

Wyoming Department of Family Services Budget Footnote Study



due July 1, 2011

The following report resulted from a budget footnote requirement in the Spring 2010 legislative session (HB0001H2034/A; Section 049 Department of Family Services), and is formally submitted to the joint judiciary interim committee and the joint appropriations committee on July 1, 2011.

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Executive Summary

Each year between 800 and 900 Wyoming children/youth under the age of 18 enter the state district/juvenile court system and are court-ordered into placements outside of their homes for the first time. When children/youth are placed outside of their homes, the Wyoming Departments of Family Services, Health, and Education all contribute to the financial support of the children/youth. On January 28, 2010, Department of Health (WDH) Director Dr. Brent Sherard, and Department of Family Services (DFS) Director Tony Lewis met with members of the Legislature's Joint Appropriations Committee regarding Medicaid payments for children/youth placed in psychiatric residential treatment facilities (PRTFs). Of concern were the increasing number of children/youth in out-of-state PRTFs and the estimated costs of PRTF placements and change in federal regulations (see Appendix C) in the State's next biennial budget. DFS was asked to coordinate the study for the Departments of Health, Education, and Family Services, and the resulting footnote was approved as Enrolled Act No. 46 as part of the DFS 2011-2012 biennial budget.

The present study revealed a number of general findings related to the requirements of the footnote. Historically, utilization of 'bed days' across all three agencies has increased from 2006 to 2010 (the years considered in the study), as has the amount of money expended for these services, with a peak in spending occurring in 2009. Currently, there are 83 crisis beds; 137 group home beds; 484 residential treatment beds; and, 107 psychiatric residential treatment facility (PRTF) beds in Wyoming. The study found, however, that of the 107 PRTF beds, only 62 are truly utilized as longer-stay beds, while the other 45 are often used to stabilize a client (one week or less) and then refer that client to a longer-stay PRTF.

Regarding the use and costs of out-of-state placements as compared to in-state placements, the proportion of funds spent out-of-state on residential care for children/youth vary by agency. While DFS has spent no more than 6% on out-of-state placements over the past 5 years, WDE spent as much as 11%, and WDH spent as much as 66% on out-of-state placements in the same time period. It should be noted that each agency pays for a different portion of an individual's care while he/she is placed in a facility, so these raw figures must be interpreted alongside that information. Overall, these three agencies spent \$16,844,124.55 on out-of-state care for youth in 2010, as compared to a total of \$29,006,796.06 spent on in-state care in the same year. The proportion of dollars expended on out-of-state services has increased from 22% in 2006 to 58% in 2010, largely led by increased Medicaid spending on out-of-state services.

The committee's research into the documented reasons for the use of out-of-state providers revealed that only 15 to 16% of all case files reviewed contained a written reason for the out-of-state placement; the other 85% of files did not list a reason. The most common reason for out-of-state placements in MDT reports was that the placement occurred prior to DFS custody, whereas Judicial Orders revealed the most common reason was that a service was not available in Wyoming.

A number of recommendations resulted from this study, including:

- Judicial orders were generally found to be out of compliance with statutory requirements related to their obligation to justify an out-of-state placement, and should be monitored for adherence to this process.
- The assessment of children/youth should be standardized.
- Wyoming should continue to develop community-based services capacity and train providers in the high-fidelity wraparound practice model to improve alternatives to out-of-home placement.
- A factor in consideration of placement options in-state is the level of awareness of the services available in Wyoming which must be increased for all placement decision makers, including the district/county attorneys, judges, MDT members, DFS case workers and probation officers, Guardians Ad Litem, public defenders, and families.

Introduction

Each year, between 800 and 900 Wyoming children/youth under the age of 18 who enter the state district/juvenile court system are court-ordered into placements outside of their homes for the first time. These children/youth are court ordered into out-of-home placements for a variety of reasons: some are victims of abuse and neglect; others are exhibiting “out of control” behavior, either at home or school; some have committed crimes; and many have emotional, mental health, and/or substance abuse problems. The population discussed in this study does not include children/youth who are involved in either municipal or circuit court unless they are concurrently involved in the district/juvenile court system.

When children/youth are placed outside of their homes, the Wyoming Departments of Family Services, Health, and Education all contribute to the financial support of the children/youth. In state fiscal year (SFY) 2010, the combined expenditures across the three agencies were \$45,850,920.61 for the following types of out-of-home placements: crisis shelters; Group Homes (GH); Residential Treatment Centers (RTC), both in-state and out-of-state; and Psychiatric Residential Treatment Facilities (PRTF), both in-state and out-of-state. During the five (5) year study period, the DFS average daily count of utilization for RTCs was 291 beds.

On January 28, 2010, Department of Health (WDH) Director Dr. Brent Sherard, and Department of Family Services (DFS) Director Tony Lewis met with members of the Legislature’s Joint Appropriations Committee regarding Medicaid payments for children/youth placed in psychiatric residential treatment facilities (PRTFs). Of concern were the increasing number of children/youth in out-of-state PRTFs and the estimated costs of PRTF placements and change in federal regulations (see Appendix D) in the State’s next biennial budget.

Following discussion and consideration, Senator Mike Massie was asked to coordinate with both Departments on a budget footnote that would direct a study aimed to clearly define different levels of 24-hour youth care, including criteria for PRTF placement; estimate needed future capacity for different levels of care; and describe community alternatives for 24-hour care. DFS was asked to coordinate the study for the Departments of Health, Education, and Family Services, and the resulting footnote was approved as Enrolled Act No. 46, as part of the DFS 2011-2012 biennial budget.

The Footnote to the Wyoming Department of Family Services’ Budget required the following:

- A moratorium on new residential beds for two (2) years (2011 – 2012 biennium) while the work is completed and recommendations are developed based on study analyses.
- The Wyoming Departments of Family Services, Health, and Education along with youth service providers will work in partnership to address the following in a singular report:
 - Historical utilization rates, regional trends, existing capacity of residential beds;
 - Historical use and costs of out-of-state residential placements;
 - Documented reasons for using out-of-state providers (decision-making process, practice, sampling of reasons for this placement);
 - Recommendations related to statutory or procedural changes to encourage Wyoming children to remain in-state;
 - Levels of care necessary to serve children/youth, projected need for services, availability of levels of care; and
 - Community-based alternatives to residential care.

Description of Committee’s Creation and Membership

Following the passage of the Budget Footnote, the DFS requested each agency or organization required to participate in the study identify representatives to be part of a team. Following that request, WDH,

Wyoming Department of Education (WDE), and Wyoming Youth Services Association (WYSA) submitted names of representatives and a meeting schedule was established. Additionally, the DFS added other key stakeholders to the team from the Governor's Office, as well as the Guardians Ad Litem program.

Literature Review

The initial stages of discovery and information gathering led the committee to conclude that many of the practices under consideration in this study are still in the very early stages of development in the field. In most cases, our research uncovered many states or agencies that stated the importance of determining desirable capacity, cost, return-on-investment, or suitable levels of care for children/youth in residential treatment, but there were very few complete evidence-based reports to support these ideas. We detail the most reliable information related to the treatment of children/youth in secured residential facilities and the transition of the field to more community-based treatment alternatives in this literature review, and while this is only a part of what this study examined, the theme is certainly prominent across all requirements of the study.

RTCs and PRTFs are important pieces of the continuum of care for children/youth who have serious emotional disturbances and have behaviors that cannot be managed effectively in community-based settings. RTCs and PRTFs are among the most restrictive mental health (MH) services provided to children/youth. The research and literature on residential treatment suggests that while these facilities are necessary, community-based alternatives are not only less costly, but may result in better outcomes for children/youth and families. Research also suggests that public systems should focus on promoting practice and policy that will ensure that comprehensive mental health services and supports are available to improve the lives of young people and their families.

In 2005 approximately 50,000 children/youth per year were admitted to residential treatment facilities (Surgeon General, 2008). According to the 2008 Surgeon General's Report, MH admission to RTCs and PRTFs has been justified on the basis of community protection, child protection, and some treatment benefits. However, these justifications have not always withstood research scrutiny. The most promising outcomes for high-needs children/youth have been associated with family-focused, community-oriented residential programs that feature structured, intensive interventions that involve both the family and the community to support the child(ren)/youth in his/her home community.

A recent U.S. Surgeon General's report (2008) indicates too often that children/youth are placed in highly restrictive settings when more appropriate community-based services are available. There is growing evidence which suggests that children/youth can be effectively served in their homes and communities in lieu of residential treatment placements. A number of literature reviews and research on residential treatment suggest that community-based treatment programs are often superior to institution-based programs. In fact, studies show that, except for children/youth with highly complex needs and/or dangerous behaviors, such as fire setting or repeated sexual offenses, programs in the community with intensive family-centered interventions are more effective than institutional settings.

Magellan Health Services (2008) developed a response to the overall reliance on residential treatment for children/youth with serious emotional disturbances and the under-utilization of evidence-based alternative treatments. In general, they found that residential treatment is not effective for many children/youth. They suggest that while gains may be made between admission and discharge, the improvement is not maintained following discharge. In addition, the authors reported that residential treatment may have serious adverse effects on many children/youth. When residential treatment was compared to Therapeutic Foster Care (TFC), the research suggested that children/youth in residential care did worse on developmental

measures one year following placement, and had two to three times higher re-admission rates than those placed in TFC.

Another study by Duchnowski, Hall, Kutash, and Friedman (1998) stressed that residential treatment facilities should be reserved for children/youth who display dangerous behavior and cannot be controlled in an unsecure setting. In addition, they found that children/youth were being placed too far from home, often out of state, which removed them from their families and natural support systems. Under these circumstances, facilities were unable to draw upon the strengths of the child/youth's communities. They found that few children/youth thrive when they are hundreds or thousands of miles away from their parents, friends, relatives, and teachers. This isolation results in a reduction in the efficacy of treatment, usually at an increased financial cost.

Overall, the literature suggests that residential treatment facilities are a necessary component in the continuum of care. The most effective residential treatment facilities are family-centered, smaller in scale, and in close proximity to the child/youth's home community. Wyoming continues to examine other perspectives on residential treatment, such as the national Building Bridges Initiative (BBI). This initiative is guided by a steering committee with national residential and community organizations, families, and children and youth members. The initiative works to identify and promote practice and policy that will create strong and closely coordinated partnerships and collaborations between families, children, youth, communities, and residentially-based treatment and service providers. It is suggested that residential treatment should remain part of the continuum of care. However, it should be short-term, the focus should be on targeted behavioral and mental health needs, it should be family focused, and the outcomes should be very clear and time-limited.

A number of other states have implemented research based models for community-based treatment, including Maryland¹ and Wisconsin (Milwaukee²). Similar efforts are currently underway here in Wyoming, from the high-fidelity wraparound trainings conducted by the Wyoming Department of Health, Mental Health and Substance Abuse Services Division, to the federal Children's Health Insurance Program Reauthorization Act (CHIPRA) grant (jointly managed by WDH and DFS, which aims to implement a Care Management Entity to improve care coordination for Medicaid clients). As well, many Wyoming residential treatment providers utilize wraparound techniques in the provision of services. The efforts in-state and by other states should be examined for additional examples of implementing a continuum of care for the youth most likely to encounter an RTC or PRTF.

¹ Maryland - Maryland has developed a State Resource Plan to document the State's capacity for out-of-home placement, the needs for placement among children in care and efforts to align capacity with need across Maryland's jurisdictions. The Maryland Children's Cabinet has focused efforts and funding towards development and implementation of a statewide system of regional Care Management Entities (CME) for the provision of community-based services, including Medicaid Rehabilitation Option and Wraparound services. Regardless of how children enter the system, the Agency through which they enter, their reasons for coming into placement, or whether they are placed once they are under the care and custody of the State, the Children's Cabinet is committed to providing all children with individualized services and supports that will promote their safety, permanency, and well-being.

² Milwaukee - Wraparound Milwaukee is a unique type of managed care program operated by the Milwaukee County Behavioral Health Division that is designed to provide comprehensive, individualized and cost effective care to children with complex mental health and emotional needs.

Methodology

Study Approach

The study was completed through the course of three (3) phases, which are detailed below.

- Phase I – Discovery included:
 - Structured data collection efforts to gather information from DFS, WDE, and WDH regarding:
 - Historical utilization rates, regional trends and existing capacity from all types of in-state residential facilities; and
 - Historical utilization rates and costs of utilizing out-of-state providers for residential services.
 - Documented reasons for using out-of-state providers as opposed to in-state providers and the decision making process and factors leading to a determination of where a child is placed, including a sampling of reasons listed in judicial orders;
 - Research and analysis of current best and promising practices related to the continuum of care for youth ordered into out-of-home placements; and
 - Development of appropriate Levels of Care necessary to serve children in Wyoming.
- Phase II – Analysis of Data and Research included:
 - Analysis of all utilization and financial data from DFS, WDE, and WDH related to all types of in-state and out-of-state residential facilities;
 - Analysis of the reasons documented in judicial orders for using out-of-state providers as opposed to in-state providers; and
 - Discussion of initial findings related to data and levels of care with the committee.
- Phase III – Development of Recommendations for Legislature included:
 - Finalization of data analytics and tabular results regarding utilization, cost, and reported reasons for child placement;
 - Finalization of Levels of Care document; and
 - Committee discussion regarding changes in law or procedure to encourage in-state placements.

Data Collection and Analysis

Bed utilization and financial data were collected from appointed representatives from each of the three state agencies typically responsible for paying for some portion of an out-of-home residential placement (DFS, WDE, WDH). Judicial order data were collected from DFS field staff based on a sample of 129 cases (of the total 217 cases of out-of-state placements within a three (3)-year period).

Description of utilization and financial measures. The expenditures for the specified placement types and the total number of days in placement for each of the placement types were selected as the most appropriate measures to report historical utilization by representatives from the agencies specified in the study. In addition, these two measures shared enough commonality in regards to data structure across all three agencies that they could be reliably calculated and aggregated.

The “sum of expenditures” measure provides a longitudinal view of the combined agency expenditures for each service type across time (a five (5)-year period). This measure also shows the combined total dollars spent across the three agencies, so that the total costs can be examined and evaluated based on their relationship both to the overall state budget and individual agency budgets.

The total days for the specific placement types is the most specific measure to quantify utilization because it shows the actual number of days utilized during the year. This measure can be used to examine changes across time for the five year period in the study, as well as to examine changes for in state and out of state providers across time. The two measures in combination should provide readers with the ability to examine changes in expenditure and utilization patterns across time, and to examine the relationship between cost and utilization.

Description of judicial order measures. A standardized review process was used to examine court orders and MDT reports for children/youth placed out of state between July 2007 and July 2010. A coding scheme of eight possible reasons for out of state placement was used for each order/report. The reasons included no justification given; no MDT held prior to placement; the specific service/treatment not available in Wyoming; no availability in Wyoming facilities at the time of placement; quality of service is better out of state; distance to out-of-state location is closer than in-state location; placement was made prior to DFS custody (i.e., parental placement); and all in-state resources were exhausted (see Appendix C for the complete report).

Results

Multi-Agency Expenditures. Table #1 contains the sum of expenditures for Group Home, Residential Treatment, and Crisis Center services (see the “Service Type” column) for state fiscal years 2006 through 2010. Each of the three state agencies are represented separately by colors/rows (DFS, WDE, WDH; see the “Agency” column). Expenditures for in-state and out-of-state providers are reported separately (see the “Location” column). Graphical depictions of the percentage of in-state versus out-of-state expenditures by year are available below Table 1 (Figures 1-4).

Table #1: Expenditures by Agency

AGENCY	Service Type	Location	2006	2007	2008	2009	2010
DFS	GROUP HOME	In State	\$2,359,379.45	\$3,433,348.31	\$3,807,581.00	\$3,932,499.00	\$3,932,909.94
DFS	GROUP HOME	Out of State	\$73,514.55	0	\$50,925.00	0	\$35,236.16
DFS	RESIDENTIAL TREATMENT	In State	\$8,852,228.56	\$8,924,026.96	\$9,448,619.33	\$10,123,860.43	\$6,993,729.15
DFS	RESIDENTIAL TREATMENT	Out of State	\$123,302.38	\$39,219.55	\$33,867.18	\$23,496.98	\$460,137.72
DFS	CRISIS CENTER	In State	\$ 2,111,949.00	\$2,660,850.00	\$2,529,450.00	\$2,475,447.00	\$2,753,830.00
Family Services TOTAL			\$13,520,373.94	\$15,057,444.82	\$15,870,442.51	\$16,555,303.41	\$14,175,842.97
WDE	RESIDENTIAL TREATMENT	In State	\$8,554,798.49	\$9,164,102.74	\$9,329,656.16	\$9,996,830.52	\$7,524,469.05
WDE	RESIDENTIAL TREATMENT	Out of State	\$298,924.22	\$536,817.46	\$606,215.23	\$853,344.32	\$975,235.46
Education TOTAL			\$8,853,722.71	\$9,700,920.20	\$9,935,871.39	\$10,850,174.84	\$8,499,704.51
WDH	RESIDENTIAL TREATMENT (Medicaid)	In State	1,585,025.00	2,111,350.67	2,197,671.64	2,269,942.88	1,903,212.06
WDH	RESIDENTIAL TREATMENT (Medicaid)	Out of State	\$2,676,116.00	\$3,823,352.53	\$5,589,615.85	\$6,828,956.43	\$7,284,083.22
WDH	RESIDENTIAL TREATMENT (Foster Care)	In State	6,933,338.06	8,123,052.61	9,465,490.13	9,056,673.00	5,898,645.86
WDH	RESIDENTIAL TREATMENT (Foster Care)	Out of State	\$3,022,493.53	\$4,365,191.81	\$6,672,149.80	\$8,646,754.61	\$8,089,431.99
Health TOTAL			\$14,216,972.59	\$18,422,947.62	\$23,924,927.42	\$26,802,326.92	\$23,175,373.13
Grand Total			\$36,591,069.24	\$43,181,312.64	\$49,731,241.32	\$54,207,805.17	\$45,850,920.61

Figure 1: DFS Group Home Expenditures Percentage In- vs. Out-of-State 2006-2010

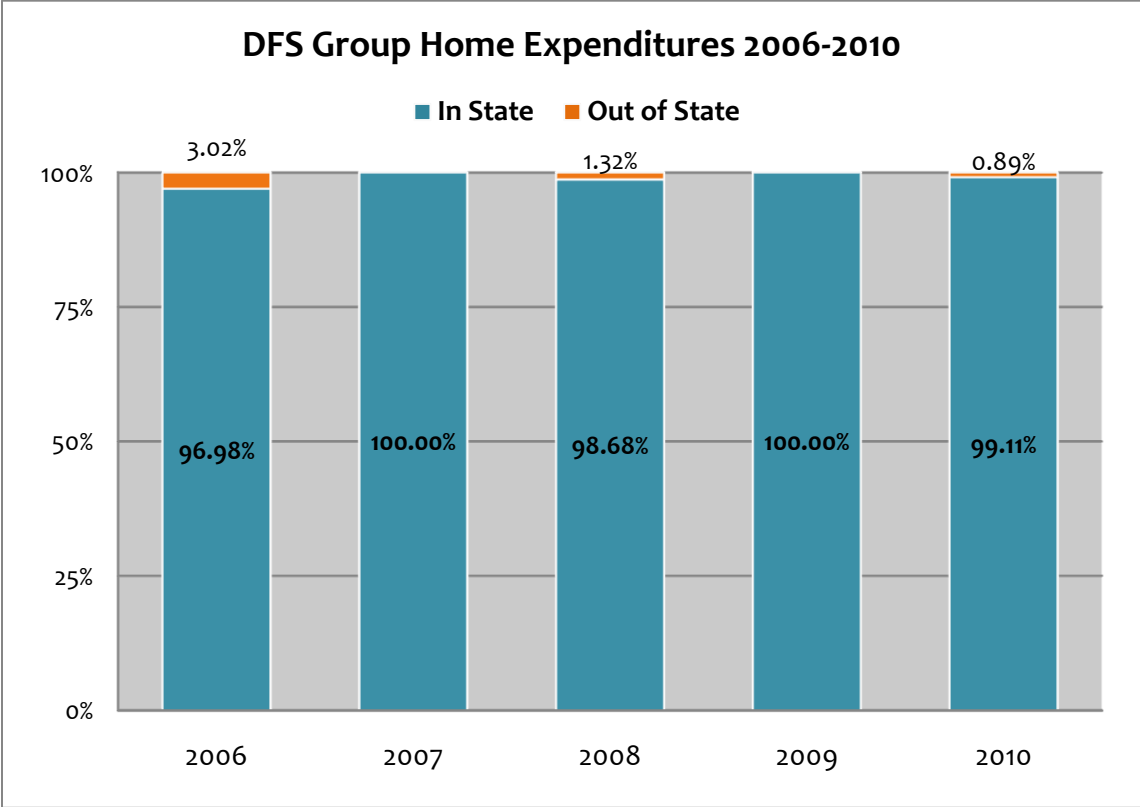


Figure 2: DFS Residential Treatment Expenditures Percentage In- vs. Out-of-State 2006-2010

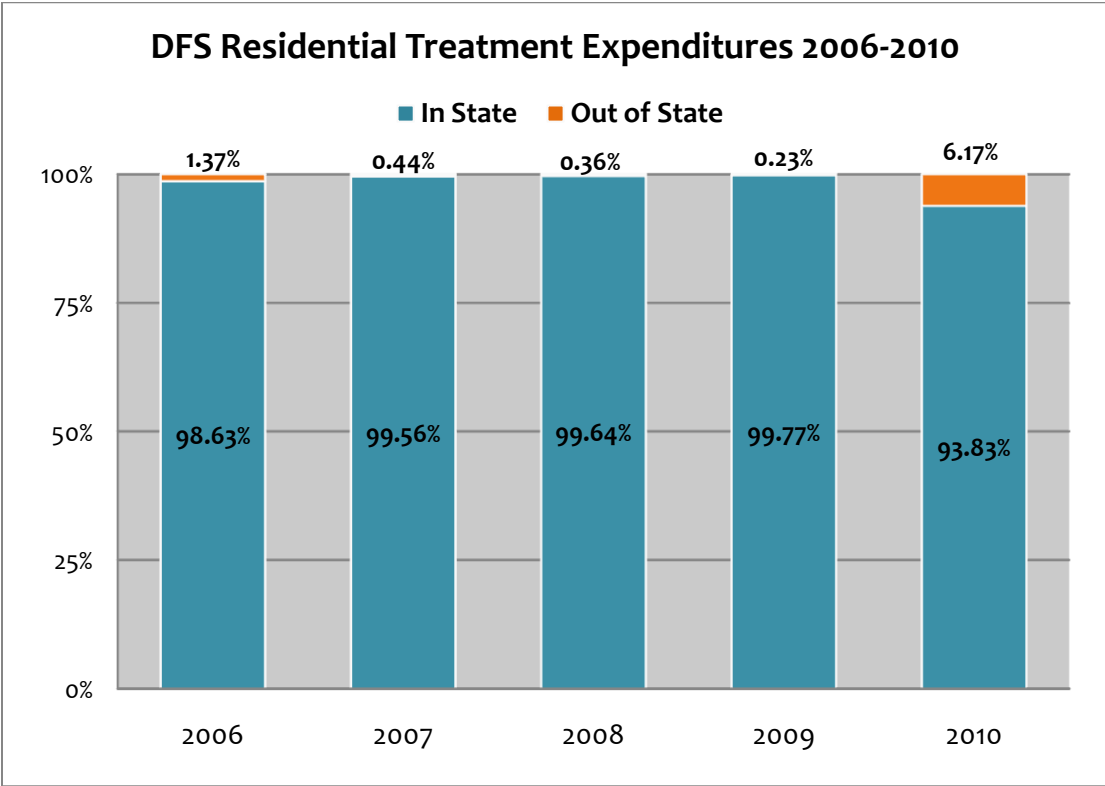


Figure 3: **WDE Residential Treatment Expenditures Percentage In- vs. Out-of-State 2006-2010**

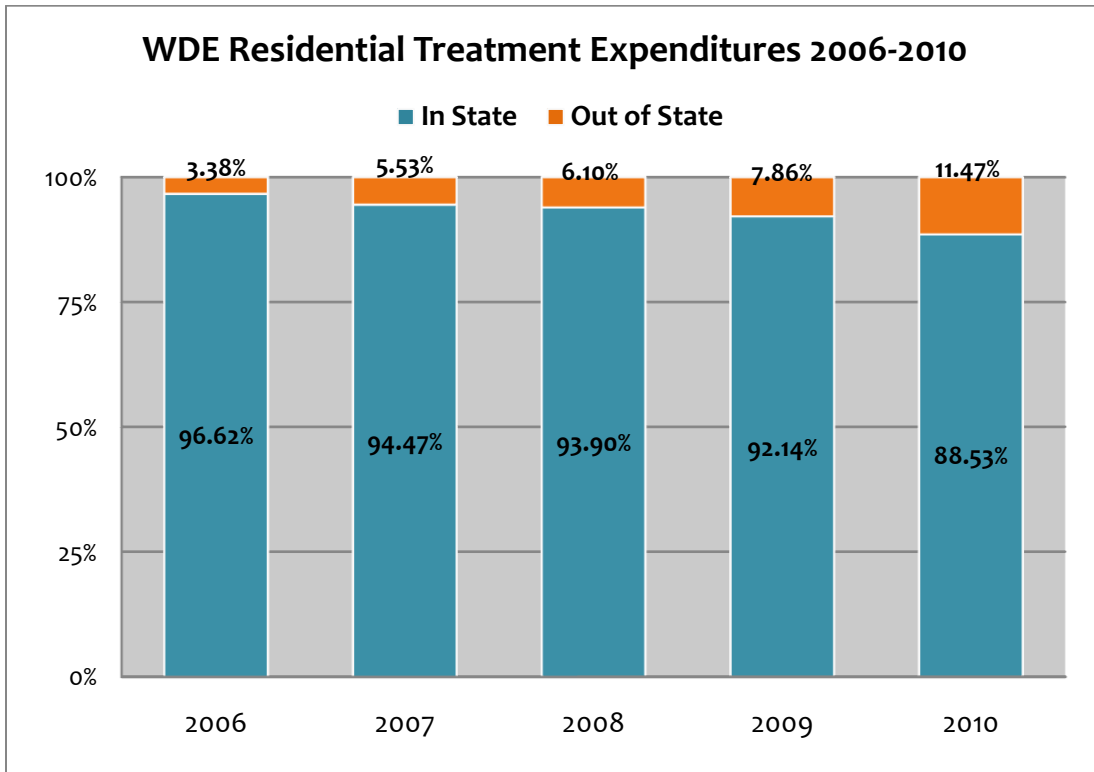
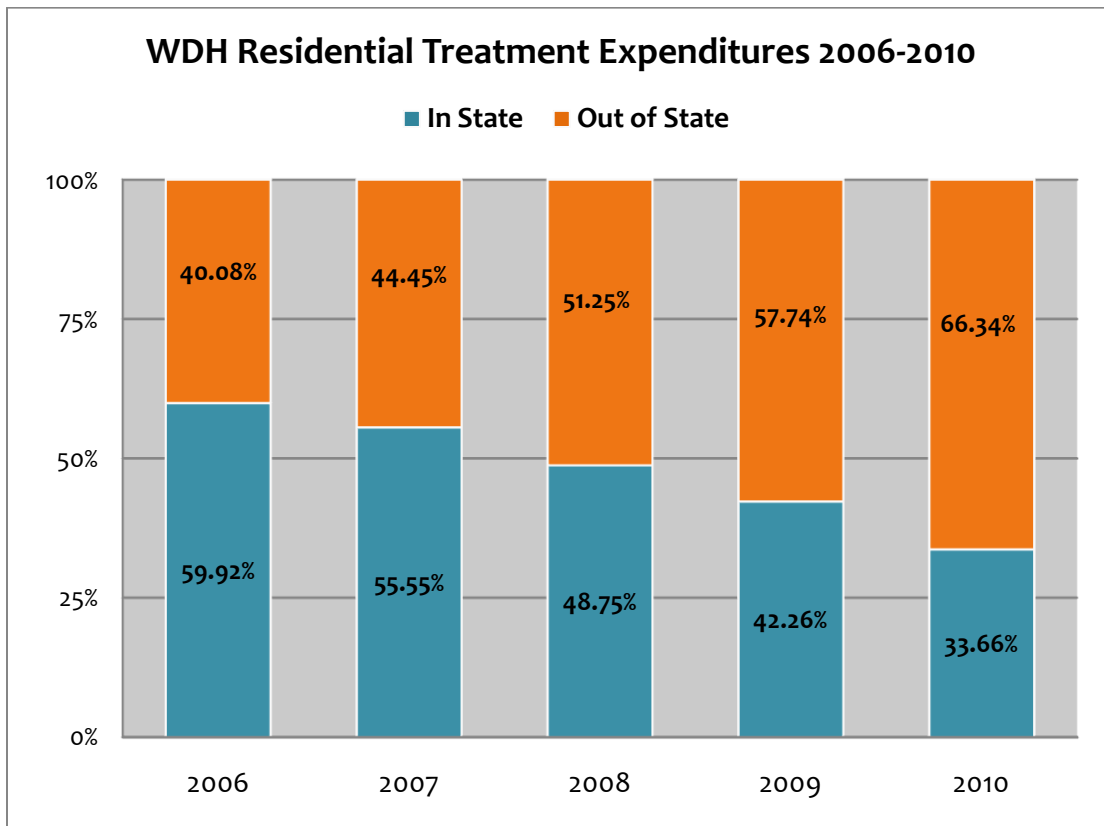


Figure 4: **WDH Residential Treatment Expenditures Percentage In- vs. Out-of-State 2006-2010**



Multi-Agency Placement Days. Table #2 contains the total number of days paid for DFS and WDH for the placement types of Group Home, Residential Treatment, Psychiatric Residential Treatment, and Crisis Center care for state fiscal years 2006 through 2010. The data is again presented according to state agency, placement type, location, and year. Department of Education placement days are not reported because Department of Education placements are court ordered and in the custody of the Department of Family Services (although WDE does indeed make placements at the local level). Please take note of the cautionary statement beneath the table.

Table #2: Total Days of Placement by Agency (Utilization)**

Agency	Placement Type	Location	2006	2007	2008	2009	2010
DFS	Group Home	In State	30,929	32,027	35,550	34,358	32,857
DFS	Group Home	Out of State	1,278	309	562	0	16
DFS	Residential Tx	In State	101,853	99,753	95,204	92,340	70,491
DFS	Residential Tx	Out of State	8,542	8,655	11,400	20,402	22,298
DFS	Psychiatric RTF	In State	3,051	4,674	3,578	995	1,592
DFS	Psychiatric RTF	Out of State	2,146	2,627	3,724	3,902	2,432
DFS	Crisis Center	In state	4,405	4,434	4,525	5,152	4,570
DFS	Crisis Center	Out of State	0	26	0	30	0
DFS TOTAL			152,204	152,505	154,543	157,179	134,256

Agency	Placement Type	Location	2006	2007	2008	2009	2010
Health	Medicaid RTC	In State	4,324	6,096	6,468	6,262	2,586
Health	Medicaid RTC	Out of State	2,108	2,550	4,761	11,601	6,768
Health	Medicaid PRTF	In State	2,350	3,013	2,832	2,646	4,359
Health	Medicaid PRTF	Out of State	6,157	8,813	11,477	9,573	15,067
Health	Foster Care RTC	In State	34,561	44,188	45,165	42,563	16,443
Health	Foster Care RTC	Out of State	6,299	4,687	10,007	15,276	8,951
Health	Foster Care PRTF	In State	2,452	1,657	1,555	1,075	11,274
Health	Foster Care PRTF	Out of State	5,109	10,075	11,626	14,888	18,899
Health TOTAL			63,360	81,079	93,891	103,884	84,347

** We have not included an overall total count (DFS+Health) of days here because DFS and Health days should not be combined unless the "Foster Care" days are not included from Health. The counts will be duplicative due to the fact that the DFS days would represent at least some the same 'days of care' from Medicaid-eligible Foster Care youth. The reader should not attempt to divide expenditures by days for a per-day rate, as the total expenditures in a given year include more claims and costs than the bed-day-rate paid by the agencies to providers.

Existing Residential Capacity. Table #3 contains the number of licensed beds per placement type by Region for the State of Wyoming.

Table #3: Existing Residential Capacity by DFS, Juvenile Services Regions

	Placement Type			
	Crisis Placement # of Crisis Beds	Group Home	Residential Tx	Psychiatric RTF
Region 1: Park, Big Horn, Washakie, Hot Springs, Fremont Counties	15	60	50	
Region 2: Uinta, Teton, Sweetwater, Sublette, Lincoln Counties	19	37	64	
Region 3: Carbon, Albany, Laramie, Goshen, Platte, Converse, Niobrara Counties	(26 allocated) 12	10	152	62
Region 4: Sheridan, Johnson, Campbell, Weston, Crook, Natrona Counties	23	30	219	45
STATE TOTALS	(83 allocated) 69	137	484	107

Justification for Out-of-State Placements. Figure 5 shows the distribution of justifications found in MDT reports (please note that only 16% of such reports contained any justification). In about half of the reports, the justification for an out-of-state placement was that it was made prior to DFS custody.

Figure 5: MDT Reported Justifications for Out-of-State Placement

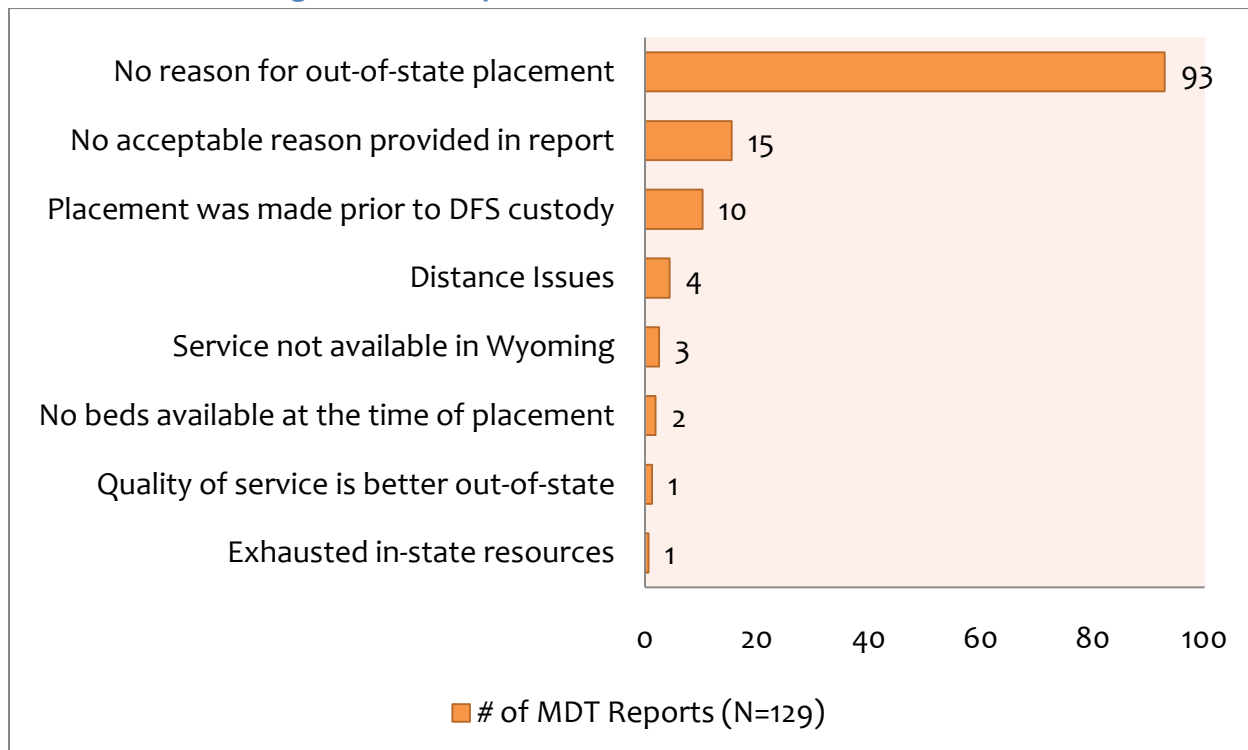
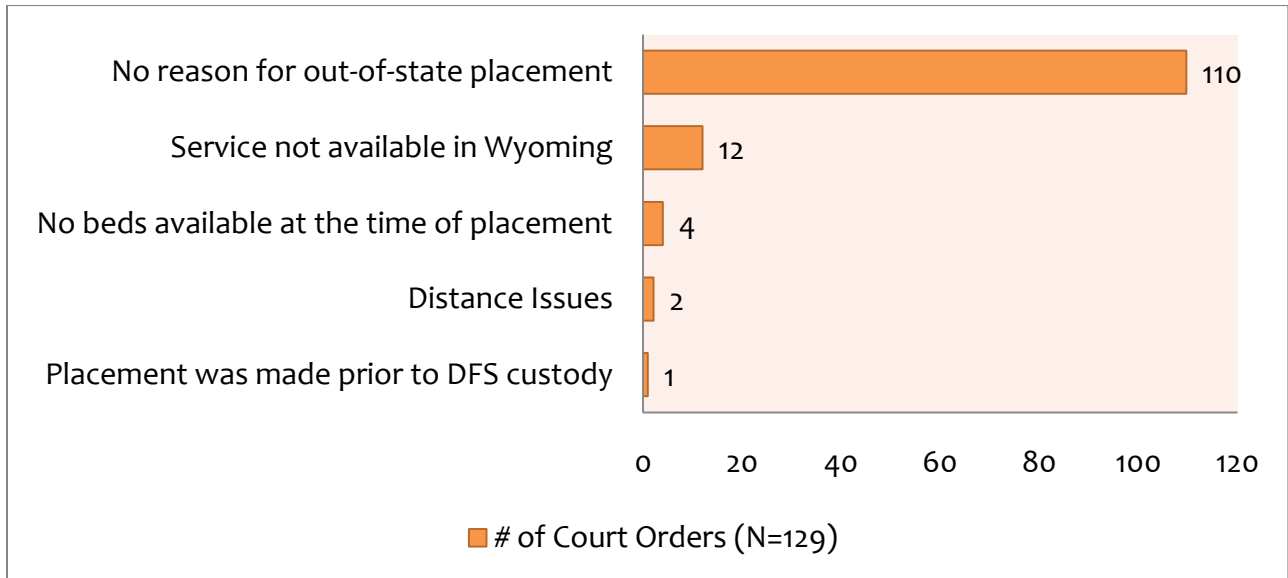


Figure 6 shows the distribution of justifications found in court orders (please note that only 15% of such orders contained any justification). In over half of the orders, the justification for an out-of-state placement was that the service needed by the youth was not available in Wyoming.

Figure 6: Court Order Reported Justifications for Out-of-State Placement



Discussion

Multi-Agency Expenditures. As can be seen in Table #1, the proportion of funds for out-of-state care as compared with in-state care is generally low, except in the case of the Wyoming Department of Health.

DFS spending patterns. DFS pays a small percentage of all group home funds for out-of-state group homes (e.g., in 2010, 99% of funds went to in-state group home placements). DFS expenditures for residential treatment have varied over the years, with less money spent on out-of-state residential treatment in 2007, 2008, and 2009 as compared to 2006 or 2010. The in-state spending did not vary as much between 2006 and 2007/08/09, but dropped dramatically from 2009 to 2010 (as out-of-state spending rose that same year).

WDE spending patterns. WDE has shown a pattern of increased out-of-state spending from 2006 forward. While only 3% of funds went to out-of-state residential care for youth in 2006, 11% of funds went out-of-state in 2010.

WDH spending patterns. WDH shows the greatest proportion of out-of-state spending among the three agencies. Approximately 40% of expenditures went to out-of-state residential care in 2006, with that figure increasing to 66% of expenditures in 2010.

The patterns shown here for each agency merit additional consideration and discussion by key personnel in each agency and across agencies to determine whether the general trend of increased purchase of out-of-state care will continue to increase.

Utilization: Multi-Agency Placement Days. The information presented in Table 2 shows that total placement days for DFS have remained somewhat constant, with a dip occurring between 2009 and 2010. On the other hand, total placement days paid by WDH have generally increased from 2006 to 2010, with the greatest

number of placement days occurring in 2009. More specifically, in some categories, out-of-state placement days have decreased from 2006-2010 (e.g., DFS Group Home out-of-state utilization), whereas in other cases, days have increased significantly (e.g., WDH Foster Care PRTF out-of-state utilization). In other categories, total days of placement have remained somewhat constant over the past five (5) years (e.g., DFS Group Home in-state utilization). It should be noted that WDE placements do occur locally but are not represented here due to data constraints.

Levels of Care and Capacity.

Wyoming Departments of Family Services, Health, and Education defined the levels of care necessary to serve children/youth, including a description of the behaviors and diagnoses a child/youth might exhibit and the most appropriate level of care to best meet his/her needs. In addition, a well defined array of community-based services from prevention; early intervention; immediate intervention; intermediate interventions, including alternatives to residential care; residential; and aftercare has been defined as a roadmap for local communities, counties and/or regions for planning and resource allocation. Levels of out-of-home placement include:

- Family Foster Care
- Therapeutic Foster Care
- Kinship Care
- Group Home
- Residential Treatment Center (RTC)
- Psychiatric Residential Treatment Facility (PRTF)
- Acute Psychiatric Hospitalization

Please see Attachment A for additional information about the Levels of Care and Attachment B for additional information about the comprehensive service array, including alternatives to out-of-home placement.

Justifications for out-of-state placement discussion. Through the present review of 150 court cases (court orders, MDT reports and additional information from DFS caseworkers), DFS found that overall the requirements of Wyoming Statutes § 14-6-229(a)(v), § 14-3-429(a)(v), § 14-6-429(a)(v), and § 21-13-315(a)³ were not met. Seventy-two percent of the multidisciplinary team reports reviewed did not mention any reason for the out-of-state placement (with another 8% of cases not even having an MDT prior to placement occurring). Additionally, only 15% of the court orders reviewed contained justifications that met the requirements. Even in the court orders that included a justification, information required by the statute was missing. The majority of the court orders reviewed (84%) stated that the placement was in the best interest of the child/youth, but did not provide a specific reason why and out-of-state placement was needed (see Appendix C for the complete report).

³ Wyoming Statute §§ 14-6-229(a)(v), § 14-3-429(a)(v), § 14-6-429(a)(v), and § 21-13-315(a): The court shall not order an out-of-state placement unless: evidence has been presented to the court regarding the costs of the out-of-state placement being ordered together with evidence of the comparative costs of any suitable alternative in-state treatment program or facility, as determined by the department pursuant to W.S. § 21-13-315(d)(vii), whether or not the placement in the in-state program or facility is currently available; the court makes an affirmative finding on the record that no placement can be made in a Wyoming institution or in a private residential treatment facility or group home located in Wyoming that can provide adequate treatment or services for the child; and the court states in the record why no in-state placement is available.

Recommendations

The recommendations provided here utilize the array of analytics and informational findings determined in the course of this study. While there is certainly no single sure-fire method in determining that a child/youth is placed appropriately and close enough to his/her home community to improve success, the committee provides the following recommendations to begin to move the needle toward a more whole-person approach.

Statutory Recommendations

Pursuant to Wyoming Statute §§ 14-6-229(a)(v), § 14-3-429(a)(v), § 14-6-429(a)(v), and § 21-13-315(a), the Juvenile Court has an obligation to justify an out-of-state placement on the record:

(v) The court shall not order an out-of-state placement unless:

- (A) Evidence has been presented to the court regarding the costs of the out-of-state placement being ordered together with evidence of the comparative costs of any suitable alternative in-state treatment program or facility, as determined by the department pursuant to W.S. § 21-13-315(d)(viii), whether or not the placement in the in-state program or facility is currently available;
- (B) The court makes an affirmative finding on the record that no placement can be made in a Wyoming institution or in a private residential treatment facility or group home located in Wyoming that can provide adequate treatment or services for the child; and
- (C) The court states in the record why no in-state placement is available.

It is the general finding of this committee that in many cases, judicial orders and/or MDT reports are not adhering to the requirements of this statute. Our specific recommendations follow.

1) **Promulgation of Multi Disciplinary Team (MDT) Rules/Guidelines**

MDTs are a valuable component of the Juvenile Court process in Wyoming. Pursuant to Wyoming Statutes §§ 14-3-427, 14-6-227, and 14-6-427, the MDT has responsibility for reviewing the child/youth personal and family history, school records, mental health records, DFS records, and any other pertinent information, for the purposes of making case planning recommendations. In formulating recommendations, the MDT shall give consideration to the best interest of the child/youth, the best interest of the family, the most appropriate and least restrictive case planning options available, as well as costs of care. Wyoming Statute also specifies membership of the team. While statute specifies membership and responsibility of the MDTs, there is variability of the purpose and functions of the MDTs throughout the state.

The Children's Justice Project in conjunction with state agencies and juvenile court stakeholders, have developed a Multi-Disciplinary Team Guidebook which addresses the purpose and function of MDTs. It is recommended the Legislature assign rule promulgation authority regarding MDTs for adoption of the MDT Guidelines. This would provide for consistency in implementation regarding purpose and functions across the state. In addition, the rules could be supported by contracts with MDT coordinators and training of MDT coordinators.

2) **Expansion of Community Juvenile Services Boards (CJSB) Required Members**

The Footnote Study team recommends expansion of the focus of the established CJSBs to include all children/youth in the community, such as those children/youth who are court involved as a result of child abuse/neglect or Children In Need of Supervision (CHINS). In

order to accommodate an expanded focus, Wyoming Statute § 14-9-105(a), which mandates representatives for the CJSB, should be amended to include a representative from the guardian ad litem program. (See page 21 for additional information regarding CJSBs.)

Procedural Recommendations

- 1) **Assessment/Evaluation of children/youth – standardized process and assessments/evaluations – ongoing collaboration with WDH and University of Washington and increased utilization of the evaluation service.**
 - a. The Wyoming Department of Health has executed three (3) contracts with Wyoming’s medical school, the University of Washington, to address gaps in clinical access and services in Wyoming; the most critical to the population discussed in this report is:
 - i. MDT Evaluations serve the purpose of providing psychiatric evaluations for court involved children/youth to ensure clinical information is available to the MDT so the team can recommend the most appropriate level of service, including possible placement, for the child/youth, to the district/juvenile court.

National research and best practice standards are in agreement in supporting clinical assessment of children/youth who show signs of emotional or behavioral problems. Experts agree that if a child/youth is going to receive effective treatment for problems, the nature of the underlying problem must be accurately diagnosed. Because of the high incidence in this population of emotional and mental health problems, as well as developmental and learning disabilities, many court-ordered placement children/youth should be receiving clinical assessments to inform placement and treatment decisions. The focus over the short term is to work with local community stakeholders, including the DFS caseworkers and probation officers, to increase the utilization of this service to ensure there is clinical information available to the MDT prior to the child/youth’s placement out of the home.

1. Currently, the State of Wyoming has a severe shortage of child/youth mental health providers, and specifically, only six (6) child/adolescent psychiatrists serving the entire state. Access to these experts is very limited, and children/youth often find themselves on waiting lists for a comprehensive clinical assessment. The juvenile court process often “out paces” the access and timing for these assessments for many children/youth to inform the recommendations to the court. In the absence of any clinical input, the MDT may recommend a treatment option based on their experience with other children/youth or may recommend a placement in order for the child/youth to receive a clinical assessment.
2. In an effort to address issues around rapid access to child psychiatrists in Wyoming, the Wyoming Department of Health contracted with the University of Washington for MDT Evaluations. This service, when requested, adds clinical consultations to the court process. One goal is to have clinical information from qualified providers inform the placement recommendations made to the court PRIOR to the actual placement. The other goal is to have community-based services and interventions considered before a residential placement.

2) **Development of community-based service capacity across state, including alternatives to out-of-home placement.**

Even though Wyoming statutes support the concept of community-based services for children/youth; many communities around the state lack a continuum of alternatives to meet their needs. Where local programs are not fully developed, out-of-home and out-of-community treatment may be the only options. There have been many efforts across multiple agencies for the past several years with the goal of enhancing community-based services, developing capacity for community-based services across the state, and identifying alternatives to out-of-home placements. The next several paragraphs will highlight some of the ongoing interagency work that will continue over the next several years to increase child(ren)/youth and family success/health, which has the potential to decrease the number out-of-home placements while increasing the capacity for provision of community-based services.

- a. In 2010, Wyoming Department of Health, Medicaid, was awarded a Children's Health Insurance Program Reauthorization Act (CHIPRA) Quality Demonstration Multi-State Grant. Wyoming is planning and implementing a Care Management Entity (CME) Provider Model, which is an organizational entity that serves as a centralized accountable hub to coordinate all care for a child/youth with complex behavioral health challenges who are involved in multiple systems, and their families. A CME develops community-based service capacity, organizes an array of quality community-based services and pays for services, with pooled federal, State, and local funding, needed by children/youth who suffer with Serious Emotional Disturbance (SED). In addition, the CME provides a (1) child/youth guided and family driven, strengths-based approach that is coordinated across agencies and providers; (2) intensive care coordination; (3) home and community based services and peer supports as alternatives to costly residential and hospital care for children/youth with severe behavioral health challenges.

The underlying goals of a CME are to (1) improve clinical and functional outcomes; (2) enhance system efficiencies, and control costs; (3) foster resiliency in children/youth and families. To achieve these objectives, a CME works to: improve access to appropriate services and supports; reduce unnecessary use of costly services (e.g., out-of-home placements and lengths of stay); employ health information technology to support service decision making; and, engage children/youth and their families as partners in care decisions to improve their experience with care.

- b. Community Juvenile Services Boards (CJSB) are in place in 12 of 23 counties, with five (5) pending implementation. The boards were established as a community, county or multi-jurisdictional planning entity around identification of a central point of intake, juvenile detention standards and programs, continuum of care and identification of funding. Local assessments were conducted to identify community services, gaps in services and funding provided to develop services to fill the gaps. In many communities, the focus of the CJSBs have been on juvenile delinquents, the Footnote Study team recommends expansion of the focus of the established CJSBs to include all children/youth in the community, including those children/youth who are court involved as a result of child abuse/neglect or Children In Need of Supervision (CHINS).
- c. Children's Mental Health Waiver – The Children' Mental Health Waiver is a Department of Health, Medicaid program with a limited number of funding opportunities that, by using High Fidelity Wraparound, aims to help children/youth reduce their level of service needs and increase their natural supports in a relatively short amount of time. It provides individualized

services and support based on unique strengths and needs of children and youth with serious emotional disturbances and their families. It utilizes a team and goal oriented process for success. When Wraparound and the Waiver is used successfully it can:

Keep youth with serious emotional disturbances that need mental health treatment in their home communities with their parents/families involved in all aspect of their treatment thereby preventing custody relinquishment

Strengthen families' skills to support the physical, emotional, social and educational needs of their children/youth.

Reduce, and in some cases, prevent the length of psychiatric hospital stays.

- d. High Fidelity Wraparound is a facilitated team based practice model (which can be evaluated and tracked) designed to integrate natural and professional supports, with the family in the driver's seat. A Wraparound team is formed to help define and refine family strengths, culture, vision and needs; prioritize needs and create the plan; and then carry out the plan one prioritized need at a time until the formal team is no longer needed because the vision of the family has been achieved. High Fidelity Wraparound is generally used for children/youth and families with more complex needs (involved in more than one system or in need of a higher level of care). High Fidelity Wraparound is the practice model for the Children's Mental Health Waiver plan and services and has been adopted as the practice model for the Wyoming CHIPRA Demonstration Grant. In addition, numerous State agencies have embraced the model as a way of working with children/youth, families and individuals with complex needs and multiple system involvement (i.e., Healthy Families Succeed, Department of Workforce Services (DWS); Probation and Parole, Department Of Corrections (DOC)).

The state of Wyoming has the ability to evaluate implementation of High Fidelity Wraparound activities (fidelity means there is an exactness to the process, adherence to details, and a strict observance to the rules of the process which is supported through training and coaching), as well as track outcomes. As of 2009, nine controlled studies have been published in scientific journals, which highlight general findings of better functioning and mental health outcomes for wraparound groups and reduced recidivism and better juvenile justice outcomes.⁴

- e. Juvenile Detention Alternatives Initiative involves a structured planning process around creating more effective and less expensive alternatives to detention, such as community service, counseling, day education treatment, home detention, and electronic monitoring. It fits well with Community Juvenile Service Boards, and presently, the three counties that have regional juvenile detention centers (Sweetwater, Laramie, and Campbell) are participating and two others counties (Natrona and Fremont) are expected to come on board over the next year.
- f. Wyoming Planning Team for At-Risk Children, Youth and Families - Wyoming citizens receiving state services often receive those services from multiple agencies. The agencies frequently share responsibilities in providing those services. In 2006, the leadership and management of the Department of Family Services and the Wyoming Department of Health began monthly discussions on matters confronting both agencies when trying to serve the

⁴ Suter, J.C. & Bruns, E.J. (2009).

same clients. The meetings started out rather informal with the main purposes to share information on agency programs and problem-solve specific concerns. It became apparent the Wyoming Department of Education (WDE) and a Governor's Office representative were missing stakeholders from the monthly meetings and in the summer of 2008, WDE and Judge Gary Hartman (ret.) began regular participation. The group assumed the name of the Wyoming Planning Team for At-Risk Children, Youth and Families (PTAC), creating a charter outlining its operational standards, including devoting one meeting per quarter to issues specifically affecting at-risk children, youth and families. In the spring of 2009, the DOC and the DWS joined the PTAC. In early 2011, administration changes in the state provided an opportunity for PTAC to work to more clearly articulate team goals/outcomes and define the focused priorities for the coming year.

- g. Wyoming Department of Family Services will work to increase the awareness of services available in Wyoming for all placement decision makers, including the District/County Attorneys, Judges, MDT members, DFS caseworkers and probation officers, GALs and Public Defenders and families. The Department of Family Services has developed a Resource Guide for Children, Youth and Families. The Resource Guide is intended to provide the community, and those who are involved in the interest of children/youth and families, a comprehensive overview of the array of possible appropriate and available community services that can be utilized by and for children and their families. The continuum identifies risk factors and behaviors common to each of the six levels and appropriate interventions. The Resource Guide includes the levels of out-of-home placement, indicating facilities across the state at each level, an identification of the services provided, and the kinds of children/youth best served in each facility. The Resource Guide for Children, Youth and Families will be distributed to all community stakeholders and will be available on the DFS website and others. Additionally, WYSA will also use their website to detail the specific services offered by their member agencies across the state.
- h. Utilization Management of Residential Treatment Centers (RTCs) - Utilization management is a process designed to ensure the delivery of the best care possible for children/youth who require Residential Treatment level of service by determining the care is necessary, appropriate, and aligned with best practice. The process is focused on identifying and removing unnecessary and redundant care, and promoting best practice. The Utilization management includes processes to address: (a) easy and early access to appropriate treatment; (b) working collaboratively with participating providers in promoting delivery of quality care according to accepted best-practice standards; (c) addressing the needs of special populations; (d) identification of common illnesses or trends of illnesses; (e) identification of high-risk cases for intensive care management; and (f) prevention, education, and outreach. The Department of Family Services will develop a utilization management process for Residential Treatment Centers over the next two (2) years, working collaboratively with other state agencies and the treatment providers across the state. The utilization management process will provide valuable information regarding the levels of- and quality of services needed to serve Wyoming children/youth; both in residential settings and in the community upon discharge.

References

Building Families Initiative (2009). Residential services in transition: Meeting the challenges. *Children's Voice*, 18, 6.

Duchnowski, A.J., Hall, K.S., Kutash, K., & Friedman, R. (1998). The alternatives to residential treatment study. *Outcomes for Child and Youth with Behavioral and Emotional Disorders and Their Families*.

Magellan Health Services Children Services Task Force. (2008). Perspectives on residential and community-based treatment for youth and families. *Magellan Health Services, Inc.*

Suter, J.C. & Bruns, E.J. (2009). Effectiveness of the wraparound process for children with emotional and behavioral disorders: A meta-analysis. *Clinical Child and Family Psychology Review*, 12(4), 336-351.

U.S. Surgeon General. (2008). *Mental health: A report of the surgeon general*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institute of Health, National Institute of Mental Health.

Appendix A

LEVELS OF OUT – OF – HOME PLACEMENT

Level 1 – Family Foster Care

Level 2 – Therapeutic Foster Care (TFC)

Level 3– Group Home

Level 4 – Residential Treatment Center (RTC)

Level 5 – Psychiatric Residential Treatment Facility (PRTF)

Level 6 – Acute Psychiatric Hospitalization (stabilization or long-term in a regular hospital)

Level 1: FAMILY FOSTER CARE

Regular and specialized family foster care - is defined as a home setting which provides temporary care of children/youth who have been placed in the custody of the Department of Family Services (DFS) by court order because they cannot remain in their own home due to suspected or substantiated physical abuse, sexual abuse, neglect, or other circumstances necessitating out-of-home care. Court hearings are held every six (6) months to review the case and determine if continued placement in out-of-home care is necessary.

Placement may include living arrangements in homes of relatives or kin (related by blood, marriage or adoption or other individuals who have a close, caring relationship with the child/youth and/or family) or non-relative caregivers. Foster homes may be certified or not although non-relative caregivers are generally certified to provide foster care either through DFS or a certified Child Placing Agency. Foster parents work collaboratively with the child/youth's multidisciplinary team to assist the child/youth and his/her parent(s) meet their case plan goals.

Children/youth who have developmental, emotional, behavioral, or medical needs requiring specialized care may qualify for specialized foster care in which case caregivers either already have or receive the training, education and/or skills they need to meet the unique needs of the child/youth and may qualify for a higher reimbursement rate to help cover the additional costs of caring for the child/youth. A child/youth designated to be in specialized foster care 1) qualifies for a higher level of care, but the services are either not available in his/her community and the child/youth can receive the care needed in his/her foster home; or 2) does not qualify for the next level of care (e.g. Therapeutic Foster Care). The foster family may be asleep during the child/youth's sleeping hours.

Who should be admitted to a foster home?

A child/youth who is unable to safely remain in his/her own home and who can live in a home setting is appropriate for a regular or specialized foster care. Foster care is not the entry point to accessing inpatient psychiatric services, PRTFs, SRTCs and RTCs.

Children/youth who are appropriate for this service may have the following behaviors:

Not applicable. A foster home is the least restrictive type of out-of-home care when a child/youth is placed in DFS custody. The child/youth's behavior is typically not the reason they are in a foster home.

The following are required for admission:

There are no specific admission requirements other than the parent(s) have signed a time-limited voluntary placement agreement or the juvenile court 1) orders the child/youth to be placed in DFS custody; 2) makes a finding that it is contrary to the welfare of the child/youth to remain in their home; and 3) makes a finding that reasonable efforts have been made to keep the child/youth in the home or that immediate circumstances existed making reasonable efforts unnecessary.

Level 2: THERAPEUTIC FOSTER CARE

Therapeutic Foster Care (TFC) - is defined as a home setting which provides access to comprehensive mental health and substance abuse treatment services, either in the home or outpatient, to children and adolescents who have experienced a level of dysfunction that makes it impossible to function in their own homes or in foster care. TFC provides a moderate level of structure and supervision to support age appropriate behavior. The family may be asleep during the child/youth's sleeping hours. The family must be available to meet the child/youth's treatment needs 24 hours a day. This service provides a structured and supervised environment for the acquisition of skills necessary to enable the child/youth to improve level of functioning to achieve and/or to maintain the most realistic level of independent function where earlier treatment gains are somewhat fragile and the child/youth is subject to regression.

Who should be admitted to TFC?

A client may be appropriate for admission to TFC if they are fairly accepting of the treatment process and have experienced a level of dysfunction that makes it impossible to function at an age appropriate level in their homes or in foster care. TFC is not the entry point to accessing inpatient psychiatric services, PTRFs, SRTCs and RTCs.

What are the criteria for admission to TFC?

The following outlines TFC admission criteria:

1. The child/youth must have received a medical or psychiatric evaluation AND psychological or any other evaluation/assessment.
2. The child/youth is fairly accepting of the treatment process.
3. The child/youth has displayed difficulty in his/her own home or in a lower level of care.
4. The child/youth can receive education in the public school system.

The following are required within 14 days of admission to TFC:

1. Initial diagnostic assessment.
2. Medical, psychiatric and substance use history.
3. Family and social assessment.
4. Client assets and strengths.
5. Developmental history and current developmental functioning with respect to physical, psychological and social areas, including age appropriate adaptive functioning and social problem-solving.
6. Psycho-educational assessment.
7. An assessment of the need for psychological testing, neurological evaluation and speech, hearing and language evaluations.
8. A problem list, related to the reasons why the client was admitted to this level of care.
9. Identification of interventions for the immediate management of the problems identified in 8.
10. The treatment objectives (desired client responses) expected to be met by the time of the first continued stay review.

Children/youth who are appropriate for this service may have the following behaviors:

1. Difficulty following directions.
2. Frequent arguments with caretakers, siblings, teachers etc.
3. Mild self-injurious behavior, risk taking, or sexual promiscuity.
4. Suicidal thoughts.
5. Frequent fights at home, school or community.

6. Frequent verbally aggressive outbursts.
7. Frequent property damage.
8. Inability to engage in age appropriate activities without constant supervision (little league, scouts, etc.).
9. Low to moderate risk for sexually victimizing others.
10. Possible involvement with the juvenile justice system.
11. Infrequent school suspensions.

Level 3: GROUP HOME

Group home (GH)- is defined as a home or group living setting that may provide mental health and substance abuse treatment services to children and adolescents, either in the home or outpatient. These children/youth have experienced a level of dysfunction that makes it impossible to function in the community without an increase in structure and supervision. Group Homes provide a moderate level of structure and supervision to support age appropriate behavior. The staff may be asleep during the child/youth's sleeping hours if there is an operable alarm system and there are no children/youth present who are a danger to themselves or others. Staff must be available to meet child/youth's needs 24 hours a day.

Who should be admitted to a group home?

A client may be appropriate for admission to a group home if they are fairly accepting of the treatment process and can function in the public school system. Many of these children/youth have suffered abuse/neglect within their own families and as a result have a great deal of trouble adjusting to a family setting. An adolescent close to becoming an adult and working on independent living skills may also be appropriate for this type of group living, as opposed to a family setting. Group homes are not the entry point to accessing inpatient psychiatric services, PRTFs, SRTCs and RTCs.

What are the criteria for admission to a group home?

The following outlines the group home admission criteria:

1. The child/youth must have received a medical or psychiatric evaluation AND psychological or any other evaluation/assessment, if placed at this level post juvenile court adjudication.
2. The child/youth is fairly accepting of the treatment process.
3. The child/youth has displayed difficulty in a family setting such that placement with a family would not be indicated.
4. The child/youth can receive education in the public school system.

The following are required within 14 days of admission to a group home:

Initial diagnostic assessment.

1. Medical, psychiatric and substance use history.
2. Family and social assessment.
3. Client assets and strengths.
4. Developmental history and current developmental functioning with respect to physical, psychological and social areas, including age appropriate adaptive functioning and social problem-solving.
5. Psycho-educational assessment.
6. An assessment of the need for psychological testing, neurological evaluation and speech, hearing and language evaluations.
7. A problem list, related to the reasons why the client was admitted to this level of care.
8. Identification of interventions for the immediate management of the problems identified in 8.
9. The treatment objectives (desired client responses) expected to be met by the time of the first continued stay review.

10.

Children/youth who are appropriate for this service may have the following behaviors:

1. Significant difficulty following directions.
2. Frequent arguments with caretakers, siblings, teachers etc.
3. Mild self-injurious behavior, risk taking and/or sexual promiscuity.
4. Suicidal thoughts.
5. Frequent fights at home, school or community.
6. Frequent verbally aggressive outbursts.
7. Frequent property damage.
8. Inability to engage in age appropriate activities without constant supervision (little league, scouts, etc.).
9. Low to moderate risk for sexually victimizing others.
10. Involvement with the juvenile justice system.
11. Infrequent school suspensions.

Level 4: RESIDENTIAL TREATMENT CENTERS

Residential Treatment Center (RTC) – is defined as a provider facility or distinct part of the organization which renders an interdisciplinary program of mental health treatment to individuals under 21 years of age who have persistent dysfunction in major life areas. The dysfunction is of an extent and pervasiveness that requires a protected and highly structured therapeutic environment. These organizations, or distinct part of organizations, exclude those that provide acute psychiatric care, partial hospitalization, group living, therapeutic schooling, primary diagnosis substance abuse disorder treatment, or primary diagnosis mental retardation or developmental disability treatment.

RTCs provide comprehensive mental health services to children and adolescents who are in need of quality, pro-active treatment at a higher level of supervision and structure than can be provided in a Group Home (and may provide substance abuse treatment services, according to the level of certification from the Wyoming Department of Health). This setting has a higher level of consultative and direct service from psychiatrists, psychologists, therapists, medical professionals, etc. The child or adolescent needs supervision by awake staff during time when the child or adolescent is sleeping. In addition to diagnostic and treatment services, RTCs should also provide instruction and support toward attainment of developmentally appropriate basic living skills/daily living activities that will enable children and adolescents to live in the community upon discharge.

The focus of a RTC is improvement of a client's symptoms through the use of evidence-based strategies, group and individual therapy, behavior management, medication management, and active family engagement/therapy; unless evidence shows family therapy would be detrimental to the client. Unless otherwise indicated, the program should facilitate family participation in the treatment planning, implementation of treatment planning, and timely, appropriate discharge planning, which includes assisting the family in accessing wrap-around services in the community.

Who should be admitted to a RTC?

A client may be appropriate for admission to a RTC if she/he has a professionally evaluated behavioral condition and is responsive to the need for intensive, active, therapeutic intervention, which requires a staff secure treatment setting in order to be successfully implemented. This setting has a higher level of consultative and direct service from psychiatrists, psychologists, therapists, medical professionals, etc. RTC service is not the entry point to accessing acute psychiatric hospitalization.

What are the criteria for admission to a RTC?

The following outlines the RTC admission criteria:

1. The child/youth must have received a medical or psychiatric evaluation resulting in a diagnosed behavioral condition AND psychological or any other evaluation/assessment.

2. The child/youth is only minimally accepting of the treatment process.
3. The child/youth's educational needs must also be met in a setting provided by the residential provider.
4. There are documented attempts to treat the client with the maximum intensity of services available at a community level or less intensive level of care that cannot meet or has failed to meet the needs of the client.
5. Without intervention, there is clear evidence that the client will likely decompensate and present a risk of serious harm to self or others.

The following are required within 14 days of admission to a RTC:

1. Initial diagnostic assessment.
2. Medical, psychiatric and substance use history.
3. Family and social assessment.
4. Client assets and strengths.
5. Developmental history and current developmental functioning with respect to physical, psychological and social areas, including age appropriate adaptive functioning and social problem-solving.
6. Psycho-educational assessment.
7. An assessment of the need for psychological testing, neurological evaluation and speech, hearing and language evaluations.
8. A problem list, related to the reasons why the client was admitted to this level of care.
9. Identification of interventions for the immediate management of the problems identified in 8.
10. The treatment objectives (desired client responses) expected to be met by the time of the first continued stay review.

Children/youth who are appropriate for this service may have the following behaviors:

1. Inability to follow directions and conform to structure of school, home or community.
2. Repeated, sometimes violent arguments with caretakers, peers, siblings and/or teachers.
3. Moderate level of self-injurious behavior, risk taking, and/or sexual promiscuity.
4. Suicidal actions/history of serious suicidal actions.
5. Almost daily physical altercations in school, home or community.
6. Frequent verbally aggressive and provocative language.
7. Frequent and severe property damage.
8. Probable juvenile justice system involvement.
9. Frequent school suspensions.
10. Moderate to high risk for sexually victimizing others.

Children/youth who exhibit escalating behaviors (as described above) may require a facility or intervention to provide for a "physically secure" environment (the facility has locks).

Level 5: PSYCHIATRIC RESIDENTIAL TREATMENT FACILITIES

Psychiatric Residential Treatment Facility (PRTF) is defined as 24-hour, supervised, inpatient level of care provided to children and adolescents up to age 21 who have long-term mental health or psychiatric illnesses and/or serious emotional disturbance(s) that are not likely to respond to short-term interventions and have failed to respond to community based intervention(s).

PRTF's provide comprehensive mental health and substance abuse treatment services to children and adolescents who, due to severe emotional disturbance, are in need of quality, proactive treatment. In addition to diagnostic and treatment services, PRTF's should also provide instruction and support toward attainment of developmentally appropriate basic living skills/daily living activities that will enable children and adolescents to live in the community upon discharge.

The focus of a PRTF is on improvement of a client's symptoms through the use of evidence-based strategies, group and individual therapy, behavior management, medication management, and active family engagement/therapy; unless evidence shows family therapy would be detrimental to the client. Unless otherwise indicated, the program should facilitate family participation in the treatment planning, implementation of treatment planning, and timely, appropriate discharge planning (which includes assisting the family with varying levels of support and services to ensure a safe, stable and nurturing home environment. This is often referred to as wrap-around services. In effect, it means wrapping a child/family with support until the family reaches an adequate level of self sufficiency). Wyoming EqualityCare provides wrap around services within the Children's Mental Health Waiver.

Who Should be Admitted to a PRTF?

A client may be appropriate for admission to a PRTF if he/she has a psychiatric condition that cannot be reversed with treatment in an outpatient treatment setting and the condition is characterized by severely distressing, disruptive and/or immobilizing symptoms which are persistent and pervasive.

Who Should Not be Admitted to a PRTF?

A client who is experiencing acute psychiatric behaviors is not appropriate to be admitted to a PRTF. PRTF services are not the entry point to accessing inpatient psychiatric services.

What are the criteria for Admission (ADM) to a PRTF?

The following outlines the PRTF admission criteria: The client must meet all 5.

The client presents with a longstanding (at least 6 months) psychiatric diagnosis characterized by severely distressing, disruptive and/or immobilizing symptoms that are persistent and pervasive and which cannot be reversed with treatment in an outpatient treatment setting, or is being stepped down in intensity from an acute psychiatric facility. The diagnosis must meet the criteria for an Axis 1 as defined by the DSM-IV.

Examples would include the following:

- The presence of emotional distress.
 - Regression, depression, low frustration tolerance, irritability and/or other psychiatric symptoms that interfere with the client's ability to change behavior and/or mood, form a therapeutic alliance or sustain engagement in treatment.
 - Impaired reality testing.
 - A condition consistent with an eating disorder diagnosis as described in the current edition of the DSM.
1. There are documented attempts to treat the client with the maximum intensity of services available at a less intensive level of care that cannot meet or has failed to meet the needs of the client within the past 6 months. The client must have failed to respond to outpatient interventions. Six months of alternative, less restrictive levels of care must have been tried and have failed, or are not psychiatrically indicated. ^{7,8}

Exception: The client has had a sudden, acute onset of psychiatric illness, and a lower level of care is not psychiatrically indicated.

2. At least one of the patterns of behavior listed below must be present:
 - a. Persistent, pervasive and frequently occurring oppositional/defiant behavior.
 - b. Reckless and/or impulsive behavior, which represents a disregard for the well-being and/or safety of self/others.
 - c. Aggressiveness and/or explosive behavior.
 - d. Gestures with intent to injure self/others, which have not resulted in serious injury, without evidence that such gestures are immediately progressing to life threatening behavior.
 - e. Self-induced vomiting, use of laxatives/diuretics, strict dieting, fasting and/or vigorous exercise.
 - f. Extreme phobic/avoidant behavior.

- g. Extreme social isolation.
 - h. History of repeated life threatening injury to self /others, resulting in acute care admissions within the past 12 months. The client is not currently considered at risk to inflict life-threatening injury to self/others in the residential treatment setting.
- 3. Without intervention, there is clear evidence that the client will likely decompensate and present a risk of serious harm to self or others.
 - 4. A psychiatric evaluation by a psychiatrist that specializes in Child/Adolescent Psychiatry and/or a psychological evaluation by a clinical psychologist that specializes in Child/Adolescent Psychology. Psychiatrists and psychologists must be licensed and in good standing. The evaluation must take place no more than 30 days prior to PRTF Admission. ^{7,9}

Level 6: ACUTE PSYCHIATRIC HOSPITALIZATION

Acute inpatient psychiatric hospitalization is defined as the highest intensity of medical and nursing services provided within a structured environment providing 24-hour skilled nursing and medical care. Full and immediate access to ancillary medical care must be available for those programs not housed within general medical centers.

All of the following are required to meet the medical necessity criteria:

- 1. The patient must have been diagnosed with a psychiatric illness by a physician or psychiatrist.
- 2. Symptoms of illness must be in accord with those described in the Diagnostic Statistical Manual of Mental Disorders, Edition IV (DSM-IV).
- 3. One or more of the following must be present:
 - a. Patient presents with suicidal ideation and intention, which represents significant risk of harm, medically significant self-mutilation, and/or a recent lethal attempt to harm self, such that 24-hour/day hospitalization and observation are necessary for the patient's safety.
 - b. Patient presents with a recent history of grossly disruptive, delusional and/or violent behaviors representing clear and present danger of serious harm to others.
 - c. The patient's psychiatric condition severely impairs his/her basic functional capacity as evidenced by disorganized, uncontrolled thinking/behavior that represents a genuine and proximal risk of danger to self such that 24-hour/day nursing and medical treatment is required.
 - d. Diagnosis and/or treatment(s) is/are clearly unsafe or impossible to be provided in an ambulatory setting and can only be accomplished with 24-hour intensive nursing and medical care.

Appendix B

EXERPT FROM DFS RESOURCE GUIDE FOR CHILDREN, YOUTH AND FAMILIES WYOMING SYSTEM OF CARE/SERVICE ARRAY

The Resource guide is intended to provide the community, and those who are involved in the interest of children and families, a comprehensive overview of the array of possible appropriate and available community services that can be utilized by and for children and their families. The continuum identifies risk factors and behaviors common to each of the six levels and appropriate interventions.

(Risk Factor/Behavior Chart)

RISK FACTORS/BEHAVIORS BY POPULATION

	Prevention	Early Intervention	Immediate	Intermediate	Residential	Aftercare
Child	<ul style="list-style-type: none"> No risk factors needed 	<ul style="list-style-type: none"> Substance abuse School disruption Truancy School dropout Traffic/status offense HIV/AIDS risk behavior Antisocial behavior Health or mental health concerns Developmental disability Performance at school Behavior at school Low birth weight 	<ul style="list-style-type: none"> Abnormal or nonexistent attachment and bonding Moderate substance abuse Property crimes Chronic Low-level and first time misdemeanor offenses Violent delinquency Repeat status offenses Serious traffic offenses Moderate Health or mental health concerns 	<ul style="list-style-type: none"> High health or mental health concerns High substance abuse Repeat/serious offenses against property/people with low to moderate risk of re-offense Serious felony offenses Violent offenses (in need of supervision) 	<ul style="list-style-type: none"> Extreme health or mental health concerns Extreme substance abuse Repeat violent and serious crimes Felony level crimes 	<ul style="list-style-type: none"> Substance abuse recovery maintenance Offenders transitioning back into the community Transitioning back to community from residential care
Adult	<ul style="list-style-type: none"> No risk factors needed 	<ul style="list-style-type: none"> Substance abuse Antisocial behavior Negative attitude toward being a parent Physical and mental health issues Developmental disability Low IQ Language barriers Attitudes towards drugs Lack of prenatal care Corporal punishment No employment 	<ul style="list-style-type: none"> Moderate substance abuse Moderate physical or mental health Issues Chronic misdemeanor offenses and jail sentences Neglect adjudication 	<ul style="list-style-type: none"> High substance abuse High physical or Mental Health issues Felony offenses Abuse adjudication Unreasonable corporal punishment 	<ul style="list-style-type: none"> Extreme substance abuse Extreme physical or mental health issues Serving a prison sentence Neglect/abuse adjudication 	<ul style="list-style-type: none"> Substance abuse recovery maintenance Mental health residential recovery maintenance Probation/parole Transitioning back to community from residential care Neglect/abuse adjudication
Family	<ul style="list-style-type: none"> No risk factors needed 	<ul style="list-style-type: none"> Economic factors Management problems Divorce or custody issues 	<ul style="list-style-type: none"> Economic factors Family conflict Domestic violence in home 	<ul style="list-style-type: none"> High level of domestic violence in home 	<ul style="list-style-type: none"> Any family member in residential care or in need of residential care 	<ul style="list-style-type: none"> Any family members transitioning back to community from residential care



LEVELS/POSSIBLE ASSESSMENTS*

Prevention	Early Intervention	Immediate	Intermediate	Residential	Aftercare
CASII Level 0 ----- CASII Level 1 ----- CASII Level 3 ----- CASII Level 4 ----- CASII 5 or 6 ----- CASII Level 2					
PACT Low ----- PACT Low ----- PACT Moderate ----- PACT Moderate/High -----					
Levels of Care					
----- Low CPS Risk ----- Moderate Assessment ----- High Assessment -----					
CAN ECSII Washington MH Eval Safety Assessment					



EFFECTIVE MODELS AND SERVICES BY POPULATION**

<p>Child 0-3</p>	<ul style="list-style-type: none"> • Early Care and Education • DD Services • Early Head Start 	<ul style="list-style-type: none"> • Early Care and Education • DD Services • Advocacy • Early Head Start 	<ul style="list-style-type: none"> • Mental Health Evaluations 	<ul style="list-style-type: none"> • Outpatient Mental Health Services • Family Foster Care • Kinship Care • Group Homes • MST • FFT • ACT (Assertive Community Treatment) 	<ul style="list-style-type: none"> • Foster Care • Therapeutic Foster Care • Kinship Care 	<ul style="list-style-type: none"> • Foster Care • Therapeutic Foster Care • Outpatient Mental Health Services
<p>Child 4-12</p>	<ul style="list-style-type: none"> • Alternative Schools • Before and After School Programs • Tutoring/Mentoring • IDEA/IEP • Special Needs Education • Boys and Girls Club • DD Services • DD Waiver • Head Start • Positive Youth Development 	<ul style="list-style-type: none"> • Before and After School Programs • Outpatient Mental Health Services • Tutoring/Mentoring • Truancy Prevention • IDEA/IEP • Special Needs Education • Boys and Girls Club • DD Services • DD Waiver • Advocacy • Head Start • Positive Youth Development 	<ul style="list-style-type: none"> • Mental Health Evaluations • Before and After School Programs • IDEA/IEP • Special Needs Education • Diversion 	<ul style="list-style-type: none"> • Outpatient Mental Health Services • Children’s Mental Health Waiver • Family Foster Care • Kinship Care • Group Homes • MST • FFT • ACT (Assertive Community Treatment) 	<ul style="list-style-type: none"> • Children’s Mental Health Waiver • Foster Care • Therapeutic Foster Care • Kinship Care • Crisis Centers • Group Homes • Residential Treatment Centers • Psychiatric Residential Treatment Facilities • Acute Crisis Stabilization • In-Patient Substance Abuse Treatment 	<ul style="list-style-type: none"> • Foster Care • Therapeutic Foster Care • Outpatient Mental Health Services • Outpatient Substance Abuse Treatment
<p>Child 13-18 Child 13-18 (cont)</p>	<ul style="list-style-type: none"> • Crisis Centers • Vocational/Job Training for Youth • Youth Support • Before and After School Programs • Tutoring/Mentoring • Special Needs Education • Boys and Girls Club • DD Services • DD Waiver • Positive Youth Development 	<ul style="list-style-type: none"> • Crisis Centers • Vocational/Job Training for Youth • Youth Support • Community Service • Outpatient Substance Abuse Treatment • Before and After School Programs • Outpatient Mental Health Services • Tutoring/Mentoring • Truancy Prevention • Special Needs Education • Boys and Girls Club • DD Services • Substance Abuse Support Groups • DD Waiver • Advocacy • Positive Youth Development 	<ul style="list-style-type: none"> • Crisis Centers • Diversion • Juvenile Probation • PACT Assessment • Mental Health Evaluation • Independent Living • Outpatient Substance Abuse Treatment and Evaluations • Alternative Schools • Special Needs Education • Drug Courts/Court Supervised Treatment Programs • Substance Abuse Support Groups 	<ul style="list-style-type: none"> • Crisis Centers • Juvenile Probation • Substance Abuse Day Treatment • Intensive Supervision Programs • Outpatient Mental Health Services • Alternative Schools • Electronic Monitoring • House Arrest • Drug Courts/Court Supervised Treatment Programs • Children’s Mental Health Waiver • Family Foster Care • Kinship Care • Group Homes • MST, FFT and ACT (Assertive Community Treatment) 	<ul style="list-style-type: none"> • Foster Care • Therapeutic Foster Care • Kinship Care • Crisis Centers • Group Homes • Residential Treatment Centers • Psychiatric Residential Treatment Facilities • Acute Crisis Stabilization • In-Patient Substance Abuse Treatment • Juvenile Detention • BOCES • Wyoming Boys and Girls School (only if adjudicated delinquent) • Children’s Mental Health Waiver 	<ul style="list-style-type: none"> • Intensive Supervision Programs • Electronic monitoring • Foster Care • Therapeutic Foster Care • Outpatient Mental Health Services • Outpatient Substance Abuse Treatment • Independent Living • Vocational/Job Training for Youth

Adult	<ul style="list-style-type: none"> • Parenting • Faith-Based Organizations • Financial Counseling • Adult DD Services • Traumatic Brain Injury Waiver • Quality of Life Services • DD Services 	<ul style="list-style-type: none"> • Outpatient Substance Abuse Treatment • Parenting • Job Training • Vocational Rehabilitation • Financial Counseling • Adult DD Services • Traumatic Brain Injury Waiver • Outpatient Mental Health Services • Quality of Life Services • Substance Abuse Support Groups • DD, Long-term Care , and Assisted Living Waivers • Advocacy 	<ul style="list-style-type: none"> • Outpatient Substance Abuse Treatment and Evaluations • Domestic Violence Programs • Parenting • Mental Health Evaluations • Outpatient Mental Health Services • Quality of Life Services • Drug Courts/Court Supervised Treatment Programs • Substance Abuse Support Groups 	<ul style="list-style-type: none"> • Substance Abuse Day Treatment • Domestic Violence Programs • Outpatient Mental Health Services • Quality of Life Services • Drug Courts/Court Supervised Treatment Programs 	<ul style="list-style-type: none"> • In-Patient Substance Abuse Treatment • In-Patient Mental Health Services for Adults • Quality of Life Services 	<ul style="list-style-type: none"> • Outpatient Substance Abuse Treatment • Domestic Violence Programs • Parenting • Outpatient Mental Health Services • Quality of Life Services
Family	<ul style="list-style-type: none"> • Faith-Based Organizations • Financial Assistance for Health Related Costs • County Mental Health Centers • Quality of Life Services • Nurse/Family Partnership 	<ul style="list-style-type: none"> • Family Counseling (Outpatient MH Services) • In-Home Support • Financial Assistance for Health Related Costs • County Mental Health Centers • Quality of Life Services • Substance Abuse Support Groups • Advocacy • Nurse/Family Partnership 	<ul style="list-style-type: none"> • CASA (Abuse/Neglect Court Action Only) • Domestic Violence Centers • In-Home Support • County Mental Health Centers • Quality of Life Services • Substance Abuse Support Groups 	<ul style="list-style-type: none"> • CASA (Abuse/Neglect Court Action Only) • Domestic Violence Centers • County Mental Health Centers • Quality of Life Services 	<ul style="list-style-type: none"> • CASA (Abuse/Neglect Court Action Only) • Quality of Life Services 	<ul style="list-style-type: none"> • CASA (Abuse/Neglect Court Action Only) • Domestic Violence Centers • In-Home Support • County Mental Health Centers • Quality of Life Services

* Note: The listed assessments and assessment outcomes are not always necessary or required. They are listed as a planning tool only.

** Note: Alternatives to higher levels of care: Services can be accessed and utilized in the levels below indicated and for other populations; particularly if the child and/or family has existing protective factors or the child's or families' protective factors can be cultivated. This list is not exhaustive and does not prescribe a one-fits-all approach.

Appendix C

Out-of-State Residential Treatment Center/Psychiatric Residential Treatment Center Placement Justifications

Budget Footnote Research Study

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Wyoming Department of Family Services,

Quality Assurance Unit

According to Wyoming Statutes §14-6-229(a)(v), § 14-3-429(a)(v), § 14-6-429(a)(v) and § 21-13-315(a):

The court shall not order an out-of-state placement unless:

Evidence has been presented to the court regarding the costs of the out-of-state placement being ordered together with evidence of the comparative costs of any suitable alternative in-state treatment program or facility, as determined by the department pursuant to W.S. 21-13-315(d)(viii), whether or not placement in the in-state program or facility is currently available;

The court makes an affirmative finding on the record that no placement can be made in a Wyoming institution or in a private residential treatment facility or group home located in Wyoming that can provide adequate treatment or services for the child; and

The court states on the record why no in-state placement is available.

Enrolled Act No. 46, Section 049, footnote to the budget requires an examination of the documented reasons for using out-of-state providers as opposed to in-state providers and the decision making process and factors leading to a determination of where a child is placed, including a sampling of reasons listed in judicial orders.

Through a case review, the present study examined the reasons, provided in multidisciplinary reports and court orders, for out of state placements in residential treatment centers (RTC's) or psychiatric residential treatment centers (PRTC's).

Method

According to data from WYCAPS, there were 217 out-of-state placements in RTC/PRTC's between July 2007 and July 2010. A random sample of 150 of those cases was conducted for this study.

Field staff across the state provided the following case documents:

1. Placement History
2. Multidisciplinary Team (MDT) Report prior to placement
3. Placing Court Order
4. Document stating the child's key issues (if not in the above documents)

Procedures

A standardized review process was utilized. Each court order and MDT report was examined for specific language related to the reason or justification for the out-of-state placement. Reasons fell into one of the following categories:

1. No justification given
2. No MDT held prior to placement
3. Specific service/treatment not in Wyoming
4. No availability in Wyoming facilities at the time of placement
5. Quality of service is better out-of-state
6. Distance to out-of-state is closer than in-state
7. Placement was made prior to DFS custody (i.e. parental placement)
8. All in-state resources were exhausted

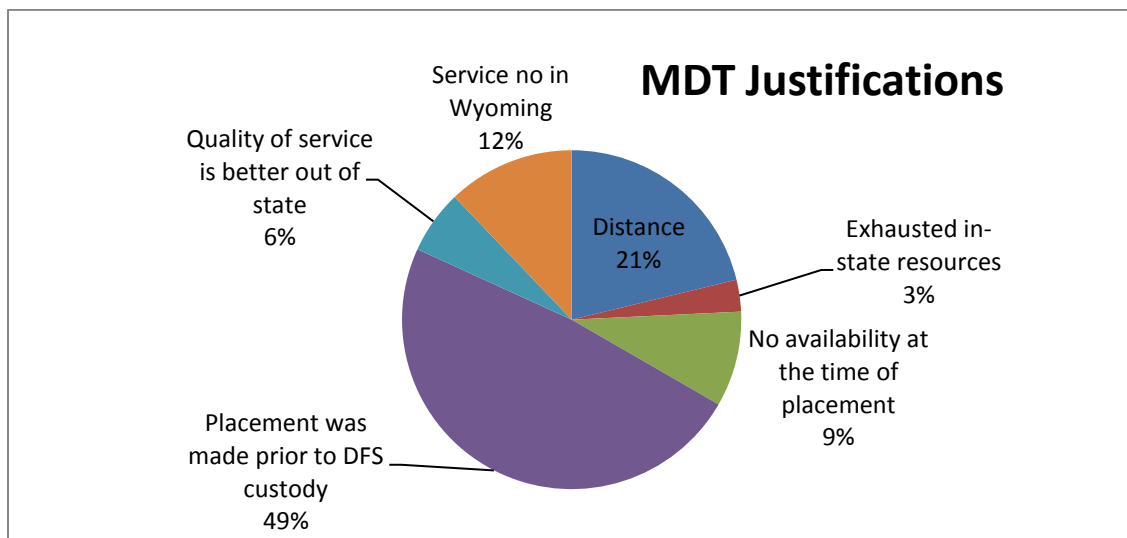
The reasons provided in the MDT reports and court orders were recorded separately. Next the number of placements prior to placement at the out-of-state RTC/PRTC were counted and documented. Additionally, the type of placement prior to the placement in question was documented. In addition to that information, the child's key issues were identified, based on documents provided and were recorded. Key issues were categorized in three categories; behavior, mental health and/or physical health.

Results

Twenty-one of the cases sampled were excluded from the study because case file information was unavailable. Therefore, a total of 129 cases were reviewed for documented reasons for out-of-state placement in RTC's and PRTC's. 111 of the cases were placements in RTC's and the other 18 were in PRTC's. 19 of the cases were Child Protection cases, 83 were Juvenile Services cases and 27 were Youth and Family cases.

Multidisciplinary Team (MDT) Reports Data

Approximately 16% of the MDT reports reviewed contained justifications that met the requirements of the state statute. While 72% did not mention any reason for the out-of-state placement and 8% did not have a MDT prior to placement. Below is a breakdown of the justifications provided in the MDT reports, where justifications were present.



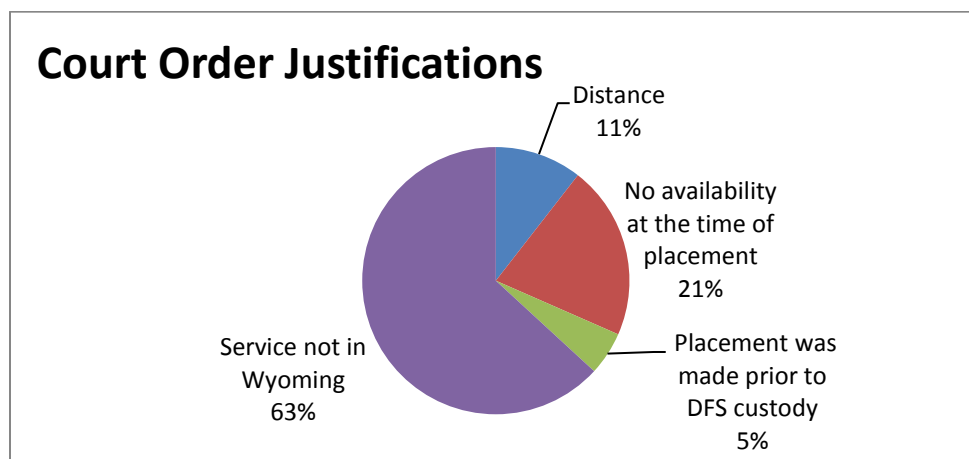
Almost half of the MDT reports that contained justifications for the out-of-state were justified by MDT members as being placements that were made prior to DFS custody. For example, one MDT report stated that “Parents placed him there and midway through could not pay for it, since it was a Medicaid placement we changed his custody to DFS to pay for the rest of treatment”. While the court order in that particular case stated the following, “On September 4, 2008, the juvenile appearance for his initial appearance and was placed in the legal and physical custody of the Department of Family Services for placement in the Crisis Shelter so that a psychological and substance abuse evaluation could completed.”

In other cases, letters were written to the county attorney’s office requesting custody so that the child could stay in treatment because Medicaid was no longer paying for the placement. (See attachment A)

Overall, MDT reports were lacking detailed information regarding the reason for using an out-of-state RTC/PRTC placement over an in-state resource/s.

Court Order Data

Approximately 15% of the court orders reviewed contained justifications that met the requirements of the state statute; however only a few of the court orders contained language about evidence being presented to the court regarding the costs of the out-of-state placement or evidence of the comparative costs of any suitable alternative in-state treatment program or facility. 85% of the court orders examined did not contain any justification for the out-of-state placement. Below is a breakdown of the justifications provided in the court orders, where justifications were present.



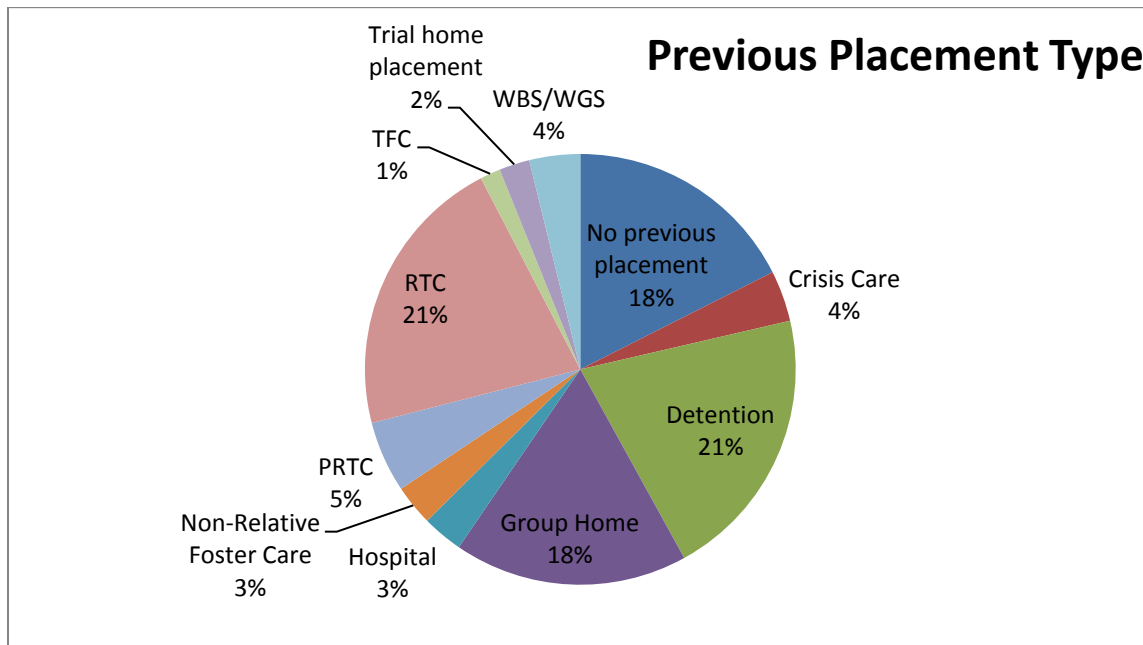
Of the court orders that included language justifying the reason for choosing an out-of-state placement, majority were due to the service not existing in Wyoming. (See Attachment B, for example)

Other court orders without justifications that met the statute requirements were vague and included a reason for the placement however, did not include a reason why an out-of-state facility was chosen over an in-state facility. (See Attachment C, for example)

Overall, the judicial reviews that were reviewed lacked the documentation required by state statute §14-6-229(a)(v)(C). Additionally, in court orders where justifications were present, it was difficult to determine whether or not those justifications were accurate because the court order contained pre-written language and did not coincide with the MDT reports justification. However, these court orders were included in the cases that have justifications.

Placement Data

Of the cases reviewed, 18 % of the out-of-state RTC/PRTC placements were first time placements. 84% of the cases had one or more placements prior to the current out-of-state placement. 26% of the cases had five or more placements prior to the current RTC/PRTC placement. Below is a breakdown of the previous placement type before the current placement in an out-of-state RTC/PRTC.



Key Issues

According to the data collected in the 129 cases that were reviewed, 91% of the child’s key issues were identified as being behavioral and the other 9% were mental health. None of the cases were children with physical health as a key issue.

Discussion

Based on the criteria and the documents reviewed in this study, overall, the statute requirements were not met. A number of cases began as voluntary placements and according to case documents, when private funding was unavailable the department took custody and began paying for the placement. In these cases, the appropriate justification for the out-of-state placement was not in the court order or in the MDT report. In addition, in several areas across the state, MDT’s were not being held prior to out of state RTC/PRTC placements.

In a large percentage of the cases the out-of-state RTC/PRTC placements being reviewed was the first placement the child had. In areas where the distance to out-of-state RTC/PRTC placements were closer than in-state facilities, court orders contained that justification.

In court orders that included a justification for the out-of-state placement, statute requirements were still not completely met. For example, court orders stated that the particular placement met the needs to the child however, did not specify whether or not in-state resources were considered. Additionally, in the majority of MDT reports reviewed, it does not appear that a discussion about in-state resources or the comparative costs is taking place.

In some areas form court orders (attachment D) have been developed that include the desired language from the statute. However, the MDT reports did not mirror the information in the court orders. In other areas, Minute Orders were used to place a child in an out-of-state RTC/PRTC (attachment E). These orders lacked any justification at all. Majority of the court orders reviewed stated that the placement was in the best interest of the child but did not provide a reason why an in-state placement was not being used.

Limitations

There was some difficulty obtaining all of the records for the sample, particularly in cases which were closed and destroyed. Those cases were excluded from this study.

References

WYCAPS

Case File Documents

WY Statute §14-6-229

Appendix D

PRTF/RTC Historical Documentation

PAST:

- 2009 – Medicaid paid Residential Treatment centers (RTCs) and Psychiatric Residential Treatment Facilities (PRTFs) to provide services to Wyoming children. Medicaid paid these facilities a per diem rate which included room and board and medical expenses.
- March, 2009 – WDH discontinues SAGE Federal grant due to budget restraints and increased federal match in year 4 of the grant.
- May, 2009 – Mandated state agency budget cuts (5% and 10% cuts).
- September, 2009 – Centers for Medicare and Medicaid (CMS) directed Wyoming to cease per diem payments to RTCs. CMS advised Wyoming that Medicaid could only pay a per diem rate to “certified” PRTFs.
- September, 2009 - PRTF/RTC working group is formed to assist and mitigate ramifications cause by the CMS directive to distinguish between PRTFs/RTCs. Group includes DFS; WDH, Medicaid; APS Healthcare Inc.; Governor’s Office and others. Working group meets monthly.
- October 21, 2009 – Meeting with Sheilia Pires, agency directors (including Superintendent McBride, Directors Lewis, Evans, Sherard and Lampert) and the Governor to discuss “Funding Systems of Care”.
- December, 2009 – Wyoming applies for Children’s Health Insurance Program Reauthorization Act (CHIPRA) grant, per Wyoming Planning Team for Children, Youth and Families (PTAC) approval, as a solution to high Medicaid PRTF/RTC costs, poor outcomes, system changes and continued development of Systems of Care.
- February, 2010 – Wyoming awarded CHIPRA grant.
- March, 2010 – DFS Budget Footnote placing moratorium on number of RTC beds and requiring study of RTC utilization, cost, etc.

PRESENT:

- Continued budget cuts and high cost and poor outcomes of PRTF/RTC placements.
- Two (2) in-state PRTFs (Wyoming Behavioral Institute and St. Joseph’s Children’s Home); 24 out-of-state PRTFs.
- Medicaid can only cover “medically necessary” services and cannot cover any service or cost beyond those “medically necessary” services provided to Medicaid eligible children.
 - * Per the CMS directive, Medicaid can no longer pay a per diem rate to RTCs;
 - * Medicaid can pay for “medically necessary” PRTF placements;
 - * Medicaid can pay for “medically necessary” mental health and medical services, whether they are court-ordered or not.
- DFS pays for RTC room and board. Medicaid may reimburse an RTC or RTC Medicaid providers for treatment services if the child is Medicaid eligible and the services are “medically necessary”.

FUTURE:

- Implementation of a Care Management Entity (CME) through the CHIPRA grant, including continued development of Systems of Care, reduction of PRTF/RTC placements, better care and outcomes for children.

Appendix E

Crisis Beds, Group Homes, and RTCs

Gray background = No Detention, Group Home, or Crisis Services available within the County.

