Keeping Families Together

A Community Initiative

The Children's Mental Health Planning Committee convened in 2008 to build a plan to transform the Children's Mental Health System in Utah. The goal of the Committee is to create a comprehensive service delivery system to enable children and youth to stay in their homes and communities and to keep families together.

Committee Members:

Committee members met as a committee and subcommittees to formulate this plan. National experts were a part of this planning process and committee members came from: the Division of Substance Abuse and Mental Health, Division of Child and Family Services, Juvenile Justice Services, Juvenile Courts, community mental health centers statewide, family groups (NAMI, Allies With Families, New Frontiers for Families, the Parent Center), the University of Utah Department of Psychiatry, Intermountain Healthcare, Salt Lake County Substance Abuse Services, Governor's Office of Budget and Planning, Utah Association of Counties, Utah Department of Health, the Children's Center, the Utah State Hospital, and Utah State Office of Education.

Vision:

Utah's children and youth should be safe, healthy, in their homes, in school and out of trouble. Research shows that children and youth should be with their families whenever possible rather than in restrictive, expensive settings that yield poor outcomes and limit family involvement. In the current economic environment, there is a great need to build a more cost-effective system of care that coordinates services, eliminates duplicative efforts and inefficiencies, and offers a full continuum of services.

Specific Components of this Vision:

1. Keep families together
2. Increase prevention and early intervention services
3. Provide statewide, cross-systems education for families regarding the signs and symptoms of mental illness as expressed in children and youth
4. Save State and Federal dollars by developing a process to formally access and utilize natural and informal supports (extended family, friends, church, scouting troops, Boys and Girls Clubs, NAMI, etc.) both as prevention strategy for unnecessary use of mental health care, and as an exit strategy from professional care;
5. Reduce costs by utilizing appropriate levels of care in the least restrictive environment for the shortest, appropriate duration; and
6. Redirect funds from less effective treatments and/or high cost placements to appropriate levels of community-based care and to children with inadequate funding.
7. Support families in culturally appropriate ways.

Target Populations:

1. Children/youth and families in need of brief mental health interventions.
2. Children/youth and families with serious mental health treatment needs, including those youth who are at-risk for, or are having symptoms of major mental illness.
3. Children and youth who receive services from multiple child-serving agencies and/or are at risk for out-of-home placement or who are frequent users of costly, hospital services.
4. Children and youth who are no longer in parental custody or who are at risk for entering the custody of Juvenile Justice/Child and Family Services.

Objectives:

While remaining cost effective and efficient, reengineer current expenditures to create family-driven/youth guided, community-based care that keeps children with their families, in their communities and with increased opportunities for permanency. Implementation of this plan will also result in: increased educational and employment attainment; reduced emergency room costs; reduced inpatient costs; reduced involvement in juvenile justice systems; coordinated mental health promotion, early intervention and treatment services; shortened lengths of stay in State's custody; and reduced recidivism to high cost services.

Key Features:

1. Implement an innovative model (with rural adaptations when needed) where ***outcome and/or evidence-based practices are utilized***.
2. Model components ***maintain defined fidelity while remaining flexible*** to the individual needs of the child/youth and family.
3. There ***is high service coordination*** between child serving agencies (including but not limited to substance abuse/mental health, child and family services, DSPD, Dept. of Workforce Services, juvenile justice, education, juvenile court, public and private health care) and ***strong utilization of natural and informal supports***
4. Use of ***family-driven and youth-guided practices*** (families and youth guide and direct their own care)
5. Intensive services are provided by teams ***within homes and communities*** as an alternative to institutional levels of care.
6. Targeted children and youth will be served in a comprehensive wrap-around process facilitated by a certified ***Family Resource Facilitator*** who has life experience with a child with mental illness and who advocates for the family.

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