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# **A New Service Array for Children with Serious Emotional Disturbance**

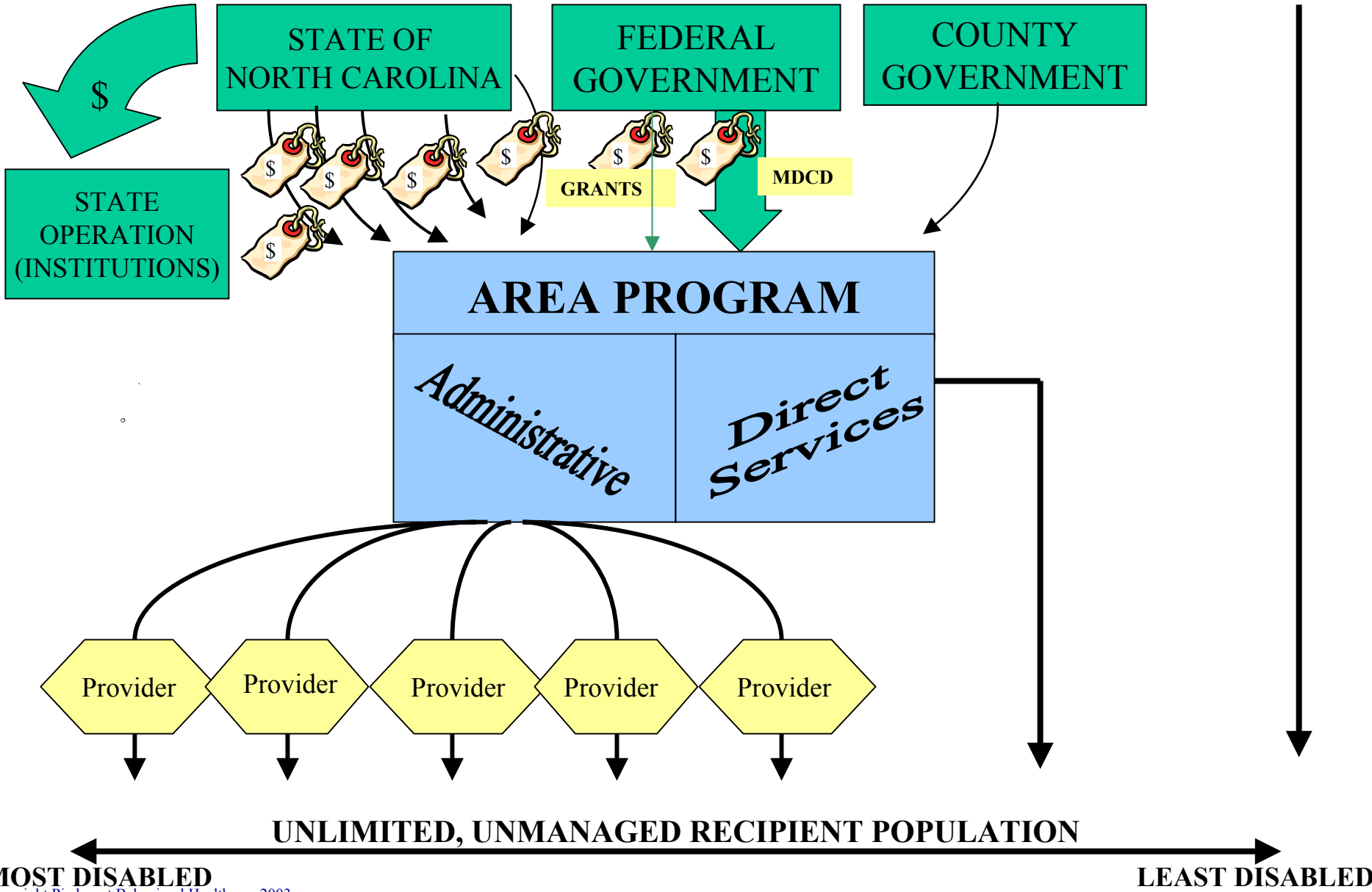
Presented by

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and Delinquency Prevention  
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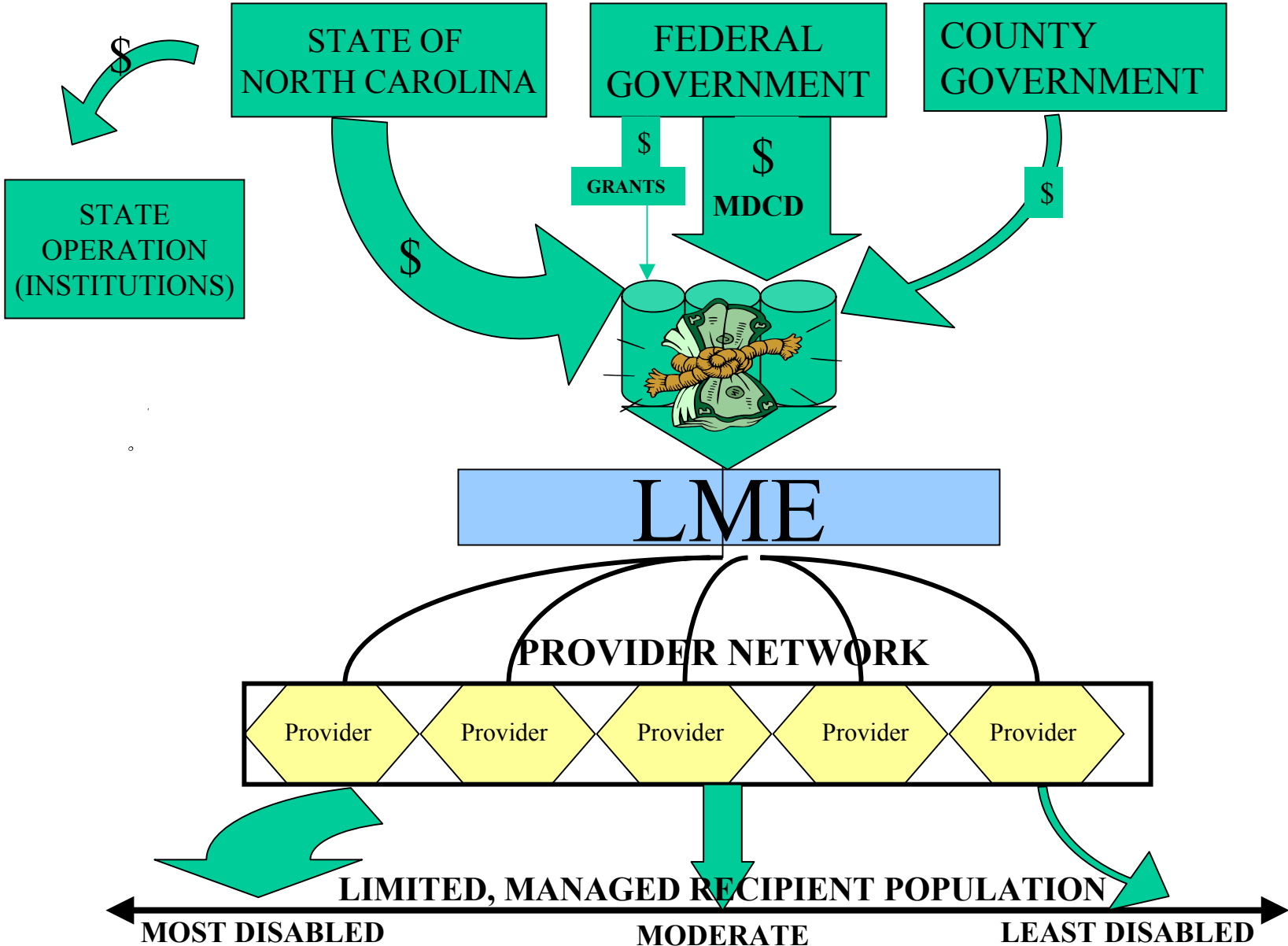
# CURRENT SYSTEM

TOP  
DOWN  
SYSTEM



# REFORMED SYSTEM

BOTTOM  
UP  
SYSTEM



# Section I: What Exists Now

The following four levels of care for children with serious emotional disturbance are currently provided by Piedmont Behavioral Healthcare or their contractors:

- Inpatient
- Child and adolescent residential
  - o Therapeutic foster care
  - o Group homes
  - o Non-secure residential
  - o Secure residential
  - o Psychiatric Residential Treatment Facility

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- Partial hospitalization
- Day Treatment
- Outpatient
  - Family Preservation Services
    - Solution-focused Model
- Community Based Treatment
  - Child ACT team
  - Summer programs
  - In- home behavior modification program
  - Skill development

# Section II: What's Been Recommended

- Improve clinical competency of providers, especially child residential
- Train providers to handle crisis situations that do not warrant hospital or medical intervention
- Respite
- In home interventions
- Wrap-around services

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- School supports-need to differentiate services provided by paraprofessionals vs. professionals. Currently the only distinction is a significant cost difference.
- Day treatment options for children
- Intensive Outpatient Treatment
- After school and summer programs for prevention, education, treatment and supervision
- Age grouping of children in services must be reviewed with parameters established

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- Family preservation type of home intervention programs
- ACT teams for children
- Family support groups that work
- Enhanced family involvement in treatment of children

# Section III: Detailed Descriptions of Recommended Additions to Current Service Array

- Sheila Pires, PhD, from Georgetown University, in a recent presentation to the President's Commission on Mental Health emphasized that the interventions with the highest level of efficacy for children and adolescents include intensive case management, in-home services and therapeutic foster care. Dr. Pires also stated that there is a significant body of research that supports that the interventions with the least efficacy include inpatient treatment, residential treatment and therapeutic group homes. The recommendations that follow are all based on interventions with the most evidence supporting their efficacy.

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# Recommendation#1: Replicate Wraparound Milwaukee

Wraparound Milwaukee is a highly successful program that focuses on family and children's strengths. It provides one service plan for each family across systems of care. Its basic tenet is community based treatment and care, is needs driven vs. categorical service driven and seeks parent choice in the selection and provision of services.

Wraparound Milwaukee is a public care management organization. Its charge is to manage care of children with serious emotional and mental health needs that are at immediate risk of residential treatment, correctional placement or psychiatric hospitalization. It pools \$30 million dollars in funds from child welfare, mental health, Medicaid, and Juvenile Justice. All referrals come through Child Welfare of Juvenile Justice.

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## Program components include:

- Fiscal and operational management
- 24 hour mobile crisis team
- Care coordination
- Provider network that includes 80 agencies and 230 agency and individual providers
- Extensive use of informal supports, e.g., Boys and Girls Clubs, churches, civic organizations

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## Diagnostic profiles of children served include:

- 65% Conduct Disorder
- 50% Depression/Oppositional Defiant Disorder
- 46% Attention Deficit Disorder
- 25% Substance Abuse Disorder

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## Outcomes include:

- Average daily residential treatment population reduced from 375 placements to 60 placements
- Psychiatric Inpatient Treatment reduced from 5000 days per year to under 200 days with an average LOS of 2.8 days
- Better clinical outcomes
- Reduced recidivism of delinquent youth served
- Increased school attendance
- High level of parent satisfaction
- Reduction in cost of care

The monthly cost for WAM is \$4350 vs. \$7200/mo for residential treatment, \$6000/mo for correctional placement or \$600/day for psychiatric inpatient care.

# Recommendation #2: Multisystemic Therapy

Multisystemic therapy (MST) is a family and home-based treatment that addresses the known determinants of serious antisocial behavior in adolescents. MST treats those factors in the environment that contribute to the adolescent's problems. Such factors might include poor problem solving skills, family issues such as ineffective discipline, poor academic performance and association with deviant youths. Treatment goals are highly individualized in collaboration with the family. Family strengths are used as levers for therapeutic change. MST interventions use the best of evidence-based empirical treatments such as cognitive behavior therapy and family therapy. The primary goals of MST are to reduce out-of-home placements and empower families to resolve future difficulties.

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Central to the success of MST is the use of a home-based model of service delivery including low caseloads and time limited duration of treatment. Home-based interventions provide the necessary level of intensity necessary to treat youth with serious clinical problems and their multi-need families. Studies are currently underway to measure its effectiveness with youth having serious clinical problems that have a history of psychiatric emergencies as an alternative to emergency hospitalization.

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- The primary goals of MST are to:
  - o Reduce youth criminal activity
  - o Reduce other types of antisocial behavior such as drug abuse
  - o Achieve these outcomes at a cost savings by decreasing rates of incarceration and out-of-home placement.

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Randomized clinical trials have demonstrated both the efficacy of MST in achieving the goals above as well as the importance of therapist adherence to the MST treatment protocol. Therapists and supervisors receive training in one of three ways. First, a 5 day intensive on-site orientation is provided. Second, 1.5 day booster sessions are provided quarterly. Finally, treatment teams and their supervisors receive weekly case consultations from the MST experts.

MST treatment typically lasts about four months, with multi-family contacts occurring in the home each week. As families approach discharge from the program, the frequency of contact lessens.

# **Recommendation #3: Therapeutic Foster Care**

Therapeutic foster care (TFC) is considered the least restrictive form of out-of-home therapeutic placement for children with severe emotional disorders.

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# Common features in therapeutic foster home programs include:

- Children are placed with foster parents who are trained to work with children with special needs
- Usually each foster home takes one child at a time, and caseloads of supervisors remain small
- Therapeutic foster parents are paid a higher stipend than that received by traditional foster parents
- Therapeutic foster parents receive extensive preservice training and in-service supervision and support. Frequent contact between case managers or care coordinators and the treatment family is expected, and additional services such as mental health services are provided as needed.

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- The goal of therapeutic foster care is to enable a child to overcome emotional, behavioral or psychiatric problems in a highly supportive, individualized, and flexible residential placement, thereby assisting the child to return home or move to a less intensive foster setting. TFC is utilized for both long term individualized residential treatment and for short-term crisis stabilization. The South Carolina model of TFC also provides Temporary De-escalation Care Services (TDC) through its foster care program. These TDC Services are designed to de-escalate potential crisis situation and/or provide a therapeutic outlet for a child's emotional problems. The goal is to prevent the permanent disruption of a child's placement. This service is short in duration and emphasizes the stabilization of the child.
- Outcome measures for the South Carolina TFC program indicate that 73% of children placed in TFC were discharged to a less restrictive environment and 90.5% of young people had no illegal offenses during that period.

# Recommendation #4: Intensive Case Management

Intensive case management is designed to assist young people who have been diagnosed with a psychiatric disability and their families. Intensive case managers work intensively with a child's family to coordinate with teachers and other helping professionals to develop an individualized comprehensive service plan. Qualified and specially trained professionals assess and coordinate the supports and services necessary to help children and adolescents live successfully at home and in the community. Caseloads are small (12 recipients to one ICM) and the intensity level of ICM for children and youth is demonstrated by the 24 hour/day, 7 days/wk response capacity.

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Research and experience indicate that case management is a valuable and widespread element of mental health services for children with severe emotional disturbance. In two controlled studies the Children and Youth Intensive Case Management program was evaluated. In the first study, the authors found that children in ICM spent significantly more days in the community between episodes of psychiatric hospitalization and were hospitalized for fewer days than before enrollment (Evans et al., 1994). A subsequent study looked at a random sample of children enrolled in ICM. Major behavior improvements and decreases in unmet medical, recreational and educational needs compared with findings at enrollment were noted in a three year follow-up study. In addition, although the children in ICM spent more days in psychiatric hospitals before enrollment, they used inpatient services significantly less than did non-ICM enrollees (Evans & Huz et al, 1996).

# Recommendation

## #5: Homebased Services

Homebased Services are designed to replicate the kind of intensive and coordinated services for emotional and behavioral problems which children receive in more costly residential placement facilities. Instead of moving the child to the service, the service is brought to the family and the child. Services are provided on site to the child and family in their home, school and community environment; the level of intensity is need based. The Homebased Therapist in the Bowen Center Model ([www.bowencenter.org](http://www.bowencenter.org)) is available to the client for regularly scheduled appointments as well as emergencies on a 24/hr basis.

In addition, individual therapy, group therapy and doctor's services are among the other services accessed by 85% OF Homebased Clients to help meet treatment goals.

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- Criteria for placement include:
  - o Children at risk of residential placement
  - o Children involved in a current and immediate crisis
  - o Children involved with multiple agencies in the community

Length of stay in homebased therapy is for a period between six and twelve months. At termination from homebased services, the client is transferred to less intensive services as progress toward treatment goals is achieved.

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Hospitalization or placement is viewed as part of treatment, rather than the sole component. Such placements, therefore, are short, temporary and implemented for a specific purpose in relation to the client's goals. In FY'97, only 17% of crises in the home resulted in emergency hospitalizations, with only 6% requiring two or more hospitalizations.

# Recommendation #6: Virtual Residential Program (VRP)

Family Preservation services, Inc. has developed a virtual residential program designed to provide families, schools and communities with a community-based alternative to unnecessary out-of-home placements, and/or to expedite successful reunification of youth and their families following residential, psychiatric or foster home placements.

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The Virtual Residential Program is described as a distinctive service methodology that unites highly structured, Multisystemic in-home services with the intensity of a residential approach. The average intensity of services initially is thirty-five hours per week, with focus on defusing imminent risk factors and implementing crisis stabilization plans. Services are initially planned within an eight week time frame and extended in four week increments based on treatment team recommendations. Step-down services are available to transition clients toward less restrictive services at the earliest possible opportunity.

# Section IV: The Reconfigured Children's Service Array for Counties Serviced by Piedmont Behavioral Healthcare

One of the most significant changes that a behavioral healthcare system experiences in the shift from a fee-for service model to a capitated model is the expansion of their service array. This is due to a new interest in preventative, early intervention and effective lower cost interventions that allow the provision of more services to more people within the capitated amount. In year 1 it is recommended that the following services be augmented or added to the Piedmont Behavioral Healthcare Service Array. These recommendations are based on both community recommendations and a review of current evidence-based practices in specific areas as discussed above. The current array is presented with new or augmented services **highlighted** to assist in their identification.

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- Inpatient
- Child and adolescent residential
  - Therapeutic foster care (**Expanded**)
  - Group homes
  - Non-secure residential
  - Secure residential
  - Psychiatric Residential Treatment Facility
  - **Virtual Residential Treatment**
- Partial hospitalization
- Day Treatment

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- **Outpatient**
  - Family Preservation Services
    - Solution-focused Model
- **Community Based Treatment**
  - Intensive Case Management (**Expanded**)Child ACT team
  - Summer programs
  - In- home behavior modification program
  - **Home-based Services**
  - Skill development
  - **Wrap Around Milwaukee**
  - **Multi Systemic Therapy**

# Section V: Implementation

## Recommendations for Year I and Year II

The following priorities were established based on input from both Piedmont Behavioral Healthcare directors and stakeholders representing the five county area for the proposed LME. Both groups based their prioritizations on those interventions they believe will send a clear message to the community that the LME represents both a change in treatment philosophy and in the current array of services.

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## **Year I priorities were as follows:**

- **Expansion of intensive case management for children and adolescents** (Both stakeholders and staff selected this as the #1 priority for Year I)
- **Home-based services** (Stakeholders group for year I)
- **Expansion of Therapeutic Foster Care** (Both stakeholders and staff selected this as a Year I priority)

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## **Year II priorities were as follows:**

- **Wrap Around Milwaukee** (Stakeholders unanimously selected this as their #1 priority for year 1; only 1 staff selected it for year 1)
- **Virtual Residential Programs** (Staff unanimously selected this as #1 priority for Year II; only 1 stakeholder selected it for year II)
- **Multi Systemic Therapy** (Both stakeholders and staff selected this a priority)

# Section I: What Exists Now

For children in crisis:

- 24/7 emergency on-call system
- Crisis unit (60-90 days)-takes day admissions only
- Davidson County provides 24/7 case management services for 40 at-risk children
- Davidson County has access to 3 beds per month at Mills Home; take admissions Monday through Friday and must have DSS or Juvenile Justice involvement

# Section II: What's Been Recommended

For children in crisis:

- Foster homes
- 23 hour observation
- Residential-crisis respite
- Family Preservation services-team to support, on call to go into home if needed during times of crisis to de-escalate and then back out
- ACT Teams:
- Expand for adults with mental illness
- Study for children
- Study DD/MI ACT team

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- Mobile Crisis teams:
  - Study model, how it would work locally, can it be done in a cost effective manner. These teams can be expensive; may not work as well in rural settings; must have law enforcement buy-in.
- Support for persons in out of home placements-link and transition back to home setting; there must be continuity/coordination by :
  - Case management
  - Physician
  - Therapist
- Warm line for consumer support
- Improvement of Involuntary Commitment process to be more supportive of consumers during times of such stress.

# Section III: Detailed Descriptions of Recommended Additions to Current Service Array

- *Comprehensive Psychiatric Emergency Program (1 for adults and 1 for children to start)*
  - *The Comprehensive Psychiatric Emergency Program (CPEP) operates separately from the main emergency department of the medical center. CPEP includes 72-hour extended observation beds, and one or more mobile crisis units. CPEP provides emergency psychiatric evaluations for people who are in crisis and may initiate treatment activities while in the program. All discharges from CPEP who require additional mental health services require a discharge plan. Both the CPEP and the mobile crisis units operate 24/7. CPEP has been a major success in reducing unnecessary hospitalization and offering intensive psychiatric assistance in times of crisis.*

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*The New York State Office of Mental Health, the District of Columbia and Maricopa County in Arizona all use this model to provide for psychiatric observations beds. In Maricopa County, the extended observation units are often used to evaluate a client and initiate treatment prior to making a determination for involuntary commitment. The 72 hour observation period is a critical component in averting involuntary commitment and stabilizing the client.*

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# *Mobile Crisis Team-Youth*

*Rochester, New York has established Youth Emergency Services (YES). Child crisis specialists provide rapid access to services for children in psychiatric crisis. These specialists provide assessment and appropriate short-term crisis counseling. When appropriate, they link the child/family with other services and resources. Four major interventions are provided that include:*

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- *Emergency Case Management*

- This function is designed to facilitate referrals to ongoing mental health services and assist the family with accessing other necessary services that will stabilize the family environment. The crisis specialist refers youth/families for emergency case management.

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- *Mobile Crisis Team*

- This service is attached to the Comprehensive Psychiatric Emergency Program (CPEP). The Mobile Crisis Team provides on-site services for children who are unable to go directly to a Youth Emergency Services provider. Child specialists on the team meet with the child and family in the home, school, or community and provide a one-time assessment and follow-up. This service serves to frequently prevent either hospitalization or the removal of a child from the home. Primary services are provided to children experiencing suicidal ideation, exhibiting self-destructive behavior, and suffering from intense, severe, and acute emotional and psychiatric disabilities.

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- *Home Based Crisis Intervention*
  - This service provides intensive in-home therapy, advocacy and skill building for a duration of six weeks, 6-10 hours per week. The primary goals of this intervention are to stabilize the crisis situation, keep the child safely at home and divert a psychiatric hospitalization.

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- *Children's Crisis Residence*

- This crisis residence provides short-term residential care for children (ages 5-17) who are in acute emotional distress but not in need of psychiatric hospitalization. Children referred to this program are in a psychiatric, emotional or behavioral crisis. Placement is voluntary and is not to exceed fourteen days. The goal of the placement is to address the presenting problem while avoiding the use of the hospital emergency department or an inpatient admission. Most children return home within two weeks with ongoing support. While in placement, the child can continue to attend school if the district will supply transportation. If not, an in-house tutoring program is available where the child can complete schoolwork provided by the district.

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- *Crisis Respite Care*

- This service is facility-based. One such facility in Columbus, Ohio (Miles House) is designed to meet the needs of individuals during crisis. Miles House is a 16-day program that can serve as many as eight persons at a time. As an alternative to hospitalization, Miles House is a supportive setting serving persons 18 years or older. The hallmark of this facility is that it treats persons with respect and dignity while stabilizing their crisis situations.
- Child crisis respite models are available as well.
- Lengths of stay can be as short as overnight or up to 16 days. Most stays are shorter in duration, especially in those systems in which alternative wrap around services are available.

# Section IV: The Reconfigured Crisis Service Array for Counties Serviced by Piedmont Behavioral Healthcare

- For children in crisis:
  - o 24/7 emergency on-call system
  - o Crisis unit (60-90 days)-takes day admissions only
  - o Davidson County provides 24/7 case management services for 40 at-risk children
  - o Davidson County has access to 3 beds per month at Mills Home; take admissions Monday through Friday and must have DSS or Juvenile Justice involvement
  - o **Advance Directives as age-appropriate**
  - o **Mobile Crisis Teams**
  - o **Crisis Respite**