CHILDREN'S SYSTEMS OF CARE

by Sue O'Connell
for the Children, Families, Health, and Human Services Interim Committee
June 2008

Background

Many states are starting to build what is known as a "system of care" for children with mental health needs. The system is a partnership of service providers, family members, teachers, and other involved in the child's life. When appropriate, other participants may include school representatives, child welfare and developmental disabilities caseworkers, chemical dependency counselors, and juvenile justice officials.

These partners develop a plan for providing services from all appropriate agencies in a manner that:

- focuses on the family and is based on the family's perspectives, values and preferences;
- meets the needs of each child and family;
- builds on the identified, unique strengths of each child and family; and
- allows regular review of the child's progress toward the goals set in the plan.

Participants in the process work together to emphasize flexibility in funding the needed services, to share responsibility for the success of the plan, and to keep family members informed about what they need to do to participate in the process.

This approach is known as a "wrap-around" philosophy or process.

The federal Substance Abuse and Mental Health Services Administration (SAMHSA) has provided grants to many states to start building their systems of care.

Montana's System of Care

Montana is still working to develop its system of care and to put the wrap-around process into place, funded in part by a five-year SAMHSA grant. A statewide committee with two parts oversees the process:

- The Statutory Planning Committee is made up representatives from state agencies and divisions that work with children.
- The Community Planning Committee is made up of representatives from five "Kids Management Authorities," teams from other communities, and mental health providers.

The SAMHSA grant has helped fund the five Kids Management Authorities (KMAs), which are local teams of parents, youth, advocates, mental health providers, and state agency representatives. The KMAs are located in:

- Butte,
- Helena, serving three counties,
- Havre, serving Hill County and the Fort Belknap and Rocky Boys Indian Reservations,
- Yellowstone County, and
- The Crow Indian Reservation, which partnered with the state in obtaining the SAMHSA grant.

Other local planning teams have formed on a voluntary basis, without the federal funding.

KMAs have two functions:

- To create a process for identifying and creating resources within a community and developing policies for delivering services for children in a unified way.
- To take part in the care team for individual children.

In addition, the Department of Public Health and Human Services has been providing training on the wrap-around philosophy to people across the state, many of whom also take part in sessions that allow them to provide the training in their own areas.

What Lies Ahead for Montana

While Montana has started the system of care process, work is continuing on how to strengthen and expand the system. Toward that end, the Community Planning Committee conducted a two-day planning session in January 2008.

One of several documents developed at that time is attached, listing the barriers that KMAs encounter when trying to provide services for families.

Sustainability of the system is also an issue that looms on the horizon. The federally funded KMAs currently must match their federal funds with a 50% local match. That ratio changes at the end of September 2008, when the federal share decreases to 33% and the matching funds must increase to 66%. The 2007 Legislature allocated $371,000 in each year of the biennium for system of care activities. These funds will assist with the higher matching requirement, but may not be enough help the five KMAs fully meet the requirement.

The state and the KMAs also are planning ahead to determine which of the system of care elements that were put into place during the grant period can and should be kept in place without the federal funds.

The Department of Public Health and Human Services has submitted a request for $300,000 in the next biennium for system of care sustainability. The request is working its way through the state budget process, for possible inclusion in the governor's budget.

Cl0425 8154soxg.

From the System of Care
Community Planning Committee
January 2008

What are barriers KMAs encounter when trying to provide services for families?

1. Not getting regular referrals from system partners
   - Need more diversify of referral sources, for example, from schools.
   - KMAs work with some critical situations; not receiving early intervention referrals.
   - Some agencies (juvenile probation in Billings) are developing internal policies to support referral to the KMA.
   - Would KMAs have the capacity to respond to a lot of referrals, if using wraparound process?

2. Hard to serve youth that aren't Medicaid eligible or will lose Medicaid eligibility upon return home.
   - When child in the DD Waiver leaves the community, youth loses Waiver slot. Hard to return to community services without access to Medicaid

3. In some communities Juvenile Justice kids aren't processed through KMA.
   - Youth have to have SED and Medicaid to access most services.
   - Juvenile probation officers not convinced of value of using KMA

4. KMAs require a Mental Health Diagnosis
   - Schools do not want to label kids, especially SED.
   - Stigma of a diagnosis

5. Transportation
   - Difficult for parents to find transportation to visit with child and/or participate in meetings.
   - Case manager not allowed to transport
   - Transportation options in many communities limited.

6. Lack of participation from Child and Family Services system.
   - Social workers concerned about being able to demonstrate permanency outcomes for difficult family situations
   - Perceived lack of value to participation

7. Lack of Basic support services for families to help them meet address child's needs.

9. Some KMA members are not receptive to parent participation.

10. More participation from First Health.
    - Some KMAs miss First Health clinical expertise and information.

11. Not enough lead time for discharge planning for youth returning to the state or community from RTC or group care.

12. Lacking buy-in from youth case management.
    - Professionally driven rather than family driven.

13. Lack of respite care and other community services