



Robert Wood Johnson Foundation

Mental Health Services Program for Youth (MHSPY) Replication

June 2000

Grant Results

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SUMMARY

The *Mental Health Services Program for Youth Replication* was a national program set up by the Robert Wood Johnson Foundation (RWJF) to follow-up on the results of the *Mental Health Services Program for Youth* that ran from 1988 to 1998.

The original program was a \$20 million effort designed to demonstrate that through a collaborative effort between states and local communities, a more comprehensive, effective service system for seriously mentally ill youth could be developed.

The purpose of the *Mental Health Services Program for Youth Replication* was to assist states with relatively small grants to enable them to use and apply an array of tools and techniques developed in the eight sites in the original program.

Key Results

- Eight of 12 states developed capitated market-oriented systems of care. The four states that had not reached this point by the end of the program were moving in this direction when the program ended.
- Early data from the states indicates the following results:
 - In Illinois, more than 1,000 children were enrolled in wraparound plans, which led to a net reduction of 1,000 children in residential treatment centers.
 - The Dawn Project in Indiana documented a reduction by 50 percent in the cost of residential care.

- In Mississippi, in the first year of implementation, the project reported a 95 percent reduction in institutional out-of-community placements.
- In San Francisco, there was a decrease in hospital use of more than one third, residential placements were at one-half of the projected rate, and re-arrests were reduced by 28 percent.
- In Massachusetts, the total number of hospital days dropped from 56 in the previous 12 months, to 17 in the first 12 months of the program.
- In Michigan, none of the children with a substantiated abuse/neglect complaint had a similar complaint one year after receipt of wraparound services.

Program Management

Both programs were managed through a national program office at the [Washington Business Group on Health](#), Washington, D.C., a nonprofit national health policy and research organization whose membership includes many of the nation's major employers.

Funding

In July 1993, the RWJF Board of Trustees authorized up to \$750,000 for sites in the replication program. It planned to make start-up grants to 10 states to help those states improve the organization and financing of their service delivery systems for seriously mentally ill children.

In April 1996, RWJF authorized \$150,000 for grants to two additional sites, bringing to 12 the number of states that could receive support and technical assistance.

The 12 states that participated in the *Mental Health Services Program for Youth Replication* were: California (using funding that remained from the original program), Florida, Illinois, Indiana, Massachusetts, Michigan, Minnesota, Mississippi, New York, South Carolina, Texas, and Washington.

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THE PROBLEM

The service delivery system for individuals with chronic health conditions, including serious mental illness, has historically been fragmented, uncoordinated, and inefficiently organized.

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RWJF STRATEGY

Recognizing both the significance of the problem and the misguided imbalance in resource allocation, the Robert Wood Johnson Foundation (RWJF) took a series of national programs to promote the development of coordinated service systems for chronic illness, including mental illness.

The Original Mental Health Services Program for Youth

One of RWJF's most significant efforts in the mental health field was the *Mental Health Services Program*

for Youth, which was authorized in May 1988. RWJF's funding — \$20.4 million over a six-year period — was the largest single influx of money into the children's mental health system at that time.

In 1989, 40 states submitted applications. Twelve one-year planning grants were awarded to sites in:

- California
- Kentucky
- Michigan
- North Carolina
- North Dakota
- Ohio
- Washington, D.C.
- Oregon
- Pennsylvania
- Vermont
- Washington
- Wisconsin

In 1990, the eight sites that made the most progress during the planning year and presented the strongest plans were awarded implementation grants that provided funding for an additional five years.

The implementation grant states were:

- California
- Kentucky
- North Carolina
- Ohio
- Oregon
- Pennsylvania
- Vermont
- Wisconsin.

The program was designed to demonstrate that through a collaborative effort between states and local communities, a more comprehensive, effective service system for seriously mentally ill youth could be developed.

The children who participated in the program were perhaps the most difficult and expensive population that state administrators and multiple service providers are responsible for serving.

These children, aged 0–18, were diagnosed with a psychiatric illness (such as schizophrenia, hyperactivity, depression, anorexia nervosa, and conduct disorders) that persisted for one year or longer and severely affected the child's ability to function.

In many cases, \$180,000 in public funds per year for each individual were spent to provide institutional care; and lifetime costs per individual could exceed \$1 million.

The program took a two-pronged approach:

- At the state level, it fostered coordination of services between mental health and related child-serving agencies (e.g., child welfare, juvenile justice, and special education) and made major changes in the public financing systems.
- At the community level, it promoted interagency cooperation and the development of new mental health and related services for young people.

Evaluation Findings

The findings from the evaluation of the original *Mental Health Services Program for Youth* conducted by Leonard Saxe with a team of evaluators first from Boston University School of Applied Social Science and then from the Florence Heller Graduate School for Advanced Studies at Brandeis University (grant ID#s 013612, 017015, and 013613), can be summarized as follows.

- **The program caused a reduction in out-of-state, out-of-county, and out-of-home placements.**
- Vermont's project reduced the number of children in restrictive out-of-state placements (in psychiatric hospitals or residential schools) by 54 percent in 15 months from April 1993 to July 1994.

This state also more than doubled the proportion of children living at home with their families (from 13 percent to 32 percent) by March 1993.

- North Carolina's project reduced out-of-county placements by 42 percent (from 52 in 1990 to 30 in 1992).
- **It decreased use of restrictive service options.** In Kentucky, Medicaid inpatient psychiatric expenditures decreased by 33 percent from 1990 to 1992 (from \$32 million to \$21.6 million) and the average length of stay also decreased by a third.
- North Carolina's site reduced the rates of inpatient use by 42 percent in 1992 compared to a statewide increase of 26 percent.
- **It created a cost-effective system of care.** Wisconsin reported a 65 percent reduction in the average cost of serving their children (from \$36,000 to \$23,000 per child).
- Vermont data indicated that the average cost of serving children returning to their communities from out-of-state placements was reduced from \$57,000 per child to \$43,000 per child.
- **Client functioning improved.** Ohio, Oregon, Kentucky, and Vermont charted progress on a broad range of functionally defined areas (e.g., stability of living situation, ability to stay in school, and improvement in general functioning) with a clear trend toward improved functioning of the children.
- For example, Oregon reported that children improved in their living situation (74 percent), general functioning (60 percent), and school placements (82 percent).
- **Innovative financing was developed.** Sites implemented several innovative financing strategies, including:
 - Decategorizing multiple categorical funding streams into a blended funding pool.
 - Reform of their Medicaid and child welfare financing streams.
 - Development of managed care payment models.
 - Negotiation with private insurers and firms providing a mental health "carve out" benefit for a more flexible set of benefits.

These reforms added several million dollars in increased community-based service delivery capacity per site, and allowed providers to develop a more comprehensive and flexible range of services.

As Saxe and Theodore P. Cross wrote about the program in [To Improve Health and Health Care 1998–1999, The Robert Wood Johnson Foundation Anthology](#):

One of the [*Mental Health Services Program for Youth's*] lessons is that there is an alternative to the two extremes of centralized health care and individually directed health care. [This program] and Fort Bragg [a project similar to it] suggest that local communities can develop systems to help individuals.

Because families cannot deal with serious health problems alone, some way to provide professional support and resources to those in need must be found. [*Mental Health Services Program for Youth's*]-sponsored programs were able to mobilize a variety of resources to provide individually tailored services, and not all of these were from traditional health care providers.

RWJF Decides on a Replication

When the original *Mental Health Services Program for Youth* was in the fourth of its five years, RWJF moved forward with the idea of an accelerated replication program for several reasons:

- *Mental Health Services Program for Youth* had achieved several noteworthy results, particularly in the areas of:
 - Reorganizing service delivery systems.
 - Developing new and innovative financing models.
 - Reducing the number and duration of out-of-county and state institutional placements.
 - Improving the living situation and general functioning of clients served by the program.
- State officials in more than 20 states and numerous local officials requested ongoing technical assistance from the national program office staff.
- The program had created models in a number of sites that were particularly relevant to the policy direction of proposed national health care reform efforts concerning mental health benefits.

In early 1993, given the major changes in the nation's health care system that seemed ready to unfold in the near future with national health reform, it seemed a good time to help a larger number of states and communities to restructure their children's mental health service delivery system.

A Federal Initiative

Building on the experiences and successes of the original *Mental Health Services Program for Youth* sites, in 1994, the U.S. Congress appropriated \$60 million through the federal Center for Mental Health Services to fund an initiative called the [Comprehensive Community Mental Health Services for Children and their Families Program](#).

The program created 22 sites to create community systems of care for children and adolescents with mental, emotional, and behavioral disorders and their families. The federal program also funded a technical assistance center called the National Resource Network for Children's Mental Health.

It was modeled after the *Mental Health Services Program for Youth* national program office and is also run by the Washington Business Group on Health.

Staff at the Washington Business Group on Health report that this is the first time that a national program office has been selected to serve as a national resource center for a federal program modeled after an RWJF effort.

Mary Jane England, M.D., president of the Washington Business Group on Health and *Mental Health Services Program for Youth* national program director, credits the successes of the program sites and the strong advocacy from the traditional children mental health advocates, such as the National Mental Health Association and the newly formed Federation of Families for Children's Mental Health, as the reason this initial federal funding for children's mental health was appropriated.

From 1994 through October 1999, the U.S. Congress appropriated almost \$500 million to fund 60 community sites.

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PROGRAM DESIGN

In July 1993, the RWJF Board of Trustees authorized up to \$750,000 for sites in the *Mental Health Services Program for Youth Replication*.

It planned to make start-up grants, averaging \$75,000, and to provide technical assistance and training to help 10 states improve the organization and financing of their service delivery systems for seriously mentally ill children.

In April 1996, RWJF authorized \$150,000 for grants to two additional sites, bringing to 12 the number of states that could receive support and technical assistance.

The start-up grants were designed to help these states build on the accomplishments of the original national program.

The replication program's goal was to help these states and communities better organize and finance a critical component of their health care system for youngsters with serious mental, emotional, and behavioral disorders and their families in a manner consistent with the direction of health care reform unfolding in the United States.

The key components of the states' projects were:

- Pooling public revenues that are available to treat children with serious mental, emotional, and behavioral disorders into a single funding stream, often called blended funding.
- Using capitation to manage the blended funding.
- Contracting with a care management entity to manage the funds and provide all treatment needed for the target population. This was done with a pre-paid capitated fee arrangement, where the per-person fee is paid in advance and the provider assumes some degree of risk if the fee is insufficient to cover

the treatment provided.

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THE PROGRAM

National Program Office

The national program office was housed at the [Washington Business Group on Health](#) in Washington, D.C., which had also been the national program office for the original program.

Washington Business Group on Health is a nonprofit national health policy and research organization whose membership includes many of the nation's major employers.

Two of the principals who directed the original program ran the replication program: Mary Jane England, M.D., president of the Washington Business Group on Health, was national program director. Robert F. Cole, Ph.D., deputy director of the organization, was deputy director.

In addition, Patricia Tennant Sokol, D.P.A., became associate director of the replication program.

Technical Assistance and Direction

The national program office provided consultation, technical assistance, and training workshops to help the replication states develop their capitated managed care systems.

Consultation and technical assistance, which focused on advancing the replication sites from planning to implementation, included the following activities:

- Conducted individual needs assessment for each of the replication grantees based on their goals and activities.
- Developed technical assistance workshops to identify and provide experts in the field to assist the states in their implementation.
- Found consultants who matched the needs of different participating states, and negotiated arrangements with them.
- Conducted site visits to assist grantees with their implementation schedule and provide technical assistance when grantees encountered peculiar political situations pertaining to implementation of their systems.
- Held monthly conference calls with all grantees to discuss their progress and create an esprit de corps, teaching the grantees to rely on each other for learning opportunities.
- Refined a communications strategy to assist the Replication states as well as communicate the results of the capitated market-oriented systems of care implementation in both the Replication and original projects.
- Held a series of state/regional workshops and training forums to identify and provide experts in the field to assist the replication grantees in their implementation (See the [Bibliography](#) for details.)

These consultation, technical assistance, and training activities were aimed at helping the states

implement systems and activities in the following six areas:

Financing Strategies

- Assist states in developing blended funding from agencies serving children's mental health needs (including education) by pooling existing funds spent on those services and establishing a capitated managed care system.
- Assure that states are measuring and reporting client-oriented outcomes related to the capitated managed care funding system.

Administrative Structures for Managing Care

- Identify existing automated systems that facilitate the case management, fiscal, and billing processes needed for a successful capitated managed care program.
- Build capacity in each state to handle the new administrative requirements, especially the tracking of critical indicators for outcome measurement.
- Develop "administrative services only" mechanisms for servicing a capitated managed care program.
- Promote purchasing sponsors and purchasing coalitions to create purchasing power through the capitated managed care program.
- Build capacity in each state to develop positive public information/education and communication strategies regarding their project.

Family Participation

- Insure that families are involved at all levels of the system of care and are prepared with information that will reinforce the added value of family participation.
- Help families to understand that, through active consumer participation, they can become an important voice in making managed care accountable and high quality.

Cultural Competency

- Promote the development of service delivery systems that meet the needs of culturally diverse groups within their communities.

Coherent Policy at State and Local Levels

- Work with states to design and develop their capitated managed care programs to blend and maximize the public revenues of all child service agencies to best meet the needs of the emotionally disturbed children and their families.

Service Development

- Promote the development of clinically appropriate, flexible, family-focused, and community-based services that are able to meet the individual needs of children and their families, and provide overall greater client and family satisfaction.

These services were often called wraparound services to describe the way they surrounded multi-

problem youngsters and families with services rather than with institutional walls.

Wraparound service plans are needs-driven rather than service-driven and are individualized to the child and family, combining existing or modified services, newly created services, informal supports, and community resources.

- Promote the full collaborative partnership of education and juvenile justice in the system of services with mental health, substance abuse, and child welfare.

The national program office sent letters to governors or executive offices of the 42 states that did not receive five years of grant support under the original *Mental Health Services for Youth* program soliciting proposals for a replication grant. National program office and RWJF staff reviewed the grant proposals.

Between July 1994 and October 1996, grants averaging \$75,000 each were awarded to 11 states:

- Florida
- Illinois
- Indiana
- Massachusetts
- Michigan
- Minnesota
- Mississippi
- New York
- South Carolina
- Texas
- Washington.

The twelfth site, the county of San Francisco, Calif., used funding that remained from a grant made under the original program to continue its work under this program, meanwhile adding the components of the replication sites.

New Model for Planning and Management

The *Mental Health Services Program for Youth* Replication Program used a new model for planning and management as it sought to reform the organization and management of mental health services for youth.

Harry M. Shallcross, Ph.D., a consultant to the national program office, worked with various states to implement this approach. In *Family Matters* Fall 1997 he described this model as one that:

- Uses population-specific approaches to assess needs and establish desired outcomes.
- Uses managed care methodologies for the organization and management of networks of providers.
- Applies the principles of outcomes management to these methods, which hold system design, care management, and service delivery accountable to achieve defined outcomes consistent with social policy and clinical objectives.
- Holds all providers accountable to the outcomes specified in the plan of care, and collaboration with other providers to achieve those outcomes. This is accountability beyond the traditional reimbursement parameters under fee-for-service models.
- Enables flexibility in approach to treatment planning, allowing a wide range of formal and informal services and resources to be incorporated into an organized system of care. These flexible resources

are included and coordinated through a comprehensive Plan of Care specifically designed for the special needs of the individual eligible for services.

- Allows the planning of service system requirements, utilization projections, and financing based on anticipated plans of care needed to achieve desired outcomes.
- Enables consumer and family involvement in the system design and always in the development of the individualized plan of care.

Outcomes-based planning and implementing outcomes-based systems of care requires:

- An approach to resource development and care management that aligns financing with flexible treatment planning and the implementation of individualized plans of care.
- Linking funding and reimbursement to both specifications for network composition and performance requirements.
- Integrating care management functions and objectives around a single outcomes-based plan of care.
- Flexible funding mechanisms that support the development and management of individually tailored, outcomes-based plans of care that can draw from a wide array of services and resources.
- Accountability by providers to participate in the plan of care and contribute to its objectives through a defined role. Reimbursement is linked to compliance with that defined role.
- Developing an organized array of services and settings specifically tailored for consumer needs and the capability for the consumer/family to choose service providers that are most responsive to their needs.
- Consumer-family involvement from the design of the system to the development of their individual plans of care, and their overall satisfaction with the services provided.

Challenges

The program faced four major challenges, described below.

Funding

The requests from the states for consultation and technical assistance far exceeded the money available for consultants and for national program office staff travel.

All requests were prioritized and other sources of funding were sought for those requests that could not be honored by the national program office. The states were resourceful in discovering alternate sources of funds. This funding shortfall did not affect the overall outcome of the national program.

Political Environment and Health System Change

The political environment of some of the states proved to be unstable, especially as the demands of broad-based organizational change and system reform in health care delivery increased.

The accelerated shift of state Medicaid programs' health care delivery to managed care changed the environment and affected projects.

The major emphasis, nationally, on system reform and federal block grants to the states, including proposals for reform of the welfare system that would affect the child welfare part of the organized system of care, were also major factors affecting health systems change.

The national program office worked with the states to accommodate this ever-changing landscape into the development of their implementation plans for market-oriented systems of care.

Even though political issues delayed implementation in some states, all of the projects moved forward with their implementation plans and programs are up and running.

Integrating Funding Streams

The degree to which the categorical agencies were willing to integrate their funding streams in order to provide a seamless organized system of care for children and youth with serious emotional disturbance and behavioral problems was an obstacle.

Nevertheless, in some states, this obstacle was overcome through agreements on a blended-funding model specifying the degree of collaboration or integration of effort in each state.

To some extent, these agreements define and predetermine the progress that could be made toward an integrated system nationally.

The states that exemplified ways in which agreements could be made are:

- Mississippi (through state legislation that was passed for blended funding by the child serving agencies)
- Indiana
- Massachusetts
- Michigan
- Minnesota
- New York
- Texas
- Washington.

Non-Involvement of Educational Authorities

Except in three states — Indiana, Washington, and Illinois — the involvement of local educational authorities did not evolve as hoped.

The complex obligations federal special education requirements placed on local school districts discouraged their involvement with other child-service agencies.

The projects in the three states mentioned above provide notable examples of how the federal obligations can be met and not impede involvement of the education interests in a blended-funding, family-focused, community-based organized system of care.

Assessing Children

Two assessment methodologies developed by John S. Lyons, Ph.D., of Northwestern University Medical School helped shape the family focus and the community-based approach of some of the states in the national program.

They are the Childhood Severity of Psychiatric Illness and the Child and Adolescent Strengths

Assessment.

- The Childhood Severity of Psychiatric Illness is a diagnostic risk behavior assessment and screening model used to report clinical profiles of the children served, recommended services, and eligibility criteria for those services.
- The Child and Adolescent Strengths Assessment model is used to assess strengths and resources within the child's or adolescent's natural environment and to build on them. (For more information on the methodology, see [Appendix 2.](#))

Communications

The national program office, in cooperation with RWJF's Communications Office disseminated the results of the models in the replication states through the *Family Matters* newsletter.

Nine regular issues of *Family Matters*, as well as a special 36-page issue of the newsletter that served as the national program office's Final Report, were published. During the replication program, the readership increased to nearly 10,000, including staff at sites participating in the National Resource Network (NRN).

Funding for *Family Matters* was eventually assumed by the federal Center for Mental Health Services so that the new federally funded sites could learn about the programming innovations taking place in the Replication initiatives, as well as the accomplishments of these new sites.

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OVERALL PROGRAM RESULTS

- **With the national program office's assistance, 8 of 12 states developed capitated market-oriented systems of care.** The four states that had not reached this point were moving in this direction when the program ended.
- **Early data from the states indicates the following results:**
- **In Illinois, more than 1,000 children were enrolled in wraparound plans, which led to a net reduction of 1,000 children in residential treatment centers.** This public/private collaboration saved Illinois' taxpayers \$36 million due to substitution of wraparound services for institutional placements.
- **The Dawn Project in Indiana documented a reduction by 50 percent in the cost of residential care.** This assisted payers in avoiding more than \$2 million in placement costs. The length of stay in the program for the 67 children who graduated was 11 months; of those, 36 transitioned back to their family's care or a lower level of care in the community.
- **In Mississippi, in the first year of implementation, the project reported a 95 percent reduction in institutional out-of-community placements.**
- **In San Francisco, there was a decrease in hospital use of more than one third, residential placements were at one half of the projected rate, and re-arrests were reduced by 28 percent.**
- **In Massachusetts, the total number of hospital days dropped from 56 in the previous 12 months, to 17 in the first 12 months of the replication program.** There also was a drop in the number of foster care days from 1,327 to 317 in that same time period.
- **In Michigan, none of the children with a substantiated abuse/neglect complaint had a similar complaint one year after receipt of wraparound services.**

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LESSONS LEARNED

Overall Lessons for Success

1. **The family is the key care coordinator and is present at all meetings to plan care.**
2. **Services are organized around the child and family.**
3. **50 percent of the services in the plan of care must be informal supports provided at no cost by members of the immediate community or extended family.**
4. **The funding for services must be flexible and follow the child.**
5. **Funds are used to buy appropriate services specified in the individual plan of care, not to fund "programs."**
6. **The system becomes market oriented. Some programs do not survive; others thrive by providing only the services that are specified in the plans of care.**
7. **Assessments are individual and are strength-based, not deficit based.**
8. **Assessments are completed in the home environment, not in an institutional environment, if possible.**
9. **In-depth clinical/psychiatric assessments and diagnoses are purchased from qualified providers.**

Systems Change Lessons

10. **Complex and potentially significant systems change, even on a pilot basis, requires a lengthy and in-depth process. Relationships and trust take time to build.**
11. **Use a strength-based, developmental approach to systems change that recognizes that all components have a role and must work together to more clearly define those roles and responsibilities.**
12. **Reforming finances is essential to institutionalizing change.** If child-serving systems continue to work independently with categorical funds only usable for limited services, an intensive community-based strategy to support seriously emotionally disturbed children in their families and communities is doomed.
13. **Even if there is agreement, it does not insure that change will take place.**

Agencies and Infrastructure Lessons

14. **Support is needed from above.** Commissioners of the state agencies, **directors of children-service divisions or units, and senior management** of private entities that is committed to child-centered, family-focused community-based services must be included in the project.
15. **Projects like *Mental Health Services Program for Youth Replication* require significant infrastructure development.**
16. **Agency directors must be truly committed to the philosophy that money and other resources from each agency are on the table to be joined together.**
17. **Agency directors must feel that their agencies will receive some measurable benefits.**

Families' Lessons

18. **Consumers and families need to be at the core of system design and performance measurement.** Include parents as early and as completely as possible, and really listen and act on what they say.
19. **Consumer choice must be the driver in the system of care.**
20. **Family involvement is a very powerful source of support, especially if families have the same goals for quality and outcomes as the professional system planners.**
21. **Management at the child-and-family-team level can be an effective tool in managing chronic emotional and behavioral needs of children.**
22. **To insure the focus holds, form partnerships with the parent movement — and links to organizations representing foster and adoptive parents.**
23. **Diversity/cultural competence must be addressed as an ongoing part of the system.**

Managed Care Organizations' Lessons

24. **It is crucial that the managed care organization is fully devoted to the *Mental Health Services Program for Youth Replication* philosophy and is willing to be very flexible in its procedures.**
25. **If a new managed care organization is created for the project, make sure it has sufficient start-up money.** Build in checks and balances to adjust shortfalls or overages created by the capitated rate.

Logistical Lessons

26. **Give the project its own identity (such as a name) apart from any of the funding agencies.**
27. **Sooner, rather than later, hire a project coordinator who is willing and able to do "whatever it takes" to get the project off the ground.**

Outcomes Lessons

28. **The systems involved (especially mental health and substance abuse) must be accountable for treatment outcomes as well as accountable to their consumers for timeliness and quality of services.**
29. **Organized systems of care must also take a public health view of outcomes and the overall impact on the community.**

Communications and Consensus-Building Lessons

30. **Multi-party projects are, by their nature, "multi-cultural" projects (i.e., multi-organizational-cultures).** Communication can go awry in many ways as each party hears the same words with a different overlay of understanding.
31. **Attention must be paid to communication; it must be clear and frequent. The project manager must spend a lot of time listening — and responding to concerns expressed.**
32. **Engage in consistent communication at the policy, program, and direct services level through multiple media, e.g., training, consultation, newsletters, procedural regulation.**
33. **Take time to build consensus among players i.e., mental health, child welfare, juvenile court, education — trusting relationships and a common belief are critical before talking about money.**
34. **Create mechanisms for ongoing discussions that address "tough" decisions — both for**

the client and the system.

35. **Relationship building among all levels is critical.** Increasing recognition of the role of the state in affecting the balance of power among partners in collaboratives is the first step towards solving that dilemma.
36. **People must constantly be reminded that real wraparound is not a program, but a process of providing many different kinds of services to the child and the family.**

Technical Assistance, Training, and Consultants' Lessons

37. **Technical assistance "hands-on" at the local level to persons providing services is most valuable.**
38. **Technical assistance in the form of brainstorming activities between state and local partners goes a long way toward finding ways to overcome barriers.**
39. **Share best practices and facilitate collaboratives to serve as mentors to other collaboratives.**
40. **It is not frivolous to spend money on outside consultants for two reasons: you learn from their expertise, and they bring an impartial perspective to various negotiations.**
41. **Form partnerships with universities and other thought leaders in child welfare and mental health in developing fact-based planning tools and models.**
42. **Train the workers who will be on the service coordination teams (probation officers, welfare caseworkers, school personnel) in the philosophy of the project. Build trust among all who will be working directly with the kids.**
43. **Implementing the wraparound service approach requires significant and ongoing training for service providers.**

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GRANT DETAILS & CONTACT INFORMATION

National Program

Mental Health Services Program for Youth (MHSPY) Replication

NATIONAL PROGRAM OFFICE

Washington Business Group on Health (Washington, DC)

- Amount: \$ 235,098
Dates: August 1993 to September 1997
ID#: 021947
- Amount: \$ 475,570
Dates: November 1997 to June 1998
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Authorized by the Board of Trustees in July 1993 for \$750,000. Reauthorized by the Board of Trustees in April 1996 for up to \$150,000 for additional sites.

APPENDICES

Appendix 1

Glossary

Blended funding (also [pooled funding](#)): Funding from different sources that has been consolidated. Often each source is "**categorical**" — funds that otherwise can only be used to pay for a particular category of services.

Capitation: A method for payment to health care providers that is common or targeted in most managed care arenas. Unlike the older fee-for-service arrangement, in which the provider is paid per procedure, capitation involves a prepaid amount per month to the provider per covered member, and is usually expressed as a PMPM (per member per month) fee. The provider is then responsible for providing all contracted services required by members of that group during that month for the fixed fee, regardless of the amount of charges incurred. In such an arrangement, the provider is now **at risk**, picking up risk that the payor or employer used to have exclusively in fee-for-service or indemnity arrangements.

Risk sharing: When the provider shares the financial risk for patient care with the payor or employer.

Full-risk, prepaid capitated fee: The capitated fee is paid in advance and the organization providing the treatment is at full financial risk because it commits to providing the treatment whether or not the prepaid fee meets the costs of doing so.

CASSP: The Child and Adolescent Service System Program, started by the federal government in 1982, at a total funding level of \$1.5 million.

EPSDT: A federal program that pays for treatment for every child screened and diagnosed with a condition.

MassHealth: The Massachusetts Medicaid Program

Pooled funding: Funding from different sources that has been consolidated. Also called [blended funding](#).

Quality assurance: Programs for assessing the quality of care and service in the managed care industry.

Restrictive setting: A psychiatric hospital or residential school.

TEFRA: The federal Tax Equity and Fiscal Responsibility Act of 1982; the Inpatient Psychiatric Hospitalization TEFRA option allows young people with severe emotional disturbances who need institutional care to receive home and community-based mental health services through Medicaid reimbursement.

TITLE IV-E: A federal program that provides teacher and trainee grants to schools of social work to train social workers in the specialty of child welfare.

Utilization review (UR): The evaluation of the mental health necessity (or medical necessity) and the efficiency of mental healthcare services, either prospectively, concurrently, or retrospectively; contrasted with utilization management (UM) in that UR is more limited to the physician's diagnosis, treatment, and billing amount, whereas UM addresses the wider program requirements.

Wraparound services (or programs or plans): Services that address the youth's total mental healthcare needs. These services "wrap around" core mental health interventions to develop unique treatment and support plans for each child and family served, using services from different agencies.

Appendix 2

(Current as of the time of the grant; provided by the grantee organization; not verified by RWJF.)

Assessment Methodologies

Two assessment methodologies developed by John S. Lyons, Ph.D., of Northwestern University Medical School helped to shape the family focus and the community-based approach of some of the states in the national program.

They are the Childhood Severity of Psychiatric Illness and the Child and Adolescent Strengths Assessment.

The Childhood Severity of Psychiatric Illness is a diagnostic risk behavior assessment and screening model used to report clinical profiles of the children served, recommended services, and eligibility criteria for those services. The Child and Adolescent Strengths Assessment model is used to assess strengths and resources within the child's or adolescent's natural environment and to build on them.

The Child and Adolescent Strengths Assessment model sought to identify common strengths in children and families that are important for service planning. The list of strengths consists of:

- Family strengths, e.g., has strong positive relation with at least one parent/caregiver, adult relative, brother or sister, and a sense of belonging to a family.
- School/vocational strengths, e.g., excels in or enjoys at least one subject, likes to write, reads for pleasure, has done well for at least one year of school, has a particular vocational skill, is a hard worker.
- Psychological strengths, e.g., has a sense of humor, has positive coping skills for stressful life circumstances, has the ability to trust others.
- Peer strengths, e.g., has close friends, is well liked by peers.
- Morality/spiritually strengths, e.g., has developed values/morality (e.g., honesty, respect), has expressed religious/spiritual beliefs, attends religious services regularly, participates in religious youth groups.
- Extracurricular strengths, e.g., has artistic/creative talent, has a hobby or hobbies, participates in sports.

Both models were used in Illinois and Michigan.

Florida, Texas, and New York used only The Childhood Severity of Psychiatric Illness.

Illinois conducted a pilot study that found that strengths were negatively correlated with risk behaviors; in particular, the higher the strengths the less the dangerous and aggressive behavior engaged in by the adolescent.

These findings reinforced the notion that strength-based approaches can be cost-effective in helping an adolescent avoid expensive hospital or residential placements.

Because the other sites had already begun their implementations when the findings of this study became available, the findings had no influence on the design of the other projects.

However, the findings were distributed to the projects through the article in the national program office's *Family Matters* newsletter, Fall 1997.

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(Current as of date of this report; as provided by grantee organization; not verified by RWJF; items not available from RWJF.)

Newsletters

"Family Matters." national program office of the Mental Health Services Program for Youth, a national program supported by The Robert Wood Johnson Foundation. Washington, D.C. 10 issues: Summer 1995–Fall 1997.

Sponsored Conferences

"Successful MHSPY Projects in a Blended-Funding, Family Focused, Community-Based Organized Systems of Care," a two-day workshop, Washington, D.C., February 1996.

Joint meeting of MHSPY sites with the National Resource Network and the federal Center for Mental Health Services sites, Las Cruces, N.M., April 1996.

Joint meeting with the Georgetown University Training Institutes, Traverse City, Mich., June 1996.

"Rate Setting for *Organized System of Care* Using Managed Care Tools," a workshop, Chicago, Ill., August 1996.

"Managing Change on the Edge of Chaos," "Decision Support Technology," "How Not to Re-Invent the Wheel," presentations at workshop, Chicago, Ill., December 1996.

Florida Mental Health Institute Research and Training Center Annual Meeting, special session on "Outcomes Based Management of Organized Systems of Care," Tampa, Fla., February 1997.

"Leadership in Business," final meeting of the MHSPY Replication program, Seattle, Wash., August 1997.

Presentations and Testimony

Patricia Tennant Sokol, "Collaborating Across Systems: Lessons Learned from Across the Country," at CWLA Managed Care Institute Special Issue Forum, October 16–17, Phoenix, Ariz.

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END OF NATIONAL PROGRAM OVERVIEW

PROJECT LIST

Reports on the projects managed under this National Program are listed below. Click on a project's title to see the complete report, which typically includes a summary, description of the project's objectives, its results, post grant activities and a list of key products.

California

- [San Francisco Collaborative Provides Continuum of Care for Severely Mentally Ill Youth \(June 2000\)](#)

Florida

- [Florida Develops Utilization Management System for Youth Mental Health Services \(June 2000\)](#)

Illinois

- [Wraparound Program Saves Illinois Money and Provides Better Mental Health Services for Youth \(June 2000\)](#)

Indiana

- [Indiana's 'Dawn Project' Improves Youth Mental Health Services and Saves Money \(June 2000\)](#)

Massachusetts

- [Massachusetts Integrates Services and Improves Mental Health Care for Youth \(June 2000\)](#)

Michigan

- [Michigan Initiative Helps Children with Emotional Disturbances \(June 2000\)](#)

Minnesota

- [Minnesota's Mental Health Collaborative Maximizes Federal Entitlement Reimbursement \(June 2000\)](#)

Mississippi

- [Mississippi Reduces Institutional Out-of-Community Placements for Youth with Mental Health Disorders \(June 2000\)](#)

New York

- [New Nonprofit Entity Manages Mental Health Services for Youth in New York \(June 2001\)](#)

South Carolina

- [South Carolina Seeks to Privatize its Child Welfare Services \(June 2000\)](#)

Texas

- [Lone Star State Doesn't Go it Alone in Providing Youth Mental Health Services \(June 2000\)](#)

Washington

- [Strength in Numbers: King County Service Organizations Pool Their Money and Resources \(June 2000\)](#)

The Robert Wood Johnson Foundation, based in Princeton, N.J., is the nation's largest philanthropy devoted exclusively to health and health care.