

# Children and young people with high and complex needs

CAHMS quarterly meeting  
4 December 2009

# Presentation covering

Interagency Strategy

Client information

Composite case examples

Discussion



*A service of the Ministry of Social Development*



MINISTRY OF EDUCATION

*Te Tāhuhu o te Mātauranga*



MANATŪ HAUORA

# Interagency Strategy

Agencies need to work together to improve outcomes for children and young people with high and complex needs, to:

- foster collaboration to improve outcomes
- improve the effectiveness of interventions
- build sector capability

principle - keeping children in their own community

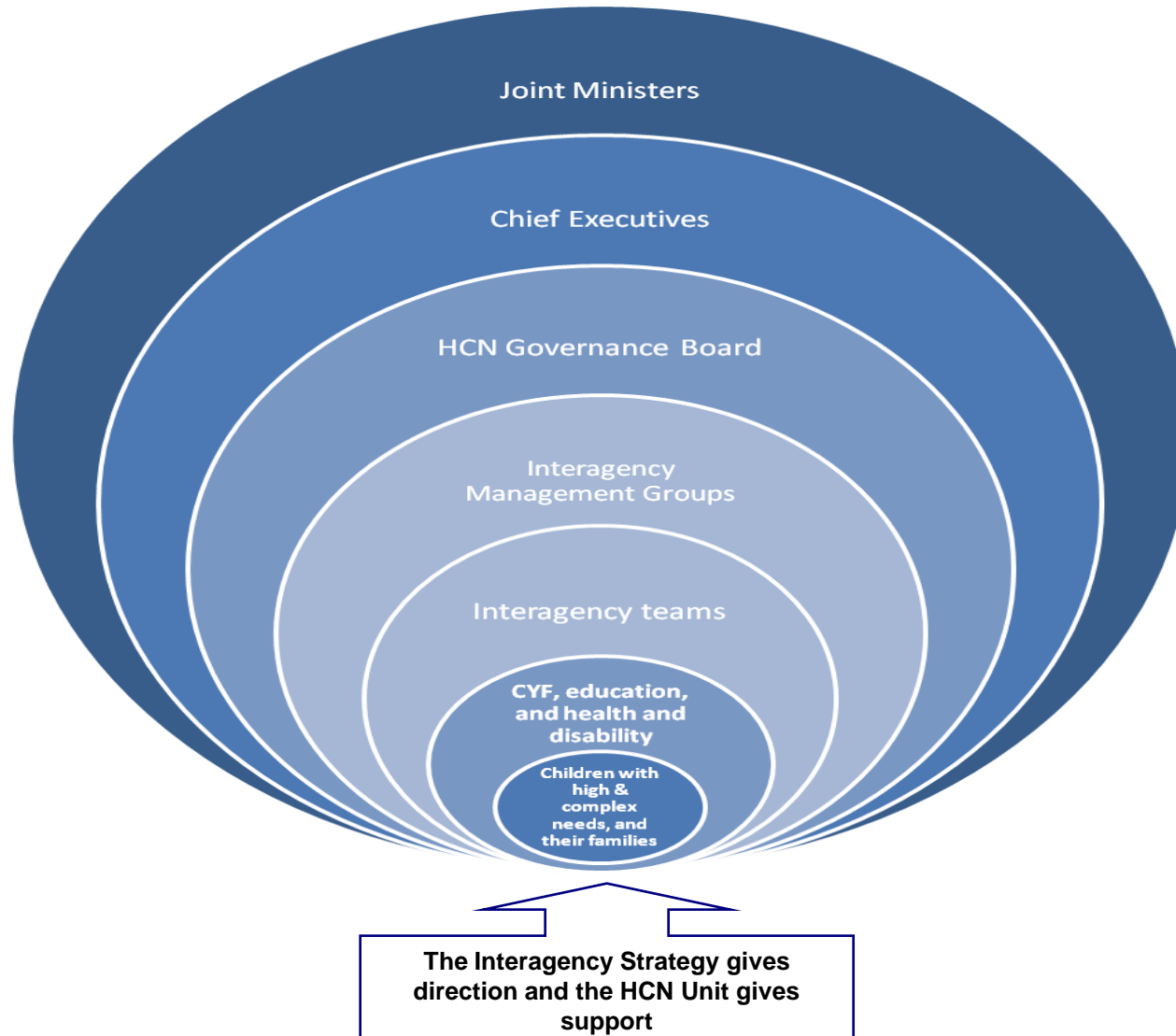
priority populations –mental health and behavioural problems



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# Interagency Strategy relationships



# HCN Unit functions to

- support collaborative working
- collect and manage information
- allocate individualised funding packages
- communicating with stakeholders

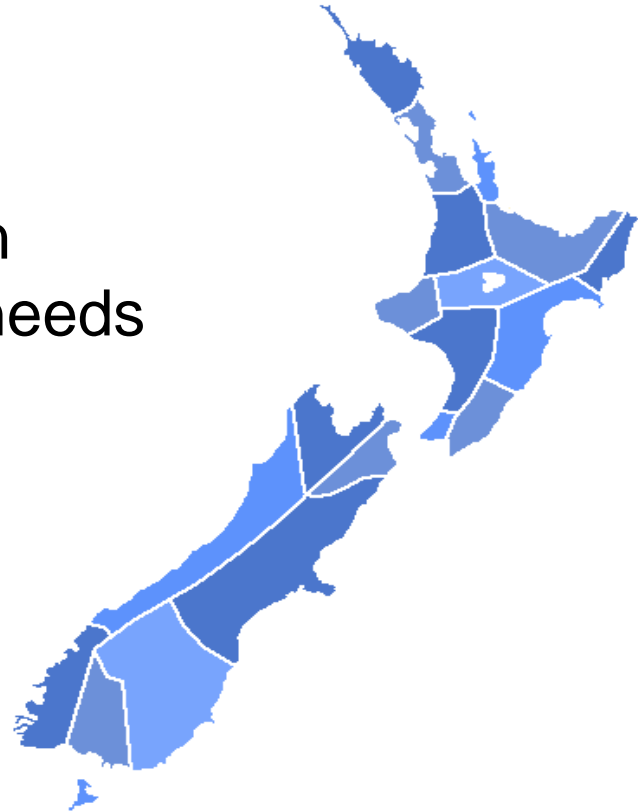
Funding is short term (1-2 years) for intensive intervention plans

# Allocating funding

HCN funding helps agencies address the high and complex needs of the children and young people in their community

In 2009, 92 children and young people received \$3million in funding to address their complex needs

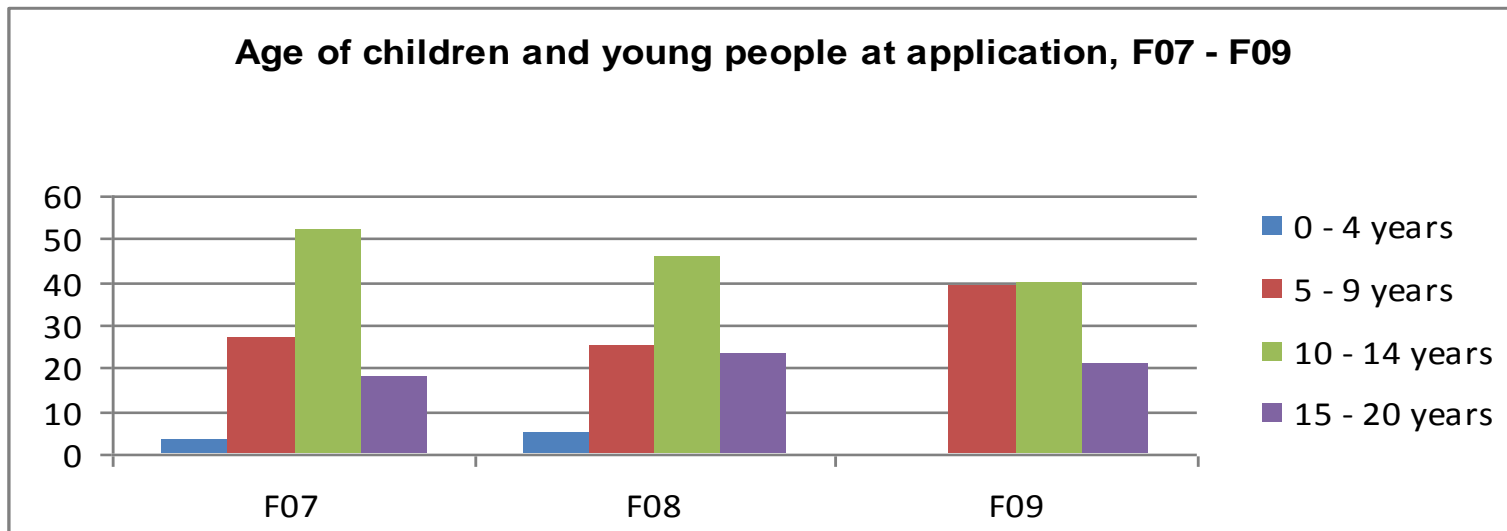
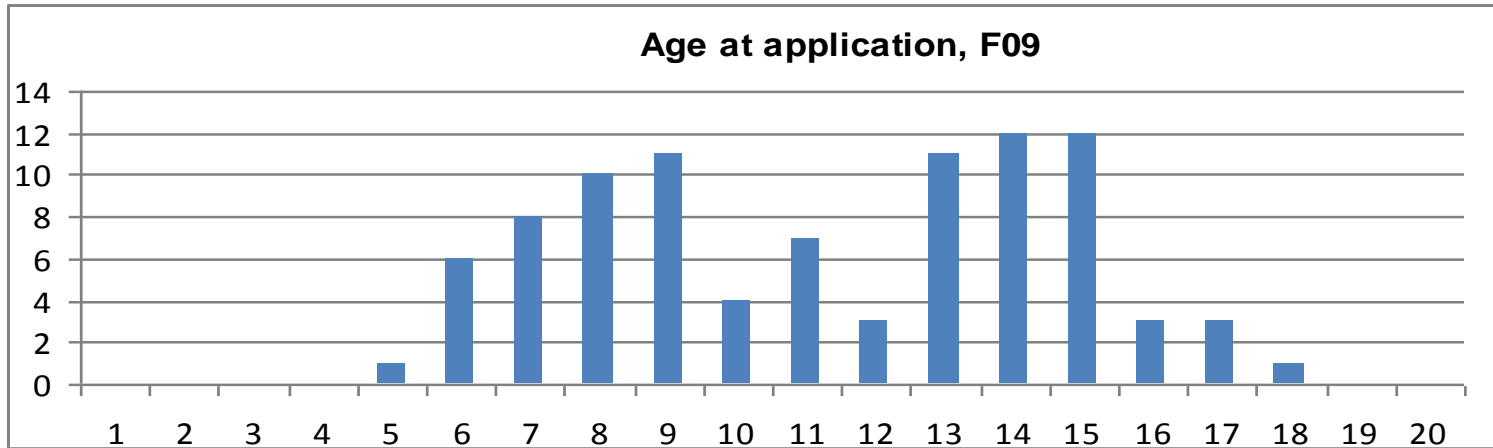
They came from all across New Zealand



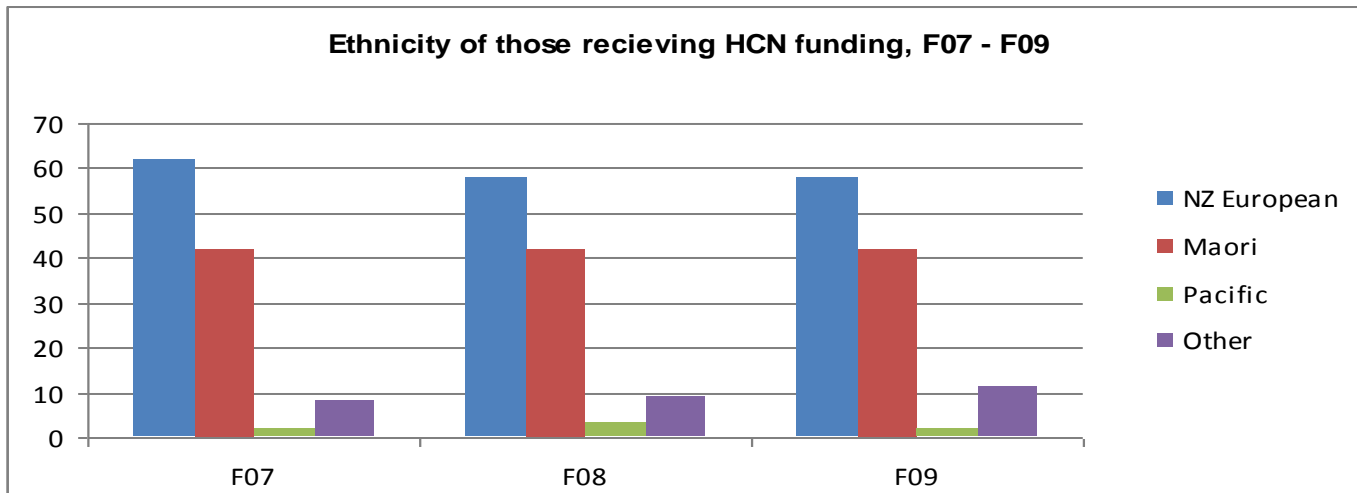
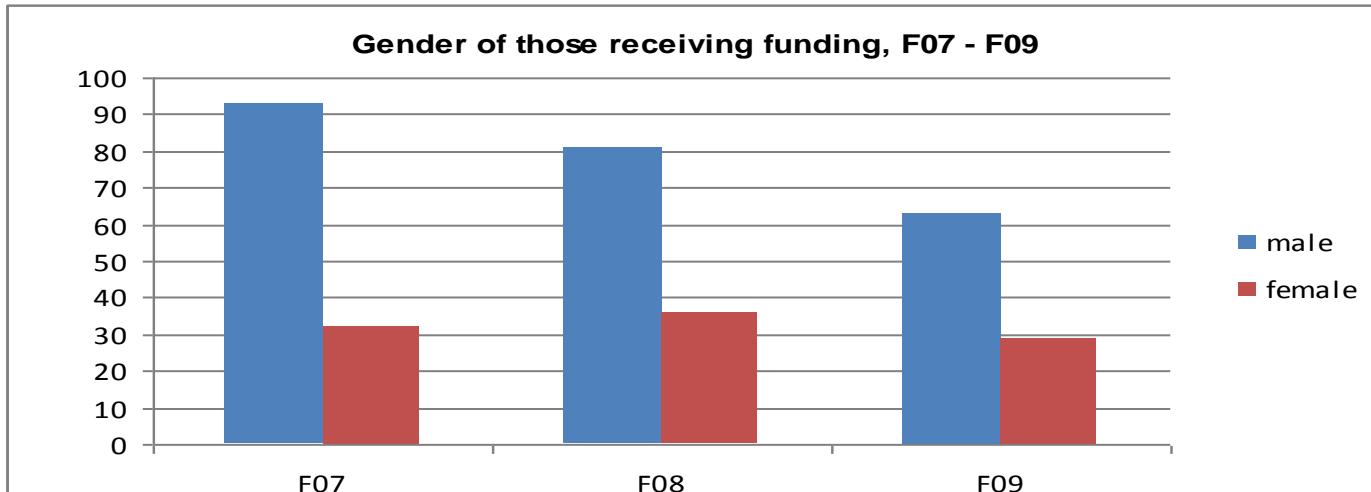
# Where do they come from

Lead Agency Region	Clients in F09	% of HCN clients	% of NZ Population
Northland	3	3%	4%
Auckland	18	20%	34%
Waikato	3	3%	10%
Bay of Plenty	5	5%	7%
Gisborne	5	5%	1%
Hawke's Bay	8	9%	4%
Taranaki	2	2%	3%
Manawatu-Wanganui	5	5%	6%
Wellington	16	17%	11%
Nelson / Tasman / Marlborough	8	9%	3%
West Coast	2	2%	1%
Canterbury	7	8%	12%
Otago	5	5%	4%
Southland	5	5%	2%
<b>Total</b>	<b>92</b>	<b>100%</b>	<b>100%</b>

# Age at application

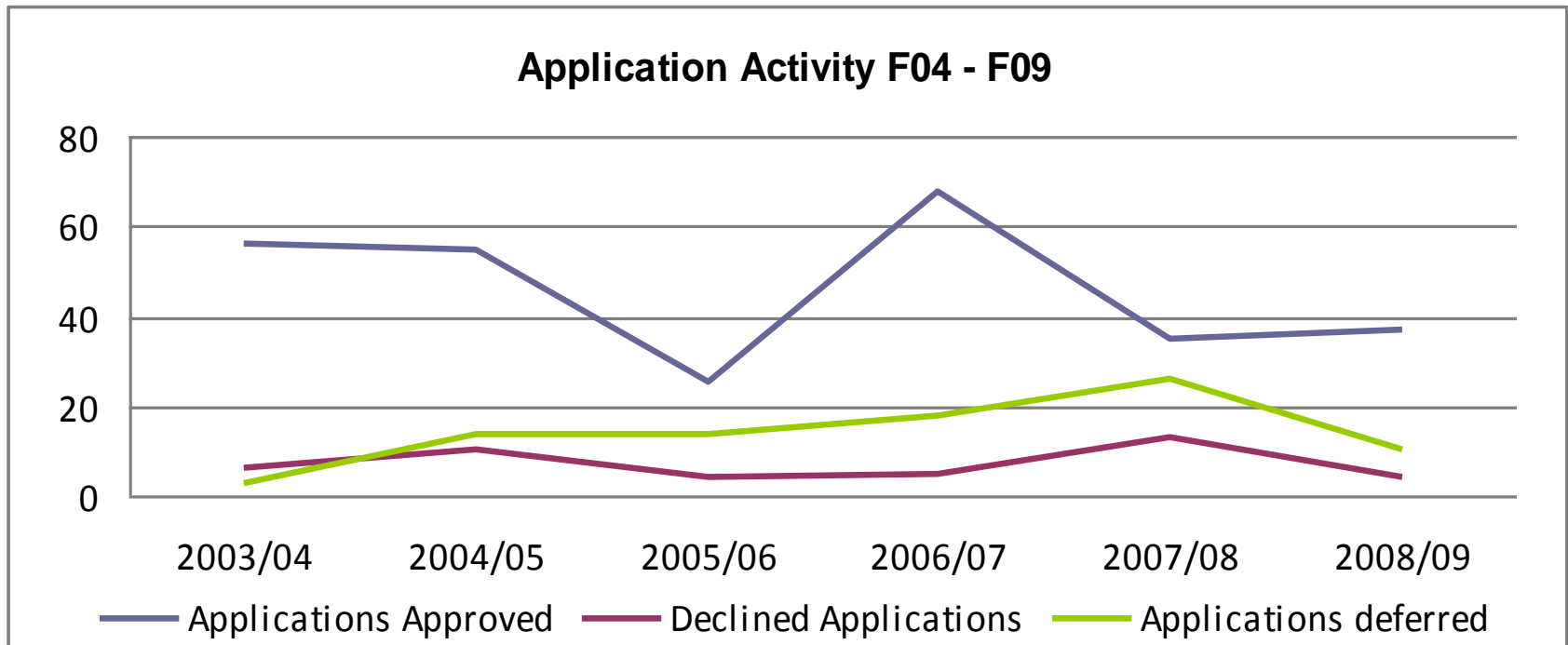


# Gender and ethnicity

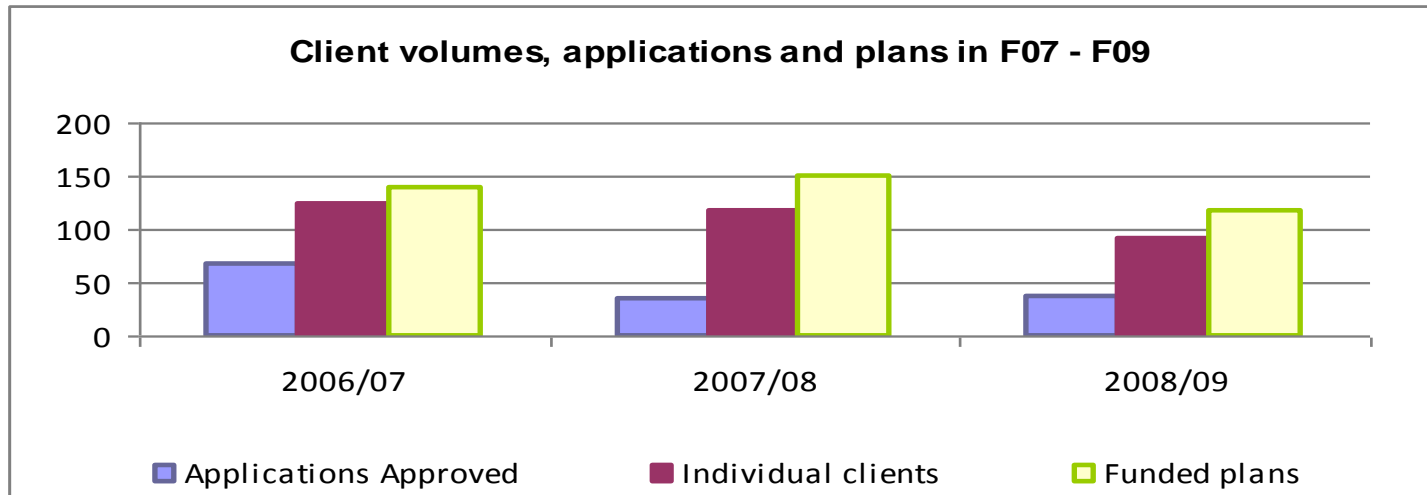


# Volumes and flows

- 92 children were funded
- 37 new applications were approved
- 117 plans were funded
- on average of two years funding



# Client volumes



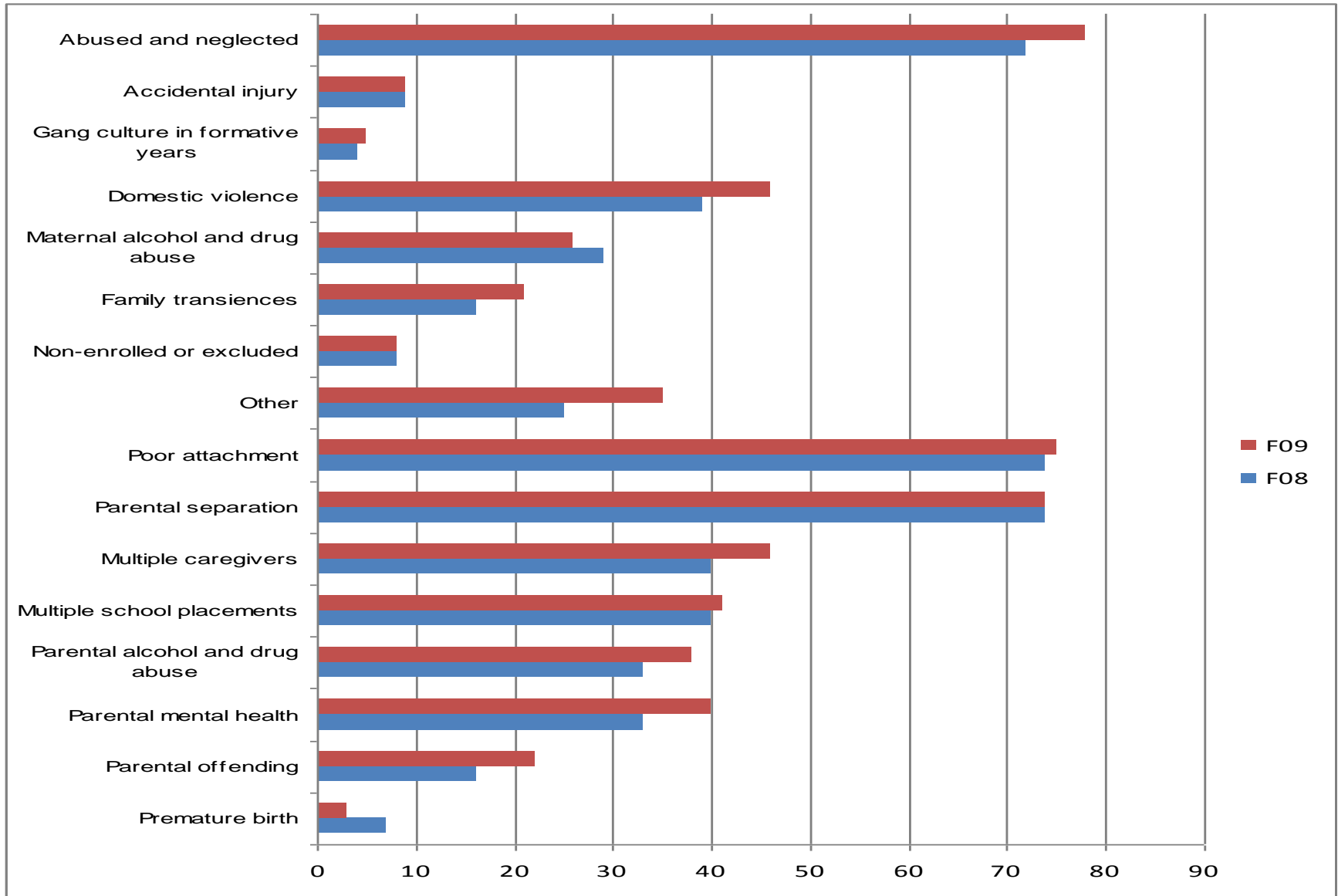
- F09 - 37 new applications approved, 117 plans funded for 92 individuals
- In F08 - 35 new applications approved, 149 plans funded for 117 individuals
- In F07 - 68 new applications approved, 140 plans funded for 125 individuals

# Application information

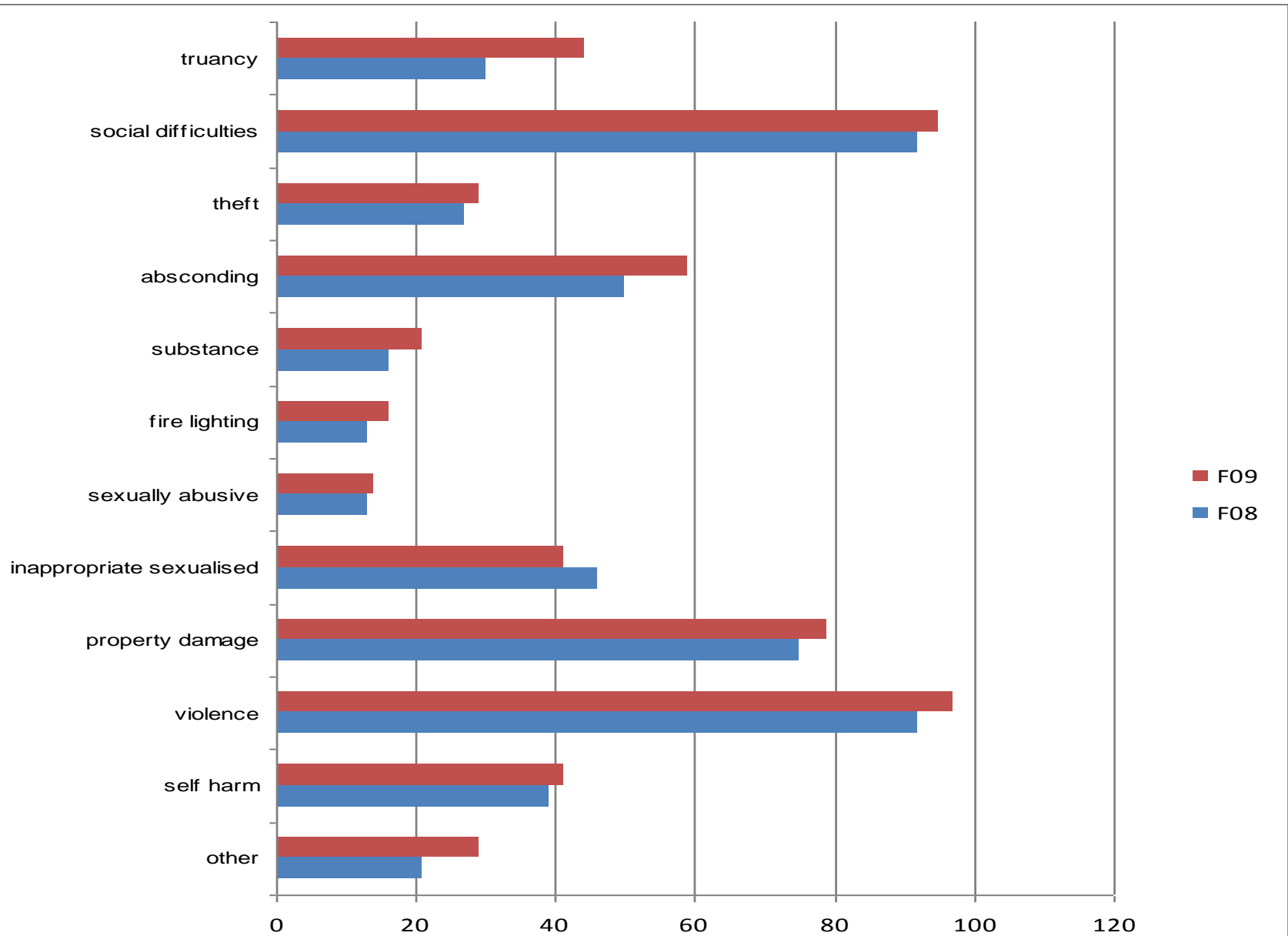
In F09 those who received HCN funding had on average:

- 6 adverse life experiences each
- 6 problem behaviours each
- 4 clinical diagnoses each
- 3 service shortfalls each

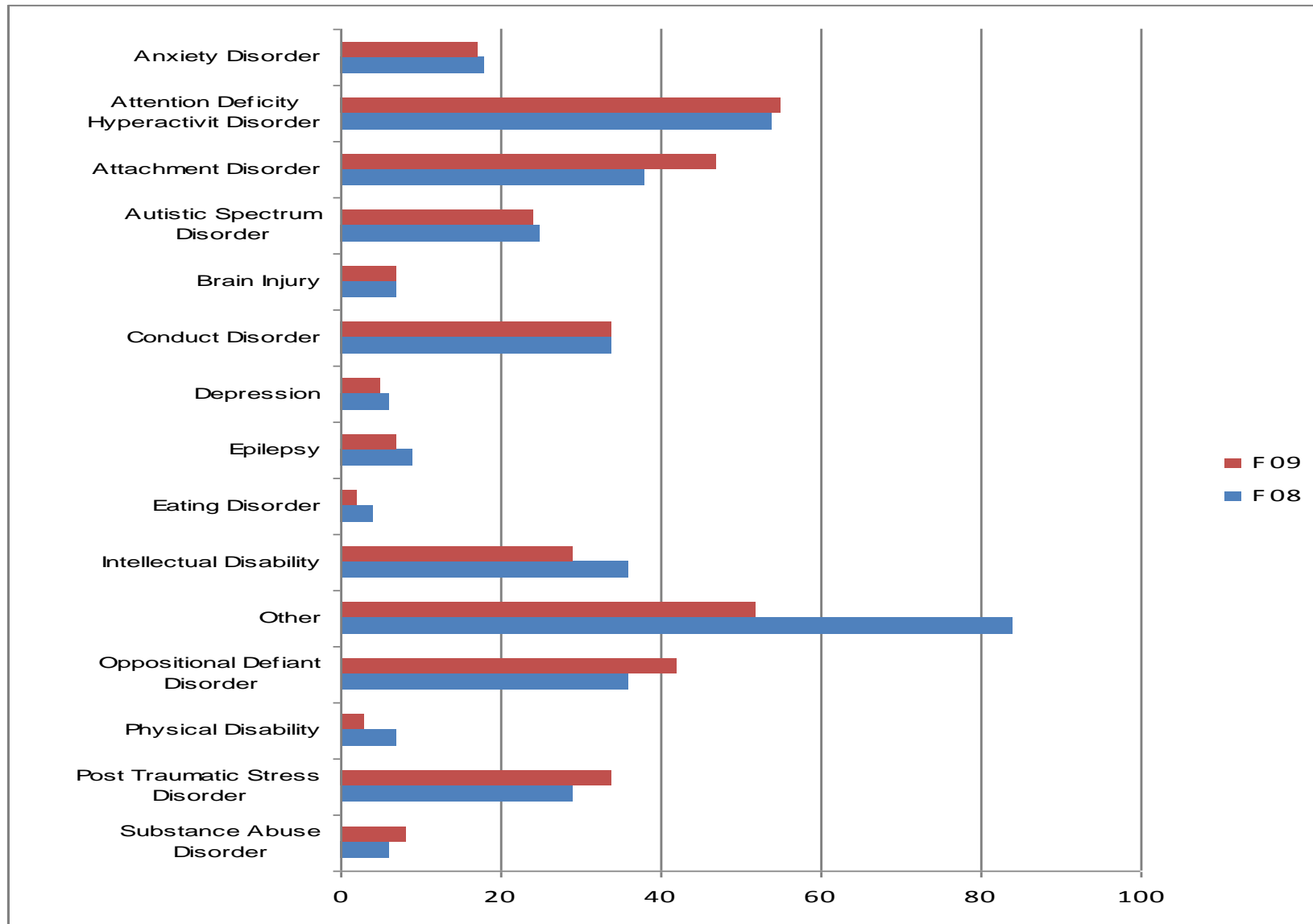
# Adverse life experience in F08 and F09



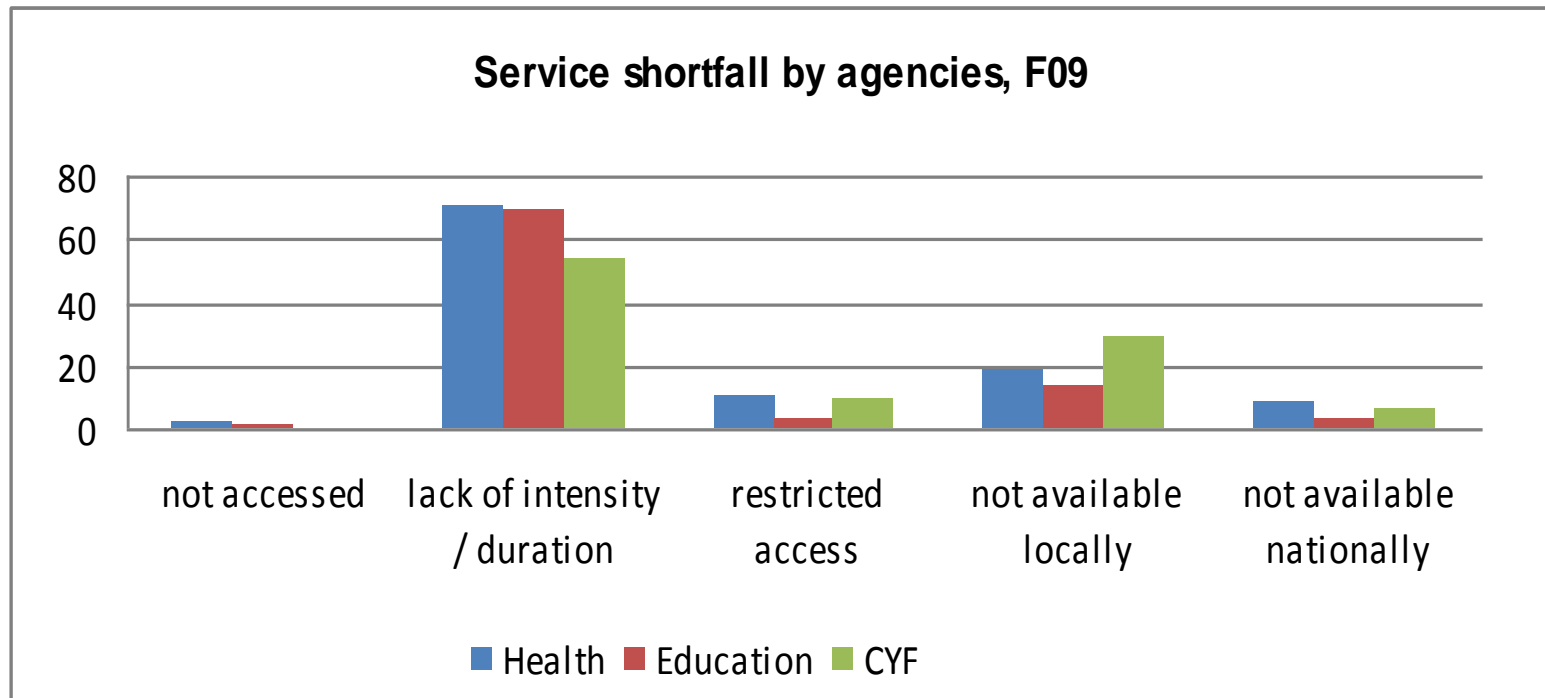
# Problem behaviours in F08 and F09



# Clinical diagnoses in F08 and F09



# Service shortfalls



- average - 3 service-type shortfalls for each child
- 88% the service is available but not at the right intensity or duration

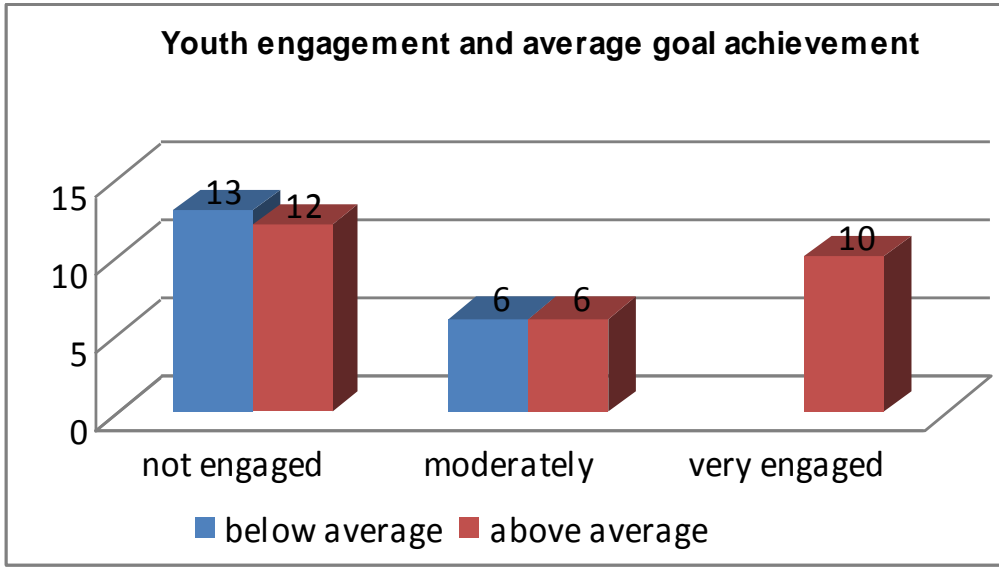
# Measuring progress

Each year all closed cases are reviewed.

In 2008, 47 children's plans were closed and reviewed

- 60% had 'very clear' or 'some evidence' of more than 50% of their goals being achieved
- 36% had 'very clear' or 'some evidence' of more than 70% of their goals being achieved.

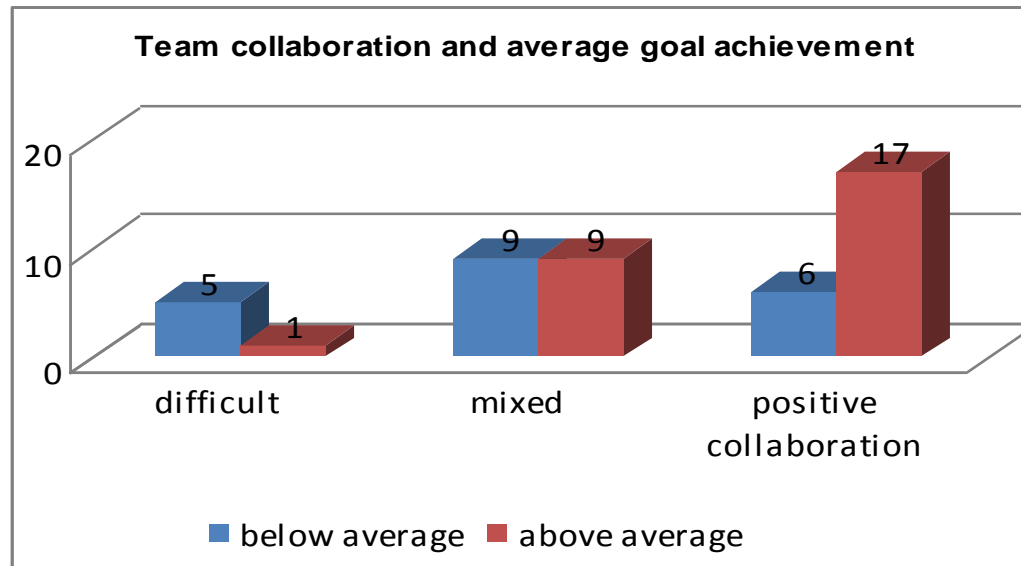
# Young person's engagement



Does the level of youth engagement increase the level of goal achievement?

Yes: when a child is very engaged with his or her plan we saw more than the average goals achieved. Partial or non-engagement by the young person appears to have little impact.

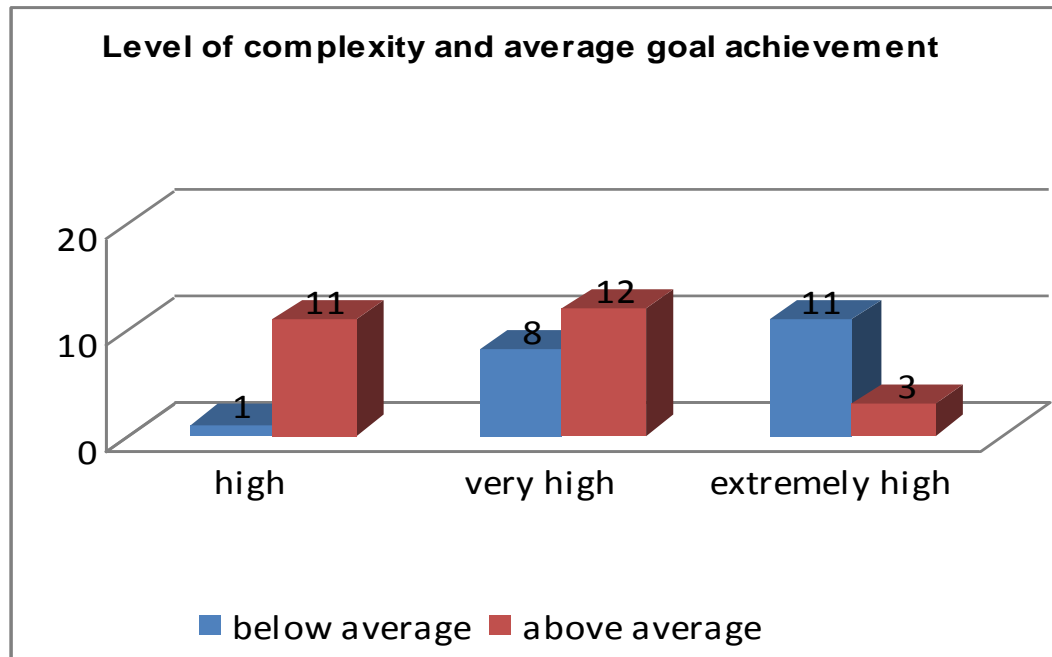
# Interagency collaboration



Does positive interagency team collaboration increase the level of goal achievement?

Yes: when team members work well together there is evidence of a higher level of goals achieved. Often different teams experience the same challenges to collaboration but view them differently. Those that viewed them positively were more likely to support a higher level of goals achieved.

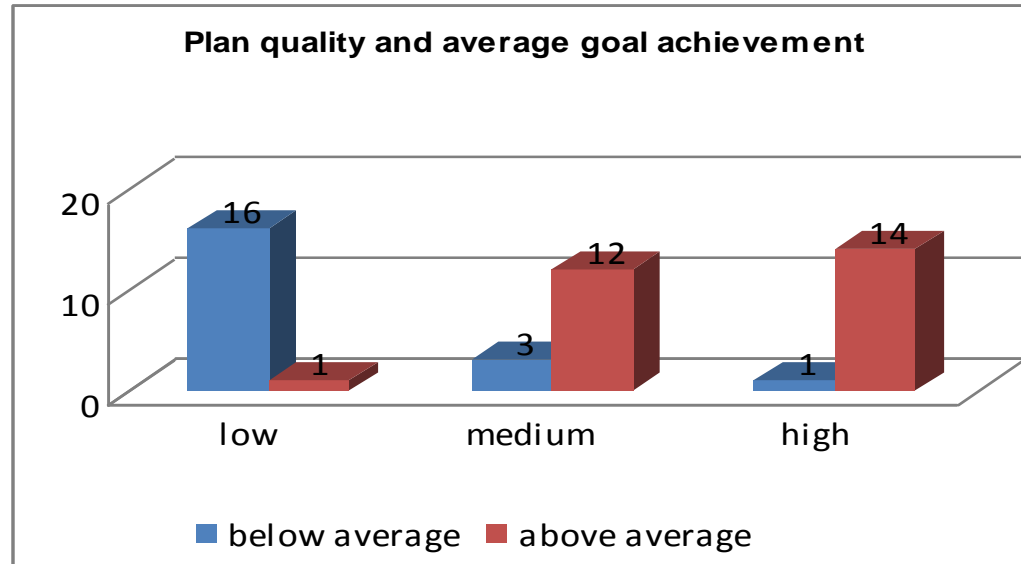
# Case complexity



Does the level of complexity affect the level of goal achievement?

Yes: interventions are more likely to be effective when the young person is identified earlier and when their needs have not become so entrenched.

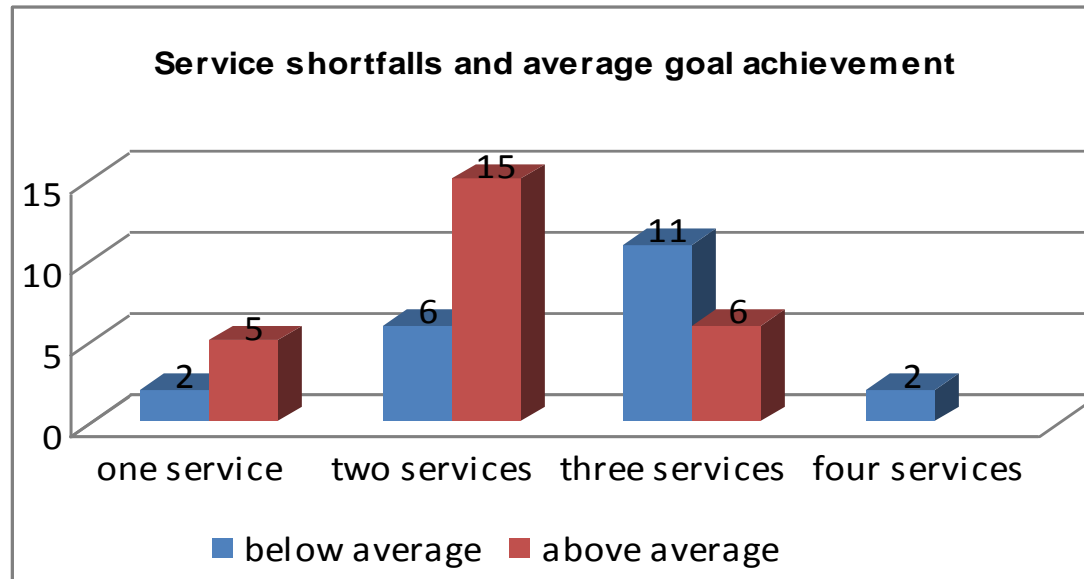
# Plan quality



Does the overall quality of the plan make a difference to the level of goal achievement?

Yes: the overall quality was assessed on the basis of five attributes: shared team understanding; specific, measurable, and achievable goals; goals achieved; robust interventions; and that the plan was easy to implement - all components of a quality plan.

# Service shortfalls



Do service shortfalls make a difference to the level of goal achievement?

Yes it can do: individualised plans can help overcome local service shortfall but there still seems to be an impact on goals achieved.

# Goal attainment scaling

Scale	Goal
+ 2	Much better than expected
+ 1	Somewhat better than expected
0	Expected outcome
-1	Somewhat less than expected
-2	Much less than expected

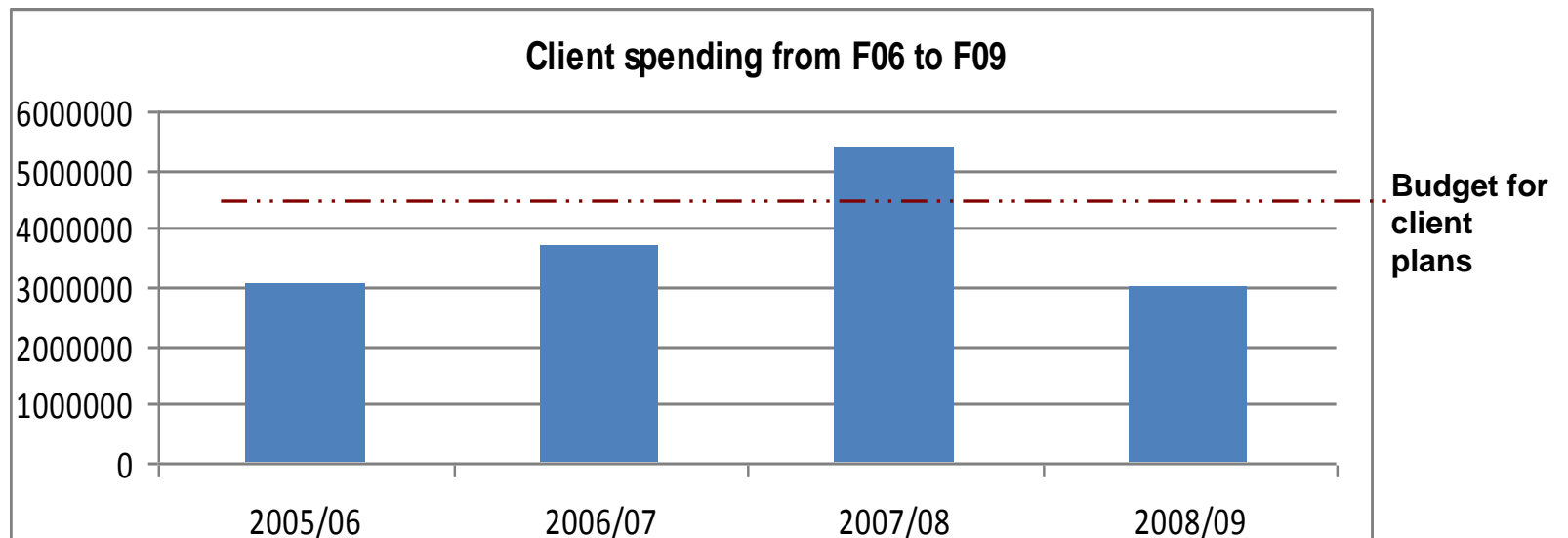
# Children's views

- where they were living and who they were living with is very important
- to be normal or regarded as normal
- any programme or service should not intrude on their time at school or with their peers
- to be active and do “fun stuff”
- wanted to be part of planning and having a hope for the future

# Services purchased

Services purchased in F09		
Service Type	Spent amount F09	Payment % F09
Care	953,056	32%
Services Coordinator	780,000	26%
Respite and other living costs	169,292	6%
Counselling or individual therapy	36,820	1%
Occupational Therapy / Physiotherapy	27,370	1%
Other therapists or specialists	198,708	7%
Behaviour Support Worker, mentor and / or personal coach	264,510	9%
Assessment and specialised programmes	35,490	1%
After school programmes	4,590	0.2%
Teacher aide, teacher costs and other education costs	399,275	13%
General health costs	12,330	0.4%
General cultural costs	960	0.03%
Recreation	31,400	1%
Family therapy, training, support and visits	29,800	1%
Clinical and Cultural Advisors	28,360	1%
Miscellaneous – including other general interventions	23,947	1%
<b>Total</b>	<b>2,995,908</b>	<b>100%</b>

# Client spending

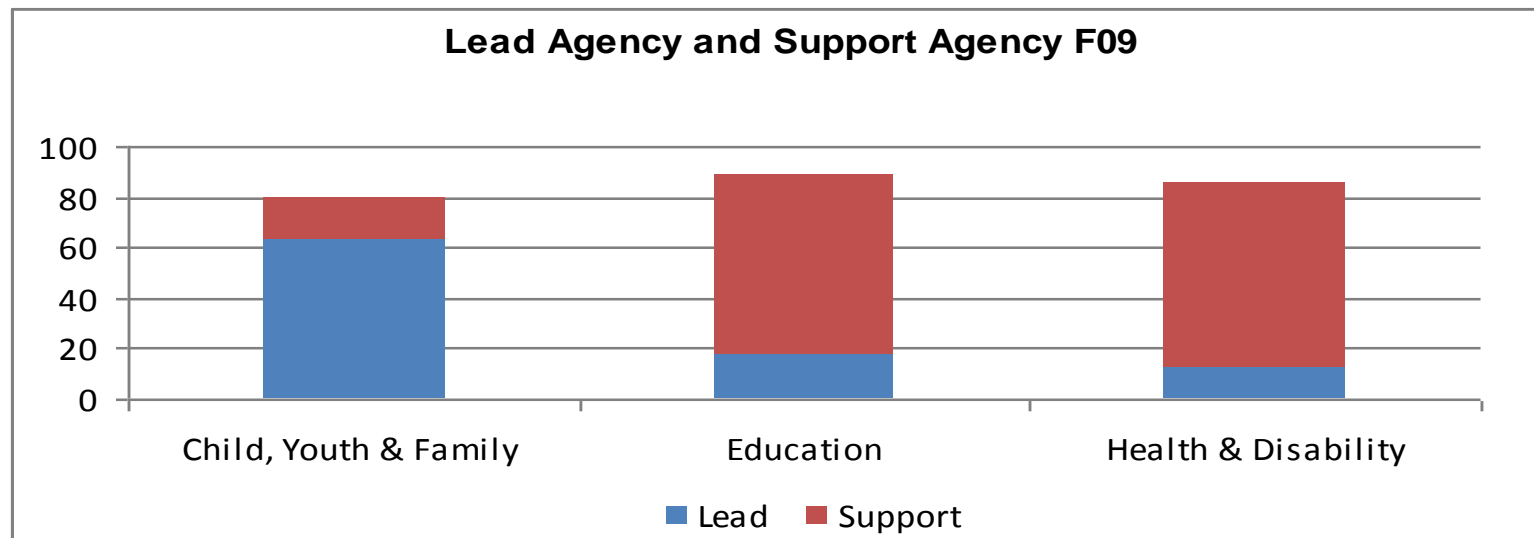


# Approved amounts

Approved amounts for individual plans in F09		
Cost Bracket	Approved F09	Approved %
0 – \$40K	38	33%
\$40 – \$80K	56	48%
\$80 – \$120K	10	9%
\$120 – \$160K	3	3%
\$160 – \$200K	4	3%
\$200K+	6	5%
<b>Total</b>	<b>117</b>	<b>100%</b>

In F09 the average approved for the 117 plans was \$66,262 and the most common amounts were in the \$40,000 to \$80,000 cost bracket.

# Lead and support agency



In each of the 92 cases not all of the three agencies were involved: Child, Youth and Family were involved with 80; education with 89; and, health and / or disability with 86.

# Practitioners' views

Practitioners feed back on the 47 cases in the closed case review reported that collaboration was:

- positive (49%) – strong and effective working together
- functional (38%) – there were challenges but generally the team was functioning
- difficult (13%) – the team struggled to work well together

The following comments were from a plan of a sixteen year-old –

- *...there's a plan, everyone knows it, and everyone works with it. They don't shy off from hard issues. The team has specialist knowledge and interdependence, each has a role to play (Ministry of Education worker)*
- *... working really well, clear lines of communication between group members. Members know the appropriate person to ring when there's a problem (Child, Youth and Family worker)*
- *... communication is great, awesome to be able to contact who I need to, very open, easy to make contact with each other, same shared vision (Care Provider)*
- *...the most collaborative team I've worked with, in terms of communication, if there are no calls I know things are going well (CAMHS worker)*

# Case study – David 14 years

The second of four children, lived with his parents near a provincial town. Family very involved in the church and family mobile during childhood - moving for father's work.

David's diagnoses: ODD, ASD (aspergers), OCD (anxiety), depression, ? CD

David's behaviours: self harm, violence aggression, inappropriate sexual behaviours, absconding, social difficulties with peers, not attending school

Other key life experiences: no early childhood education, parental mental illness, exposure to explicit sexual material in early adolescence, older sibling suicidal

# David continued

Agencies involved: GSE – 18 months, CYF 12 months

CAMHS – 18 months providing:

- family therapy and individual therapy for David
- medication

CYF tried to find out of home placements - unsuccessful due to escalating behaviours

CYF funded Triple P parenting programme

GSE willing to help but couldn't provide intensity of support

Small community – workers “stuck” with “bridges burnt”

David's behaviours increasingly dangerous and violent

# David's plan

Moved out of town to a larger center with provider skilled in dealing with challenging behaviours

- Behaviours stabilised within 3 months
- Attending school and learning
- Returned to home town 6-9 months

Return – one placement breakdown, before return to family

Private – CBT

Larger center - psychiatrist quarterly reviews

Mentor – implementing behaviour management plan and social skills programme developed by GSE

Attending school – achieving academically, has a girlfriend

# David's plan

## Success factors

- David felt safe with known consequences for behaviours
- Very skilled support workers and the right mentor
- Behaviour and social skills programme
- Medication change and monitoring
- Family and interagency team commitment
- Workers from larger center indicated a different future
- David wants NCEA level 2 – end of 2010

Home town CAMHS withdrew when moved to larger town and didn't re-open upon return

# Case study Kayla 8 years

Kayla is of Maori and Pakeha descent. Both her father and mother have mental illness and her mother used alcohol and other drugs during pregnancy. There has been family violence, parental offending and AOD use, abuse and neglect

Application information indicates Kayla's behaviour was very challenging, constantly seeking attention, damages property, assaults people, is inappropriate sexually around men and she runs away, steals and has no friends.

Kayla's diagnoses: ADHD, ODD, Attachment disorder, PTSD

# Kayla continued

Agencies involved: CYF – 24 months, GSE 36 months, CAMHS 12 months provided:

- referral to NGO for parenting support
- medication for ADHD

After an FGC Kayla moved to extended whanau in a small rural town

CAMHS in receiving area saw Kayla's caregivers. The case was closed after the caregiver family stopped medication and a private therapist engaged. CAMHS noted behaviours not resolved.

# Kayla continued

Plan is ongoing

- behaviour better - very challenging when change occurs
- beginning to learn at school –catching up academically
- private therapist –seeing Kayla, advising the caregiver
- private practitioner developed behaviour management plan – not consistent with good practice, not aligned with other therapist’s approach

*How does the team resolve the conflict of approach? Who would be best to help with this?*

# For discussion

If challenging behaviour is a symptom of distress  
– is it appropriate to close cases before the underlying drivers for the behaviour are understood, resolved, and/or managed?

Are there options for maintaining the overview of the clinical direction for these cases without doing the therapeutic work?

Apart from CAMHS, who can help the team assess whether what is recommended by private practitioners and therapists is good practice?