TO: WCHSA Children, Youth and Families PAC
WCHSA Behavioral Health PAC
WAFCA Board of Directors

FROM: Lance Horozewski, Children, Youth & Families Division Manager, Rock County
Linda A. Hall, Executive Director, WAFCA

DATE: March 6, 2018

RE: Residential Recommendations from the Workgroup on Children with Complex Care Needs

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In the fall of 2016, the Wisconsin County Human Services Association (WCHSA) and Wisconsin Association of Family & Children's Agencies (WAFCA) collaborated to form a workgroup comprised of state, county, provider and other stakeholders to identify the root causes of the increasing number of youth being placed in residential facilities outside of Wisconsin and to propose program and/or system solutions to better serve youth with complex care needs.

The attached "Residential Recommendations from the Workgroup on Children with Complex Care Needs" is the product of nearly two years of research and discussion. Beginning with the Organizational Effectiveness decision-making model, the Workgroup identified a desired future state in which "Wisconsin has a continuum of care that meets the individual needs of complex youth and their families and keeps them connected to their communities."

While the Workgroup's analysis considered recent legislative and regulatory developments, we acknowledge that there are ongoing developments that will impact the future action steps related to this proposal including:

- The number of youth placed out of state has continued to increase since the initial data was analyzed in 2016.
- The passage of the federal Families First Prevention Services Act will require new program and treatment elements of all congregate settings.
- The impending enactment of significant juvenile corrections reform measures creating regional secure residential treatment options opens up new questions regarding sufficient system capacity (staffing, etc.) to meet the regional needs of the full range of youth served in residential care.

As co-chairs of this Workgroup, we have greatly appreciated the time, energy and collaborative engagement of the Workgroup participants. While this is a challenging time for the out-of-home care system in our state, we are encouraged by the passionate commitment of all the partners at the table and the numerous examples of creative, child and family-focused solutions that are already working in regions across the state.

We look forward to the involvement of a broader range of partners as we move forward to implement the recommendations of the Workgroup.

Residential Recommendations from Workgroup on Children with Complex Care Needs

February 2018

Desired Future State: Wisconsin has a continuum of care that meets the individual needs of complex youth and their families and keeps them connected to their communities.

EXECUTIVE SUMMARY

Between October 2016 and February 2018, representatives of county human services, residential providers, the Department of Children and Families, the Department of Health Services, the Office of Children's Mental Health and Winnebago Mental Health Center gathered to consider the root causes and potential solutions to address insufficient capacity in the state to serve children with complex care needs.

The Workgroup conducted a survey on county needs, reviewed data on youth placed out-of-state, studied out-of-state providers who are serving Wisconsin youth and considered the gaps in Wisconsin's continuum of care. The Workgroup discussed the resources, workforce, facilities and training necessary to improve capacity within the system to provide the right care at the right time with a particular focus on children with complex care needs.

In this paper, we identify the major program and facility components needed for an effective treatment model for these children. We also identify key system challenges and opportunities. Workgroup members are inviting the support and participation of other system partners in the next phase of this effort, which will entail short term and long-term workgroups committed to specific projects to help fill services gaps and to build a better continuum of services for these youth. (Attachment 3)

BACKGROUND

The Workgroup on Children with Complex Care Needs (Attachment 1) met multiple times from 2016-18 to better understand the needs of children being placed in residential facilities out-of-state. While out-of-state placements might sometimes occur for specific needs including services for children who are visually or hearing impaired or for cultural reasons (tribal placements), the Workgroup sought to identify the characteristics of children with complex needs who were placed out-of-state following efforts to stabilize them in a program or service in Wisconsin. In addition, the group sought to understand the out-of-state programs and facilities where youth are currently receiving treatment.

While there is agreement by Workgroup members that increasing early intervention services and preventing residential placements is of primary importance, the group ultimately agreed to focus a portion of its efforts on developing a model of residential treatment services for this small group of youth with complex care needs.

Complex Needs of Children

Through discussion, a survey of counties and an examination of DCF CANS data (Attachment 2), the group at least partially concluded that these youth had some commonalities: a) the children being sent out-of-state have experienced traumas that they are not able to overcome in their current placements; b) they do not have a significant attachment to a responsible adult; c) they present with aggressive behavior; and d) for many of these children a number of intensive home-based approaches have been tried and failed.

Study of Out-of-State Facilities

At the June 2017 workgroup meeting, Mary Kay Wills and Sarah Lawton from Dane County discussed what they learned from their visit to Youth Villages in Memphis, Tennessee, a residential treatment program where several Wisconsin youth are currently being served. In October, Ron Hermes of DCF also visited Youth Villages, and brought back additional information on their approach and the factors essential to their success. Program elements identified included, among other things: 1) intensive treatment model providing consistent clinical support to staff; 2) single campus with multiple levels of care; 3) locked psychiatric residential treatment facility on campus; 4) cameras recording throughout the facility; and 5) bachelor's level direct care staff trained in evidence-based care model.

The information garnered from the visits with Youth Villages, the Workgroup's county survey, DCF's CANS data and the discussion at multiple meetings led to this summary of the Workgroup's thinking on the type of residential care that should be available in Wisconsin. This paper identifies some of the regulatory, workforce, systems and funding mechanisms that would need to be in place to implement new services. Beyond the Workgroup's recommendations for a new residential services model, this paper also highlights general systems issues that we have identified for further attention or modification.

PROPOSED MODEL:
Residential Services with Aftercare for Youth with Severe Trauma/Mental Health Concerns

Developing and sustaining a new level of care to serve youth with complex needs will require, among other elements identified below, active collaboration between providers, state and county partners and other systems. This residential model would incorporate evidence-informed treatment, regular access to psychiatric and crisis support, intensive direct care staffing, a flexible, secure physical plant and coordinated aftercare services. The following describes the elements of the model and then addresses challenges and considerations related to implementing these program elements. (See Attachment 4 for a single page summary of the model)

Clinical Care / Treatment Staffing

- Well-defined and well-documented clinical approach with use of evidence-informed trauma-specific interventions (Trauma-Focused Cognitive Behavioral Therapy, Eye Movement Desensitization Reprocessing, Neurosequential Model of Therapeutics)
- Well-defined and well-documented coaching and support system for direct care staff in evidence informed models of care (Collaborative Problem Solving, Dialectical Behavioral Therapy, Neurosequential Model of Therapeutics)
- Use of a trauma-informed crisis intervention model
- Use of individualized regulatory activities to proactively calm and reactively sooth youth
- Established protocols between RCCs, counties, and hospitals to assess and offer psychiatric stabilization
- Established protocols between RCCs, counties, and detention centers to assess youth for detention placement
- A crisis response team, either internal to the RCC or available in the community
- Increase clinical staff to support a higher level of care than currently available.
- Increased psychiatric support available for regular service delivery and for crisis response
- Nursing staff with medication distribution responsibility (FTE allocation based on size of unit)

- Psychoeducational sessions to teach youth about the physiology of trauma and brain development, Adverse Childhood Experiences (ACEs) and resilience (this should be a program component regardless of EBP a program uses)
- Program flexibility for clinical team to move a child to a more secured residential unit on campus for safety – fluid step up and step-down options in consultation with placing agency and treatment team, but no court action required
- Ongoing clinical supervision with weekly clinical consultation for treatment teams
- Concurrent engagement with the family or identified permanent resource in the family home to prepare for discharge. Aftercare services that are trained in the same models, trauma informed care, etc. so there is an understanding of the needs of the family and treatment received in RCC could continue with little disruption. (See more under "Aftercare" below)
- The development of parent voice and parent peer specialists to achieve quality family engagement

CHALLENGE	**CONSIDERATIONS**
Funding: Implementing evidence-informed, trauma specific interventions with fidelity will require the ongoing infusion of resources to support a robust training and coaching system.	Establish this service as a specialized service to qualify for the specialized rate. Provide grant funding to get through the certification phase of an evidence-based model. Provide start-up funding window of two years guaranteed beds to build a stable program. Guarantee transitional bed days so that if a youth is discharged in the middle of the month, the bed is still paid for until the end of the month to provide a seamless transition for the youth and possible return to the same facility if the transition is not successful. Instead of a daily rate, establish a capitated rate that enables the provider to offer the most appropriate level of care and sustain a quality continuum.
System: Developing standardized assessment protocols for psychiatric stabilization and/or detention placement will require collaboration between state departments, counties, hospitals, juvenile detention centers and providers.	Form a centralized multidisciplinary team to develop protocols and then monitor implementation to ensure adherence.
System: Providers are required to consult with and receive permission from at least the case management agency and in some cases the court, to move a youth from one level of care to another on the same campus. This process can delay the ability to step down a child to a lower level of care or move them to a higher level of care based on their changing progress or needs.	Court would order a child into a program that includes step up and down options under a single program design with a single rate. This flexible program structure would allow the provider to work collaboratively with the county placing agency and the rest of the treatment team to move the child to the most appropriate treatment setting/level of care.

CHALLENGE	CONSIDERATIONS
Workforce/Funding: We lack the psychiatric expertise in WI to be able to serve the number of children with acute and chronic mental health needs. The current rates for child psychiatrists are being paid out of the daily rate as most providers will not accept the low MA reimbursement to serve this population. Therefore, providers cannot access (due to the shortage) or afford to access more psychiatric time to manage children with severe mental health needs, resulting in the ability to only take a limited number of these children at one time. Sustaining this level of staffing requires consistent funding.	Find creative ways to incentivize child psychiatrists to come to WI to work. Work with Medicaid to increase reimbursement rates for child psychiatry to attract those providers to WI. Select a residential campus location based on best access to quality workforce.
System: The system and individual provider programs do not consistently engage parent peer specialists to support and engage family and advise staff and program design.	Work with OCMH to grow program capacity to effectively engage peer parent specialists. Study Rock County model of parent peer specialists that successfully helped stabilized adoptive placement

Direct Care Staffing

- The direct care staff ratio would be, at a minimum, 1 direct care staff to 3 youth.
- Staff have higher level of education/experience (Note: All Youth Villages direct care staff have a bachelor's degree – this could be a goal, but may not be feasible in Wisconsin)
- A backup, dedicated crisis services team would be available to all units across a campus.

CHALLENGE	CONSIDERATIONS
Workforce: We lack sufficient, experienced workforce to service high need children. Staff who work with high needs children in a residential setting require a high level of skill.	Require a minimum of a Bachelor degree or equivalent experience to work with these complex youth and value that expertise through adequate pay for the skills required. Quality clinical supervisors and leaders to offer regular coaching and reinforcement for direct care staff. Work in partnership with University/College programs to develop a specific class curriculum for working with high needs children in 24/7 care so that candidates applying for these positions better understand what will be required of them in their work with these children. Make the work more attractive for staff, for example, increase pay, more breaks during the day and more days off, and make it easier to get to residential facilities.

CHALLENGE	CONSIDERATIONS
Funding: This model would require more highly skilled/educated staff and therefore we anticipate that the direct care staffing costs would exceed the daily rate level funded through the current maximum rate. The extraordinary rate which often supports more intensive staffing does not provide a sustaining funding model for a program. In addition, the extraordinary rate process can be contentious and is not conducive to quality partnership in treatment.	Establish these youth as a specialized population to justify a specialized rate that allows development and ongoing funding for a specialized unit.

Physical plant

- Whether the campus is located in an urban or rural environment there should be enough space to provide safe outdoor play and recreational activities. Note that while a campus is not mandatory, it may be the most cost-effective way to achieve the desired model of care.
- The units should be no more than eight to ten per unit.
- Use of cameras to monitor for the safety of children and staff in shared living spaces and bedrooms; recording 24/7 so that recordings are available for quality assurance and staff training.
- Residential units that are locked for ingress and egress or, at provider option, delayed release doors. (Note: The Workgroup spent considerable time discussing the definition of "secure" and "locked." The intent is to create a trauma-informed psychiatric hospital-like security, not detention-like security. The facility could be a PRTF or PRTF-like setting where the unit is locked.)

CHALLENGE	CONSIDERATIONS
Regulatory: Clients' rights regulations prohibit the use of recording cameras in residential care centers	Consult with DHS and other stakeholders regarding legislation to authorize the use of cameras in all or select residential centers.
Funding: Federal Title IV-E funding cannot be used for a placement in a locked unit unless indicated for treatment.	Use alternative funding sources to pay for these placements. Consider developing PRTF which would shift the funding to Medicaid Work to develop a clearer definition of "locked/secure" for residential care centers to align with federal IV-E parameters
Funding: Many current residential facilities are built with large units for capacity of 10-15 per unit.	Provide one-time or short-term grants to facilities to make the necessary physical plant adjustments for smaller settings that are more conducive to serving high needs children.

System: Given the acuity of this population, it may be more challenging to select a proper campus location and receive zoning and community approval.	Attempt to find an existing residential location that could effectively expand or convert services into this new residential design.

Aftercare

- Discharge planning begins on the first day of RCC placement.
- The residential clinical team would continue to work with the family in the home after the child is discharged for six to twelve months.
- Supportive, home-based services would be wrapped around the youth and family using CCS, CLTS, CST, etc. If not provided directly by the RCC, preferred providers for aftercare services that are trained in the same models, trauma informed care, etc. so there is an understanding of the needs of the family and treatment received in RCC could continue with little disruption.
- Follow up with the family every 6 months for two years.

CHALLENGE	CONSIDERATIONS
System/Funding: In general, counties have not been able to financially support ongoing engagement with the RCC after discharge in the form of aftercare services. This is mainly due to cost, especially when the child's new living arrangement is located a distance from the RCC. Counties have expressed support for maintaining the same providers because they see the negative outcomes when families have to start all over with new providers. RCCs would also have to ensure that they have enough resources for aftercare services, which would entail additional funding.	Fund aftercare services based on the rate needed to either maintain the RCC staff for a specified period of time, which includes staff time, travel and consultation or to purchase the appropriate technology that would allow for some degree of remote aftercare services. Bundle aftercare services into the RCC daily rate.
System/Funding: Insufficient service array available in rural areas.	Revisit the Telehealth requirements to create more seamless access to care via technology in rural areas. Provide reimbursement for staff travel time to be able to access families in rural areas.

Additional considerations for implementing this new residential model

As noted above there are a range of regulatory, funding, workforce, partnership and system issues that would need to be addressed to successfully launch and maintain this new residential model. Beyond the specific challenges, the Workgroup identified a number of additional considerations/recommendations to support program success.

State Partnership in Funding and Placements. As DCF did with the specialized human trafficking programming, the state could again take an ownership role in developing and sustaining this new residential model for this specialized population. By providing a start-up investment for a minimum of two years, for example, the state

could provide the stability the program needs to firmly establish the staffing and evidence-based, trauma-informed care models.

Referral Process. To ensure that referrals to this program are appropriate, representatives from DHS, DCF and other qualified consultants should be engaged to support the referral process. Based on the profile developed by the Workgroup, this team could use predictive analytics to proactively identify children with complex needs or function as a referral review panel that uses a standardized set of criteria such as number of previous placements, extreme dysregulation, attachment issues and lack of an identified permanent resource to qualify children for this more intensive treatment level. The referral process should incorporate a universal intake process with required information submitted for all youth being considered.

Creation of a centralized team could also address a concern voiced by providers that when there is insufficient information provided at the time of referral children may not be not appropriately matched to the program services.

Licensing. The ideal licensing program would be collaborative and incorporate a trauma-informed approach that supports programs, youth in care, staff caring for youth and licensers. Just as the state adopted the collaborative system change review process for addressing CPS egregious incident reports, DCF and providers should work together to develop a licensing accountability approach that would allow providers to safely serve more challenging children and result in overall system quality improvement.

Relationship with hospitals, crisis services, law enforcement and others. As noted previously, success with these youth will require strong collaboration between providers and other system partners, in particular, law enforcement. Youth and those who care for them, at times, need law enforcement involvement for protection. System partners need to work together to develop trauma-informed strategies to address situations that require law enforcement involvement. Where systems rules get in the way, we must work together to identify systems changes required to develop approaches that allow law enforcement and providers to each fulfill their roles with respect to helping youth overcome past traumas, limitations of their mental health and to learn self-regulation.

Liability Reform. Challenging children and youth pose a liability risk for providers (harm to self, others, community, etc.) Providers are not afforded the same liability protections as those granted to government. Provider liability reform would allow providers additional latitude to bring more challenging youth into their programs.

CONCLUSION

The efforts of the Workgroup clarified the characteristics of children that are most challenging to serve and most frequently referred to out-of-state providers. The data on youth combined with a review of out-of-state provider models moved the Workgroup to focus immediate efforts on a new residential option for these children with complex needs.

Many of the challenges that providers identified relative to this new residential treatment model apply broadly as challenges across the system. Efforts to overcome and resolve some of these challenges for this specific residential proposal may help stakeholder partners identify solutions that deliver positive benefits across the continuum of care.

While there will be challenges moving to implementation, they are not insurmountable and through continued partnership, Wisconsin can build a more robust continuum of care that meets the needs of all children, including the most complex.

Workgroup on Youth with Complex Care Needs Members

Co-Chairs:
Lance Horozewski, Rock County
Linda Hall, WAFCA

Participants:
Amy Weber, Winnebago County
Ann Leinfelder Grove, SaintA
Anthony Lichtfuss, Winnebago Mental Health Institute
Brent Ruehlow, Jefferson County
Dan Brattset, Sauk County
Dee Jaye Miles, Green County
Denise Pilz, Norris Adolescent Center
Diane Scheerer, Waukesha County
Donelle Hauser, Lad Lake
Elizabeth Hudson, DHS, OCMH
Jeff Pease , Lad Lake
Joan Sternweis, Waukesha County
Julie Anstett, DHS
Kathi Cauley, Jefferson County
Kathy Markeland, WAFCA
Kim Eithun, DHS, OCMH
Lori Thuli, DCF
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Mary Kay Wills, Dane County
Renee Krueger, Lincoln County
Robert Williams, Walworth County
Robin Raj, DHS
Ron Hauser, Lutheran Social Services
Ron Hermes, DCF
Ruth Kantrowitz, Sky Residential Services
Sarah Coyle, DHS
Sarah Lawton, Dane County
Scott Strong, RISE Wisconsin

County Survey of Youth At-Risk of Out of State Placement

Attachment 2

Rank	Characteristic	Number of Children with the Characteristic	Percent of Children with the Characteristic
	Male	24	
	Female	25	
	Total Number of Children	49	
1	Complex trauma	35	71%
2	Aggression	32	65%
3	Number of prior placements	31	63%
4	Attachment issues	30	61%
5	No identified/willing permanent resource	23	47%
6	Age	21	43%
7	Sexual acting out	20	41%
8	Repeated runaway	17	35%
9	Other	13	27%
10	IQ below 70	12	24%
11	Post adoption	9	18%
12	Race/ethnicity	9	18%
13	Autism	8	16%
14	Substance abuse	3	6%

Note: 29 Counties responded to this February, 2017 survey of human services departments. Counties were asked to identify the number of youth in their county who were at-risk of placement outside of Wisconsin and then for each youth to identify all risk factors that apply.

Q1 Please identify the number of youth at-risk of placement outside of Wisconsin. Example, a youth with significant aggression and lower IQ or a youth with high episodes of runaway and suicide attempts. These are examples of risk factors associated with youth who are currently placed outside of Wisconsin.

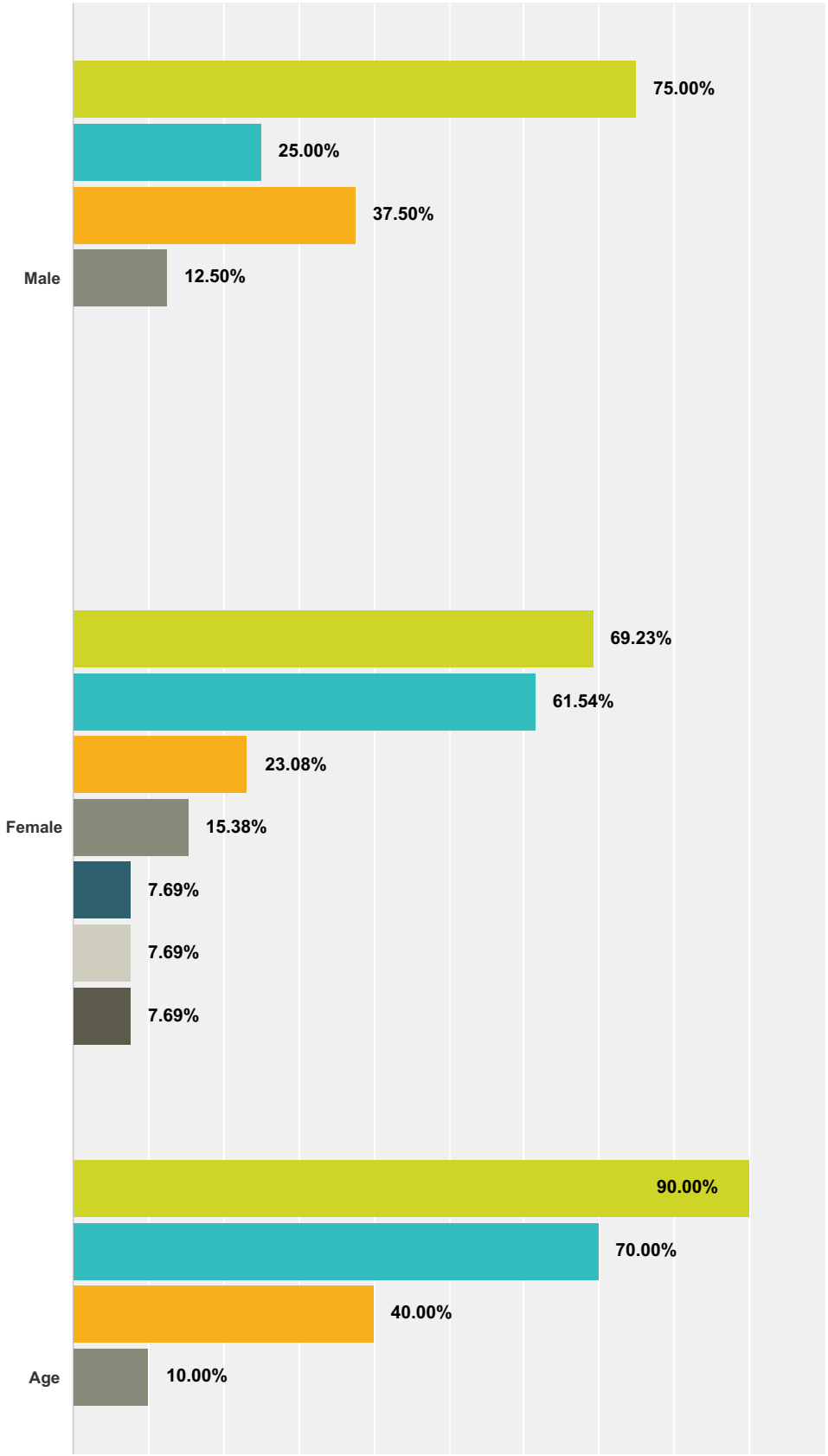
Answered: 49 Skipped: 0

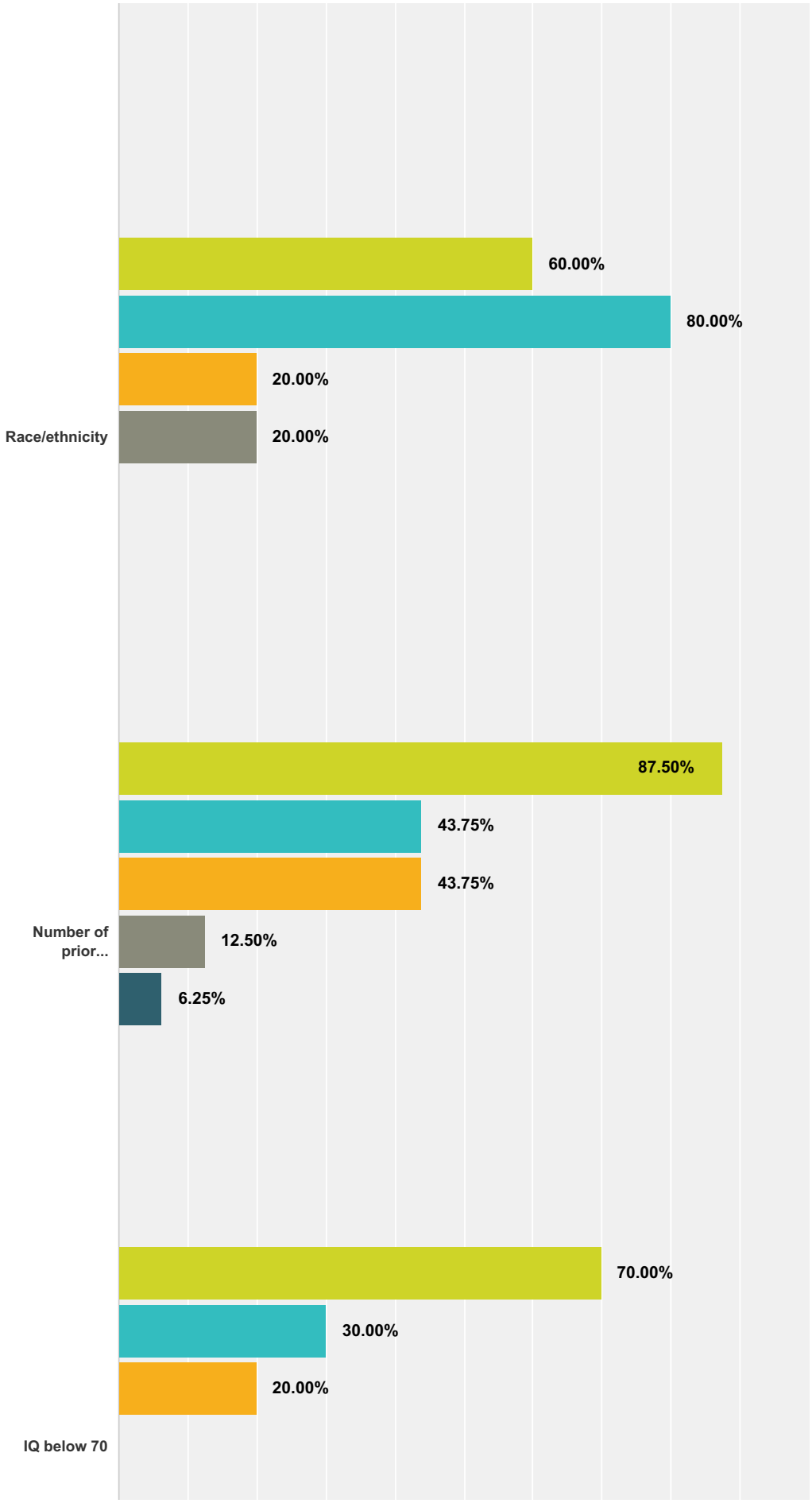
#	Responses	Date
1	4 one of which is already out of State	2/6/2017 12:50 PM
2	0	2/2/2017 3:35 PM
3	.	2/2/2017 1:43 PM
4	1	1/30/2017 4:35 PM
5	None	1/30/2017 11:09 AM
6	0	1/30/2017 10:59 AM
7	0	1/30/2017 8:30 AM
8	NONE	1/30/2017 8:30 AM
9	0	1/27/2017 2:06 PM
10	10	1/25/2017 1:30 PM
11	4	1/23/2017 1:03 PM
12	0	1/20/2017 10:52 AM
13	0	1/19/2017 2:31 PM
14	1	1/18/2017 5:43 PM
15	1	1/18/2017 2:12 PM
16	0	1/18/2017 12:43 PM
17	0	1/17/2017 2:51 PM
18	0	1/17/2017 2:49 PM
19	2	1/17/2017 9:54 AM
20	1	1/16/2017 4:31 PM
21	3	1/16/2017 4:05 PM
22	0	1/16/2017 3:48 PM
23	We are in the process of placing one now	1/16/2017 2:18 PM
24	0	1/16/2017 11:01 AM
25	0	1/16/2017 10:30 AM
26	2	1/16/2017 9:33 AM
27	0	1/16/2017 8:01 AM
28	1	1/13/2017 11:30 AM
29	1	1/13/2017 8:57 AM

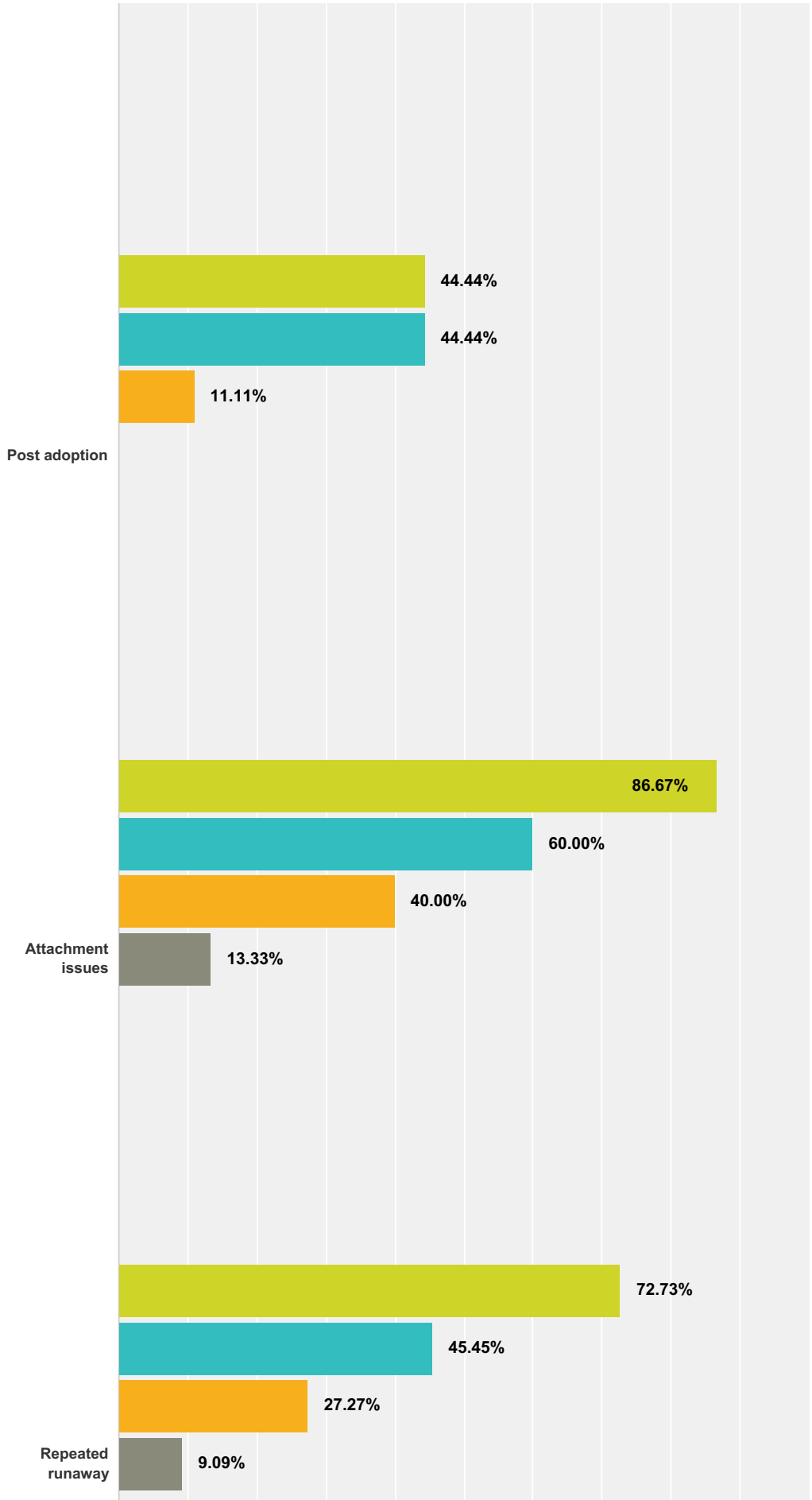
30	1	1/13/2017 8:50 AM
31	None at this time.	1/13/2017 8:37 AM
32	one	1/13/2017 7:54 AM
33	0	1/12/2017 7:27 PM
34	0	1/12/2017 5:20 PM
35	1	1/12/2017 4:33 PM
36	4	1/12/2017 4:33 PM
37	3	1/12/2017 4:26 PM
38	1	1/12/2017 4:13 PM
39	0	1/12/2017 4:11 PM
40	1	1/12/2017 4:07 PM
41	0	1/12/2017 4:02 PM
42	0	1/12/2017 4:01 PM
43	0	1/12/2017 4:01 PM
44	0	1/12/2017 3:37 PM
45	2	1/12/2017 3:15 PM
46	0	1/12/2017 3:12 PM
47	3	1/12/2017 3:06 PM
48	3	1/12/2017 3:01 PM
49	3	1/12/2017 3:01 PM

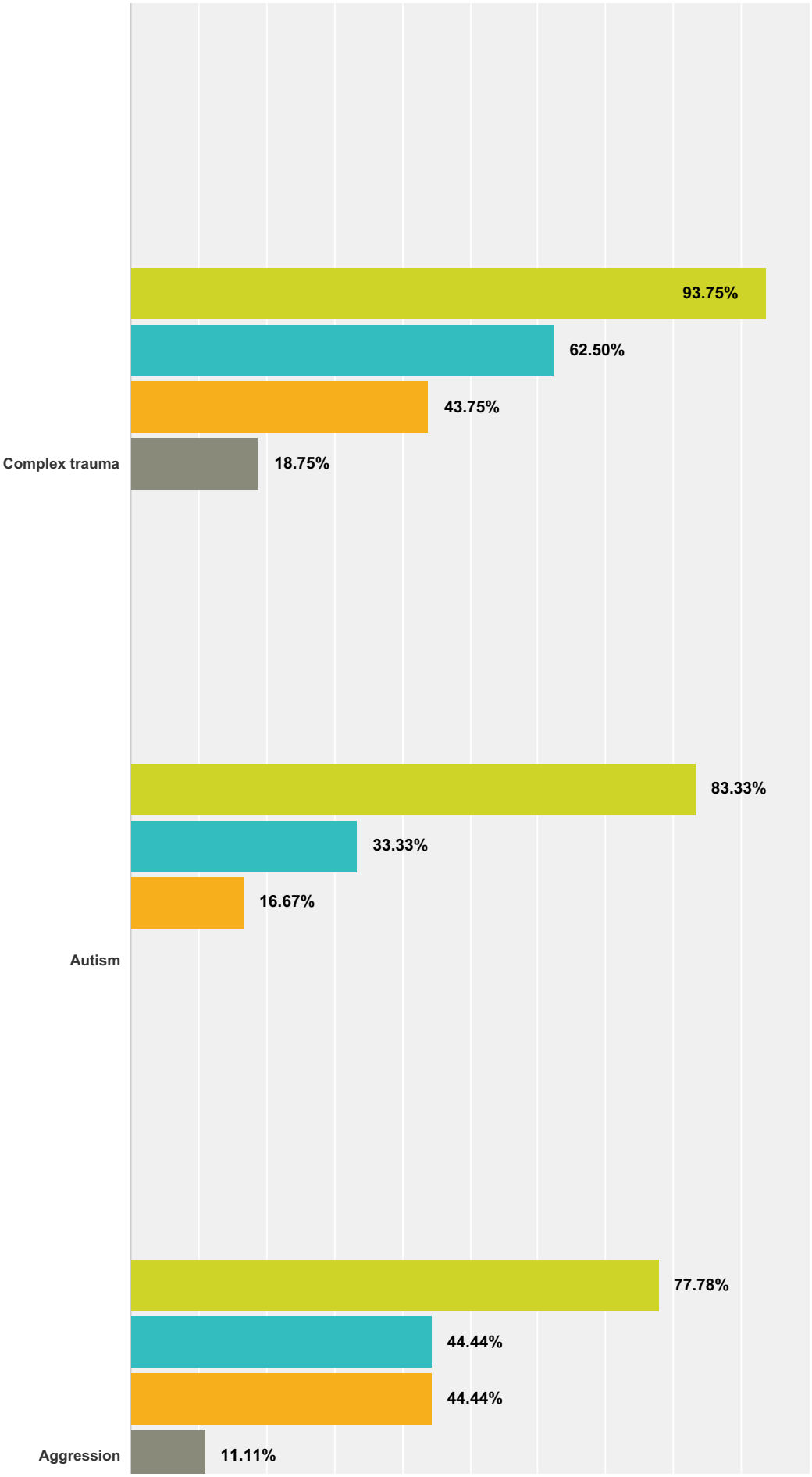
Q2 For each youth please check all risk factors that apply:

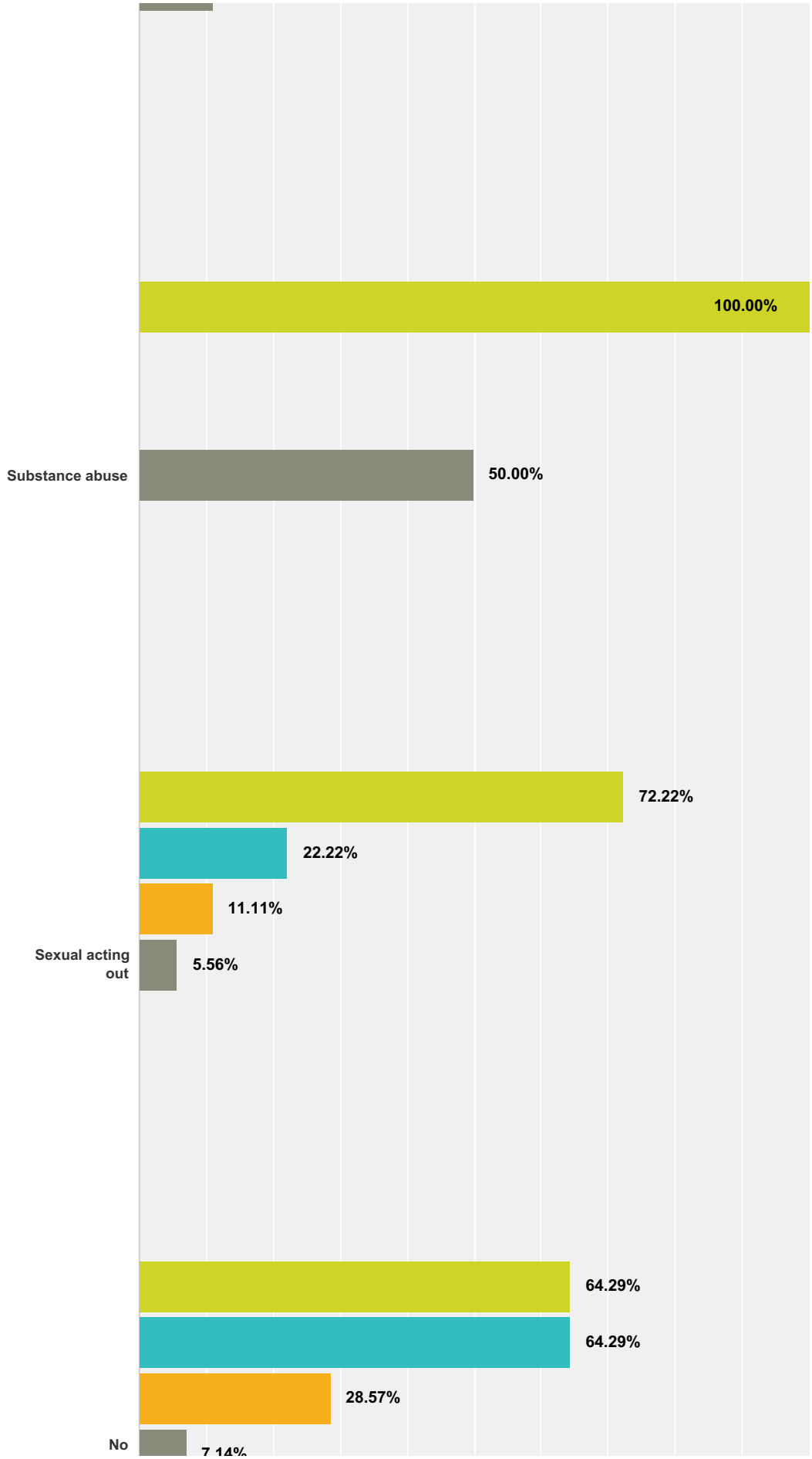
Answered: 24 Skipped: 25

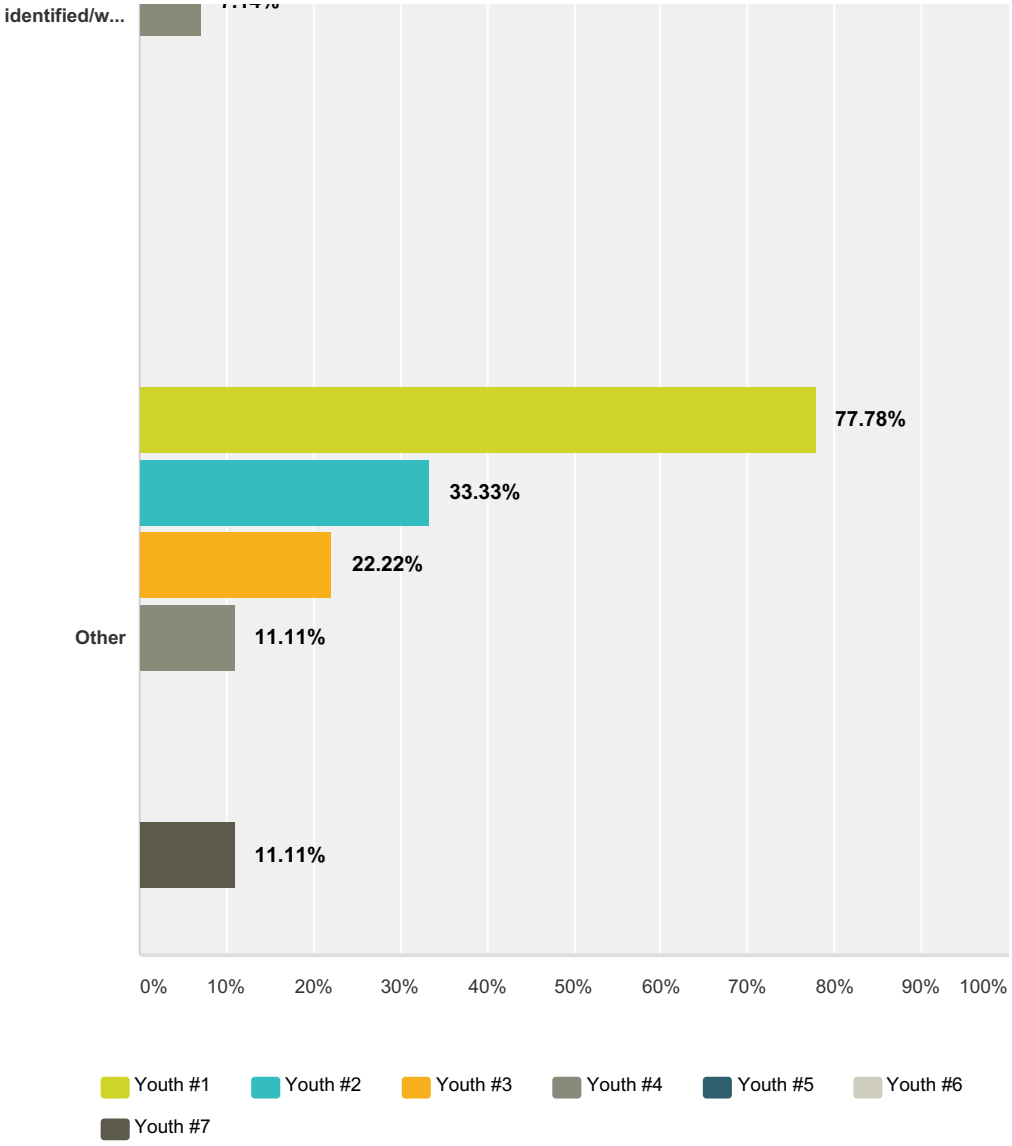



60.00%
80.00%
20.00%
Race/ethnicity
20.00%
87.50%
43.75%
43.75%
Number of prior...
12.50%
6.25%
70.00%
30.00%
20.00%
IQ below 70


Post adoption
44.44%
44.44%
11.11%
Attachment issues
86.67%
60.00%
40.00%
13.33%
Repeated runaway
72.73%
45.45%
27.27%
9.09%


93.75%
62.50%
43.75%
Complex trauma
18.75%
83.33%
33.33%
16.67%
Autism
77.78%
44.44%
44.44%
Aggression
11.11%


100.00%
Substance abuse
50.00%
72.22%
22.22%
11.11%
Sexual acting out
5.56%
64.29%
64.29%
28.57%
No
7.14%



	Youth #1	Youth #2	Youth #3	Youth #4	Youth #5	Youth #6	Youth #7	Total Respondents
Male	**75.00%** 12	**25.00%** 4	**37.50%** 6	**12.50%** 2	**0.00%** 0	**0.00%** 0	**0.00%** 0	16
Female	**69.23%** 9	**61.54%** 8	**23.08%** 3	**15.38%** 2	**7.69%** 1	**7.69%** 1	**7.69%** 1	13
Age	**90.00%** 9	**70.00%** 7	**40.00%** 4	**10.00%** 1	**0.00%** 0	**0.00%** 0	**0.00%** 0	10
Race/ethnicity	**60.00%** 3	**80.00%** 4	**20.00%** 1	**20.00%** 1	**0.00%** 0	**0.00%** 0	**0.00%** 0	5
Number of prior placements	**87.50%** 14	**43.75%** 7	**43.75%** 7	**12.50%** 2	**6.25%** 1	**0.00%** 0	**0.00%** 0	16
IQ below 70	**70.00%** 7	**30.00%** 3	**20.00%** 2	**0.00%** 0	**0.00%** 0	**0.00%** 0	**0.00%** 0	10
Post adoption	**44.44%** 4	**44.44%** 4	**11.11%** 1	**0.00%** 0	**0.00%** 0	**0.00%** 0	**0.00%** 0	9
Attachment issues	**86.67%** 13	**60.00%** 9	**40.00%** 6	**13.33%** 2	**0.00%** 0	**0.00%** 0	**0.00%** 0	15

Repeated runaway	**72.73%** 8	**45.45%** 5	**27.27%** 3	**9.09%** 1	**0.00%** 0	**0.00%** 0	**0.00%** 0	11
Complex trauma	**93.75%** 15	**62.50%** 10	**43.75%** 7	**18.75%** 3	**0.00%** 0	**0.00%** 0	**0.00%** 0	16
Autism	**83.33%** 5	**33.33%** 2	**16.67%** 1	**0.00%** 0	**0.00%** 0	**0.00%** 0	**0.00%** 0	6
Aggression	**77.78%** 14	**44.44%** 8	**44.44%** 8	**11.11%** 2	**0.00%** 0	**0.00%** 0	**0.00%** 0	18
Substance abuse	**100.00%** 2	**0.00%** 0	**0.00%** 0	**50.00%** 1	**0.00%** 0	**0.00%** 0	**0.00%** 0	2
Sexual acting out	**72.22%** 13	**22.22%** 4	**11.11%** 2	**5.56%** 1	**0.00%** 0	**0.00%** 0	**0.00%** 0	18
No identified/willing permanent resource	**64.29%** 9	**64.29%** 9	**28.57%** 4	**7.14%** 1	**0.00%** 0	**0.00%** 0	**0.00%** 0	14
Other	**77.78%** 7	**33.33%** 3	**22.22%** 2	**11.11%** 1	**0.00%** 0	**0.00%** 0	**11.11%** 1	9

#	Other (please specify)	Date
1	Youth 1-Firesetting, severe enuresis and encopresis Youth 2-GI Issues, including encopresis Youth3 Memory loss Youth 4- Incompetent, aggressive, sexually assaultive, masturbates excessively to soothe	2/6/2017 12:50 PM
2	o	2/2/2017 1:43 PM
3	We have no youth at risk to be placed out of the state at this time	1/17/2017 2:49 PM
4	No respite options or services available in Green County to help the family with the youth's behavior.	1/17/2017 9:54 AM
5	Significant mental health issues	1/16/2017 4:31 PM
6	Diagnosed with schizoaffective disorder too	1/16/2017 2:18 PM
7	Male: significant sexual aggression, unstable mental health, and running away behavior. Female: Cognitive issues along with aggressive behavior when she becomes angry. She was placed in several foster homes before being adopted. Her parents can no longer control her behavior and don't want her home. She is currently in an RCC waiting for a step down to treatment foster care.	1/16/2017 9:33 AM
8	youth has assistive needs such as wheelchair due to spina bifida, requires cathater - which he can do.	1/13/2017 7:54 AM
9	Non verbal was the number one reason cited	1/12/2017 4:33 PM
10	Fire setting, urinating	1/12/2017 4:26 PM
11	fire setting	1/12/2017 4:07 PM
12	I have a youth that after an 8 month wait list was able to be placed in a RCC in WI. She was denied by the out of state placements we inquired.	1/12/2017 3:15 PM

Q3 We would like to hear what successes your jurisdiction has had related to meeting the needs of very complex youth. Please list programs or practice efforts that have worked:

Answered: 32 Skipped: 17

#	Responses	Date
1	Anu Parent Coaching Family Training Program Trauma training for caregivers--Tier 2 of Wisconsin Trauma Project TF-CBT Family Find Dual Status Youth Protocols CCS for youth	2/6/2017 12:57 PM
2	We staff collaboratively with all units to determine what programs/supports should be initiated.	2/2/2017 3:36 PM
3	.	2/2/2017 1:43 PM
4	Utilize CCS and community mental health programs. Some complex youth are difficult to treat in the community.	1/30/2017 11:10 AM
5	Mentoring, CCS, CLTS, Independent living skills	1/30/2017 11:00 AM
6	This is a constantly frustrating problem. We try to piece together services locally to serve these kids when we have the right parent, relative or foster parent and then secondly we work very hard with Advocates or American Foundation (when they have a matching treatment fosterhome to develop services that are based on the needs of the adolescent.	1/30/2017 8:33 AM
7	CCDHHS has a tendency to work with youth in the community and wrap services around the family. Either through CCS/CST/CLTS/FSU. Our philosophy of community and family based services helps prevent out of homeplacement.	1/30/2017 8:31 AM
8	We have currently placed two of our youth outside of WI. Two female girls are placed in TN	1/23/2017 1:03 PM
9	We have no children placed out of State. However, the State of WI needs more RCC's for females. This is a high need and state-wide.	1/20/2017 10:54 AM
10	Working together as a team with schools, other agencies, and program areas. We have had successful outcomes from Homme Home, Oconomowoc, and Northwest Passage as well. Some challenging cases actually find more successful outcomes keeping the youth in the home with intensive services. Other times, there are cases where there is more success within the home when the family has minimal service interventions and they take care of things on their own. In certain case situations, over responding to a family/youth situation actually makes things worse.	1/19/2017 2:39 PM
11	CCS Programming Report Center Programming Trauma Focused Therapy- TF-CBT/ Trauma Parenting Group ART	1/18/2017 2:14 PM
12	Northwest Passage Rawhide	1/17/2017 2:52 PM
13	Lutheran Social Services Family Partnership Initiative wraparound case management services, CST, Post Reunification Grant, Orion Safety Services, CLTS	1/17/2017 9:56 AM
14	collaborative work between child welfare and clinical units, development of local, specialized providers, creative thinking-willingness on part of staff to try unconventional ideas to make community placements successful	1/16/2017 4:34 PM
15	Comprehensive Community Services (CCS) Family Partnerships Initiative (FPI through LSS)	1/16/2017 4:07 PM
16	We are paying on parents rent and car payment so the parent can stay home and care for her child. We are also paying high CCS/CLTS rates for providers to come into the home and support the parents.	1/16/2017 2:19 PM
17	We are starting to look at out of state placements as we are increasingly unable to find appropriate resources and placements within the state. We have many parents who are going without necessary respite because there is none available for their children, leading to an increasing volatile situation.	1/16/2017 11:03 AM
18	Independent living, CST	1/16/2017 9:34 AM
19	Our county utilizes CCS/CST	1/16/2017 8:01 AM
20	In most complex cases the successful strategy to date has been to authorize an extra-ordinary payment for the youth. That is not a feasible long-term strategy. In one situation we were able to support the youth at home by designing a crisis response plan which included law enforcement. When this particular youth acts out (her goal is hospitalization - she likes it there) the parents call law enforcement and the responding officer stays with her at the home until she is settled again. Each episode includes collaboration with the crisis response social worker. We're 4 months into this plan and the acting out episodes are decreasing in duration.	1/13/2017 9:06 AM

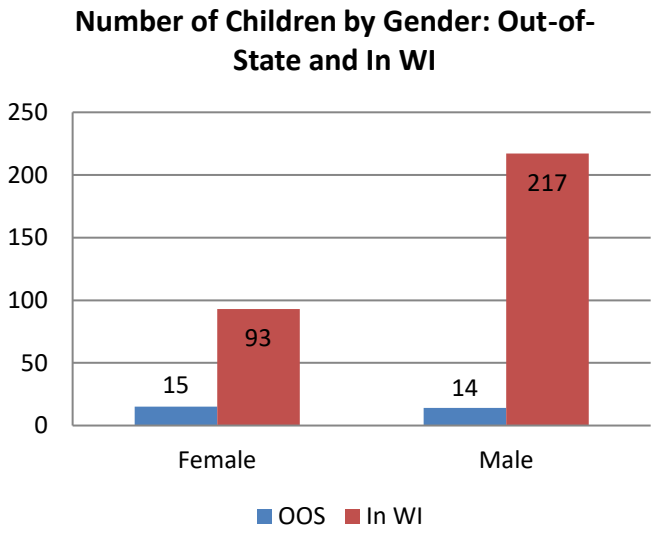
21	None in Out of State placements. We utilize Treatment Foster Homes in the Region. We use Group Homes & RCC's as appropriate. There are not enough resources!	1/13/2017 8:39 AM
22	Out of area treatment foster care Additional respite and services through CLTS	1/12/2017 5:21 PM
23	Developing a Level 5 home, it has been 7 months however and we are looking at another 6 months	1/12/2017 4:34 PM
24	Intensive wrap around services Child specific level 5 home	1/12/2017 4:26 PM
25	Group homes, CST (wraparound services), CLTS...	1/12/2017 4:14 PM
26	N/A	1/12/2017 4:11 PM
27	Cross System/Dual Status work between CPS and Juvenile Justice. Wrap around programs CCS, CLTS Trauma informed care Family Find Respite Regular team meetings with those involved with the child County's willingness to develop programs specific for child (ie: level 5 foster home)	1/12/2017 4:11 PM
28	n/a	1/12/2017 4:01 PM
29	We have utilized a number of GH placements that have been effective, particularly Prentice House in Ashland for Juveniles with both behavioral and AODA issues. We have had some success with intensive in home services combined with respite and sanctions, depending on the case. We also utilize NW passages for good evaluations and recommendations for treatment but they often have long wait lists.	1/12/2017 3:14 PM
30	One youth was stabilized at Winnebago, a rather lengthy stay, and was able to move to treatment foster care.	1/12/2017 3:06 PM
31	1. Level 5 homes 2. Treatment foster homes that bring evidenced-based services into the home. 3. intensive wraparound services ordered by the court. 4. short-term stabilization in shelter care or a group home	1/12/2017 3:03 PM
32	Trauma Informed Care Practice CCS - Wrap around Mental Health Programming CST - Coordinated Services Teams (wrap around approach) Support from Imagine a Child's Capacity as well as the Wiseman Center in Madison WI	1/12/2017 3:02 PM

Summary of Children Placed in Residential Care Centers (RCC)

There were 29 children placed out-of-state in Residential Care Centers and a total of 310 children placed in-state in Residential Care Centers for the time period of November 1, 2016 to November 30, 2016.

Table 1: Demographics

a. Gender



b. Case Type

Case Type	OOS	WI
Child Welfare	2	45
Child Welfare & Juvenile Justice	2	24
CPS - Licensed / Certified Provider	1	
CPS Family - Initial Assessment	1	11
CPS Family - Initial Assessment & JJ	2	39
CPS Family - Ongoing	6	94
CPS Family - Ongoing & JJ	6	26
ICPC	1	
Juvenile Justice	4	64
Pre-Adoptive Child	4	6
DCF Guardianship - County Custody		1
Grand Total	**29**	**310**

c. Placement Target Population

Placement Target Population	OOS	WI
CHIPS - Abuse and Neglect (NYA - 61)	15	133
CHIPS - Other (NYA - 64)	4	37
Delinquency (YA - 06)	8	110
JIPS (YA - 6)	2	25
N/A		2
Voluntary Placement (NYA - 64)		3
Grand Total	**29**	**310**

d. Previously Adopted

Previously Adopted			
	Yes	**No**	**Grand Total**
WI	57	253	310
Out-of-State	8	21	29
Grand Total	**65**	**274**	**339**

Table 2: Child Age

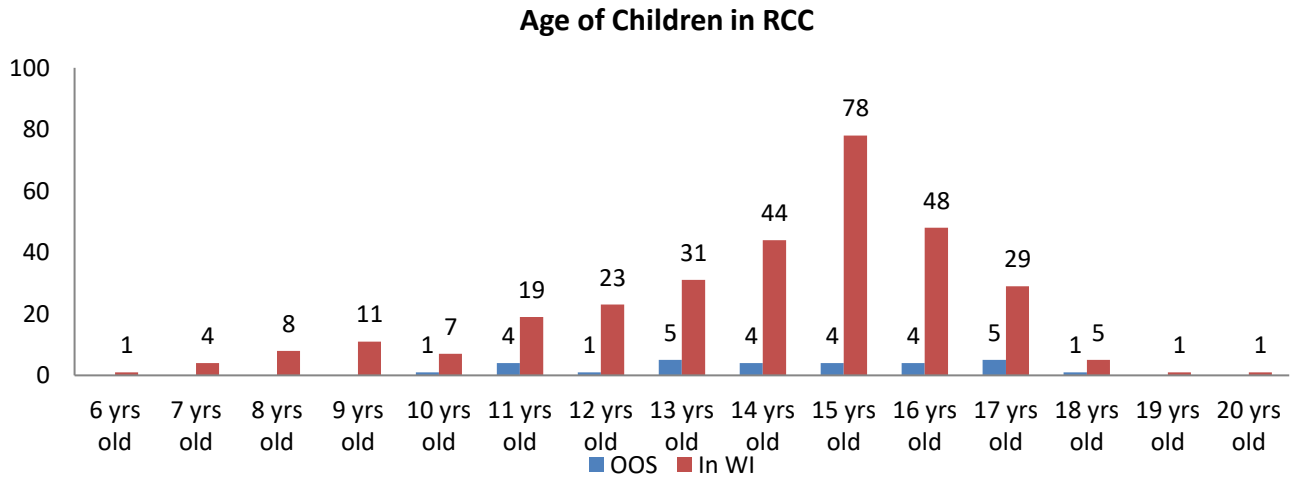


Table 3: Child Race

Out-of-State

- Black/African American: 14 children (9 female, 5 male)
- White: 13 children (4 female, 9 male)
- American Indian/Alaskan Native: 2 children (2 female, 0 male)
    - Also ICWA children

Wisconsin

- Black/African American: 71 children (28 female, 43 male)
- White: 215 children (55 female, 160 male)
- Asian: 4 children (2 female, 2 male)
- American Indian/Alaskan Native: 13 children (5 female, 8 male)
- Unable to determine: 7 children (3 female, 4 male)

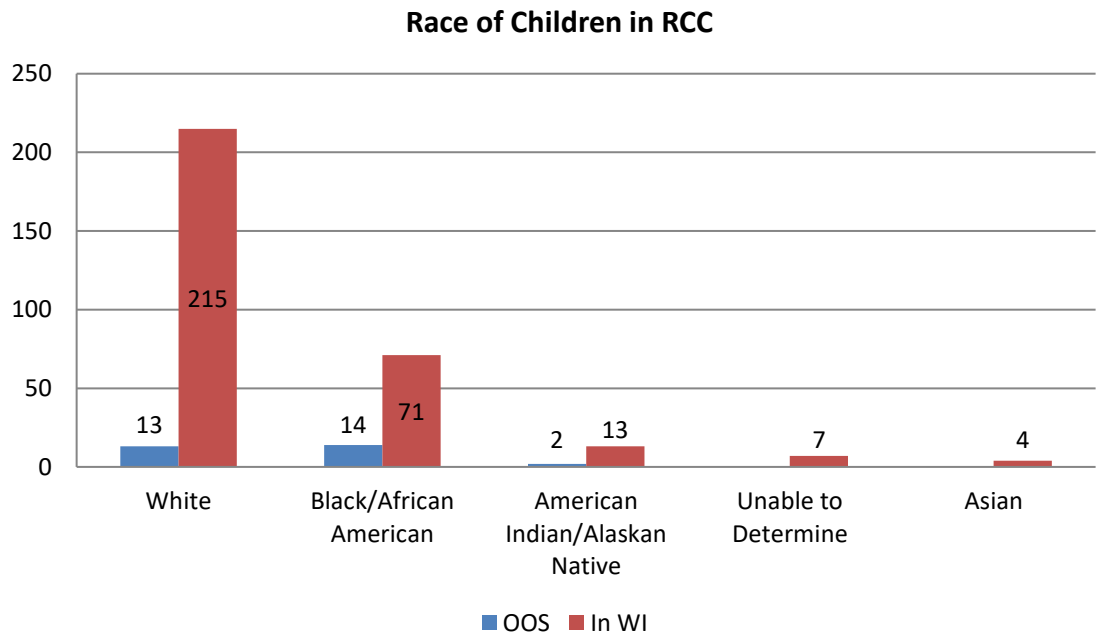


Table 4: Placing Counties of Out-of-State Placements in RCC Facilities

18 counties have needed to use facilities outside of Wisconsin.

- 8 Placements
    - Milwaukee
- 3 Placements
    - Rock
- 2 Placements
    - Dodge
    - State
    - Waukesha
- 1 Placement
    - Burnett
    - Crawford
    - Douglas
    - Florence
    - Grant
    - Jefferson
    - La Crosse
    - Lafayette
    - Menominee
    - Monroe
    - Sheboygan
    - Wood

54 counties in WI had children in RCC facilities.

- 55 Placements
    - Milwaukee
- Between 17 and 10 Placements
    - Dane
    - Rock
    - Marathon
    - Eau Claire
    - Fond du Lac
    - Racine
    - Waukesha
    - Dodge
    - Kenosha
- Less than 10 Placement
    - 45 counties

Table 5: States where Children are Placed

State	RCC Facility	# of Placements
Illinois	Allendale Association	7
	Center On Deafness	1
	Chaddock	1
Tennessee	Youth Villages Girls Center	2
	Youth Villages Boys Center	1
Arkansas	Millcreek of Arkansas	3
Minnesota	Gerard Academy	1
	Mille Lacs Academy	2
Nebraska	Boys Town	3
Iowa	Woodward Academy	1
	Hillcrest Family Services	1
Indiana	Campagna Academy	1
	Indian Oaks Academy	2
	RTC Resource Acquisition Corporation	1
Michigan	Detroit Behavioral Institute	1
	Vista Maria	1

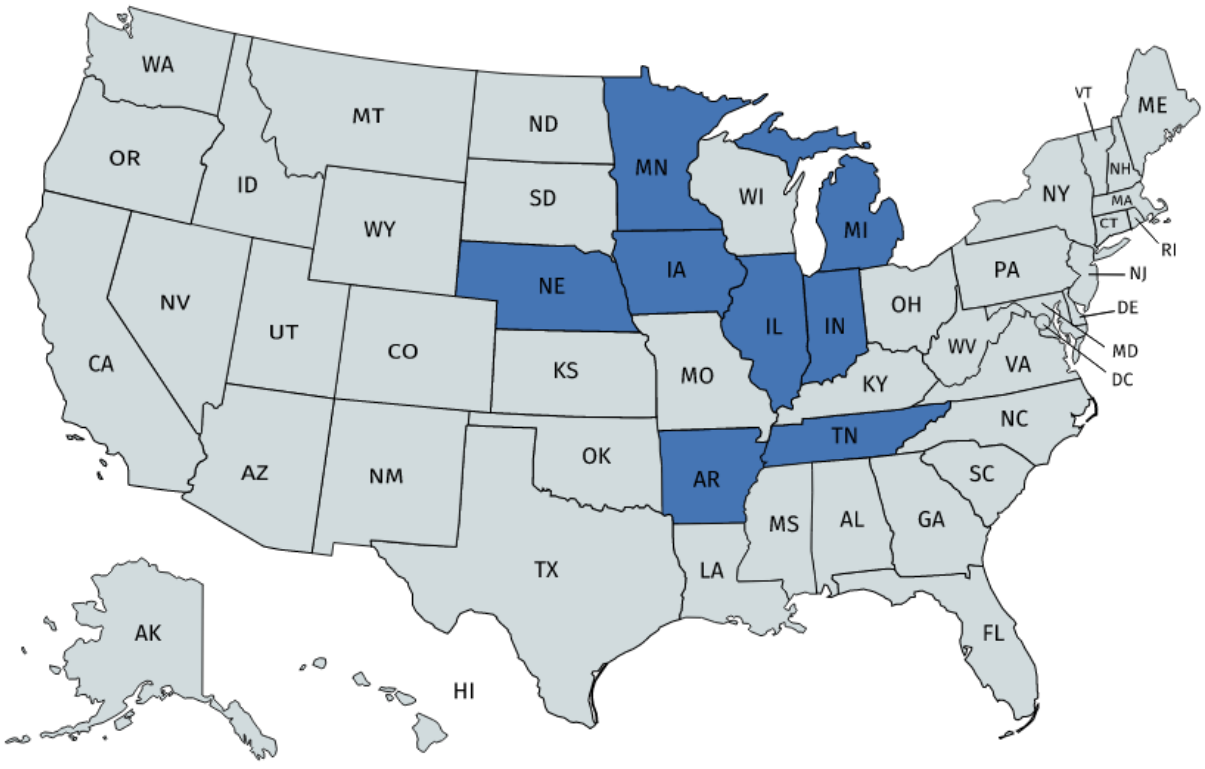
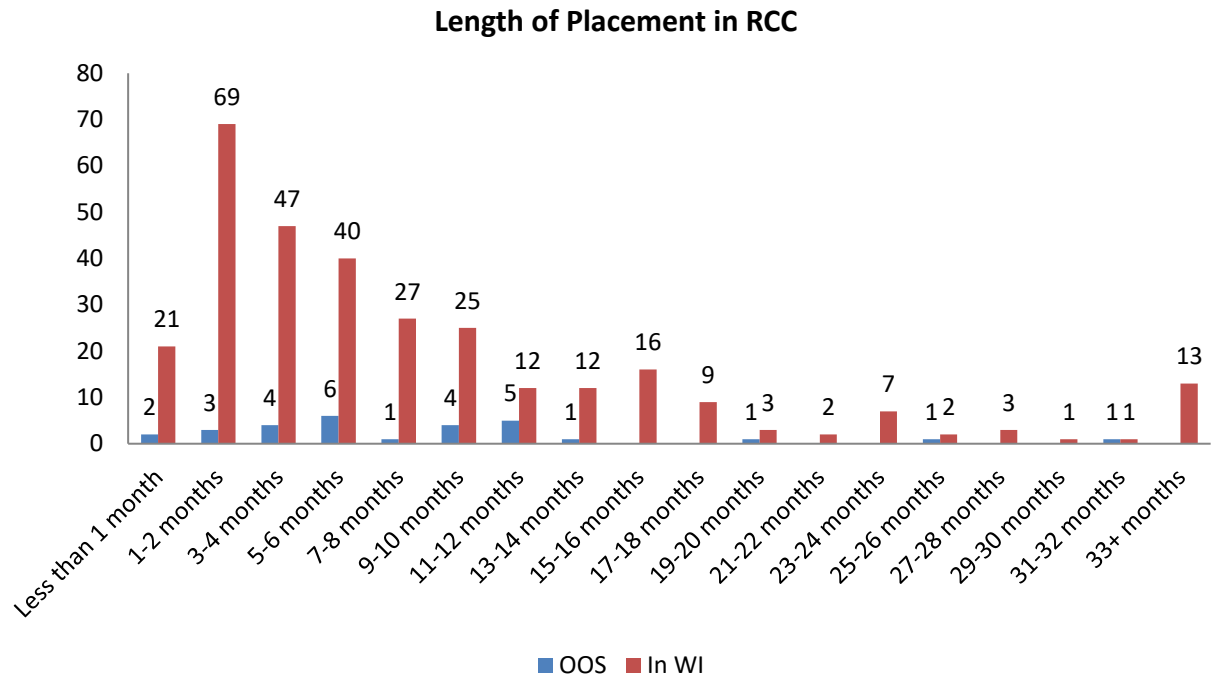


Table 6: Placement Length Months



NOTES:

- 31 month placement: 16 year old male placed at Center On Deafness (IL)
- 26 month placement: 18 year old male (ICWA) placed at Indian Oaks Academy (IL)
- 20 month placement: 14 year old female placed at Gerard Academy (MN)

Table 7: Outcomes of All Children Placed at an RCC in CY 2016

CY 2016: Exits from RCC	
Age of Majority	12
Custody Transfer to DHS/Other Institution/Non-Corrections	1
Guardianship	1
Reunification w/ Parent(s)/Primary Caretaker	175
Transfer To Another Agency	2
Total Children	**191**

Table 8: Discharges of All Children Placed at an RCC in CY 2016

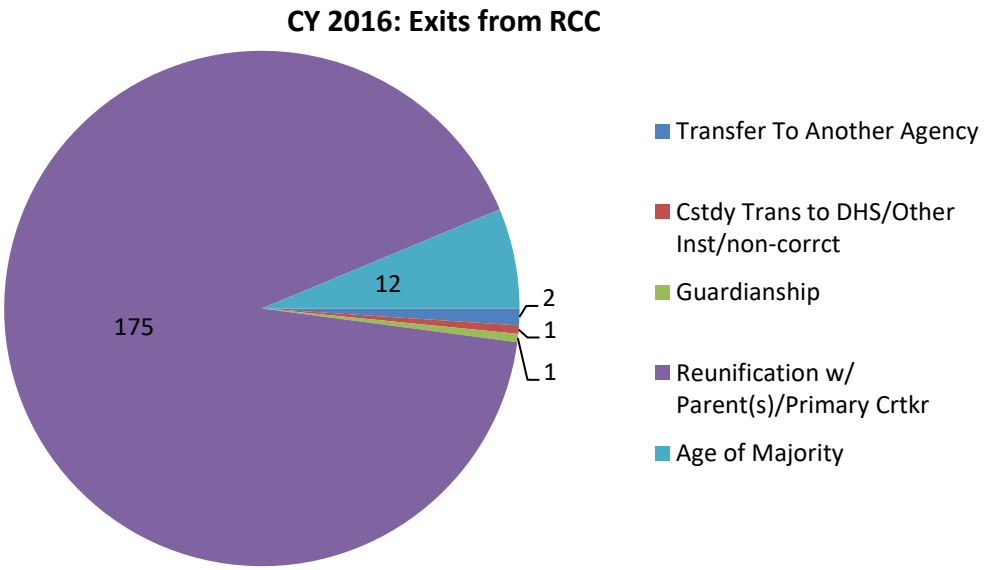
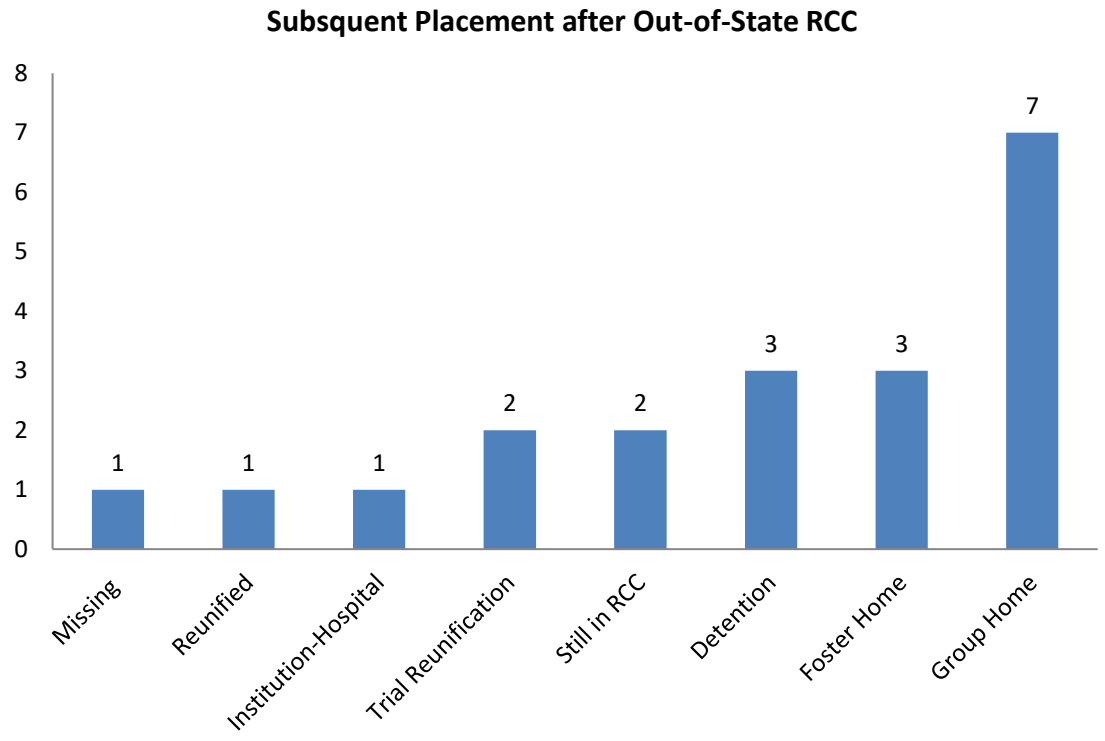


Table 9: Subsequent Placement after Out-of-State RCC in CY 2016



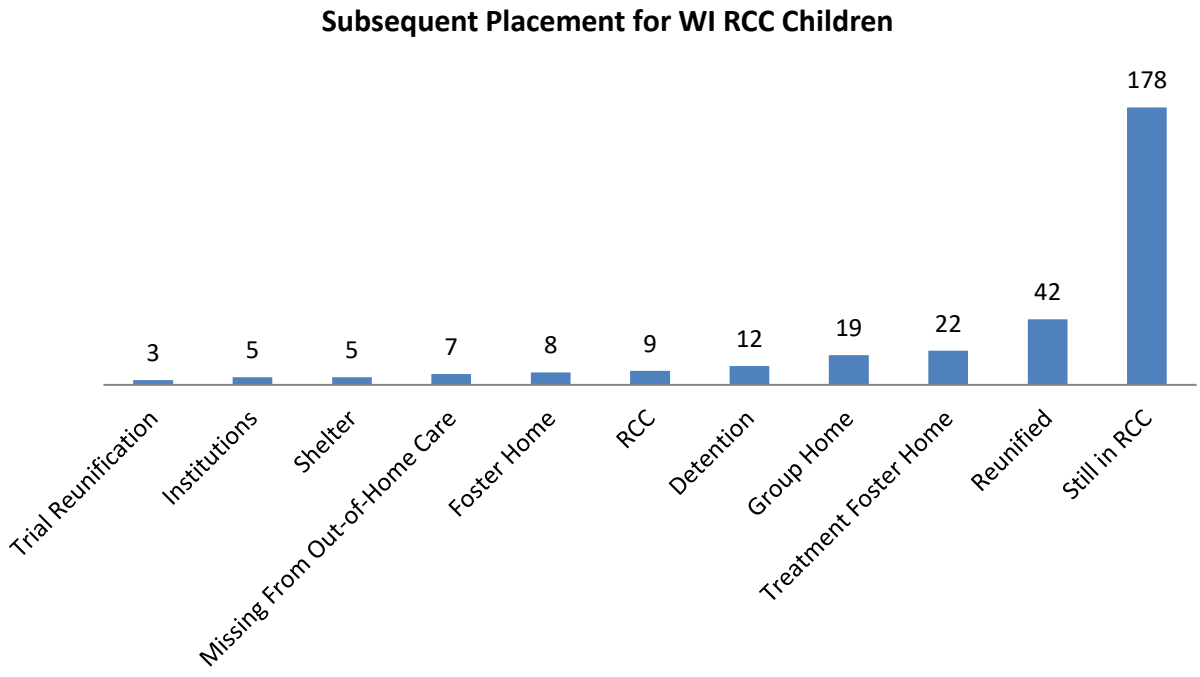


Table 10: Children Placed at an RCC by Monthly Increments

Nov-16	RCC: WI	RCC: Out-of-State
Less than 1 month	21	2
1-2 months	69	3
3-4 months	47	4
5-6 months	40	6
7-8 months	27	1
9-10 months	25	4
11-12 months	12	5
13-14 months	12	1
15-16 months	16	
17-18 months	9	
19-20 months	3	1
21-22 months	2	
23-24 months	7	
25-26 months	2	1
27-28 months	3	
29-30 months	1	
31-32 months	1	1
33-34 months	0	
35-36 months	1	
37-42 months	6	
43-64 months	6	
Total Children	**310**	**29**

Summary of Child and Adolescent Needs and Strengths (CANS) Data

As evidenced in tables 11 through 17 on the following pages, children placed out-of-state at residential care centers (RCC) have multiple need, which require significant case planning and treatment planning. In general, as evidenced in **Table 12**, children placed in out-of-state RCCs experience high rates of trauma, specifically in the areas of emotional abuse, neglect, sexual abuse, physical abuse, and witnessing family violence.

Many of the children placed in out-of-state RCCs have high needs associated with their adjustment to the trauma, as displayed in **Table 13**, which presents as attachment needs, including diagnoses of Reactive Attachment Disorder (RAD). Additionally, these children experience intrusions, such as intrusive thoughts, dissociation, and higher rates of grief and separation. The scores show they are struggling to manage their trauma experiences.

Children placed in out-of-state RCCs display difficulties in social relationships in many different life areas, including difficulties in relationships with their immediate and extended families and in relationships with other adults and same-age peers (**Table 14**). It is important to note that some of these relationship challenges may occur simultaneously with high attachment needs, as described above. In other words, due to the attachment needs displayed, children may experience difficulties in the various relationships in their lives.

Additionally, many of the children placed in out-of-state RCCs have few life skills developed and will need treatment planning and case planning to focus around developing life skills to better ensure a successful transition to adulthood (**Table 14**).

Children placed in out-of-state RCCs also present with high levels of emotional and behavioral needs as evidenced in **Table 15**. Specifically, many of the children struggle with anger control, anxiety, conduct, depression, impulsivity/hyperactivity, and oppositional behavior.

Lastly, many of the children placed in out-of-state RCCs have few strengths that are developed (**Table 17**). Respectively, children placed in out-of-state RCCs have few strengths present in the areas of decision making, family and peer relationships, relationship permanence, recreational opportunities and talents/interests, as well as vocational skills. Many of the children placed in out-of-state RCCs, as described above, have challenging relationships with their family members, peers, and other adults in their lives, which translates into having few positive relationships that the children can rely on for support and assistance which could mitigate some of their needs (as highlighted above).

In summary, many of the children placed in out-of-state RCCS have high needs and few cornerstone strengths. Treatment planning at the RCCs should focus on addressing the child's trauma history, developing relationship permanence with at least one person in the child's life, building life skills, and addressing the complex mental health needs. It is important for staff to be trauma informed in order to successfully and adequately work with children, who have significant trauma histories that compound their functioning in multiple life domains.

Table 11: Child and Adolescent Needs and Strengths (CANS) tool Average Score

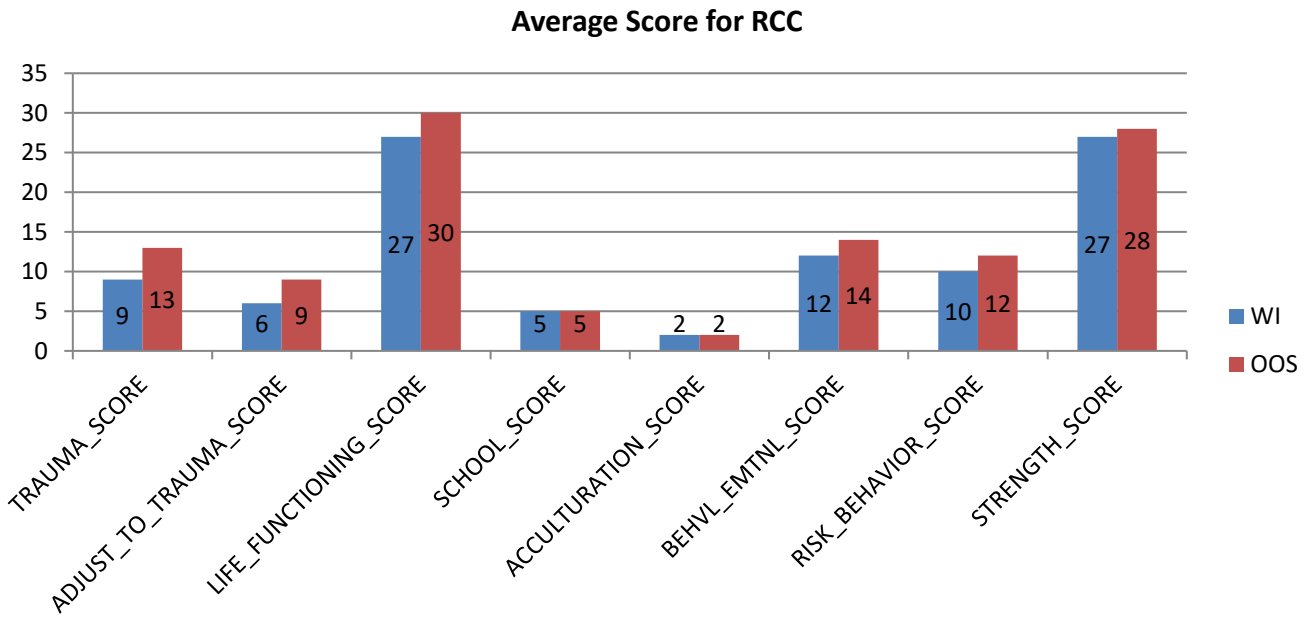


Table 12: CANS Scoring Rate by Indicator: Trauma

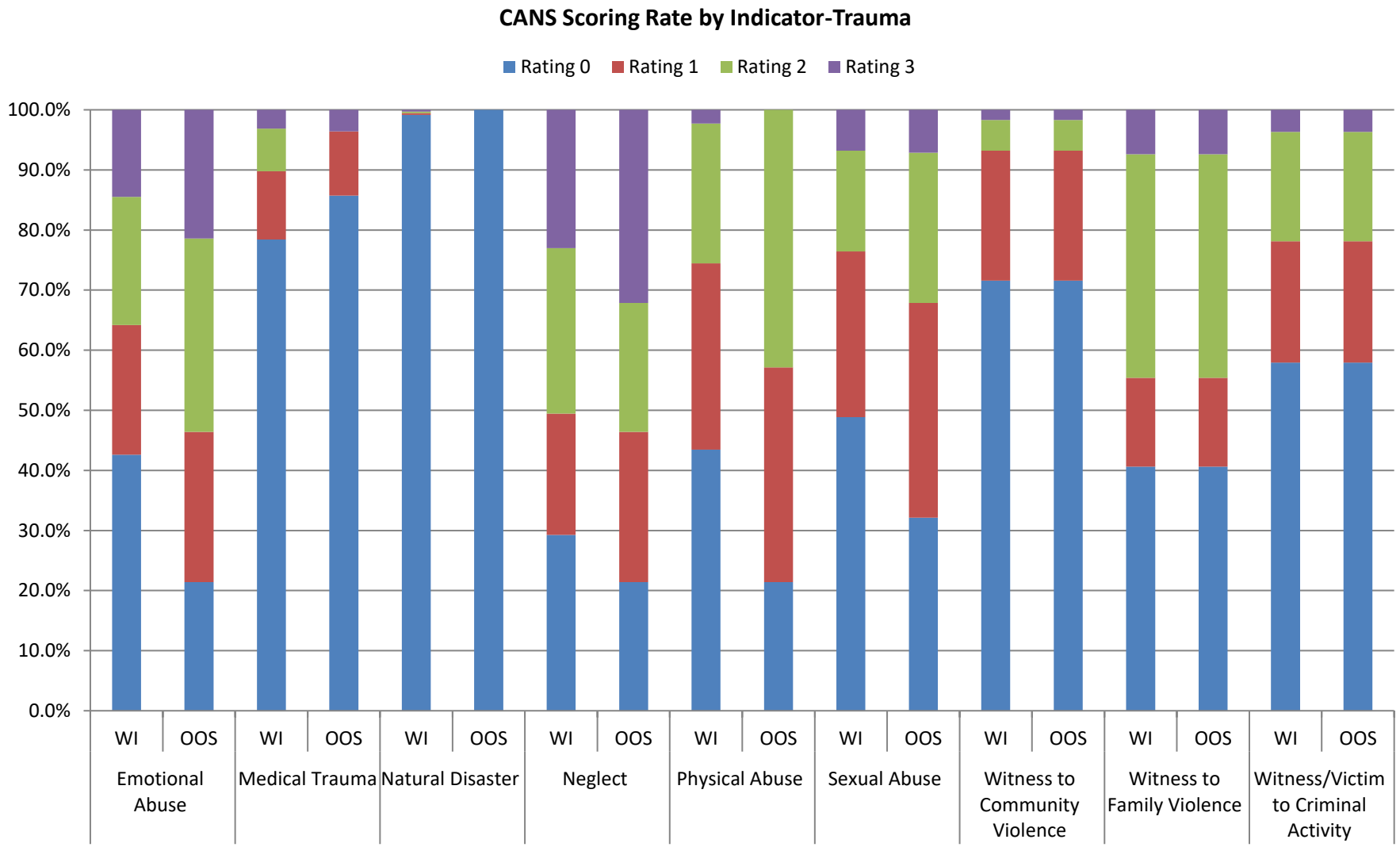


Table 13: CANS Scoring Rate by Indicator: Adjustment to Trauma

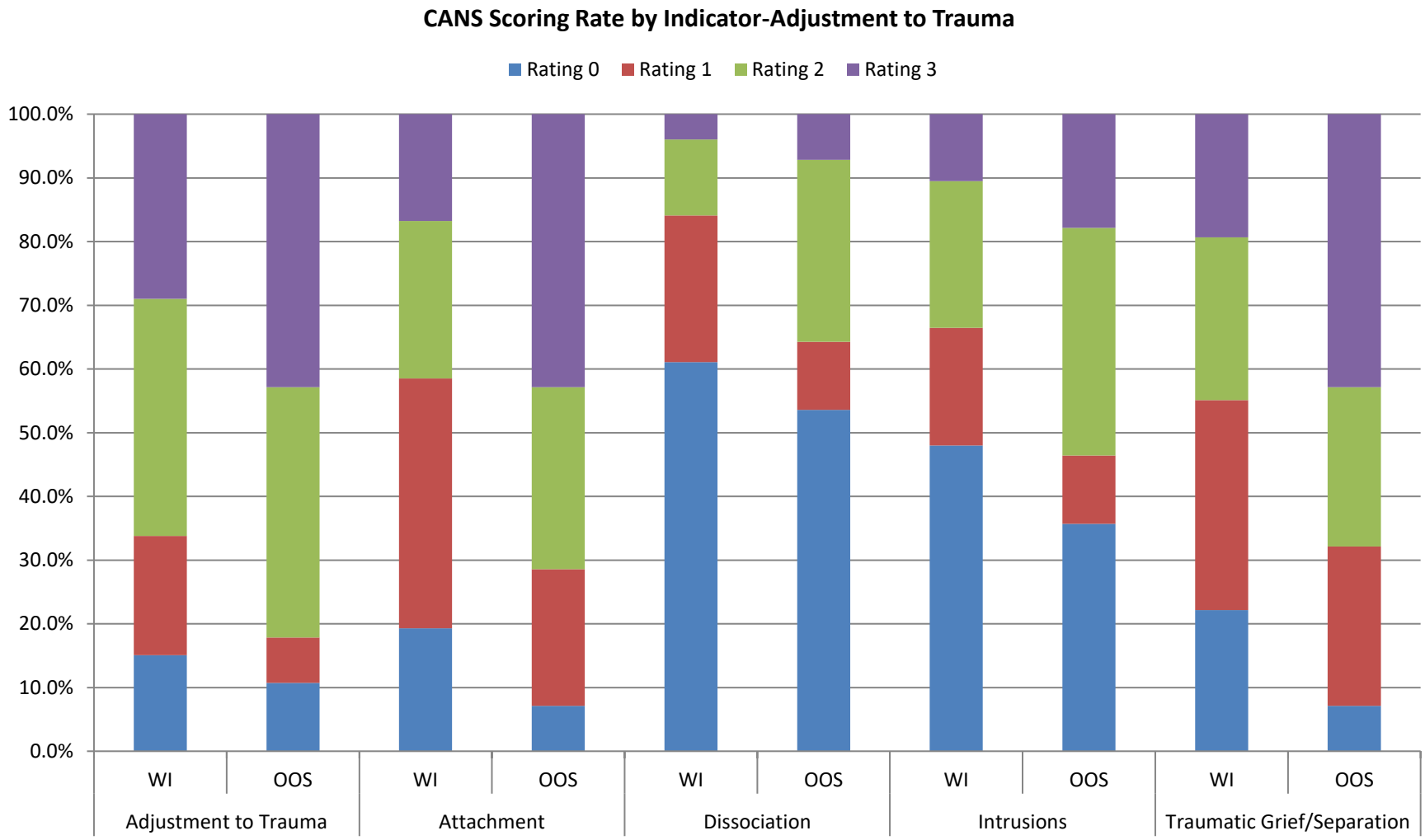
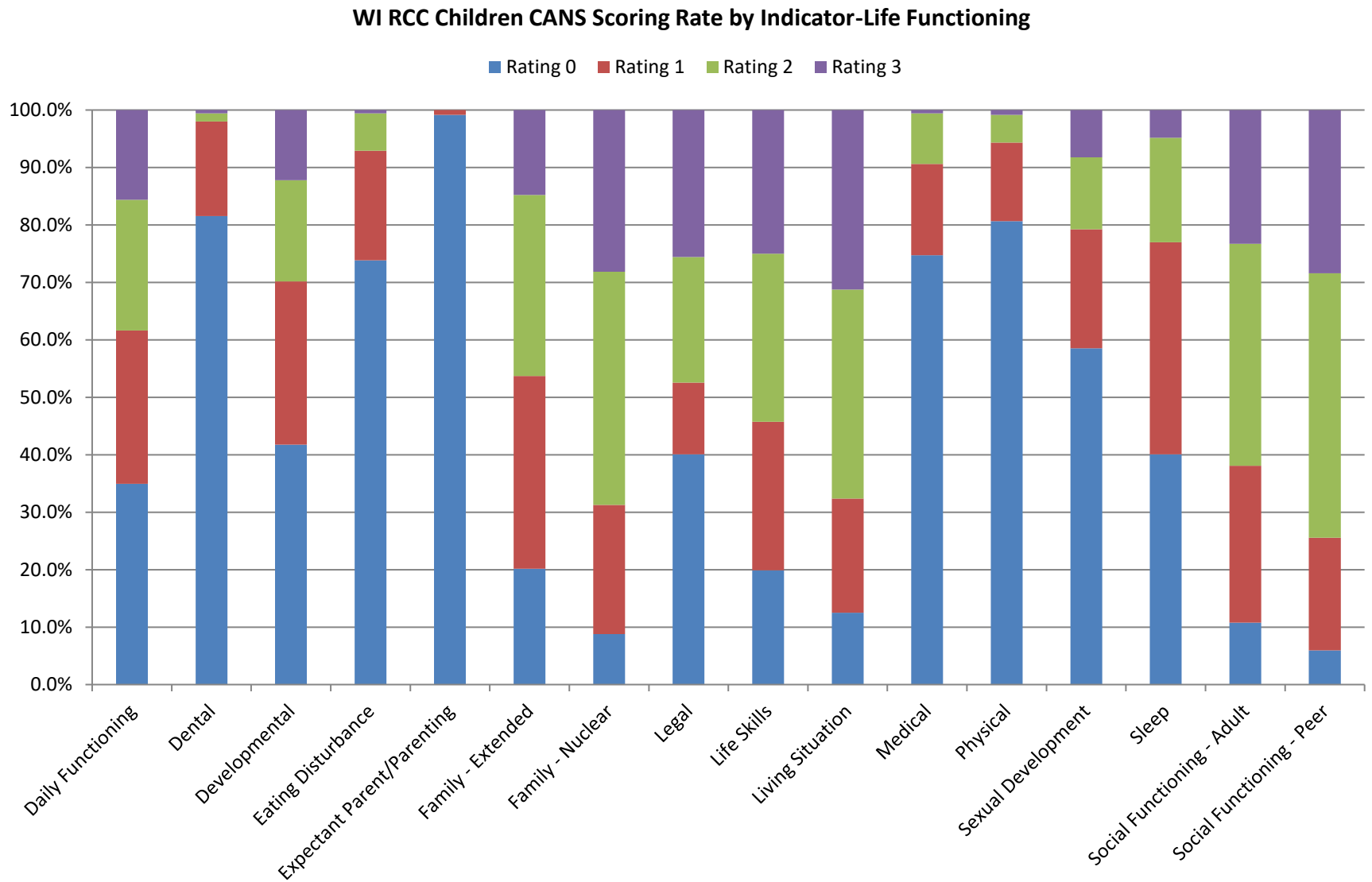


Table 14: CANS Scoring Rate by Indicator: Life Functioning



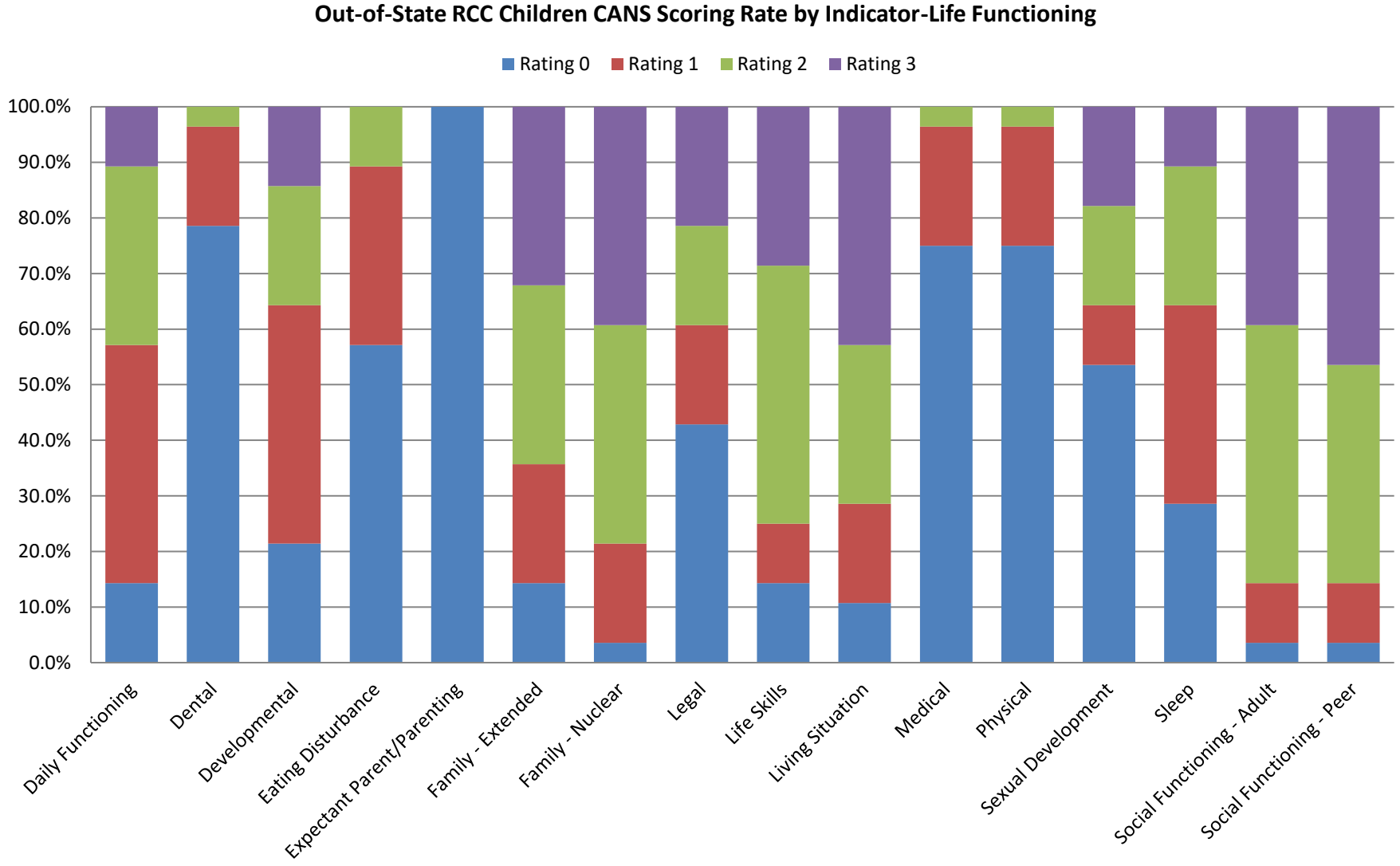
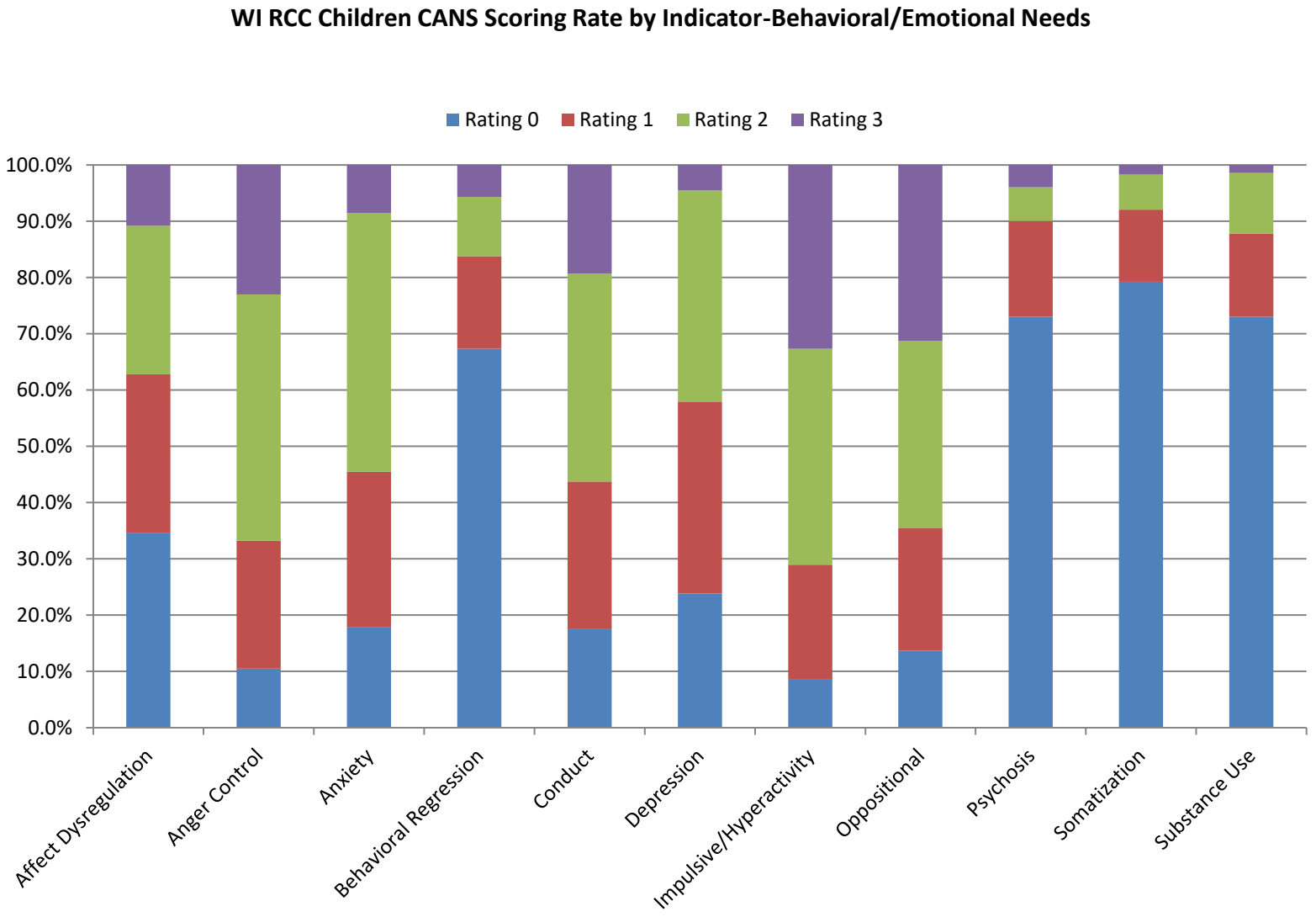

Out-of-State RCC Children CANS Scoring Rate by Indicator-Life Functioning
Rating 0
Rating 1
Rating 2
Rating 3
100.0%
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
Daily Functioning
Dental
Developmental
Eating Disturbance
Expectant Parent/Parenting
Family - Extended
Family - Nuclear
Legal
Life Skills
Living Situation
Medical
Physical
Sexual Development
Sleep
Social Functioning - Adult
Social Functioning - Peer

Table 15: CANS Scoring Rate by Indicator: Behavioral/Emotional Needs



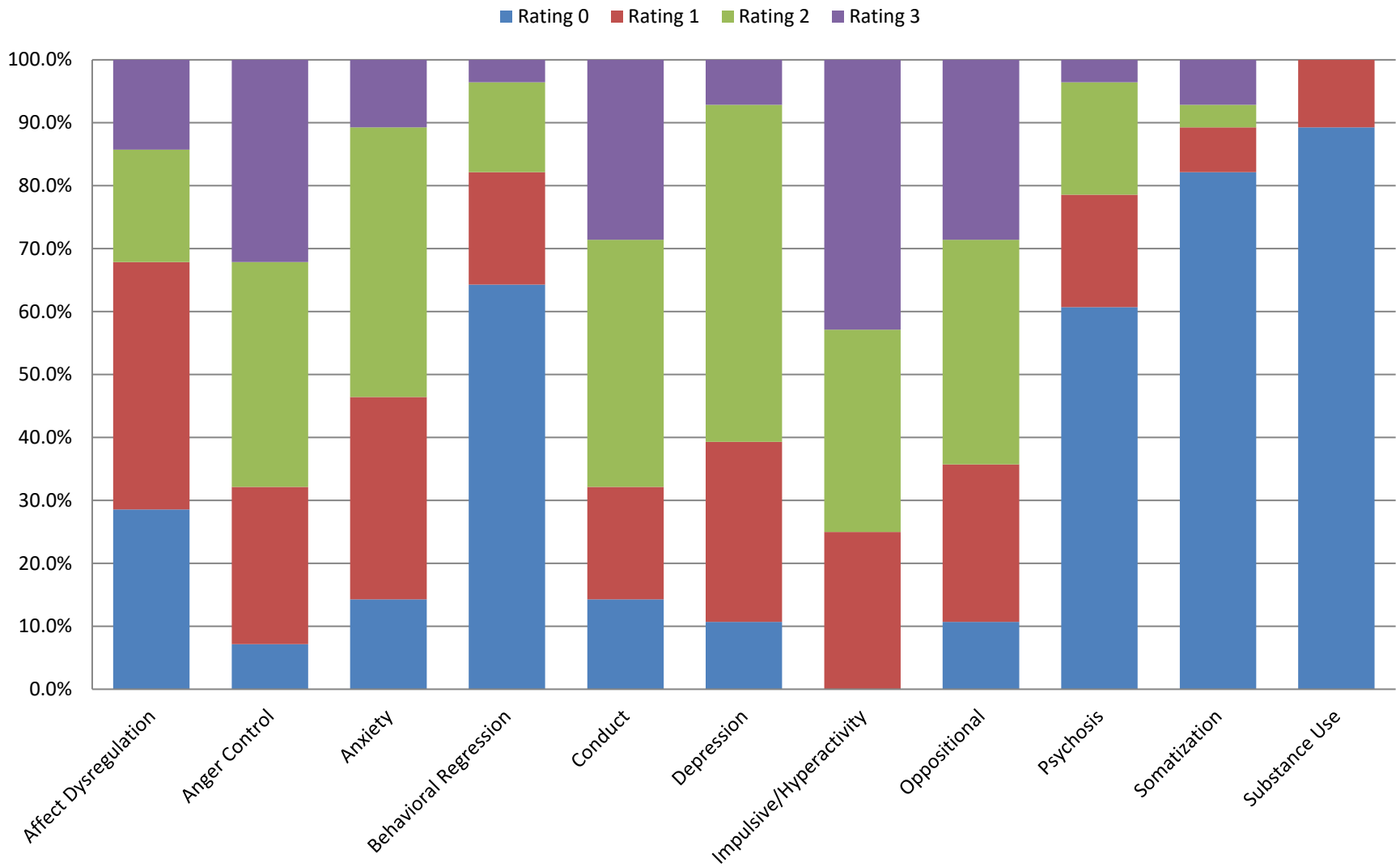

Out-of-State RCC Children CANS Scoring Rate by Indicator-Behavioral/Emotional Needs
Rating 0
Rating 1
Rating 2
Rating 3
100.0%
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
Affect Dysregulation
Anger Control
Anxiety
Behavioral Regression
Conduct
Depression
Impulsive/Hyperactivity
Oppositional
Psychosis
Somatization
Substance Use

Table 16: CANS Scoring Rate by Indicator: Risk Behaviors

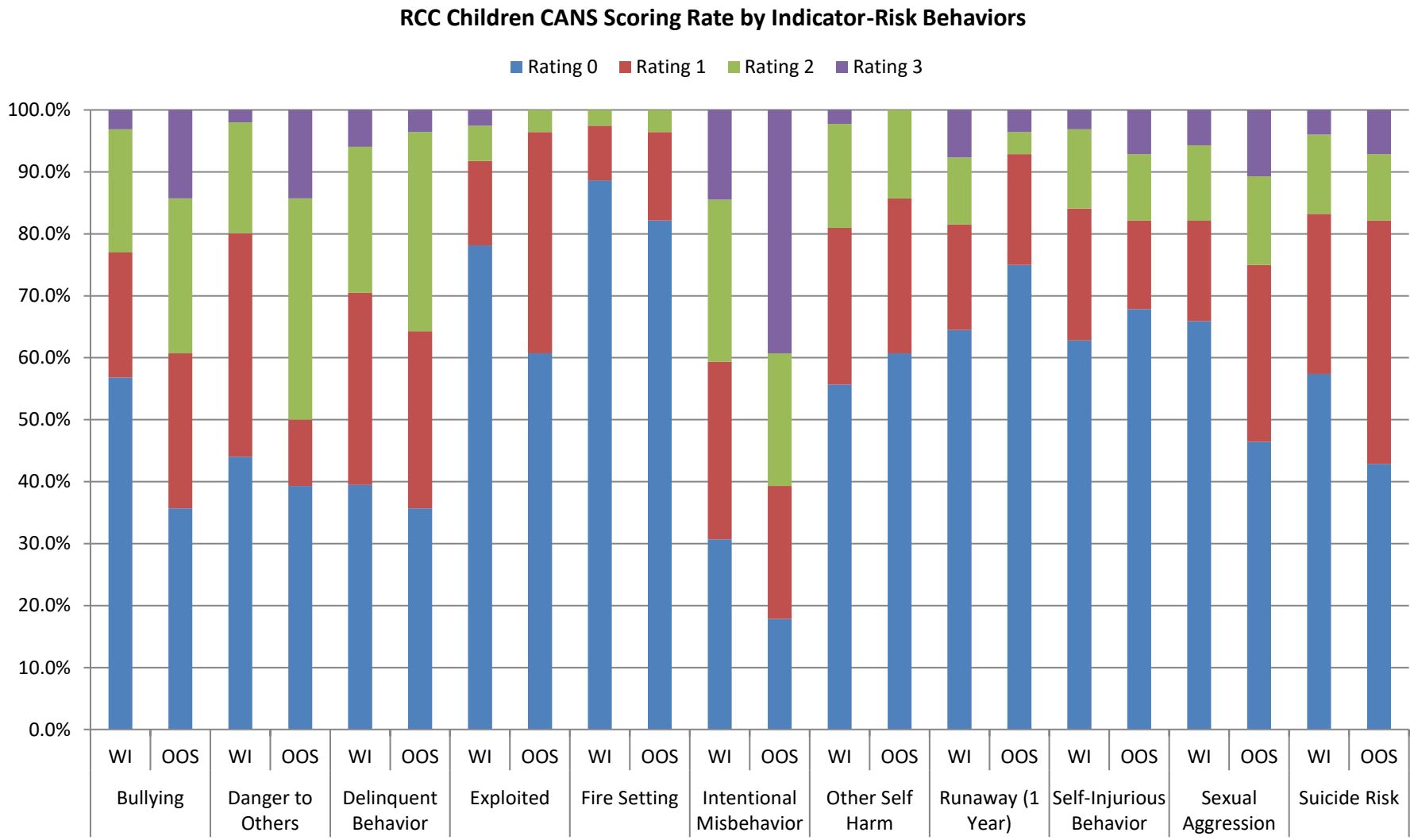
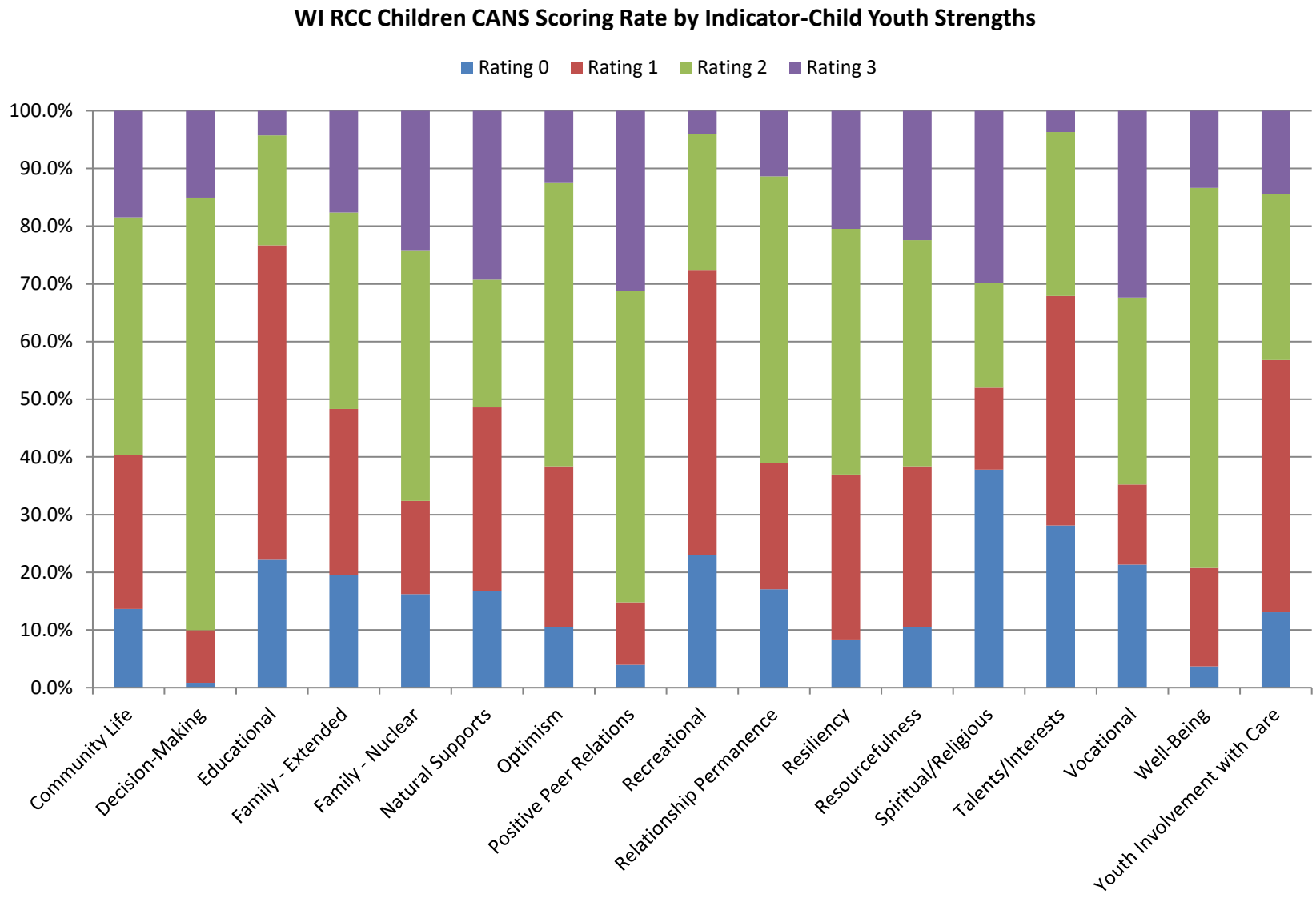
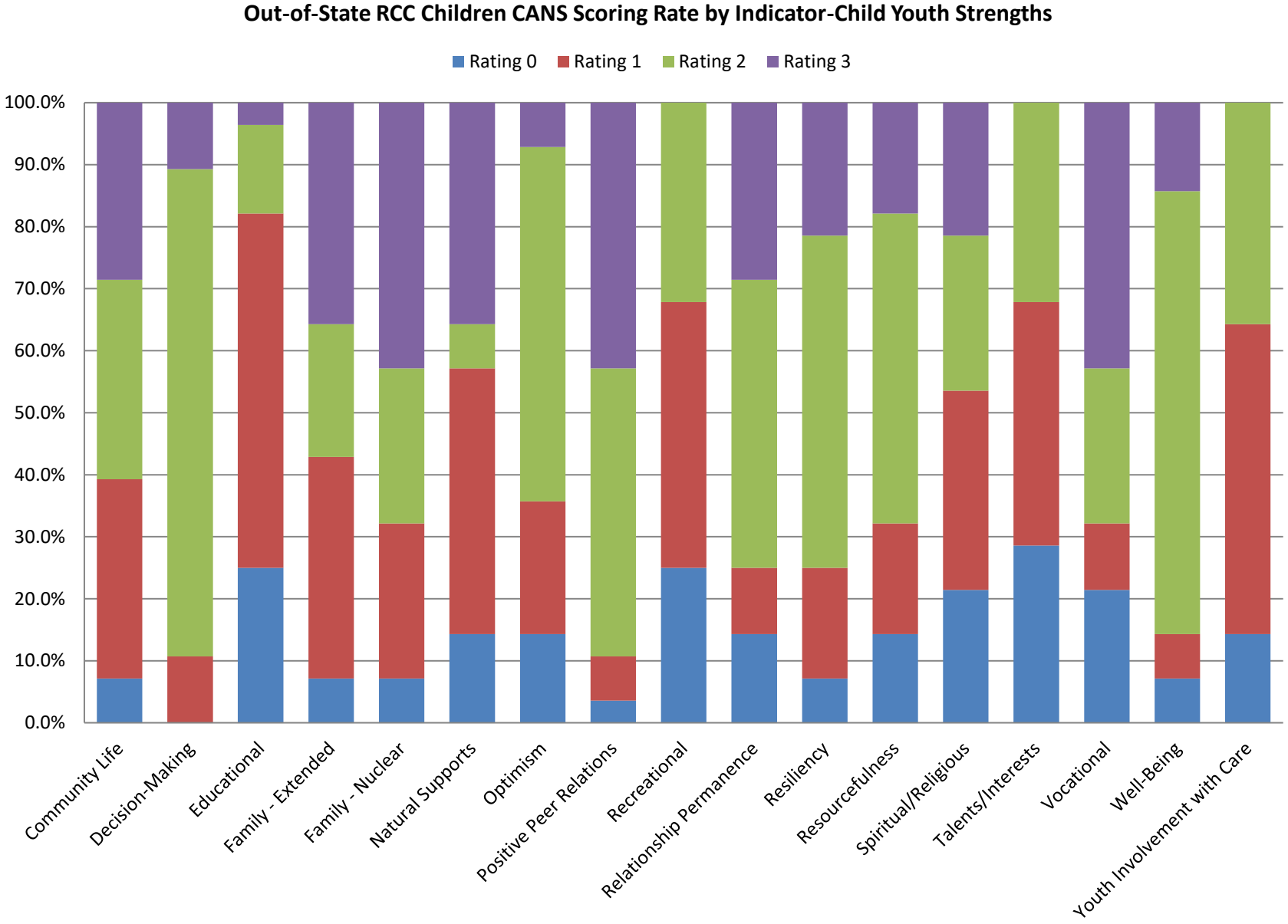


Table 17: CANS Scoring Rate by Indicator: Strengths




Out-of-State RCC Children CANS Scoring Rate by Indicator-Child Youth Strengths
Rating 0
Rating 1
Rating 2
Rating 3
100.0%
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
Community Life
Decision-Making
Educational
Family - Extended
Family - Nuclear
Natural Supports
Optimism
Positive Peer Relations
Recreational
Relationship Permanence
Resiliency
Resourcefulness
Spiritual/Religious
Talents/Interests
Vocational
Well-Being
Youth Involvement with Care

CANS Data and County Survey Results

Next Steps Workgroup Tasks 2018 – Care for Children with Complex Needs

The following table of "action items" outlines priority items directly related to developing, implementing and supporting a new residential services model. The Workgroup recognizes that there are numerous efforts underway across the state to improve mental health services and supports for children and families.

Therefore, for the next phase of this effort, Workgroup members will align with specific action items either as lead organizations or partners and invite other stakeholders to participate in and/or advise of other efforts underway that could effectively dovetail with the Workgroup's action items.

	Description	Action	Proposed Leads
Policy and Regulation			
	Moving through service levels without court approval	Consult with CCIP/judges about statutory change. Option to order to a program that would include step up and down (like Type 2)	WAFCA
	Allow use of cameras in residential care	Consult with client rights and advocates. Draft statutory change and/or revised client rights rule for children's services.	WAFCA, DCF
	Secure setting option	Clarify what is currently allowed under statutes and rules for "secure" in residential	DCF
	Modify liability protections for congregate care	Work with group of providers to draft proposed statutory changes and find legislative sponsor to initiate bill drafting	WAFCA
Child Psychiatry			
	Expand access to psychiatric services.	Other groups are already invested in growing the child psychiatry workforce. Identify initiatives and connect to their efforts.	Children & Youth Committee, Wisconsin Council on Mental Health
Improved practice and collaboration			
	Expand access and support for evidence-informed treatment	Identify groups that are currently supporting implementation of evidence-informed practices. Consider models like the CWPDS to increase access to training and ongoing coaching support.	
	Collaborative licensing	Consider application of the system change review process utilized by DCF and the counties to transform the response to CPS egregious incidents to form a collaborative, trauma-informed care approach to licensing.	WAFCA, WCHSA, DCF

Residential Services with Aftercare Demonstration Projects			
	Description	**Action**	**Proposed Leads**
	While some elements of a new residential care program model are dependent on policy change, it may be possible to develop one or more preliminary demonstration projects that incorporate many of the positive elements of the Youth Villages continuum of care model	Meet with DCF to discuss issuing an RFI inviting providers to propose a model of care for youth that meet the complex needs criteria. The model should include: • Sustainable funding structure • Continuum of service on single campus • Psychiatric back up • Crisis support/crisis team (NOTE: The Workgroup considers this to be a near term strategy. The meeting will occur spring 2018 with a report back to the Workgroup at the May 2018 meeting)	WAFCA
Psychiatric Residential Treatment Facility (PRTF) Proposal			
	Description	**Action**	**Proposed Leads**
	The Youth Villages model incorporates a psychiatric residential treatment facility (PRTF) on their campus. Wisconsin does not currently have PRTF as a treatment option.	Develop a budget proposal to add PRTF certification to DHS and seek approval for Medicaid coverage of PRTF services that are provided through a trauma-informed approach.	WCHSA, DHS

Proposed Model: Residential Services with Aftercare for Youth with Severe Trauma/Mental Health Concerns

Clinical Care / Treatment Staffing

- **Well-defined and well-documented clinical approach** with use of evidence-informed trauma-specific interventions (Trauma-Focused Cognitive Behavioral Therapy, Eye Movement Desensitization Reprocessing, Neurosequential Model of Therapeutics)
- Well-defined and well-documented **coaching and support system for direct care staff** in evidence informed models of care (Collaborative Problem Solving, Dialectical Behavioral Therapy, Neurosequential Model of Therapeutics)
- Use of a **trauma-informed crisis intervention** model
- Use of **individualized regulatory activities** to proactively calm and reactively sooth youth
- **Established protocols** between RCCs, counties, and hospitals **to assess and offer psychiatric stabilization**
- **Established protocols** between RCCs, counties, and detention centers **to assess youth for detention placement**
- A **crisis response team**, either internal to the RCC or available in the community
- **Increased clinical staff** to support a higher level of care than currently available
- **Increased psychiatric support** available for regular service delivery and for crisis response
- **Full-time nursing staff** with medication distribution responsibility
- Psychoeducational sessions to teach youth about the physiology of trauma and brain development, Adverse Childhood Experiences (ACEs) and resilience
- Program flexibility for clinical team to move a child to a more secured residential unit on campus for safety – **fluid step up and step-down options** in consultation with placing agency and treatment team, but no court action required
- Ongoing clinical supervision with **weekly clinical consultation for treatment teams**
- **Concurrent engagement with the family** or identified permanent resource in the family home to prepare for discharge
- The development of **parent voice and parent peer specialists** to achieve quality family engagement

Direct Care Staffing

- The direct care staff ratio would be, at a minimum, **1 direct care staff to 3 youth**.
- **Staff have higher level of education/experience** (Note: All Youth Villages direct care staff have a bachelor's degree – this could be a goal, but may not be feasible in Wisconsin)
- A backup, dedicated **crisis services team** would be available to all units across a campus.

Physical plant

- Whether the campus is located in an urban or rural environment there should be **enough space to provide safe outdoor play and recreational activities**. Note that while a campus is not mandatory, it may be the most cost-effective way to achieve the desired model of care.
- The units should be no more than **eight to ten per unit**.
- **Use of cameras to monitor** for the safety of children and staff in shared living spaces and bedrooms; recording 24/7 so that recordings are available for quality assurance and staff training.
- Residential units that are **locked for ingress and egress** or, at provider option, delayed release doors. (Note: The Workgroup spent considerable time discussing the definition of "secure" and "locked." The intent is to create a trauma-informed psychiatric hospital-like security, not detention-like security. The facility could be a PRTF or PRTF-like setting where the unit is locked.)

Aftercare

- **Discharge planning** begins on the first day of RCC placement.
- The **residential clinical team would continue to work with the family in the home after the child is discharged for six to twelve months**.
- Supportive**, home-based services would be wrapped around the youth and family** using CCS, CLTS, CST, etc.
- Follow up with the family every 6 months for two years.