

# DSHS | Children's Mental Health Initiative

Coordinating Care and Improving Mental Health Outcomes for Children and Youth



## Effective Therapy Interventions for Kids and Families

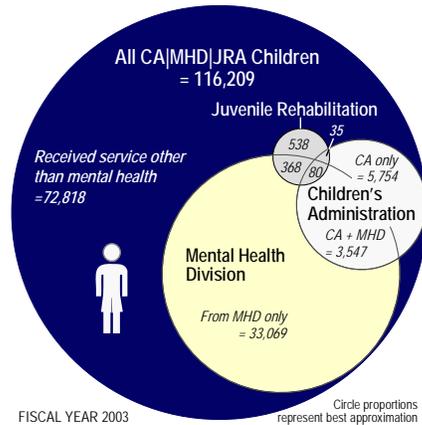
Children and youth with mental health needs are served by many programs operated or funded by DSHS. Many mental health practices, including therapy interventions, have been studied nationally and in our state to determine how effectively they impact the lives of children, youth, and families. Effective practices result in improved mental health and better functioning at home and school; increased likelihood of staying at home or being in a stable placement; and reduced levels of juvenile crime. DSHS wants more children, youth, and families to have the opportunity to receive therapies that have been proven to be effective and that will better serve youth with multiple complex needs. Thus, DSHS has created the Children's Mental Health Initiative (CMHI) to coordinate delivery across three DSHS programs – Health and Rehabilitation (mental health), Children's (child welfare), and Juvenile Rehabilitation. The data below sets the stage for four CMHI strategies by demonstrating need.



## OVERVIEW | Multiple Points of Contact with a Big Price Tag

### Children and youth now receive mental health services throughout DSHS

Mental health services delivered here

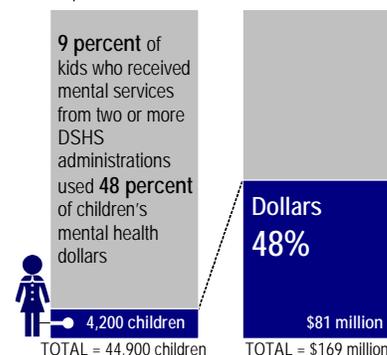


- Coordination is difficult for kids who need mental health services from two or more administrations.
- Of the 116,209 served by CA, JRA, and/or MHD in Fiscal Year 2003 (smaller circles), **37 percent of the combined caseload (43,391 children) received mental health services.**
- About **9 percent (4,030) of these children and youth** received mental health services from two or more administrations:

3,547	From CA and MHD
368	From JRA and MHD
35	From CA and JRA
80	From CA, MHD, and JRA

## 9 percent of kids used half of the mental health dollars for all kids

A few use half of the dollars  
DSHS Expenditure, FY 2002



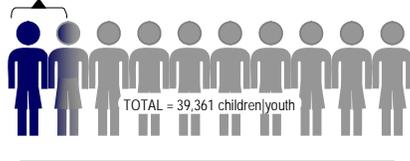
- In Fiscal Year 2002, over **126,000** children and youth received services from three DSHS programs: CA, JRA, and/or MHD.
- 44,900** of these children and youth received at least one mental health service from one of the systems during that year.
- Collectively, the mental health services for those 44,900 young people **cost \$169 million.**
- Half of that expenditure (\$81 million) was spent on the 9 percent** who received mental health care from two or more programs.

## Children and Youth with Mental Health Needs

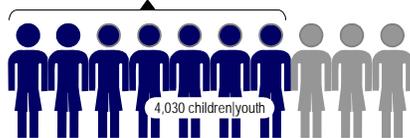
### Receiving treatment or placement away from home sometime during year

How many got treatment or placement away from home at some point in 2003?

Of those using mental health services from one DSHS program, 14 percent.



Of those using mental health services from more than one DSHS program, 68 percent

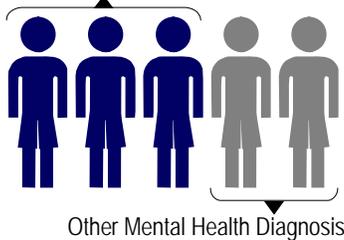


- In 2003, of the **39,361 children** and youth who used mental health services one program (CA, JRA, or MHD), **14 percent** spent some time in treatment or placement away from home.
- In 2003, of the **4,030 children** who used mental health care from two or three administrations, **68 percent** spent some time in treatment or placement away from home.
- Typically, those spending time away from home are in foster care, inpatient or residential treatment, or a JRA institution.

### Conduct, mood, and anxiety issues frequent for those with complex needs

With conduct disorders most frequent  
Highest Need 4,030 Children and Youth, FY 2003

3 of 5 with Conduct,  
Mood, Anxiety Diagnosis

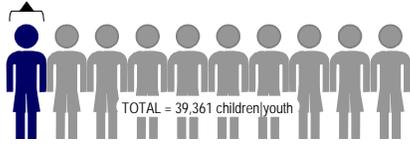


- **Conduct, mood, and anxiety disorders are the most common diagnoses** among the 4,030 youth with complex needs – three of five have these diagnoses.
- Among the 4,030 children/youth with complex needs:
  - Seven out of ten are **teenagers**.
  - Six out of ten are **male**.
  - Three out of ten are a minority race or ethnicity.

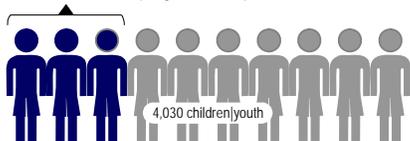
### Juvenile justice involvement

How many have been convicted of a misdemeanor or felony?

Of those using mental health services from one DSHS program, 12 percent.



Of those using mental health services from more than one DSHS program, 30 percent

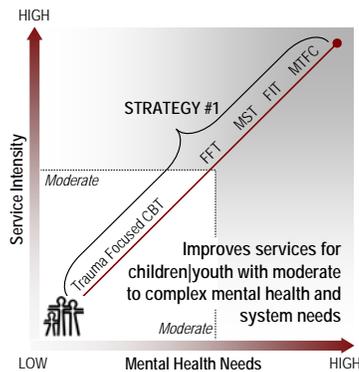


- Of the **39,361 children** and youth who used mental health services from one program (CA, JRA, or MHD), **12 percent** have been convicted of a misdemeanor or felony at some time in their life.
- Of the **4,030 children** who used mental health care from two or three programs, **30 percent** have been convicted of a misdemeanor or felony at some time in their life.

*NOTE: These criminal justice data are drawn from the WSIPP Criminal Recidivism Database, augmented by JRA records. The percentages are probably an underestimate.*

# Implementing Strategies That Help Children and Youth

## STRATEGY 1: Introduce and expand use of Evidence Based Practices

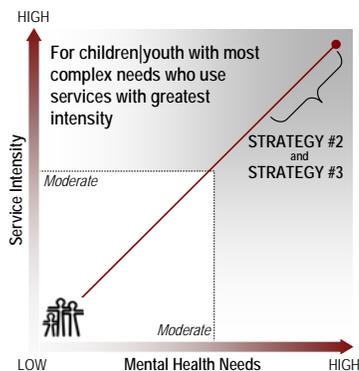


Evidence Based Practices (EBPs) are shown to **result in positive school, home, and community outcomes** for children and youth with mental health needs.

*Strategy 1 establishes:*

- Common quality assurance, adherence, monitoring protocols, plus incentives that support use of EBPs, across all three administrations.
- Common referral to jointly administered approach for children/youth.

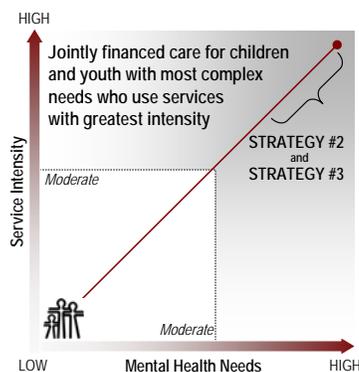
## STRATEGY 2: Coordinated care for children and youth with complex needs



*Components of Strategy 2 include:*

- A shared assessment tool.
- Coordinated care planning.
- Coordinated service delivery.
- Expanded parent and youth voice.
- A single-lead case manager for the children, youth, and families with the most complex needs.
- Shared standards for services across DSHS programs – agreement on EBPs applied.

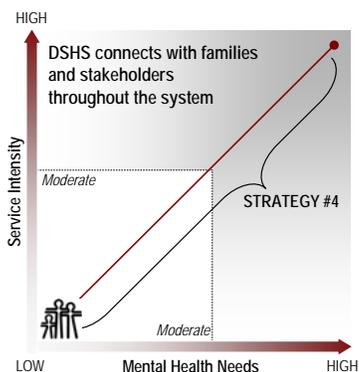
## STRATEGY 3: Jointly manage and finance care for kids with complex needs



*Under Strategy 3, we:*

- Adopt a capitated rate structure for contracts to providers who work with children and youth that have very complex mental health needs and who use services with high intensity.
- Pool funding resources.
- Modify service and financing infrastructure as needed to effect change throughout the system.

## STRATEGY 4: Connect with families and stakeholders through ongoing plan

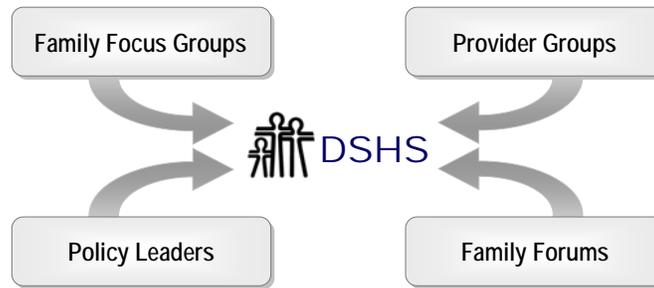


*Strategy 4 applies across the entire children's mental system and:*

- Involves families, advocates, and providers in implementation planning to include family forums and focus groups.
- Shares information about best practices and builds support for the use of EBPs.
- Assures formal feedback mechanisms through stakeholder meetings and routine updates.

## Seeking Family, Youth and Stakeholder Input

**Strategy 4** of the DSHS Children’s Mental Health Initiative will involve **ongoing efforts to inform and hear from families, youth, and stakeholders** regarding the implementation of the Children’s Mental Health Initiative Strategies 1 through 3.



### Next Steps

April and May 2005	Draft proposals to Assistant Secretaries – All four strategies
April and May 2005	Stakeholder conversations
May and June 2005	Convene Family Focus Group, Strategy 4
July 2005	Begin implementation – Strategies 1, 2 and 3
July 2005	Convene Family Focus Group, Strategy 4
Sept 2005-Sept 2006	Detailed implementation plan and startup, Strategies 2 and 3
December 2006	Full implementation for Strategies 2 and 3

### Next Steps

#### Four Strategies Toward Effective Therapy Interventions

The Children’s Mental Health Initiative will be implemented using the four strategies identified on the previous page. All CMHI strategies support families, children, and youth to build strong, productive relationships. Our work recognizes the role of parents and their right to make choices that benefit their child and family. We believe that the services we introduce through this effort will add valuable options for parents to consider.

#### An Evaluation Design and Lessons Learned

A common plan for monitoring and evaluating of the initiative and its component EBPs is under development. It will track and describe the set of young people and families involved in each EBP, and monitor changes in enrolled children during and right after treatment. Later, it will address program impacts by comparing enrolled children with similar children receiving customary treatment, and assessing changes in outcomes during a year or two following treatment. When possible, the monitoring and evaluation plan will use administrative data.

Child life changes addressed in the evaluation will include functioning, self-reported quality of life, problem behavior, clinical status, substance abuse, injuries, accidents, arrests, and convictions. School grades and school problems will be obtained if possible. Service use changes include days in restrictive settings and out-of-home placements, overall DSHS service costs per client and per family, and intensity of services provided.

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