Integration of Policy & Practice across State Agencies: Child Welfare, Behavioral Health & Medicaid

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Integrated Policies & Practices

Literature

- Integrating policies & practices across state agencies may improve access to mental health & addiction services for abused & neglected youth and their families (Bai, Wells & Hillemeier, 2009)
- Create an integrated framework (Burns, et al., 2004).

Issues

- Often inconsistent identification of parental risks and unmet treatment needs and underreporting of mental health problems by foster parents, social workers and providers (Libby, et al., 2005; Ragahanan, et. al., 2007)

Opportunity

Research

- Lack of research related to systems or processes developed to addresses the behavioral health needs of children in the child welfare system (APA , 2012; Children's Mental Health Network, 2012)

Context

Statewide integration of common assessment tool, referrals & across:

- Child Welfare
- Behavioral Health System
- Medicaid Funding

Context: Early Screening & Intervention Initiative

Screening

- Child Welfare Used California Mental Health Screening Tool (MHST, CMHI) from 2004 to 2010.
- Referred for Behavioral Health Assessment & Treatment
- Evaluated using cross systems data

Findings

- ~ 50% actual implementation
- More children in CPS accessed mental health services sooner
- Concentrated treatment dollars and Medicaid services on youth with an identified risks

(Center for Health Policy, 2009)

Incremental Implementation

Child & Adolescent Needs & Strength (CANS, Lyons, 2009):

- **2007 Behavioral Health Providers Statewide [Division of Mental Health & Addiction, (DMHA)]**
- **2008 Child Residential Providers [Department of Child Services, (DCS)]**
- **2008 Adult Needs & Strength Assessment (ANSA) (DMHA)**
- **2008 Integrated into Medicaid Demo Grant (DMHA)**
- **2010 Linked to Medicaid Rehabilitation Option**
- **(IN Office of Medicaid Policy & Planning)**
- **2010 Child Welfare Family Case Managers (DCS) use information to refer to MRO providers (CMHCs)**
- **2012 Linked to foster care rates (DCS)**

Comprehensive CANS

6 Dimensions

1. Youth Behavioral Health Needs
2. Life Functioning
3. Risk Behaviors
4. Youth Strengths
5. Acculturation
6. Caregiver Strengths & Needs

64 Core Items

- Depression, Impulsivity, Adjustment to Trauma, Oppositional, Substance Use
- Family, Social & School Functioning
- Danger to Self & Others
- Interpersonal Strengths, Natural Resources, Community connections
- Language & Cultural Needs
- Supervision, Parental Substance Use & Mental Health Needs

Use of Rating Information

Individualized Plan

- Link intervention plan to identified needs for youth and caregivers
- Use identified strengths to help address needs & support or develop strengths
- Monitor progress

Intensity of Service Recommendations

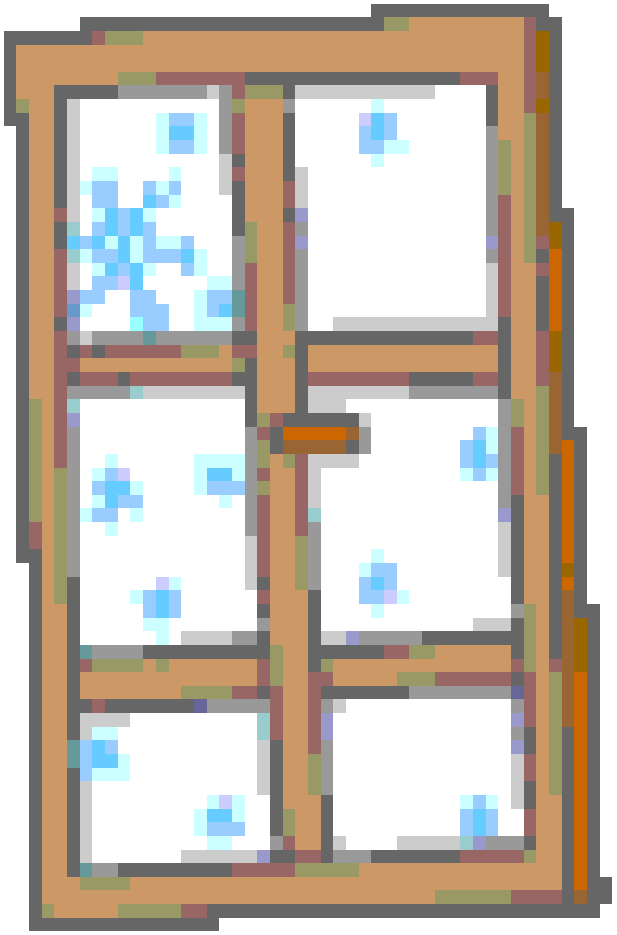
- Based on pattern of needs, algorithms recommend:
  - **Intensity of behavioral health services &**
  - **Level of placement**

    (if child removed from home)
- Recommendations related to eligibility for intensive services, MRO service packages & foster care rates

Window: CA-PRTF Medicaid Demonstration Grant

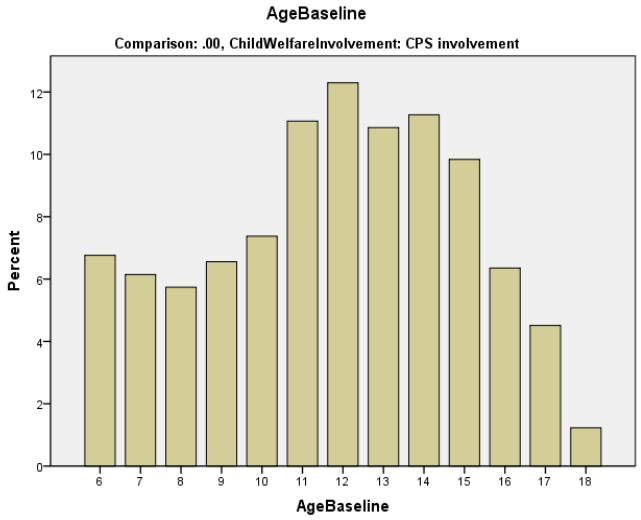
- 9 state demonstration
- Intensive Community Based Services for youth who might otherwise be served in psychiatric residential treatment facilities & their families
- National & state evaluations
- Wraparound Services Model
- Preliminary findings from

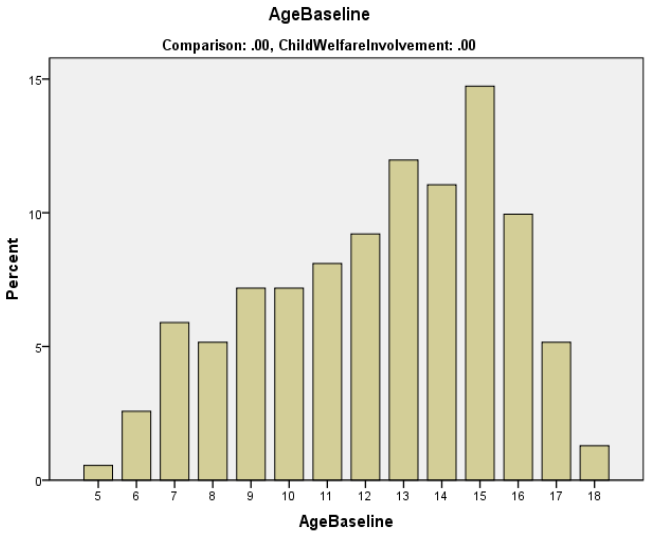
  4th year data



Profile of Youth & Families Receiving Intensive Services

	CPS Involved n = 494	Non-CPS Involved n = 557
Mean Age @ Admission	11.78	12.38
Age Range	6 - 18	5-18





Gender, Race & Ethnicity

	CPS Involved n = 494	Non-CPS Involved n = 557
Gender	69% boys	75% boys
Race	75% White 19.8% African American 1.4% Native American 4.3 % Multiracial	75% White 20% African American 5% Multiracial
Ethnicity	3.6% Hispanic	4.3% Hispanic

Length of Grant Services (LOS) (end of episode of care)

CPS Involved Youth & Families

- N = 265 youth
- Mean LOS = 306 days
- Range: 17 to 1108 days

Non-CPS Involved Youth & Families

- N = 283 youth
- Mean LOS = 264 days
- Range: 1 to 816 days

Satisfaction
(YSS, Brunk & Innes, 2003)

	CPS Youth n = 90	CPS Families n = 240	Other Youth n = 112	Other Families n = 243
Overall	4.06	4.26	4.11	4.28
Access	4.02	4.32	4.09	4.39
Participation	3.88	4.42	3.98	4.53
Cultural Sensitivity	4.08**	4.48*	4.22**	4.61*
Appropriateness	3.99	4.11	4.11	4.22
Outcome	3.69	3.45	3.81	3.57

Fidelity to Wraparound Services Model

Indiana CA-PRTF Grant

Wraparound Fidelity (WFI-4 Scores) January 2008 – June 2011

- **Statewide Average Combined Total WFI Score for 836 youth = 81%**
  - **Facilitator Statewide Combined Total (822) .829**
  - **Caregiver Statewide Combined Total (423) .795**
  - **Youth Statewide Combined Total (117) .746**

Fidelity of Indiana's Wraparound Teams

Level of Wraparound Fidelity*		Number of Teams n = 832	Percentage
High	(.85)	370	44.5%
Adequate	(.75 - .84)	287	34.5%
Borderline	(.65 - .74)	116	13.9%
Low	(< .65)	59	7.1%

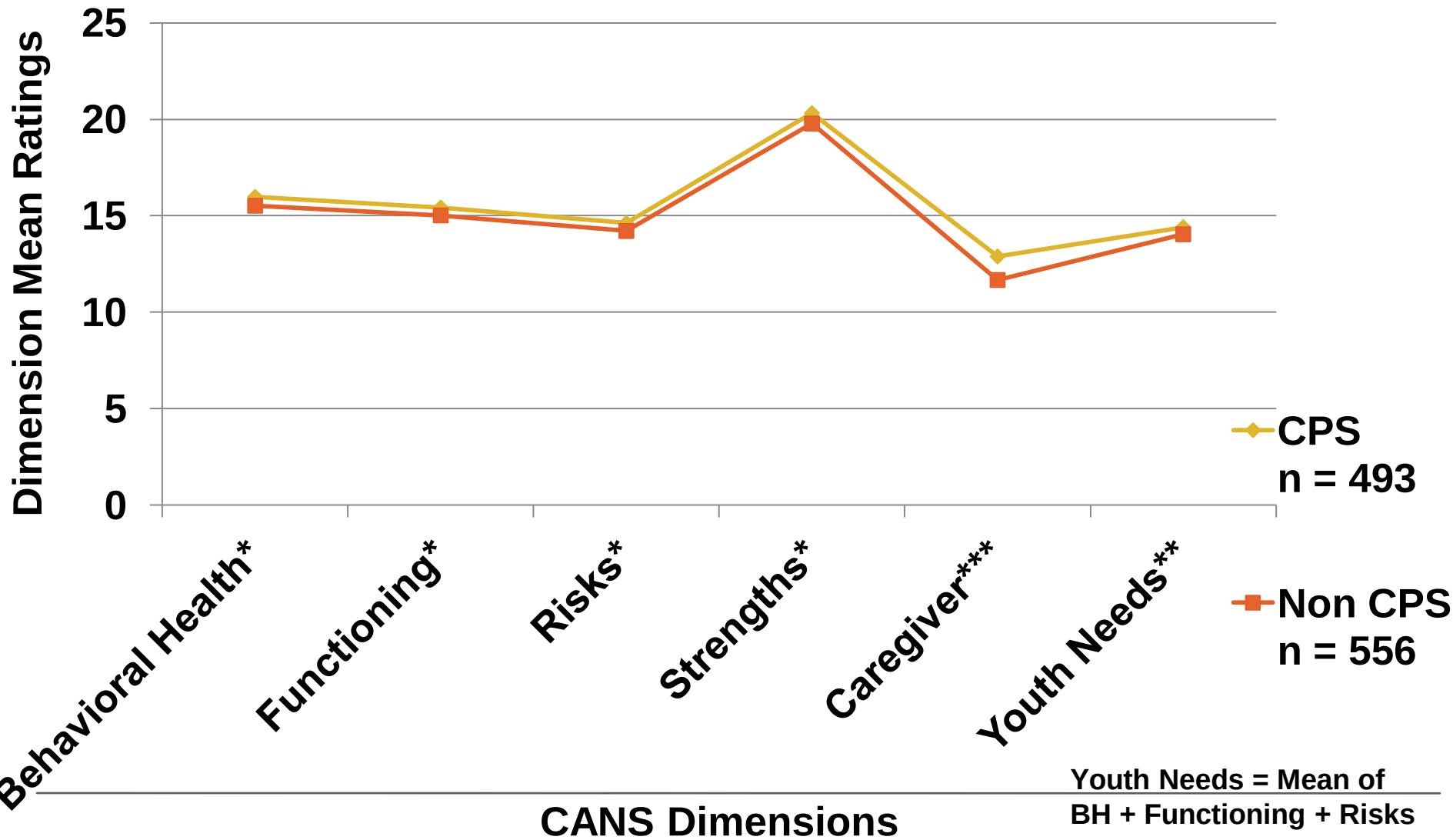
Based on most recent WFI-4 ratings for each team, June 30, 2011

***(Bruns, Leverentz-Brady & Suter, 2005)**

Reliable Change Measured by the CANS

OUTCOMES

Needs & Strengths_Beginning



Expected Reliable Improvement

- **60-80%** of youth are expected to improve in at least one of the dimensions

- **20-40%** of youth will improve in a specific CANS dimension

% Reliable Improvement for Youth_End of Grant Services

234 CPS Involved Youth*	279 Non-CPS Youth*
77% -- One Dimension	82% -- One Dimension
44% -- Behavioral Health	46% -- Behavioral Health
44% -- Functioning	45% -- Functioning
72% -- Risks	78% -- Risks
47% -- Youth Needs	50% -- Youth Needs
32% -- Caregiver S & N	30% -- Caregiver S & N
36% -- Strengths	37% -- Strengths

*Combination of Youth in Ongoing Services and Youth Who Ended an Episode of Care..Variable LOS

Costs: Medicaid Paid Claims	Mean Cost CPS Involved n = 486	Mean Cost for Other Grantees n = 554
Wraparound***	12,778	9,596
Habilitation**	10,156	7,519
Clinical*	1241	834
Total Grant***	24,538	18,877
Case Mgt (MRO)*	6,427	4,679
Inpatient Psych**	2,651	1,665
Psychotropic Meds	11,197	10,041
PRTF	12,619	13,950
Individual Treatment**	1764	1393
Total Medicaid*	76,839	66,757

Another View: Predicting Change in Needs for Youth Involved with CPS

DV: Change in Youth Needs (BH, Functioning & Risks)

Predictive Variables	B	SEB	β
Natural Supports (WFI)	-1.75	.82	-.10*
Community Based (WFI)	3.67	1.05	.16**
Strengths Based (WFI)	-4.63	1.82	-.13**
Outcomes Based (WFI)	5.95	1.32	.24***
Initial BH Symptoms (CANS)	.29	.06	.23***
Initial Functional Needs (CANS)	.73	.31	.59***
Initial Caregiver Needs (CANS)	.09	.04	.11*
Psychotropic Meds (Claims)	-6.35	.00	-.16**
Hispanic	2.83	.99	.13**

R^2 = .31 (N = 365, $p < .001$). *$p < .05$, **$p < .01$, *** $p < .001$.

A Closer Look: Regression Model Identifies Factors Predicting Improvement

DV: Change in Youth Needs (Behavioral Health, Functioning & Risks)

Predictors of Improvement	B	SEB	β
Wraparound Fidelity (Outcomes Based)	4.72	1.26	.19***
Wraparound Fidelity (Community Based)	2.44	.99	.12*
Initial Anxiety	.80	.21	.17***
Initial Conduct	.78	.24	.16**
Initial Delinquency	.58	.17	.16**
Initial School Achievement	.61	.21	.14**
Initial Social Functioning	1.03	.27	.18***
Initial Parental Substance Abuse	.59	.23	.12*
Psychotropic Medication	-5.32	.00	-.13**
Gender (Boys)	-.84	.41	-.09*
Hispanic	1.83	1.01	.08*

R^2 = .29 (n = 377 youth_CPS, $p < .001$). *$p < .05$, **$p < .01$, ***$p < .001$.

Discussion

Summary

- Grant provides opportunity to view impact of integrated policies & practices
- Youth with complex needs whose care is coordinated using WSM are likely to improve
- Findings consistent with earlier results (Effland, Walton & McIntyre, 2011)
- Monitor progress & outcomes
- Use information for quality improvement in policies and services

Limitations

- Limited to intensive services, not full spectrum of need across public services
- Convenience Samples
- Administrative data complemented by fidelity & satisfaction surveys
- Models explain only ~ 30% of change in needs…missing information

Conclusions

- Suggests benefits of sharing information across systems to monitor outcomes related to cross system integration
- Questions: Who benefits? Under what circumstances?
- Use information to help improve the quality of services and to guide policy and practice

References

Bai, Y., Wells, R. & Hillemeier, M. (2009). Coordination between child welfare agencies and mental health providers, children's service use, and outcomes. *Child Abuse & Neglect 33*, 372-381.

Brunk, M. & Innes, K. R. (2003). Caregiver perception of services and children's mental health outcomes: Are they related? In 15th annual research conference proceedings…. Tampa, FL: USF.

Bruns, E. j., Leverentz-Brady, K. M., &Suter, J. C. (2005). Is it wraparound yet? Determining fidelity standards for the wraparound fidelity index. In 18th annual proceedings…Tampa: FL: USF.

Burns, B. J., Phillips, S.D., Wagner, H. R., Barth, R. P., Kolko, D. J., Campbell, Y. & Landsverk, J. (2004). Mental health needs and access to mental health services by youths involved with child welfare: A national survey. *Journal of the American Academy of Child & Adolescent Psychiatry 43* (8), 960-970.

California Institute for Mental Health (CMHI) Workgroup. Mental Health Screening tool and the Mental Health Screening Tool for Children. www.cmhi.org.

Center for Health Policy. (2009). *Child welfare mental health screening initiative evaluation progress report, April 2009*. Indianapolis, IN: IU School of Public & Environmental Affairs.

Children's Mental Health Network. (2012).

Effland, V. S., Walton, B.A. & McIntyre, J. (2011). Connecting the dots: Stages of implementation, wraparound fidelity and youth outcomes. *Journal of Child & Family Studies 20,* 736-746.

Lyons, J. S. (2009). *Communimetrics: A communication theory of measurement in human service settings.* New York: Springer.

Raghavan, l R., Inkels, M., Franke, T., & Halfon, N. (2007). Administrative barriers to the adoption of high-quality mental health services for children in foster care: A national study. *Administration and Policy in Mental Health and Mental Health Services Research 34*, 191 – 201.

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