Department of Human Services
Addictions & Mental Health Division

CHILDREN'S SYSTEM CHANGE INITIATIVE (CSCI)
OUTCOMES AND
SUMMARY OF ACCOMPLISHMENTS
April 11, 2007

Children with High Mental Health Needs

→ **Children are being screened for and served within the Integrated Service Array according to a standardized level of need determination protocol for their mental health service needs**. Every Community Mental Health Program (CMHP) and Mental Health Organization (MHO) is using a comprehensive, validated instrument (the Child and Adolescent Service Intensity Instrument, or CASII) to determine children's mental health service needs. This instrument is part of a protocol in every county using several sources of information to make the determination.

→ **Children with high needs, and their families, typically experience a dramatic increase in the breadth and frequency of community-based mental health services following a level of need determination.** The increase is most dramatic for non-traditional services such as wraparound, case management and respite care.

→ **A wide variety of persons and agencies are able to access the mental health assessment services needed to screen children for the Integrated Service Array.** Approximately 49% of the referrals for level of need determination have come from a mental health provider, 24% have come from a child welfare worker, 9% from an educational services provider, 7% from a parent, 5% from a Juvenile Justice official, and the 6% remainder from other sources.

→ **Many children have already been screened for level of service need, and are being served, within the Integrated Service Array.** Since the CSCI implementation date of 10/1/2005, approximately 1,300 children have been referred for screening for the Integrated Service Array. 88% of these children were deemed appropriate for treatment in the Integrated Service Array.

System Structure and Function

→ **Intensive Community-Based Treatment and Support Services (ICTS) are being provided to every child entering the Intensive Service Array.** This includes a child and family team, care coordination and integrated services.

→ **All 9 Mental Health Organizations in the state have a Children's System Coordinator.** Care coordination is available and provided throughout the state in every county. However, developing the availability of adequate numbers of care coordinators, and training both care coordinators and their supervisors is still a pressing need.

→ **Every MHO has a children's system advisory committee with 51% family member representation.**

→ **Since the transition to a new system of services and supports for children, MHO enrollment of children has increased significantly.** In the first 9 months following initiation of the CSCI, MHO enrollment of children increased 4.4% (from 209,377 enrollees in the 3rd quarter of 2005, to 216,649 enrollees in the 2nd quarter of 2006).

→ **Since the transition to a new system of services and supports for children, the percentage of MHO enrolled children who are served has also increased significantly.** In the first 9 months following initiation of the CSCI, the number of enrolled children served increased from 9,198 (in the 3rd quarter of 2005) to 11,086 (in the 2nd quarter of 2006).

→ **The increases in the number of children enrolled and served by MHOs further underscore the impact of a recent 7% average decrease in MHO Intensive Treatment Services (ITS) capitation rate, and reimbursement issues surrounding psychiatric residential treatment costs which have not been adjusted to keep pace with inflation in over a decade.** However, it should be noted that overall, MHO capitation rates increased, on average, 1.4% during the 2007 rate setting process. Plan specific rates were established for 2007 only, and discussion will be ongoing with MHO contractors.

→ **Due to minimal of increases in daily rates, providers are unable to pay a livable wage to the staff who work with the children.** This results in high staff turnover and poorer treatment outcomes.

Service Utilization

→ **Following the transition to a new system of services and supports for children, the number of children admitted to a psychiatric day treatment setting (PDTS) or a psychiatric residential treatment setting (PRTS) decreased significantly**. The number of admissions to a PDTS decreased from 170 (in the 2nd and 3rd quarters of 2005) to 155 (in the 2nd and 3rd quarters of 2006). Similarly, the number of admissions to a PRTS decreased from 393 (in the 2nd and 3rd quarters of 2005) to 346 (in the 2nd and 3rd quarters of 2006).

Decreasing admissions to PRTS, while a positive sign of change, may jeopardize an already destabilized fiscal picture for psychiatric residential providers. Psychiatric residential treatment reimbursement rates were last audited over ten years ago and have not kept pace with inflation.

→ **As of the end of 2006, a significant number (over 500) of the children in the Integrated Service Array were being served in a community setting rather than in a psychiatric day treatment or residential treatment setting**. The types of services they were receiving in the community could include intensive outpatient, Wraparound, care coordination, skills training, respite care or crisis respite care [1].

→ A recent memorandum by the PSU/RRI team of researchers evaluating the CSCI indicated that **most mental health organizations in Oregon will need 3 additional care coordinators added to their region** to reach caseload ratios suggested by federal research findings. This information has been communicated to legislators.

→ **The average duration of PRTS treatment episodes has decreased from 174.6 days in the first three quarters of 2005 to 136.6 days in the remaining quarter of 2005 and all of 2006, following the transition to a**

[1] The array of services included under the rubric of "Intensive Community Based Treatment and Support Services (ICTS)" has changed since initiation of the Children's System Change Initiative (CSCI). Thus, comparing the number of children in the Integrated Service Array who received ICTS before versus after the CSCI is not meaningful.

new system of services and supports for children. PRTS providers continue to develop and broaden their service base in an effort to diversify intensive community-based treatment options available to children and their families.

→ **The average duration of PDTS episodes has increased from 382.1 days in the first three quarters of 2005 to 445.5 days in the remaining quarter of 2005 and all of 2006, following the transition to a new system of services and supports for children.** This is reflective of a community-based approach to care, as children in psychiatric day treatment are living in their communities.

Family Satisfaction and Meaningful Family Involvement

→ **During the transition to a new system of services and supports for children, parent and caregiver satisfaction with the coordination of mental health services, educational services, juvenile justice services, and child welfare services has improved (**Source: 2005 and 2006 Youth Services Survey for Families).

→ There are **114** family members **trained to participate** in advisory councils, planning groups and workgroups. **Every MHO has a children's system advisory committee with 51% family member representation**.

→ There are **16** family members participating at a **leadership level and conducting trainings** of other family members in family driven services and family involvement.

→ **11** family members are hired/subcontracted with MHOs and **providing local family involvement coordination and leadership.**

→ **14 youth are involved in advisory committees** at the local, regional and state levels.

→ **Family perception of outcomes from 2006 Youth Services Survey for Families:**

- 86 % or more were **involved** in their children's treatment
- Overall, 72% or more felt services were **appropriate**