax, CHMC]) further traumatizes the child while creating added disruption and ongoing placement crises. (3)
- There should be better communication among involuntary systems. Probation services should be more closely coordinated with mental health services. Youth

should be held accountable, and probation needs to do more on this, especially in relation to community service hours. (2)

- The one stop-shopping model of CHAP is very helpful, but the process to get it is too lengthy and we may not have enough. (2)
- The system needs more respite, more specialized respite and planned use of respite. (1)
- The team must focus on placement planning throughout use of acute care resources; it cannot end the responsibility of one service until there is another clear entity able to assume it. (1)
- The skills and energy of a specific individual clinician makes a difference in pulling everything together and keeping it on track. (1)
- Having someone like the DCFS/MH troubleshooter may be needed when teams get stuck and/or there is polarization between the professionals and the family. (1)
- Need a CHAP approach that incorporates understanding of and services that address parental substance abuse issues. (1)
- Continuity of case history information [out of state/county records] is critical for assessment, coordination of services and accessing appropriate resources. (1)
- Very complex cases need extra attention to coordination and communication, requiring a strong case manager from the very start. (1)
- Given the needs of many parents, there should be better integration of child and adult services. (1)
- There is a need for cross system training, especially in regard to DDD and mental health. Also need placements that are specifically targeted to DDD children with mental health needs. (1)

Reading the case review summaries, other themes emerged from the stories told by those interviewed:

- There was praise for, as well as occasional frustration among, collaborative partners (mental health, schools, DCFS, probation). The case review supports the fact that teams of professionals are working effectively together. However, it is difficult, because being able to count on teammates must be reinvented every time. It is not systemic, but based on the individual inclination and style of each of the professionals.
- Many family situations had mentions of substance abuse issues among the adults and frustration with getting them engaged in treatment and committed to sobriety. This seemed to be a major contributor to the need for out of home placement.
- The lack of agreement over goals and strategies among professionals and families seemed to focus on the out of home placement issue. In some cases, the professionals thought the child should be placed, and the families were ambivalent, afraid of the consequences, and unable to move forward on placement until the situation became impossible. In one instance, the reverse was clearly true; the family wanted the child out of the home and went to the top of DSHS to accomplish their goal, while the professionals didn't believe it was necessarily appropriate.
- The administrative decision process was clearly reflected in three cases: the one above, where placement was ordered from the top over the recommendations of local staff; another where placement was denied despite the advocacy of local staff; and yet

another where local staff went to the top to obtain permission to hospitalize out of state.
- The movement of the child and/or family confounded several cases across county boundary lines, creating discontinuity in service planning and delivery.
- Turnover in DCFS and mental health case managers was mentioned in the course of telling the child's story. Given all of the other challenges listed above, changes in the professional team added stress for everyone, and required rebuilding the teams' processes and goals.

When asked to identify what was helpful, what worked, the following were mentioned by those interviewed; frequency of mention is given in parenthesis:
- The partnership between DCFS/MH, team meetings and frequent consults, collaboration with crisis team, schools, PCP (12)
- Foster home placement (4)
- Mental health and medication management services (4)
- IFPS or CHAP provision of respite, crisis response, treatment aides (4)
- Specific school programs, school leading early wraparound efforts (3)
- Inpatient, because it shifted the child out of home, provided safety and medical evaluation (2)
- The IFPS worker, both because more intensity was needed and the style and energy of the provider (1)
- Crisis respite setting (1)
- Case manager pulling services together (1)
- Transition between inpatient and post inpatient—no service gaps! (1)

Those interviewed made the following observations about what was least helpful or didn't work well; frequency of mention is given in parenthesis:
- Family lack of follow through and/or active disagreement (8)
- Lack of communication, misaligned expectations among professionals (5)
- Irregular follow through of professionals, changes in staff, difficulty in accessing staff, professionals didn't attend to family concerns (4)
- The frustrating process of searching for and obtaining permission for an appropriate placement, which often simply doesn't exist (3)
- Once a week outpatient service is not enough for children with these needs, caseload a barrier to seeing more frequently, traditional therapies not always effective (3)
- Inpatient did not clarify diagnostic picture, no discharge plan (3)
- Lack of treatment aide (2)
- Needed more support from probation, police, fire (2)
- Lack of clarity around custody, due to pending dependency hearings, parental custody disputes, shifting of children among parents (2)
- The CRC is not suited for children with mental health needs (1)
- North counties crisis response (1)
- VOA refusal to send outreach worker because child was DDD (1)
- Need a structured, safe, crisis facility (1)
- Lack of knowledge regarding prior history (1)

- Difficulty in obtaining an appropriate school program (1)

An overview of the case review process with the team leaders and some team participants led to these observations:

- The process itself was very informative and positive for both the interviewers and interviewees, with an incredible sharing of perspectives on these cases and recognition of what had been accomplished through treatment for many of these children.
- The DCFS/mental health teams were working well, and staff were very supportive of one another. Workers needed to be flexible in serving the needs of these children and families, and were most effective when they were able to wear both hats (DCFS and mental health) and not be stuck in their system roles. The DCFS staff member who works with the Snohomish Children's Crisis Response Team was noted as being particularly effective in very complex situations.
- Changes in the treatment team were detrimental, with all members of the team having to work through the grief process and build new relationships.
- Both systems are so complicated, even the workers at times have trouble navigating all the parameters and explaining how things work to the other members of the team.
- These cases represented some of the most difficult served by the system, and without the close teamwork demonstrated among professionals, some of these children would not be alive.
- The problem of being able to engage the families is a constant challenge. These cases reflected the differing perspectives from the point of view of the family. Providers need to find ways to successfully align with the family as well as with the child, as the only chance for many of these children is to keep them attached to their families. Often, there is also disagreement within the family about what to do, which makes it even more complex.
- Inpatient services were mainly used for safety, and frequently did not contribute to a better diagnostic or planning perspective. If there were more children's crisis outreach, respite that is quicker and a better match to need, and more intensive OP services, such as day treatment or some structured group activity for non-school time when parents and foster parents may still be at work, inpatient might not be needed as frequently.

## Priority Recommendations

To be completed.

## Analysis of Current/Potential Financial Impact of High Need Cases

To be completed.

# Appendix A

# Appendix B

## Appendix C

## Appendix D

## End Notes

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