



Addressing Treatment Needs for Specialized Populations of Children and Youth

Executive Summary

Wisconsin's current systems of care lack the capacity and a suitable service array to provide appropriate treatment for children and youth with higher level needs and their families. Those children most profoundly impacted by this gap are more frequently being sent out-of-state to receive services, to the detriment of their recovery. Creating a system of care that meets the needs of these highest risk youth by implementing the most effective treatment protocols will contribute to a more efficient and fiscally sound continuum of services to benefit *all* Wisconsin children and families.

Addressing the systemic gaps will require development of some new and some re-designed placement options that employ evidence-informed practices led by qualified staff; improvement in assessment, referral and payment processes; and reforms in the partnership between government and the provider community.

Background

Profile of Youth in Crisis. In recent years Wisconsin has faced a growing issue related to the State's ability to provide the appropriate treatment services in the most conducive settings for children and youth who are considered to have higher level needs. Due to a gap in the current system of care, there are presently 18 children and youth (as of May 2016) who are receiving care out-of-state with several more awaiting placements who could potentially be placed out-of-state as well. The children and youth under consideration range in age from 12 to 17 and include males and females. They have been identified as having higher level needs due to presenting issues including but not limited to: mental illness with explosive, aggressive, or runaway behaviors; and cognitive impairments with delinquent and/or aggressive behaviors. While some of these children are disconnected from family, many of these children have engaged parents or guardians who cannot adequately address their mental health needs so opt to turn them over to the care of the state.¹

It is important to note that the brief case profiles available for development of this issue paper contained limited information. For example, the case profile summaries contained no information about trauma history, number of previous placements or any reporting on the family's capacities to care for their child. More thorough review of case histories would yield better insight into what could successfully meet these children's needs.

The reason most commonly identified for the current challenges around serving this population with higher level needs is a lack of program capacity. The issue of capacity is, in itself, multifaceted and there exist a number of factors that have contributed to this problem of insufficient capacity including: closure of state mental health and juvenile correctional facilities; closure of residential care centers within the past few years resulting in the loss of more than 100 beds; an increase of more than 500 children in out-of-home care, due in part to the

¹ It should be noted that those children and youth who are considered hard-to-place resulting in an out-of-state placement are the focus of this document and not those children who may be placed out-of-state due to other factors including natural supports in other parts of the country.

national opioid epidemic; agency efficiencies that have been implemented in response to rate setting which have resulted in the need for tighter, less elastic staffing patterns; and agency challenges around workforce recruitment and retention which restrict agency capacity to serve more challenging children, particularly when programs are near maximum capacity.

When the response to insufficient capacity is to send children and youth out-of-state to receive treatment, the effects are far-reaching and can significantly influence not only the children but also families and communities, not to mention having a substantial negative economic impact. Geographical distance from families and natural supports complicates family interaction, thus impeding family reunification efforts and further threatens the child and family bond. In addition, placement outside of Wisconsin makes it more difficult to facilitate quality transitions to community-based services. Perhaps out-of-state placements could be justified if the treatment programming offered unique services and supports, but there is no evidence that the out-of-state facilities to which Wisconsin children are being sent provide more skilled treatment. Rather, it appears that they may simply have systems and rules in place that allow for different service delivery standards and expectations.

Beyond these factors is the economic reality that annual payments to providers in other states for the care of now nearly 20 youth may total as much as \$3.5 million - resulting in a broader loss in Wisconsin economic activity of more than \$17 million and more than 100 jobs.²

PROMISING SOLUTIONS

The failure of existing systems to meet the needs of these challenging children and youth is both a crisis and an opportunity. Promising solutions should include an array of responses that are research-informed, trauma-focused, and targeted to deliver the right service at the right time. Services must provide stability, safety, continuity, and integrated care.

There are a number of service platforms and program models that should be considered for potential development or expansion that could more effectively meet the needs of Wisconsin's children and youth with higher level needs.

Central to the success of any proposed service or placement model is continued family engagement in the stabilization and ongoing treatment process. This includes parent training, psychoeducation, peer support, and the development of processes that utilize a team to wrap services around a child and family as a means to ensure continuity of treatment both prior to and following any placement. Engaging the family holistically requires that the system also attend to any family issues that threaten to de-stabilize the home environment including a focus on the family's ability to satisfy their basic needs.

New and Re-Designed Placement Options

- 1) Intensive Home-Based Care.** A model that has been implemented successfully in locations outside of Wisconsin is Intensive Home-Based Care which places a staff member in the home with a family at the time of a crisis with additional support and back-up provided by mental health crisis teams and law enforcement. Instead of disrupting current living arrangements, trained response workers diffuse crises at the site of the crisis for up to 72 hours. They work with the family to develop an individualized crisis plan and coordinate in-home follow-up intervention services for up to eight weeks.

² Estimate of impact on economic activity prepared by Steven C. Deller, Professor and Community Development Specialist, Department of Agricultural and Applied Economics, University of Wisconsin--Madison/Extension, <http://www.aae.wisc.edu/faculty/scdeller/>

Use of this model or other evidence-based programs such as Homebuilders (see Appendix – CEBC) in Wisconsin could potentially draw upon Medicaid crisis funding, CCS or another funding source to stabilize a child in place with 24/7 staffing support. This would allow for continued family involvement in the stabilization process as well as reducing further trauma to the child that can often result when out-of-home placement options are utilized. This would be a voluntary alternative for the family as it would require staff presence in the child’s own home.

- 2) **Short-Term Assessment/Stabilization.** Too often families and children must “fail” with less intensive interventions before qualifying for higher level care. For children with high level needs who are still at home, but experiencing a challenging mental health episode, the system should provide a temporary, short-term assessment and stabilization option. This service could be provided in a specialized treatment foster home or group home, but would most likely be offered in a residential care center. The intent of this service would be to provide an earlier intervention with quality assessment to seek to stabilize the child and get them home as soon as possible.
- 3) **Intensive Treatment Foster Care** programs provide youth with a structured environment and with foster parents who are specifically qualified to deal with challenging issues. Generally, this model requires the employment of trained professional foster parents with at least one parent at home and available to address the child’s needs. When foster homes such as these are not available to children and youth who may be functionally appropriate for a foster home placement, then congregate care can become a default option instead of a targeted treatment choice.

Wisconsin has explored intensive treatment foster care through narrow projects and pilots, but has not invested in developing the necessary regulatory and financial structures to facilitate statewide access. A key component to successfully implementing an intensive in-home treatment intervention or treatment foster care program is the funding structure, which has presented challenges in the past. Model programs such as the Teaching Family Model and Treatment Foster Care Oregon (see Appendix – CEBC) and treatment modalities like Multisystemic Therapy or Functional Family Therapy (see Appendix – EPISCenter) require the investment of resources to sustain fidelity. In order to provide the kind of well-qualified, one-on-one support that will most benefit those children and youth who do not thrive in larger congregate care settings, professional foster parents must be paid for their services regardless of placements. This funding arrangement is not currently possible under Wisconsin’s existing foster home payment structure and precludes development and retention of these skilled foster parents and homes.

- 4) **Crisis stabilization.** The system needs services that can effectively stabilize children who are placed in a treatment home or congregate care setting and at risk of disrupting. Such a well-designed stabilization resource would serve as an alternative to hospitalization and ideally prevent removal from the child’s current placement. The development of such services, accessible in all regions of the state would require contracted beds (in lieu of a daily rate) to support continuous and sustainable access.
- 5) **Refined Congregate Care Options.** As noted above, there are a number of factors that have reduced Wisconsin’s residential care capacity. In light of what is known about best practice in congregate care, the particular needs of the population of youth who are underserved within our current system, and funding changes anticipated from the federal level, the goal should be to develop specialized congregate treatment services that incorporate evidence-informed care models. Options include:
 - a. **Small Residential Settings.** Research and experience have shown that for many of the children and youth presenting with issues that can only be successfully addressed through specialized programs and services, smaller treatment settings are often the most conducive to stabilization and continued recovery. Such smaller settings would require units with 5 or fewer beds and be designed for shorter-term stays with

intensive residential treatment programming including a robust staffing pattern that incorporates more mental health practitioners; a trauma-informed culture; appropriate educational supports and quality discharge planning and aftercare services.

Such smaller settings might also incorporate secure options that are locked, but without a secure perimeter, or small units (5 or fewer youth) co-located on a residential campus to make “small” more financially viable. (See: “Secure RCC/PRTF below”)

Smaller settings were featured in the recently released research brief by Casey Family Programs entitled “Elements of Effective Practice for Children and Youth Served by Therapeutic Residential Care” (see Appendix - Casey). The Casey brief provides examples of program models and targeted interventions that are showing promise with the high-needs populations of children and youth identified in this paper. [Promising practices in residential include treatment interventions like Brief Strategic Family Therapy and program models like the Sanctuary Model (see Appendix – Casey) and Risking Connection (see Appendix – SAMHSA)]

- b. Specialized Group Homes** for one or two children may be an effective environment for youth with higher level needs who struggle in congregate care settings. Such a home would be similar to Level 5 foster care, however, Level 5 has relied on CLTS funding, which would not be available for group home care. This new licensure would need to address some of the limitations of Level 5 care, which has been hindered by a rigorous, time-consuming licensure process and substantial upfront investment without guarantee of placement approval.
- c. Secure RCC/PRTF Facilities.** Another model to consider would be a more secure setting in RCCs or Psychiatric Residential Treatment Facilities (PRTF), with designated safe spaces for de-escalation. Again, such a model would require a higher staff to youth ratio, more highly trained staff, and more therapists working more intensively with children and youth. Allowing for some locked space in a RCC or PRTF facility would provide alternatives for stabilizing crisis situations on-site rather than involving law enforcement or allowing runaway behaviors. Improving youths’ stability in the treatment setting reduces the risks to themselves and others and alleviates disruptions to the treatment process.

Wisconsin does not currently license PRTF level of care and there are acknowledged challenges associated with building this model including expense, the need for new licensure, the risk of children and youth remaining too long in this placement, and issues around ensuring census to make them sustainable. In spite of these challenges, if the issues could be adequately addressed and quality step-down options created, a PRTF-like facility could provide an alternative to more expensive hospital stays for a select number of children.

Creating smaller settings to serve Wisconsin’s higher need children and youth would be an appropriate response to Wisconsin’s gaps in capacity. Under current conditions, RCCs report that they must decline referred youth who may destabilize the RCC unit. Maintaining the appropriate balance between acuity and mix is critical for safety in RCCs. Wisconsin’s Level 5 foster homes have shown that smaller settings can be the most appropriate setting for youth who are triggered by the more populated environment in standard residential care. A smaller unit or home provides an environment that reduces triggers and enables a young person and care providers to work more proactively on self-regulation. Youth who learn to regulate on their own, can transition to a less restrictive setting and move on to increasing activities of daily living skills and academic education.

Improved Assessment, Referral and Payment Processes

In addition to enhanced placement options, there are process and procedure improvements that, if employed, would support a stronger continuum of care. However, these systemic changes will only be successful, if approached from a collaborative perspective and with the input, cooperation, and endorsement of multiple key stakeholders

Pre-placement Assessment. It is essential to the success of any treatment model that discharge planning commences immediately upon placement and remain an area of focus for all child and family team members throughout placement. A necessary first step to improving pre-placement assessment in Wisconsin is the adoption of a comprehensive assessment tool, such as the Youth Assessment and Screening Instrument (see Appendix – OJJDP), which could go beyond CANS and provide baseline information on the child and family to be used in the creation of discharge and aftercare plans.

Referral Process. An improved referral process would help both purchasers and providers identify the most appropriate treatment setting for a child who is difficult to place. Currently, county caseworkers make a referral to one or more providers. The providers they choose are often selected because the caseworker or others in their department have had a positive experience with that provider. If the provider is not able to take the youth, because they do not have an opening or because they are not equipped at that time to provide appropriate care and treatment for the youth, the caseworker is likely to send a referral email to all providers of that treatment type. When this action fails to result in a placement, the caseworker may call the original list again and ask for reconsideration. Following diligent efforts and repeated rejections, out-of-state placement is considered. This option is never preferred in these difficult cases because it usually costs more, takes the child further away from their family and the quality of the provider is less known. Devising a referral process that allows a select group of informed individuals to assist in the search for, and design of, an appropriate treatment setting is likely to improve the quality and stability of placements as well as reducing the current, inefficient swirl of paperwork that consumes caseworker and provider time without increasing the effectiveness of our system.

Convening a centralized panel to review these difficult cases and to facilitate a more targeted outreach to appropriate resources will create an alternative to “blast” referrals. This centralized panel would have the breadth of knowledge to better match youth in need of services with the best suited provider and would be able to connect the child and provider more quickly.

For these more intensive cases, the implementation of this permanency roundtable-like review would facilitate the early identification of those children and youth who may fall into the difficult-to-place category. The review process would utilize a standardized set of criteria such as number of previous placements, extreme dysregulation, and lack of permanent resource to identify children whose treatment plans require an intensified level of review. The need for such a review would be identified at an earlier point using predictive analytics.

Ideally, this centralized process would engage a statewide panel of experts and could include the authority to attach state funds/resources and essentially shift responsibility for the youth from the county to the state. This panel would be comprised of knowledgeable individuals possibly including state permanency consultants, county child and family supervisors, providers, children’s mental health clinicians, and consumers/families who have successfully navigated the system.

Payment Reforms. Providing quality services for these children and youth who are difficult to place will require some retooling of our payment models. Stable, sustainable funding is required to develop quality programs that attract and retain professional staffs who receive the level of training and support necessary to deliver trauma sensitive care. Covering the costs of smaller units becomes particularly challenging under a payment model that

only pays for days of care that are used. Such smaller units will require a methodology that insures their costs are covered whether they are full or not. In addition, funding of aftercare needs to be considered a basic component of quality care. Funding providers to follow youth back into the community will improve stability through the transition and sustain provider investment in the outcome. Purchasers and providers should work together to develop and experiment with payment models, like case rates, that incentivize movement from intensive levels of treatment into community-based settings.

Transitioning these challenging youth home and stabilizing them and their families in the community will require reforms in our mental health delivery systems and reimbursement rates, as well. Too often the siloed funding sources fail to address the holistic needs of families, including failing to address basic needs like housing and employment.

Reforms in the Partnership between Government and the Provider Community

As is true with any new initiative or systemic change, there will be obstacles to success that will need to be addressed throughout the process. Some of the obstacles to developing the previously outlined service models include: the challenges of working within the applicable licensing categories and dealing with the sometimes cumbersome timeframe associated with the licensing process, in particular in relation to Level 5 Foster Homes; ongoing concerns related to payment, start-up costs and the relationship between payment and census; recruitment and retention of highly qualified staff with the skills to work effectively with challenging behaviors; the provision of educational programming and support in smaller settings; and the resources to connect families dealing with challenging behaviors with timely respite.

Collaboration to Support Transitions. The current purchaser/provider arrangements and program boundaries must be reassessed in order to ensure that children and youth and their families experience a more seamless transition from placement back to home. It will also be essential for families to receive the additional support they require to maintain stability in the home environment. As noted above, county purchasers currently control post-discharge services and spending which leaves providers with little information and little influence once a youth returns home. Greater coordination between purchaser and provider in both planning for and supporting discharge and aftercare strategies will benefit children and youth greatly and will facilitate the achievement of better long-term outcomes.

Positive movement in this direction is already happening where counties and providers collaborate on the goals outlined by the Wisconsin Post-Reunification Support Program which include: promoting family stability and adjustment following a child's reunification to the family home; empowering parents to strengthen caregiving, problem-solving, and coping skills; and improving the short and longer term well-being of the child and his or her family members.

Licensing and Enforcement. Overall, the proposed initiatives would also benefit from a shift in the current licensing paradigm to one that is more supportive and employs a more collaborative and trauma-informed approach that would result in fewer placement disruptions. What is envisioned is a move away from licensing that threatens noncompliance/citation on every point, thus forcing a provider to give notice on a child rather than run the risk of closed placement status. The licensing relationship should move toward a quality improvement model that supports provider efforts to serve challenging children. For example, consider a child who may have been discharged from an RCC and who was successful in the program but who, during the course of a year with the provider, had two instances of ingesting small items. The two citations that were issued created concern about a possible "pattern" of noncompliance/citation that would result in closed placement status. This concern poses added risk for the provider, so the provider gives notice. Although there is no evidence that another provider would be more successful in serving the child, the licensing approach leaves the provider with limited options.

Liability Reform. It goes without saying that challenging children and youth pose a significant liability risk (harm to self, others, community, etc.) to providers who are not afforded the same liability protections as those enjoyed by government. If providers are to continue to be considered an arm of government in contracting and auditing, then efforts to reduce liability must also be implemented to afford those providers that are able to work with difficult-to-place children and youth greater incentive to do so.

CONCLUSION

There is no single strategy to address the challenge that Wisconsin faces with regard to fully serving this particularly challenging, special population of youth. It is clear that a fuller picture of the placement and trauma history of these children and their families would better inform stakeholders and contribute to the development of more targeted solutions. The investments and alternatives offered in this issue paper represent the best effort of the provider community at this stage to put forward options to address deficits in the system and gaps in service delivery. This provider community contribution combined with similar analyses/proposals under development by both state and county stakeholders should result in the formation of comprehensive solutions to keep more Wisconsin children closer to home and improve the chances for all youth in care to find safety, stability and well-being.

Proposed First Steps

1. **Improve assessment and referral.** Establish a Roundtable Review Panel and develop referral criteria to be used with the most challenging cases. Guarantee availability of the highest level of funding for youth who qualify for the Roundtable Review process. This referral process must be accompanied by a robust assessment process that identifies youth strengths and needs so that they are appropriately placed with solid treatment plans.
2. **Fill a gap in the system.** Support implementation and full funding of an intensive home-based care initiative that can serve as a model for stabilizing challenging youth in their home setting and preventing more restrictive placement.
3. **Improve placement options.** Develop two small-site residential pilots implementing programs using an evidence-based, trauma-informed program to care for:
 - a. **Site 1.** Youth with mental illness and explosive, aggressive or runaway behaviors.
 - b. **Site 2.** Youth with cognitive impairments with delinquent and/or aggressive behaviors.
4. **Gather better information for a better system.** Fund an in-depth analysis of children, whose needs are not being met by the current system, including: consideration of placement and trauma history; the systems in which youth and families were involved and when interventions occurred; and the types of services and supports that were provided. The purpose of the analysis would be to ascertain, through careful and considered review of case histories, whether there were missed opportunities or whether purchasers or providers may have contributed to the trauma that resulted in these children and youth becoming “difficult-to-place.”
5. **Recruitment and retention.** Invest in a workforce improvement initiative to: 1) make youth care work more attractive and more economically competitive; 2) promote professional growth through investments in training and career progressions; and 3) support sufficient staffing and supervisory/clinical resources to improve the quality of the care milieu.

Resources for Evidence-Informed and Promising Practices in Child Welfare and Juvenile Justice

- Casey Brief - Elements of Effective Practice for Children and Youth Served by Therapeutic Residential (Casey)
- Office of Juvenile Justice and Delinquency Prevention (OJJDP)
- California Evidence-Based Clearinghouse (CEBC)
- Substance Abuse and Mental Health Services Administration (SAMHSA)
- Washington State Institute for Public Policy (WSIPP)
- Evidence-based Prevention and Intervention Support Center (EPISCenter)
- National Child Traumatic Stress Network (NCTSN)