
CHALLENGE #5: PROVIDE COMPREHENSIVE SUPPORT AND ASSISTANCE TO YOUTH (AND CHILDREN) WITH BEHAVIORAL DISTURBANCES

“Research and experience demonstrate that the services available in the juvenile justice system to alleviate [mental health] problems are entirely inadequate.”³³

Shay Bilchik, former Administrator
Office of Juvenile Justice and Delinquency Prevention
U.S. Department of Justice

Young people who commit juvenile offenses and become entangled in the juvenile justice system suffer disproportionately from emotional disturbances and mental illness.

By some estimates, up to 90 percent of young people referred to juvenile courts for delinquency exhibit the general symptoms of “conduct disorder” or “oppositional defiance disorder.” The majority suffer with problems of substance abuse or dependency. Roughly one-third suffer with attention deficit (ADD) or attention deficit hyperactivity disorder (ADHD). Clinical depression and post-traumatic stress disorder are also disturbingly commonplace. Though estimates differ, the majority of studies on the mental health needs of juvenile offenders find that at least 20 percent suffer *severe* mental health disorders.³⁴

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Dr. David Satcher, U.S. Surgeon General

Despite the direct connection between delinquency and mental health, however, our nation’s efforts to meet the mental health needs of adolescents are seriously inadequate. The problems are three-fold:

- ♦ **Overreliance on Out-of-Home Treatment.** One-half of all the money spent in the United States for mental health treatment of children and youth pays for inpatient hospitalization. Another 25 percent pays for residential care for troubled youth in treatment centers and group homes costing hundreds of dollars per day.³⁵ Even with their high costs, however, hospitalization and other out-of-home treatments have not proven effective in resolving the mental health problems of youth. In 1999, U.S. Surgeon General David Satcher concluded that “Inpatient [hospital] care is the clinical intervention with the weakest research support.” Satcher also complained that: “In the past, admission to [residential treatment centers] has been justified on the basis of community protection, child protection, and benefits of residential treatment per se. However, none of these justifications have stood up to research scrutiny. In particular, youth who display seriously violent and aggressive behavior do not appear to improve in such settings.”³⁶ In a six-state study of children treated in publicly-funded residential treatment centers, 75 percent were either readmitted to a mental health facility (about 45 percent) or incarcerated in a correctional setting (about 30 percent) within seven years.³⁷

- ♦ **Underinvestment in High-Quality Community-Based Services.** The inevitable result of America’s overreliance on expensive and ineffective out-of-home treatment has been lack of investment in non-residential services for disturbed children and adolescents. This oversight is particularly tragic given the striking success achieved by a handful of home-based and family-focused mental health treatment models. For instance, Multisystemic Therapy (see Challenge #3) has dramatically improved the outcomes for youth who are hospitalized for emotionally disturbances. Likewise, so-called “wraparound services” (see below) – offering customized and comprehensive support and treatment services for youth in their own homes – have also shown potential to improve outcomes for troubled youth while decreasing costs for taxpayers. However, rather than providing these or other intensive community-based service strategies, most communities offer only a hodge-podge of fragmented and outdated adolescent mental health services.
- ♦ **Lack of Coordination Between Concerned Agencies.** Typically, youth troubled with emotional disturbances, developmental disabilities, or other mental health problems come in contact with multiple public agencies: department of mental health, child protective services, special education, juvenile justice, and others. However, these agencies rarely coordinate their services for youth whose cases they share in common. As a result, treatment and support efforts often work at cross purposes – leaving youth and their families confused, distrustful and ultimately unsuccessful in controlling behavior, preventing delinquency, and averting expensive placements into psychiatric hospitals, treatment centers, and juvenile corrections facilities.

WRAPAROUND MILWAUKEE SYSTEMS REFORM IN A LARGE JURISDICTION

In the early 1990s, the leaders of Milwaukee County’s mental health division had a problem. The county was spending \$18 million each year to buy care for emotionally disturbed young people in group homes and residential treatment programs. And it wasn’t working.

These youth were clearly troubled and needing services. The majority had been arrested for delinquent crimes. Many were a danger to themselves and others – and the rest were at serious risk to become a danger. However, like many jurisdictions nationwide, Milwaukee County offered emotionally disturbed youth only an expensive, one-size-fits-all response: out-of-home placement. The county was largely ignoring the homes and families from which troubled children came – and to which they would return – and it was not working with families to overcome brewing problems before they reached crisis proportions. Moreover, even youth placed into \$135 per day treatment programs often failed to stabilize their behavior or avoid relapses when they returned home after completing the treatment.

Milwaukee County began experimenting with other treatment options in 1989, after receiving an initial foundation grant. In 1994 it secured a \$15 million, 5-year federal grant to build an entirely new adolescent mental treatment system, Wraparound Milwaukee. The county’s plan was predicated on three elements: 1) developing the capacity to offer intensive, comprehensive assistance to troubled youth and their families in their own homes; 2) pooling funds

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and coordinating efforts from the various agencies working with emotionally troubled youth; and 3) sharply reducing the reliance on out-of-home care by avoiding placements whenever possible and by limiting lengths of stay for youth who are placed in residential care.

Given the high costs of residential treatment and the limited evidence of its effectiveness, as well as the growing promise of wraparound and other home-based treatment strategies for troubled youth, these might seem like common sense solutions. In reality, however, they are anything but commonplace. By putting these reforms into practice – pooling \$28 million per year from county agencies and Medicaid reimbursements to fund the Wraparound program, dramatically reducing delinquency and emotional distress for 600-700 youth per year while keeping these youth at home with their families – Milwaukee County has made itself a model for the entire nation.

UNDERSTANDING THE “WRAPAROUND” APPROACH

The “Wraparound” philosophy was initially developed in Canada during the 1970s, and it was transported to the United States during the 1980s by innovators in Alaska, Chicago, and Vermont. The concept revolves around five fundamental principles:

- ◆ **Address problems in youths’ natural environment** – i.e., home – rather than an artificial environment, where lessons learned will be difficult to translate when youth return home.
- ◆ **Work with and listen to the whole family, especially parents.** Evidence increasingly finds that the family system is both the most important determinant of behavior problems and the most important ally for therapists in reversing negative behavior patterns. Unlike most mental health modalities, where the professional is the “expert” and the individual and/or family has the problems, wraparound is based on the belief that families know best what they need. Thus, the job of professionals is to help families achieve their own goals and build the skills to sustain success.

- ◆ **Individualize services based on the needs of each youth and family,** rather than employing the one-size-fits-all approach typical in residential treatment programs. This notion of “wrapping” needed services “around” each individual young person lies at core of the wraparound concept.
- ◆ **Focus on strengths.** Even the most troubled adolescents and families have hidden aptitudes, interests, and desires. Tapping these strengths and building families’ capacity to anticipate and solve problems can be critical to avoiding crises in the future.
- ◆ **Build a support system.** Most youth have relatives, family friends, or other interested adults who care about them and are willing to provide guidance and support. Recruiting support from these natural allies – to be mentors, or provide a respite for beleaguered parents – can be an invaluable step in creating a stable environment for young people.

WRAPAROUND – MILWAUKEE-STYLE

Milwaukee County has built a unique system for applying wraparound principles to local needs. Wraparound Milwaukee targets services only to emotionally disturbed youth who are either in residential treatment or face imminent risk of placement. Though youth can be referred to the program by local child welfare officials as well as the local probation agency, most (70 percent) have a history of delinquency and many are on probation at the time of their referral to the Wraparound Milwaukee program.

Wraparound Milwaukee’s program involves four key components:

- ◆ **Care Coordinators** – The county’s Wraparound office contracts with eight local nonprofit agencies to hire, train, and supervise care coordinators, who serve as the cornerstone of the wraparound process. Though they are not trained therapists or social workers, these coordinators are college graduates who receive extensive pre-service and in-service

training in the wraparound model. Working with a caseload of up to eight youth, the coordinators: a) conduct in-depth assessments of each youth and family to identify strengths and needs; b) assemble a “child and family team” (see below) including family members, counselors, and other adults committed to helping the young person succeed; c) facilitate development of a plan of care by the child and family team; d) identify providers to offer needed services; and e) monitor the delivery of services and the overall progress of the young person.

- ◆ **Child and Family Teams** – The actual plan for each young person’s wraparound care is developed by a “Child and Family Team” – a collection of all the adults involved in supporting the family to care for the young person. These include family members, natural supporters (i.e., relatives, church members, and friends), and professionals such as probation officers, child welfare workers, and mental health professionals. Convened by the care coordinator on at least a monthly basis, the teams are responsible to create and periodically revise the plan of care for each young person.
- ◆ **Service Provider Network** – To help care coordinators find qualified providers to meet the identified needs of troubled youth, Wraparound Milwaukee has enrolled more than 170 community agencies to provide any of 60 services – everything from tutoring and after school programming to substance abuse treatment to transportation. To hold down costs, Wraparound Milwaukee has set a standard rate for each service, using its bargaining power as a large consumer of services to press providers to accept below-market rates.
- ◆ **Mobile Crisis Team** – In addition to their care coordinator and child and family team, each youth and family enrolled in Wraparound Milwaukee also has access to a Mobile Urgent Treatment Team – a 24-hour-per-day service continuously on call to intervene in family crises that might otherwise result in rapid placement into out-of-home care. Through this mobile team, and

through the crisis safety plans created for every young person in the program, Wraparound Milwaukee brings urgent situations under control without removing participants from their homes and unraveling progress made to date.

BLENDING FUNDING AND “CAPITATED RATE” FINANCING

Before Milwaukee launched the wraparound program, the county paid for more than 360 young people per night to sleep in residential treatment facilities, and it maintained a waiting list of youth approved for residential treatment and awaiting placement. Placements into residential treatment were made by a variety of county agencies – child welfare, juvenile justice, and mental health – and each agency paid the bills for any young person it referred. The average length of stay in residential treatment was 14 months, at a daily cost of \$135 per day per youth. That resulted in an overall cost of \$18 million per year – or \$60,000 for each young person.

Wraparound Milwaukee replaced this funding hodge-podge with a unified system. It collected the funds previously spent for out-of-home care by the county’s child welfare (\$8 million/year), juvenile justice (\$8 million/year), and mental health (\$1.5 million/year) agencies, and used these funds to support a continuum of services including both wraparound and residential care. Wraparound Milwaukee also captures additional funds (\$10 million per year) in Medicaid reimbursements for eligible youth, creating a total budget of \$28 million in 1999.

To ensure that the project minimizes unnecessary out-of-home care, Wraparound Milwaukee is paid on a “capitated rate” basis similar to that used by health maintenance organizations. Wraparound Milwaukee receives \$3,300 per month per child for every juvenile justice and child welfare case referred to the program, plus \$1,542 per month for each young person on Medicaid. Wraparound Milwaukee pools all of these funds and pays for all services needed by each youth participant, regardless of cost. Nonetheless, the fixed-rate funding formula ensures that the program maintains its focus on cost-effectiveness and avoids unnecessary out-of-home placements.

MINIMIZING OUT-OF-HOME PLACEMENT

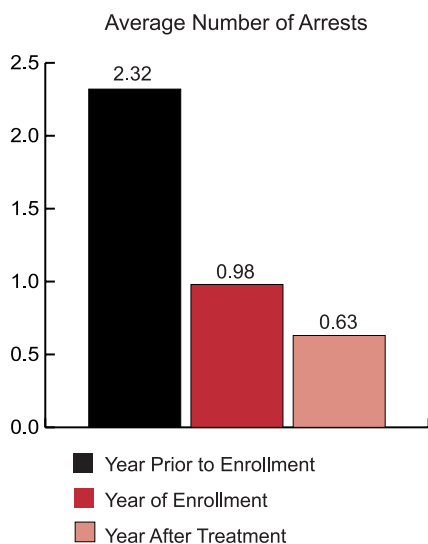
The use of wraparound services and the capitated rate financing system have both helped limit the number of young people placed into expensive residential treatment. In addition, the county also took two additional steps to limit the use of residential placements:

- ◆ **Limiting commitment periods.** Prior to wraparound, most youth placed into residential treatment (either by child welfare agencies or probation) were sent on court orders with a one-year duration. Only through a new court order could youth be released from the facility before the year was up. Today, most youth ordered into residential treatment are placed in the custody of Wraparound Milwaukee, and the initial term of treatment is usually just 90 days. The case are reviewed regularly and each young person is discharged (to begin home-based wraparound care) at the earliest possible date. *Through this system, Wraparound Milwaukee has reduced the*

average length of stay in residential treatment from 14 months to just 3.5 months.

- ◆ **County-wide crisis intervention.** Whereas most services provided by Wraparound Milwaukee are limited only to youth formally enrolled as wraparound participants, the project makes one service available to any young person in the county anytime: the Mobile Urgent Treatment Team. Historically, many young people have been placed into long-term residential treatment programs after a crisis erupts – a suicide attempt, perhaps, or an assault on a family member. The mobile team helps youth and families weather such crises without triggering a long-term residential placement. The mobile team reviews all requests for inpatient psychiatric admissions for adolescents countywide, and it offers services to help defuse crises: group homes providing short-term (up to 14 days) housing, plus treatment teams made up of psychologists and social workers who offer up to 30 days of emergency case management and family preservation assistance.

WRAPAROUND MILWAUKEE: IMPACT ON OFFENDING RATES OF DELINQUENT YOUTH PARTICIPANTS*



* Data through October 31, 2000

Source: Milwaukee County Mental Health Division

WRAPAROUND SUCCESS

When it was first establishing its wraparound program in the mid-90s, Milwaukee County conducted a pilot project targeting 25 young people who were then in residential treatment programs and had no date for release. Using Wraparound, the county enabled 17 of the 25 to return home within 90 days – thereby reducing the average three-month cost from over \$5,000 per young person to \$2,700. Eventually, 24 of the young people left residential treatment facilities and returned to the community: 17 were reunited with their families, and seven entered foster homes.

By 2000, Wraparound Milwaukee was proving that such success was possible on a broad scale. *Countywide, the program has reduced the daily population in residential treatment programs from 360 (plus wait list) down to 135 per day. In addition, psychiatric hospitalization of adolescents has declined by 80 percent since Wraparound Milwaukee went into effect.*

Even more impressive have been the substantial behavior improvements and reductions in delinquency displayed by Wraparound participants. Among 169 delinquent youth for whom one year follow-up data were available in October 2000, the average number of arrests per participant declined from 2.32 arrests during the year prior to enrollment in Wraparound Milwaukee, to .98 arrests per participant during the year of enrollment, to .63 arrests per participant in the year following treatment. (See Table #5.) Whereas 57 percent of participants committed two or more offenses during the year prior to enrollment, only 15 percent committed two or more offenses in the year following treatment – a reduction of 74 percent.

Likewise, Wraparound Milwaukee participants have also significantly improved their clinical outcomes: measures such as the Child Behavior Check List and the Child and Adolescent Functional Assessment Scale show significant improvement in emotional functioning and stability.

“The hospital and the residential treatment center have a place in the care of emotionally disturbed youth, but they should be a stabilizing place, not a place for change,” explains Dr. Chris Morano, who heads Wraparound Milwaukee’s Mobile Urgent Treatment Teams. “You can’t use the hospital to try and reform or restructure their personalities. That needs to happen in a more normalized environment that’s a true reflection of their day to day life.”

Operating Agency	Milwaukee County Mental Health Division, Child & Adolescent Services Branch
Program Type	County-run System of Care for Emotionally Disturbed Youth
Program Goals	Providing Effective Treatment and Reducing Out-of-Home Care for Emotionally Disturbed and Delinquent Youth
Target Group	Emotionally disturbed adolescents (including many delinquents) at risk for immediate placement into a residential treatment program
Key Strategies	Comprehensive home-based services; strength-based treatment; partnership with families and other caring adults; crisis intervention to prevent residential placements; capitated-rate funding to discourage unnecessary or lengthy out-of-home placements.
Primary Funding Source(s)	Pooled funding from child-serving agencies (probation, child welfare, mental health), Medicaid, as well as federal grant funding (expired in 1999).
Evidence of Effectiveness	Dramatic reductions in out-of-home placements for youth county-wide; sharp reductions in offending by delinquent participants; substantial gains in behavioral functioning
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