Effective Collaboration with Child Welfare: Building Partnerships on Behalf of Youth with Identified Mental Health Needs

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Mental Health Services Program for Youth (MHSPY) / Neighborhood Health Plan

Overview

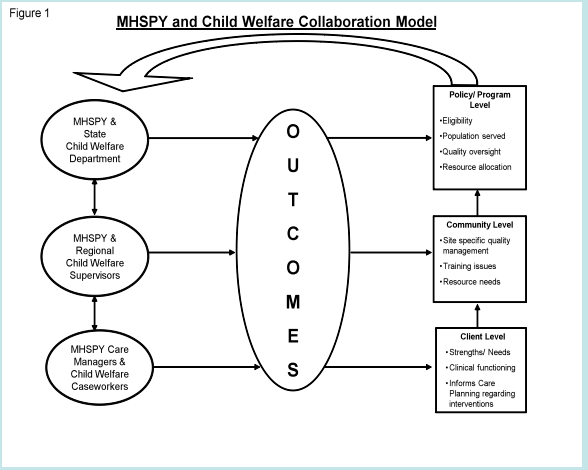
The Mental Health Services Program for Youth (MHSPY) program is an interagency collaboration designed to provide intensively integrated care coordination for children and youth with identified behavioral health needs, in partnership with families, providers, and state agency stakeholders. The MHSPY target population consists of Medicaid youth between the ages of three and nineteen living in the Boston area who have: demonstrated serious symptoms of functional impairment of at least six months; are eligible for services from at least one other child serving state agency (including Child Welfare); are in placement or are at risk of out-of-home placement; and have a caregiver who consents to the care planning process.

Methods

The MHSPY model is based on the concept of "continuity of intent," or shared purpose across intervention. Community, family and youth strengths are assessed and organized as resources to help meet the needs of the individual youth, enhance the development of resilience and facilitate the emergence of hope. A parallel process at the direct care and supervisory levels serves to foster partnerships with Child Welfare and improve outcomes for youth and families. The four-phase MHSPY engagement process: *Pre-Enrollment, Initiation, Engagement and Resolution,* provide opportunities to develop and maintain creative partnerships with Child Welfare specific to each phase of care and level of participation.

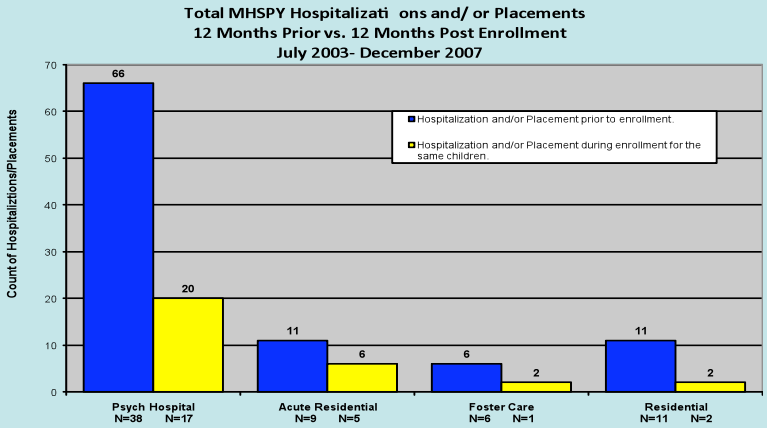
Collaboration with Child Welfare is on-going throughout the MHSPY process, as illustrated in Figure 1.

Figure 1

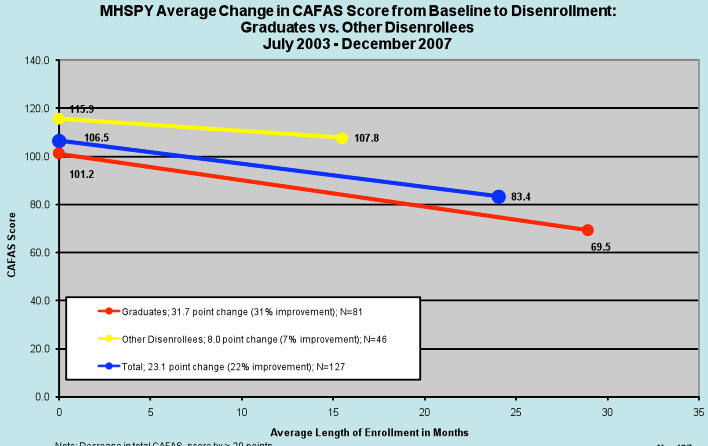


Results

74% of the MHSPY enrollees have current or prior Child Welfare involvement. **80%** of MHSPY youth have more than one diagnosis, with **43%** having Post-Traumatic Stress Disorder, consistent with high rates of community and family violence. Overall, MHSPY enrollees have an average **22%** improvement in functioning as measured by the CAFAS. The program retention rate is **98%**. Foster care use is decreased by **67%**, hospitalizations drop by **70%**, and residential placements are reduced by **81%**.



Note:
1) Of the total (N = 100), 42 children had prior placements of the type listed above.
2) Yellow bars correspond to number of events for children who are also in blue bars (children with prior placements).
3) Foster Care includes regular and specialized foster care.
4) N only includes children enrolled for a period of at least 12 months. Average enrollment in MHSPY is 17 months.
5) Children may appear in count for more than one utilization type.



Note: Decrease in total CAFAS score by ≥ 20 points indicates "reliable clinical change" (Hodges, 2004).

N = 127

Conclusions

Clinically complex youth also frequently have involvement with Child Welfare, as a result of their own or their families' needs, which requires clinicians within systems-of-care to become fluent in understanding Child Welfare mandates and requirements. Collaboration at the system, supervisor, and individual child care planning team levels facilitates continuity of intent, which improves outcomes.

Application & Practice

- ✓ Need clear stakeholder mission for overall system-of-care
- ✓ Shared purpose among members of each local team
- ✓ Recruitment and training consistent with goals
- ✓ Process is "organic;" principles can be followed but implementation must be responsive to environment
- ✓ Feedback; listen to families and system partners
- ✓ Track outcomes; share results with team

References

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2) Hepburn, K. & McCarthy, J. (2003). Making interagency initiatives work for children and families in the child welfare system. Promising approaches for behavioral health services to children and adolescents and their families in managed care systems, 3. Washington, DC: National Technical Assistance Center for Children's Mental Health, Georgetown University Center for Child and Human Development, 51-63.
3) Hodges, K. (2000). Child and Adolescent Functional Assessment Scale (2nd rev.) Ypsilanti: Eastern Michigan University.
4) Munson, C. E. (1993). *Clinical social work supervision* (2nd ed.). New York: Haworth Press.