Creating Change and Providing Hope for Nebraska's Children, Adolescents and Their Families

Pursuant to LB 542 (2007)

January 4, 2008

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I. **Executive Summary**

LB 542 created the Children's Behavioral Health Task Force. This legislatively created body was charged with creating a plan for the behavioral health needs of children, adolescents and their families in Nebraska. The Department of Health and Human Services (DHHS) has developed the following plan in order to improve Nebraska's Children's Behavioral Health system.

There are many challenges facing the behavioral health system. There can be long waiting lists for services, and when children and their families do receive help, several different providers, with different treatment plans, may be involved. As a result, children and adolescents with mental health and substance abuse issues may become involved with the juvenile justice system. In a few instances, parents must give up custody of their children in order to obtain services. Systems of care promote more effective ways to organize, coordinate, and deliver mental health and substance abuse services and supports.

Today, Nebraska has both the opportunity and the challenge of developing a system of care for our children and their families. Nebraska's State Infrastructure Grant (SIG) has researched and begun to develop the infrastructure pieces necessary to begin building our system of care. LB 542 has created public awareness by outlining a variety of recommendations intended to improve the way Nebraska delivers services to children, adolescents and their families. In February of 2008, DHHS will submit an application to the Substance Abuse and Mental Health Service Administration (SAMHSA) for a five-year Systems of Care (SOC) grant, which if awarded, will provide resources to develop further the current service array. The challenges will include the diverse geographic nature of Nebraska with unique issues that are distinct across the metropolitan, rural and frontier areas of the state.

In Nebraska and across the nation, community-based, family-centered practice that is culturally and linguistically competent is embedded within children's behavioral health. This plan and its values and strategies are designed to improve the outcomes for children, adolescents and their families affected by mental illness and substance abuse disorders. As we move forward, community-based, family-centered practice that is culturally competent are core values for building effective, ethical and consistent practices for children's behavioral health. Without our workforce making a conscious effort to embrace these values, our work may be for naught.

Among the key elements of this plan are:

1. Balanced array of services
2. Accessible services
3. Strategic use of evidence-based approaches
4. Improved service quality with existing financial resources
5. Developing facilities and services to address some of the state's most challenging children and adolescents
6. Strengthened behavioral health workforce
7. Definition of the state's role, which includes:
    a) Facilitating private treatment where possible
    b) Coordinating different systems to work together for a common vision

c) Facilitating increased interaction through common language
d) Supporting evidence-based practices
e) Securing high-risk juvenile offenders

In addition to the strategies for reform, the state's role will also include organizing our partners for coordinating the education, juvenile justice and private sector elements, and establishing the on-going organizational structure for collaborative planning. The state will provide leadership to child-serving systems to assure effective integration of policy, procedures and resources, including funding, to support an organized system of care for children, adolescents and their families.

Despite the opportunities and challenges in the near term, we move forward with confidence that by partnering with communities and other stakeholders and involving children, adolescents and their families in our planning; we will be able to provide the right service, in the right amount, in the right location. for the right length of time, at an affordable, sustainable cost. We all share the belief that safety, permanency and well-being are what we desire for our children and adolescents as we create Nebraska's Children's Behavioral Health-System of Care.

II. Foreword

We share a common vision: To provide children, adolescents and their families with the right service, in the right amount, at the right location, for the right length of time, at an affordable, sustainable cost. This plan is a step forward to ensure that Nebraska's children, adolescents and their families receive the mental health and substance abuse services they need through a comprehensive system of care. This plan is not intended to be static, but rather a living document, that will change and grow as lessons are learned and as collaborative ideas emerge.

The values and principles defined in this plan will guide our reform and will move us forward. Our reform efforts must be progressive, but true system change takes time and will require a significant commitment to collaborate broadly. Our thinking must change and our language must be common among all. Developing an array of services that focuses on assessment and identification of potential problems must also be a system that provides services that are accessible, culturally and linguistically competent, utilizing treatment that is focused and based in evidence to improve symptoms, effectively managed and coordinated, and fiscally responsible. These guiding principles must be more than written words and will be the roadmap to provide clarity for change. This change will seem slow for some and hurried for others, but we will move forward with developing a system of care that meets the needs unique to Nebraska families.

The Department would like to thank the members of the Children's Behavioral Health Task Force for their commitment of time, sharing of expertise, and challenging ideas. These were valuable and served as the basis for this plan. The Department looks forward to working with the Children's Behavioral Health Task Force regularly and over time to refine, update, and further develop this plan and its implementation.

The Department would also like to acknowledge the University of Nebraska-Public Policy Center for its collaborative spirit and assistance with the preparation of this plan as well as the members of the SIG Steering Committee who have demonstrated strong commitment and a desire for change.

III. Background

LB 1083 (2004) was enacted to reform Nebraska's behavioral health system. This legislation focused on developing community-based services and reducing the use of the three regional centers (state operated psychiatric facilities). LB 1083 also promoted increased access to services, improved outcomes for consumers, integration of services, improved quality of care, development of research based practices, and a focus on cost effective approaches including early intervention. While the language of LB 1083 included both children and adults, the focus of implementation under this legislation has been primarily on the adult behavioral health system.

The intent of LB 542 (2007) was to create a parallel level of emphasis on children and adolescents that LB 1083 (2004) provided for adults and to oversee implementation of the children's behavioral health plan until June 30, 2010. LB 542 (2007) created the Children's Behavioral Health Task Force, which was charged with preparing a children's behavioral health plan by December 4, 2007. The Children's Behavioral Health Task Force developed 16 recommendations designed to improve Nebraska's child and adolescent behavioral health system. The scope of the plan includes:

1. The development of a statewide integrated system of care to provide appropriate educational, behavioral health, substance abuse, and support services to youth and their families serving both adjudicated and non-adjudicated youth
2. The development of community-based inpatient and subacute substance abuse and behavioral health services and the allocation of funding for such services
3. Strategies for effectively serving juveniles assessed in need of substance abuse or behavioral health services upon release from the Youth Rehabilitation and Treatment Centers
4. Development of needed capacity for the provision of community-based substance abuse and behavioral health services for youth
5. Strategies and mechanisms for the integration of federal, state, local, and other funding sources for the provision of community-based substance abuse and behavioral health services
6. Measurable benchmarks and timelines for the development of a more comprehensive and integrated system of substance abuse and behavioral health services for youth
7. Identification of necessary and appropriate statutory changes for consideration by the Legislature
8. Development of a plan for a data and information system for all youth receiving substance abuse and behavioral health services.

LB 542 also requires that, "The department shall provide a written implementation and appropriations plan for the children's behavioral health plan to the Governor and the committee by January 4, 2008." This report is intended to satisfy the requirements of this LB 542 provision. The Department intends to provide the Children's Behavioral Task Force with progress updates.

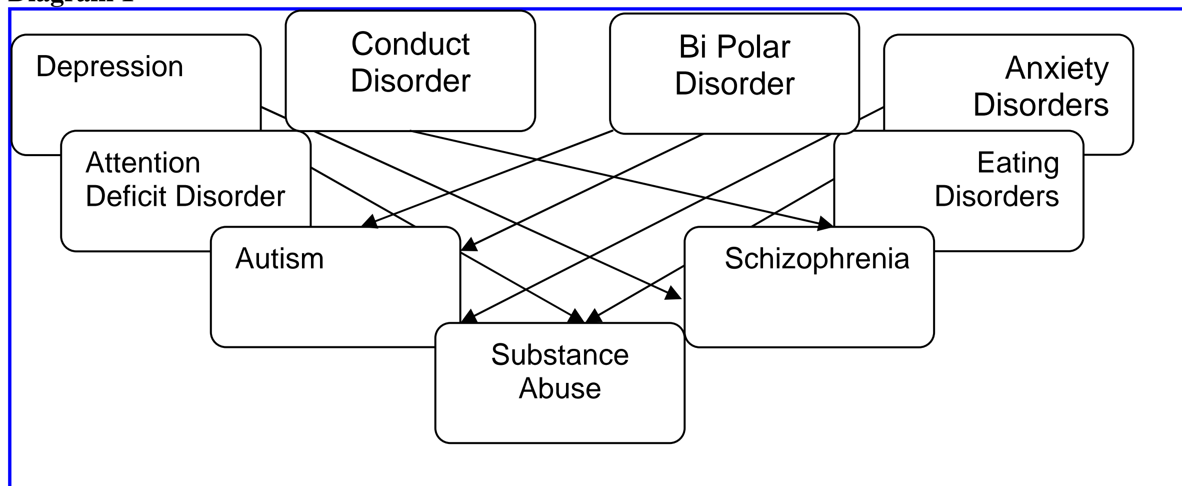
IV. The Behavioral Health Needs of Nebraska's Children, Adolescents, and Their Families

As stated in the 2000 Report of the Surgeon General's Conference on Children's Mental Health, "Mental health is a critical component of children's learning and general health. Fostering social and emotional health in children as a part of healthy child development must therefore be a national priority. Both the promotion of mental health in children and the treatment of mental disorders should be major public health goals."

The consequences of mental and emotional disorders can be severe and often include family disruption, dropping out of school, assaultive behavior, withdrawal, anxiety, addiction, self harm, risky behaviors, illegal activities, and in some situations, death. Few other conditions are as close in magnitude to the effects of behavioral health problems on youth. Despite the grave consequences, most children and adolescents with behavioral and emotional disorders remain untreated. Of the 12 million children and adolescents in this country suffering from some type of mental illness, fewer than 20% receive any treatment while, in comparison, 74% of children and adolescents with a physical handicap receive treatment (APA, 1992). Diagram 1 identifies some of the major childhood disorders which are defined in Appendix 1. The risk and protective factors are identified in Appendix 2.

In Nebraska some reports estimate that approximately 90,000 children and adolescents have a mental health or substance abuse disorder; approximately 47,000 of those children and adolescents experience significant impairment from such disorders; and approximately 21,000 children and adolescents experience extreme impairment.

Diagram 1

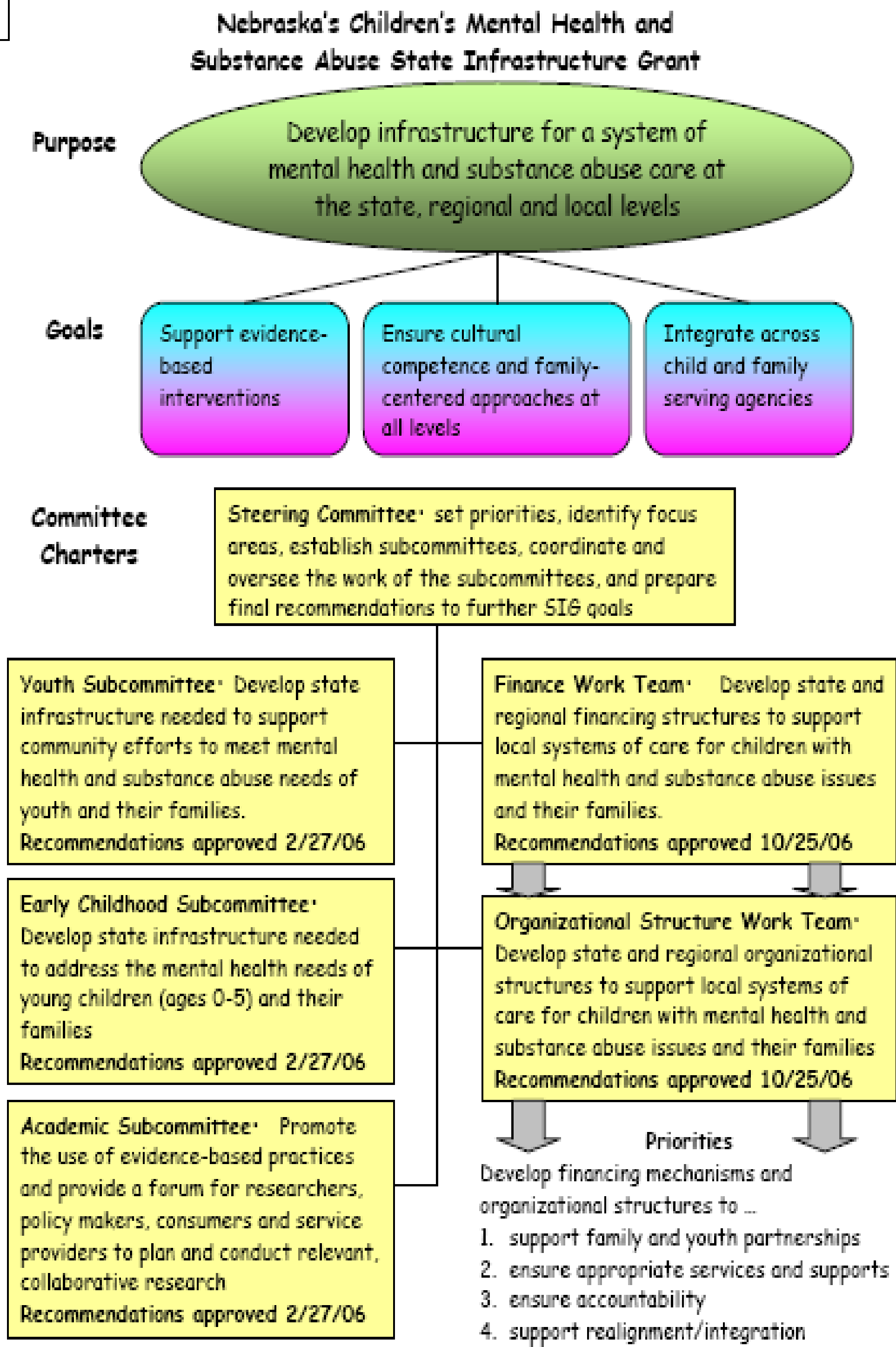


V. State Infrastructure Grant

In October 2004, the Nebraska Department of Health and Human Services was awarded a State Infrastructure Grant (SIG) from the federal Substance Abuse and Mental Health Services Administration (SAMHSA) in the amount of $750,000 per year for five years. The grant was designed to help states improve their infrastructure for community-based systems of substance abuse and mental health services for youth and their families.

This Plan is in large part based on the background research from the SIG planning experience. This broad-based infrastructure grant has involved diverse stakeholders from across the State including state and local public officials, youth with mental health and substance abuse disorders, family members of these youth, welfare, juvenile justice, education, probation, early childhood, and policy makers from the Divisions of Children and Family Services, Medicaid and Long-Term Care and Behavioral Health. Diagram 2 provides an overview of the grant purpose, goals and committee structure. Many of the recommendations for this implementation plan are based on the Nebraska's Child and Adolescent Behavioral Health State Infrastructure Grant process and work products.

Diagram 2



VI. System Issues

Several previous planning efforts have attempted to capture the major issues of Children's Behavioral Health. A review of these previous planning processes and issues has been collected by the State Infrastructure Grant planning process. There are reoccurring themes about system challenges facing Nebraska. Some of these key issues include the following:

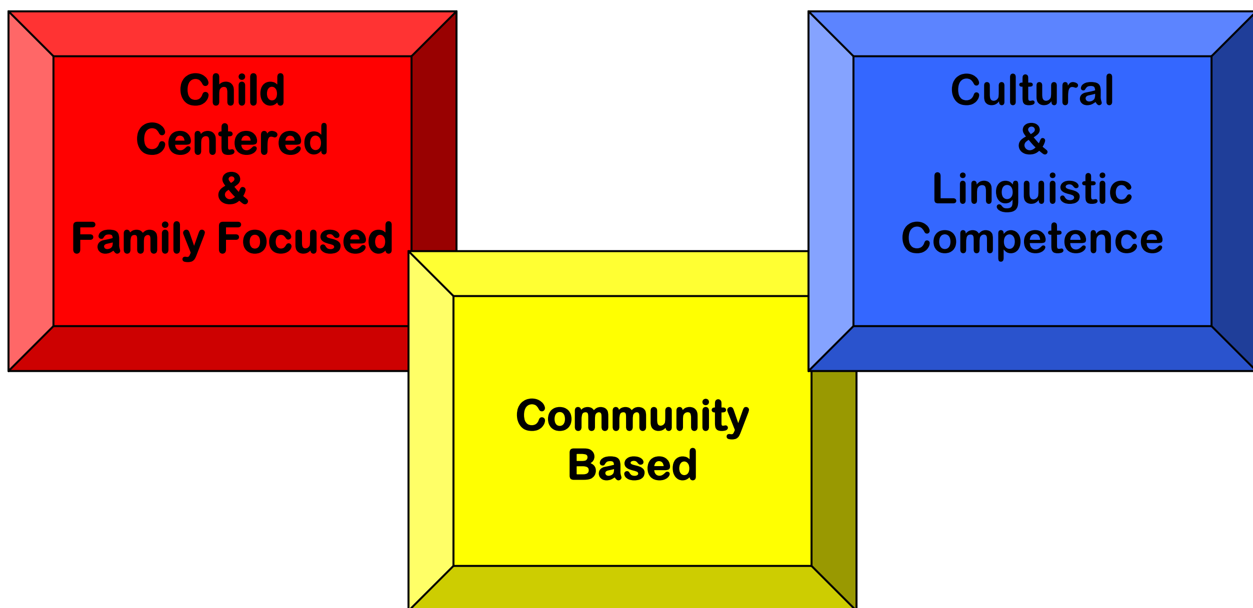
1. There is not a uniform and comprehensive screening, assessment and referral process for children and adolescents with behavioral health disorders across helping systems. Uniformity is important to ensure youth with mental health and substance abuse disorders are identified and receive appropriate services early in the process.
2. There are many Nebraska families who need care who have difficulty paying for mental health and substance abuse services for their children and adolescents.
3. Too often mental health professionals and services are not available. Eighty-six of Nebraska's 93 counties are designated as mental health professional shortage areas. The problem is particularly acute in rural and frontier areas of the state. The lack of effective community services has been identified as a significant reason for Nebraska's high rate of children and adolescents served outside their homes and communities.
4. Behavioral health programs may not be maximally effective in improving the lives of Nebraska's children, adolescents, and their families. Funding models and policy must promote the types of services demonstrated to be effective in treating mental health and substance abuse disorders in children and adolescents.
5. There are no standard measures for determining the outcomes produced by those services. No consistent method exists to measure and maintain data on the impact of service delivery consistently across systems to ensure children, adolescents, and their families improve as a result of interventions. As a result, it is impossible to determine systematically whether the expenditures of public funds have resulted in a benefit to the state and its citizens.
6. Often children and adolescents with serious emotional and substance abuse disorders have multiple needs spanning many systems including education, child welfare and juvenile justice. For these multi-need children and adolescents, the responses by these public systems are often uncoordinated. From the family's perspective, it is often difficult to navigate across systems and services and to understand the myriad eligibility requirements, assessment processes, service models, funding requirements, service coordination structures, and data collection mandates associated with each system.

VII. System of Care Principles

The Department acknowledges that the Children's Behavioral Health Task Force identified core values and guiding principles for an improved system of care. The Department offers the following values and guiding principles.

System of Care *The system is effectively managed to produce positive outcomes in a cost efficient manner.*	
Core Values	
Child/Adolescent Centered and Family Focused	The needs of the child and adolescent drive the entire planning and treatment process. Families have a voice in the services they receive, how and where they receive services, and providing feedback about their level of satisfaction with those services.
Community Based	Community based services are those services that are provided to children, adolescents and their families that are not delivered in a regional center, but are provided, when appropriate, as close as reasonably possible and appropriate to the child, adolescent and family in their home community.
Cultural and Linguistic Competence	Cultural competence is defined as an integrated pattern of human behavior, which includes but is not limited to thought, communication, languages, beliefs, values, practices, customs, courtesies, rituals, manners of interacting, roles, relationships and expected behaviors of a racial, ethnic, religious, social or political group; and the ability to transmit the above to succeeding generations. The capacity of an organization and its personnel to communicate effectively and convey information in a manner that is easily understood by diverse audiences.
Guiding Principles	
Assessment	A standardized process for identifying family behavioral health needs. This process is critical for accurately identifying the strengths and needs of children, adolescents and their families.
Access for Children/Adolescents and their Families	Our goal is to provide children, adolescents and their families with the right service, in the right amount, at the right location, for the right length of time.
Balanced Array of Services	This service array must encompass a diverse array of mental health, substance abuse and prevention services, and needs to maximize community resources that may be considered non-traditional in the context of children's behavioral health service delivery.
Utilize Best Practices	The evidence-based practices selected will effectively address the needs of the target populations and be reasonably expected to achieve desired system outcomes
Effective Care Coordination, Management and Evaluation	Seamless approaches to effectively coordinate, manage services and evaluate data (process and outcome) will be priorities for continuous quality improvement and increasing accountability
Data Driven Decision Making	Standard information that is uniformly collected about children and adolescents served by the system, used to inform decision making.
Coordinated Funding Structure	Harmonize various funding structures to provide integration of specific eligibility requirements, service delivery requirements, data collection mandates, assessment procedures, and co-payment requirements while providing for flexibility based on consumer needs.

VIII. Core Values



1. Child/Adolescent Centered and Family Focused

The needs of the child and adolescent drive the entire planning and treatment process. While this may sound like a simple concept and easy to implement, it is often the most common missing element. In order to comprehensively assess the needs of children and adolescents, our attention must be centered on those that need our assistance.

Child and Adolescent Organizations: An important component to a system of care is developing a process for children and adolescents with mental health and substance abuse challenges in order to support each other and to share their experiences and expertise. Strong child/adolescent organizations provide an opportunity to develop leadership skills, engage in social and recreational activities with peers, engage in activities to reduce the stigma of behavioral health disorders in communities, teach adults and others about behavioral health issues, share insights with professionals seeking to improve their practices, and advocate for improved public policy. Successful models of youth organizations and advocacy have been

developed in some Nebraska communities, for example: Foster Youth Councils, the Governor's Youth Advisory Council and the Circle of Nations Youth Council. Other communities have the opportunity to learn from these efforts and replicate them, should they choose. The SIG Grant will continue to be utilized as an implementation resource.

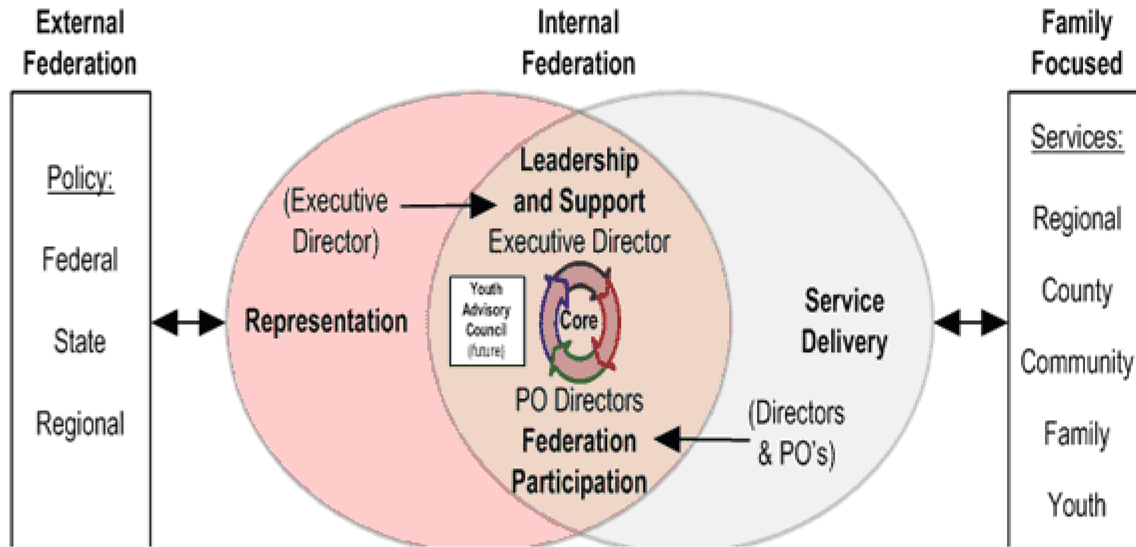
Families have a voice in the services they receive, how and where they receive services, and providing feedback about their level of satisfaction with those services. A clear focus on the family needs, hopes and what they desire for their children and adolescents must be one of the primary values that a system of care organizes itself around.

Family Organizations: Family organizations provide essential services at the local and state levels including providing peer mentoring, organizing educational/support groups, and working with policy makers to improve services for children, adolescents, and their families. To effectively engage in these activities, family organizations must have the infrastructure to maintain and expand their operations. Essential infrastructure includes a well functioning board, the ability to track multiple sources of revenue and expenditures, a program evaluation system that can demonstrate the outcomes of services, effective management of staff and volunteers, etc. Individualized technical assistance can be helpful in developing this infrastructure, allowing family organizations to succeed and thrive.

Resources from the SIG will continue to provide the technical assistance to the family organization to improve access and promote the sustainability of the Family Organizations. This approach has yielded promising practices with respect to what technical assistance has been the most helpful to family organizations. The technical assistance approach has been offered through a consortium of state agencies, the state university system and an independent consulting firm. Through an innovative and participative manner, the technical assistance was defined by Family Members who lead the family-driven organizations.

Diagram 3 illustrates the relationships among the many stakeholders involved in the technical assistance process. Without a clear understanding of their proximity to each other on this continuum of policy creation (left side) and service delivery (right side), consensus could not have been reached among the Family Organizations. The first step was a self-assessment process that allowed each Family Organization to examine itself and its role within the model below.

Diagram 3



Family-Centered Practice: The evidence is clear: when working with families, regardless of how they enter the system, using a strength-based approach allows the family to participate appropriately in the planning process. As a result, national standards for family centered practice help promote a highly individualized case plan and tailored services that build sustainable solutions from the strengths and needs of the family. This strengths-based approach to case planning provides a mechanism to respond to the unique needs of children and is more likely to increase local capacity for a responsive service array. More importantly, working with families from a strengths-based, rather than a deficits-based, approach through provision of services that support family members is proven to promote parental motivation and engagement. A listing of family-centered practice standards can be found in Appendix 3.

Child/Adolescent Centered and Family Focused
Implementation Strategies:

- Evaluate the existing child/adolescent organizations to ensure that each child/adolescent population served by the Department is represented.
- Develop and disseminate technical assistance materials and “lessons learned” to ensure sustainability of child/adolescent and family organizations.
- Ensure that policies are consistent with child-centered and family focused practices.
- Clarify the role of family mentoring in relation to the system of care.
- Expand the inclusion of family input into the practices, programs and policies developed by the Department.
- Examine whether current practices empower families to make better decisions and enhance parental capacity.
- Provide additional training to DHHS staff and community providers on family-centered practice standards.

2. Community Based

The majority of youth can and should be served within their home-community. Allowing for children and adolescents to receive services while remaining in their own school, within their own neighborhood, and in an environment where they can maintain existing relationships is optimal. In systems of care, strategies are developed that support the most inclusive, most responsive, most accessible, and least restrictive settings possible; and that safely promote child and family integration into home and community life.

Community Based Services: Community based services are those services that are provided to children, adolescents and their families that are not delivered in a regional center, but are provided, when appropriate, as close as reasonably possible to children, adolescent and family in their home community. Contracting with community-based services can help meet the needs of children and families within their own neighborhood, reducing the amount of time and burden on families who otherwise may need to travel long distances to receive such services.

Prevent the
Accumulation
of Risk Factor
Provide Timely and
Expert Evaluation
and Assessment
Facilitate Active
Involvement of
Children,
Adolescents and
Families
COMMUNITY
BASED
PROGRAMS
Build Safe
Environments to
Permit Families to
Establish
Structure,
Routines, Rituals,
and Organization
Ensure
Sufficient
Services to
At-Risk
Populations
Focus on
Resilience and
Adaptation

Examples of community service strategies include:

Faith-based and community organizations and recreational groups offering a variety of services to assist high-risk families, including community food pantries, clothing, soup kitchens, and recreational and related activities.

Schools providing social support through programs, such as Head Start, that incorporate parental involvement into early childhood education, or after-school programs that provide social and educational assistance, peer counseling, and tutoring as well as social support to children with special needs.

In-home assistance in which formal helpers provide families with the opportunity to consider each person's viewpoint on family problems and the development of new modes of interaction.

Public assistance programs offering job training, subsidized childcare, and nutritional support (e.g., the Special Supplemental Nutrition Program for Women, Infants, and Children [WIC] program).

Community Based
Implementation Strategies:

- Expand capacity to deliver increased community-based services to specific populations of children, adolescents and families.
- Review contracts with community based providers to ensure that language is consistent with identified core values.

3. Cultural and Linguistic Competence

Cultural Competence: The National Center for Cultural Competence defines culture as an integrated pattern of human behavior, which includes but is not limited to thought, communication, languages, beliefs, values, practices, customs, courtesies, rituals, manners of interacting, roles, relationships and expected behaviors of a racial, ethnic, religious, social or political group; the ability to transmit the above to succeeding generations. Cultural competence is a developmental process that evolves over an extended period.

Linguistic Competence: The capacity of an organization and its personnel to communicate effectively and convey information in a manner that is easily understood by diverse audiences including persons of limited English proficiency, those who have low literacy skills or are not literate, and individuals with communication disabilities.

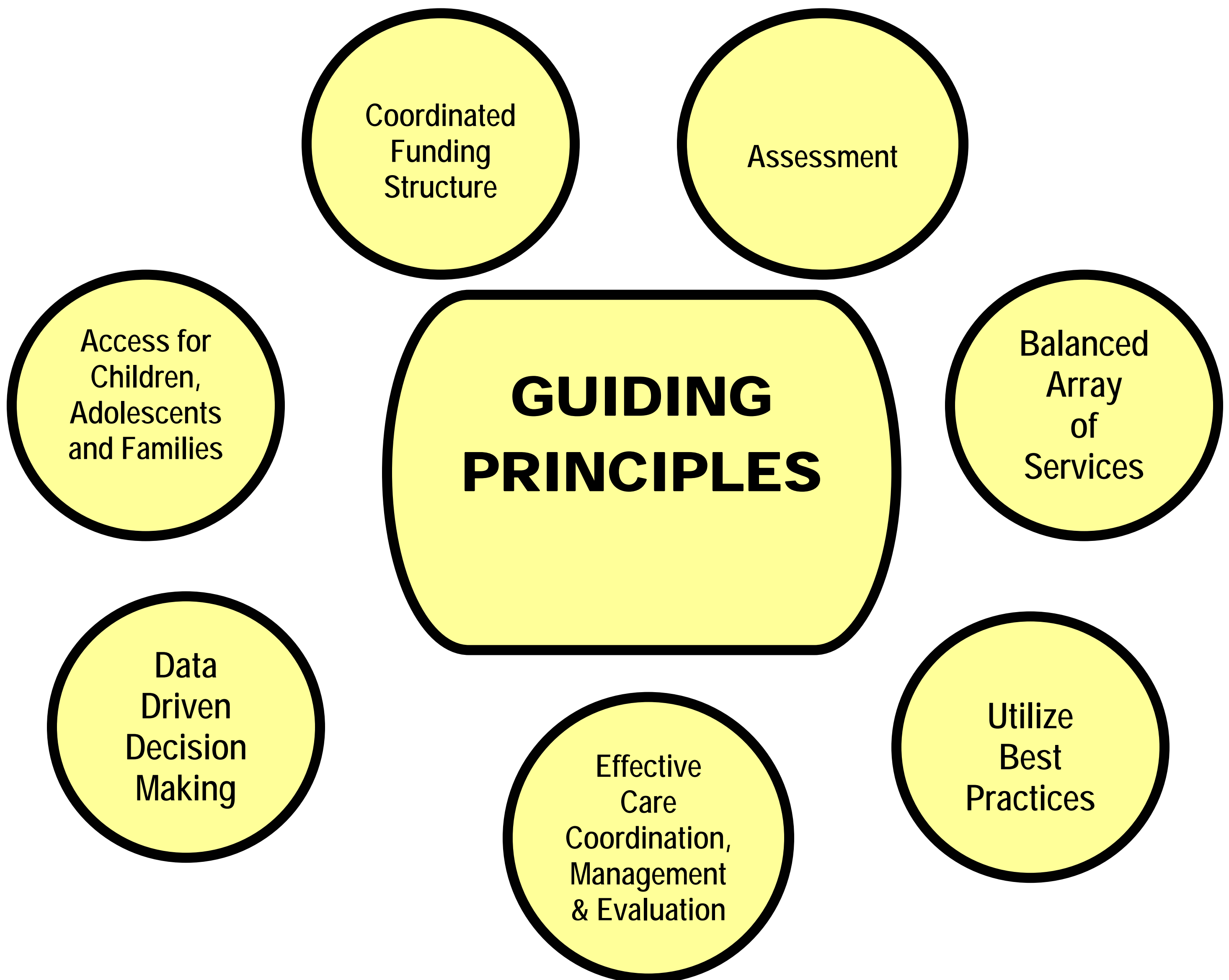
Nebraska has undergone significant demographic changes in recent years. The numbers of new immigrants have increased substantially. Challenges for the behavioral health system in serving growing minority and immigrant populations include outreach to ensure individuals are aware of services, providing welcoming environments to encourage individuals to seek treatment, capability to effectively serve individuals who may speak no or little English, understanding different cultural norms and how these norms relate to behavioral disorders, and recruiting and retaining staff who are members of subpopulations being served.

The continued development of a highly trained and competent behavioral health workforce is a critical component of a behavioral health system of care. As Nebraska transforms to a system of care, the success of this system will depend largely on a workforce that is adequate in size, accessible across the state, effectively trained and consistently supported.

The Department will develop, utilizing the resources of SAMHSA and the SIG Steering Committee, a strategic plan that will continue to examine our system's current workforce challenges in an effort to develop and sustain a strong workforce in behavioral health. The Department's goal is to provide compassionate, effective, efficient, culturally and linguistically competent services to children, adolescents and their families.

Cultural and Linguistic Competence
Implementation Strategies:

- Analyze previously completed workforce surveys in order to development a plan to improve recruitment strategies that enhance and support the current behavioral health workforce; both provider and DSSH staff.
- Utilize SIG as a resource to implement workforce development plan.
- Partner with other government agencies to enhance and support behavioral health workforce.


Coordinated Funding Structure
Assessment
Access for Children, Adolescents and Families
GUIDING PRINCIPLES
Balanced Array of Services
Data Driven Decision Making
Effective Care Coordination, Management & Evaluation
Utilize Best Practices

IX. Guiding Principles

1. Assessment

Nebraska children, adolescents and their families have been burdened with taking part in multiple assessment processes when working with the state systems of Medicaid and Long-Term Care, Children and Family Services (child welfare, economic assistance, child support and the Office of Juvenile Services), Behavioral Health and state and county juvenile justice programs (e.g., probation, juvenile assessment centers, diversion programs and others), private practitioners and schools. Currently different tools are used in each system for gathering initial assessment information to determine the level of mental health and substance abuse services necessary and placement of children and adolescents. To complete the initial assessment takes a significant amount of time for children, adolescents, and their families, and also produces a strain on systems and human resources of service providers. Assessment data are collected from numerous tools, frequently asking for the same information, and the assessment data is often not accessible across providers and systems. Some of these challenges involve navigating the federal confidentiality requirements contained in the Health Insurance Portability and Accountability Act of 1996. Moreover, the assessment includes information about the needs of children and adolescents, but often lacks information about the behavioral health needs of the youth's family.

The Division of Children and Family Services, through SIG-related strategies, has implemented a process for conducting Comprehensive Family Assessments (CFA) across Nebraska that will establish a standard process for identifying family behavioral health needs. This process is critical for accurately identifying the strengths and needs of children, adolescents and their families. Some of the benefits include:

- Assessing and treating the mental health and substance abuse needs of parents is important for the safety, permanency and well being for children and adolescents.
- Collaboration with the juvenile court will be critical as assessment drives the treatment process, which is often impacted by the juvenile court system. Receiving assessment recommendations early in the planning process is significant to determine whether or not referrals for treatment services are indicated and to prevent further penetration into the system.
- Assessment may also assist with the identification of natural or informal supports that can assist families with identifying solutions and thus avoiding more formal treatment services altogether.
- System assessment and education are the cornerstones of prevention. Assessment will further assist with the development of a comprehensive treatment plan with goals and objectives to guide the delivery of mental health and substance abuse services for the family, should they be necessary.

Information collected through the assessment can also be used in aggregate to strategically plan for both state and local needs. The CFA is a wide-ranging assessment of the family system and the adult caregivers in the family. The CFA will be provided across service delivery systems and has already been implemented in the Western Service Area within the Children and Family Services Division. The CFA will be implemented statewide and be used by treating

professionals, Protection and Safety Workers, the Integrated Care Coordination Units (ICCU), and the Professional Partners case managers located in the Behavioral Health Regions. The State Infrastructure Grant (SIG) will be utilized as an implementation resource. A copy of the CFA can be located in Appendix 4 of this report.

Assessment
Implementation Strategies:

- Statewide implementation of the CFA.
- Collaboration with the juvenile court system utilizing the "Through the Eyes of the Child Initiative" in order to facilitate information sharing.
- Identify a method to share information contained in assessments and other records among the helping professionals that are consistent with federal confidentiality requirements.
- Complete necessary revisions to data system.

2. Access for Children, Adolescents, and their Families

One of the critical issues in Nebraska's system of child and adolescent mental health and substance abuse system of care is the geographic disparity across the state." Serious barriers to effective prevention and treatment services exist for the 60 million Americans living in rural and frontier communities. One method holding promise to increase access to behavioral health services, supervision and training is through technology. The Department will conduct an analysis of the potentials and barriers of using two-way video conferencing telehealth, as access to and availability of behavioral health professionals is seriously lacking. Poverty, geographic isolation, and cultural differences further limit the amount and quality of mental health care available to these individuals. In particular telehealth can be used to provide needed services to children and adolescents in areas designated as behavioral health profession shortage areas in the State of Nebraska. Such services provide assistance to communities experiencing a workforce shortage until professionals can be recruited and trained.

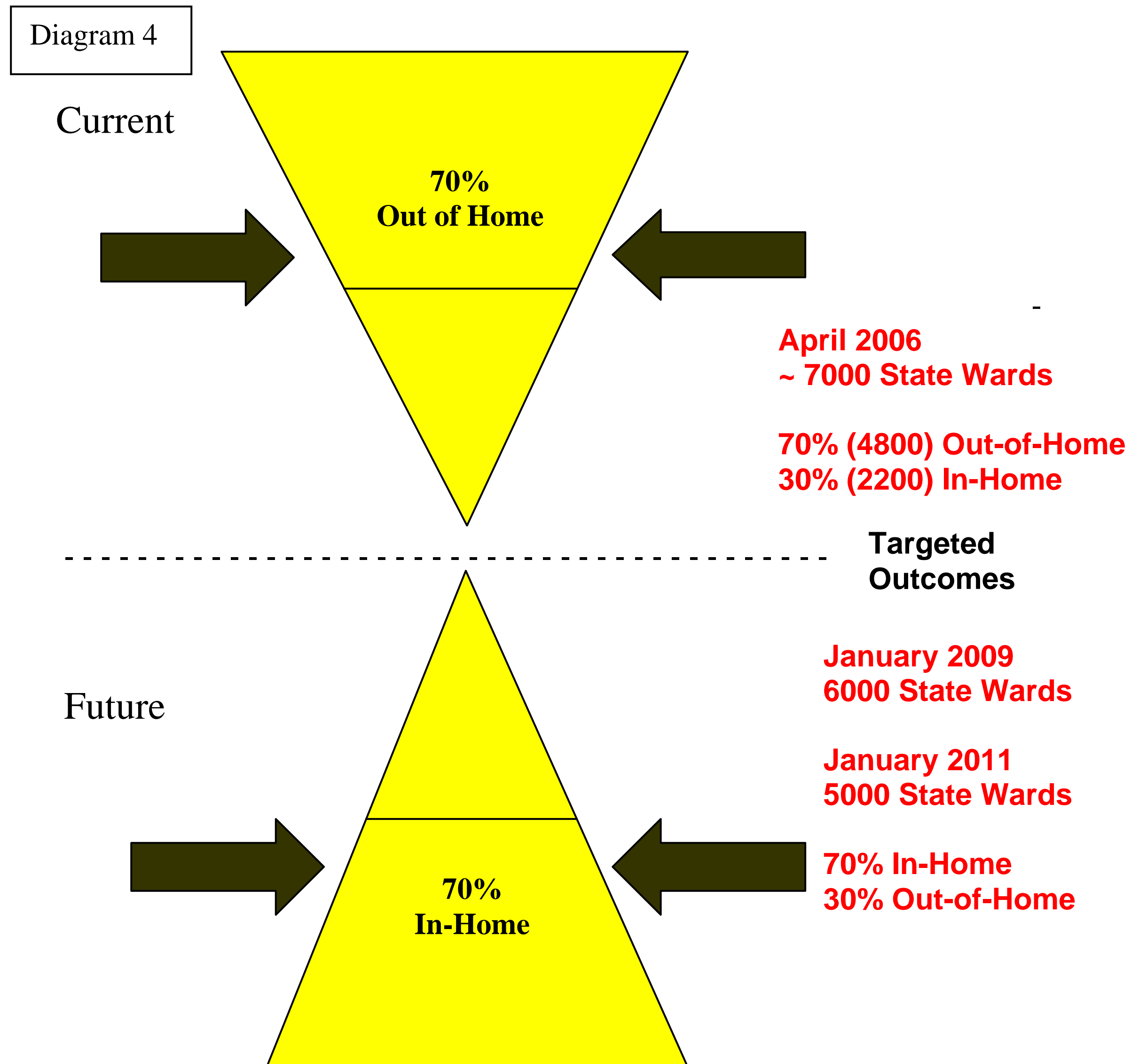
Access for Children, Adolescents, and Their Families
Implementation Strategies:

- Expand access to telehealth to include behavioral health.
- Ensure that a full array of evidence-based services and supports from prevention to treatment to follow-up will be available across the state.

3. Balanced Array of Services

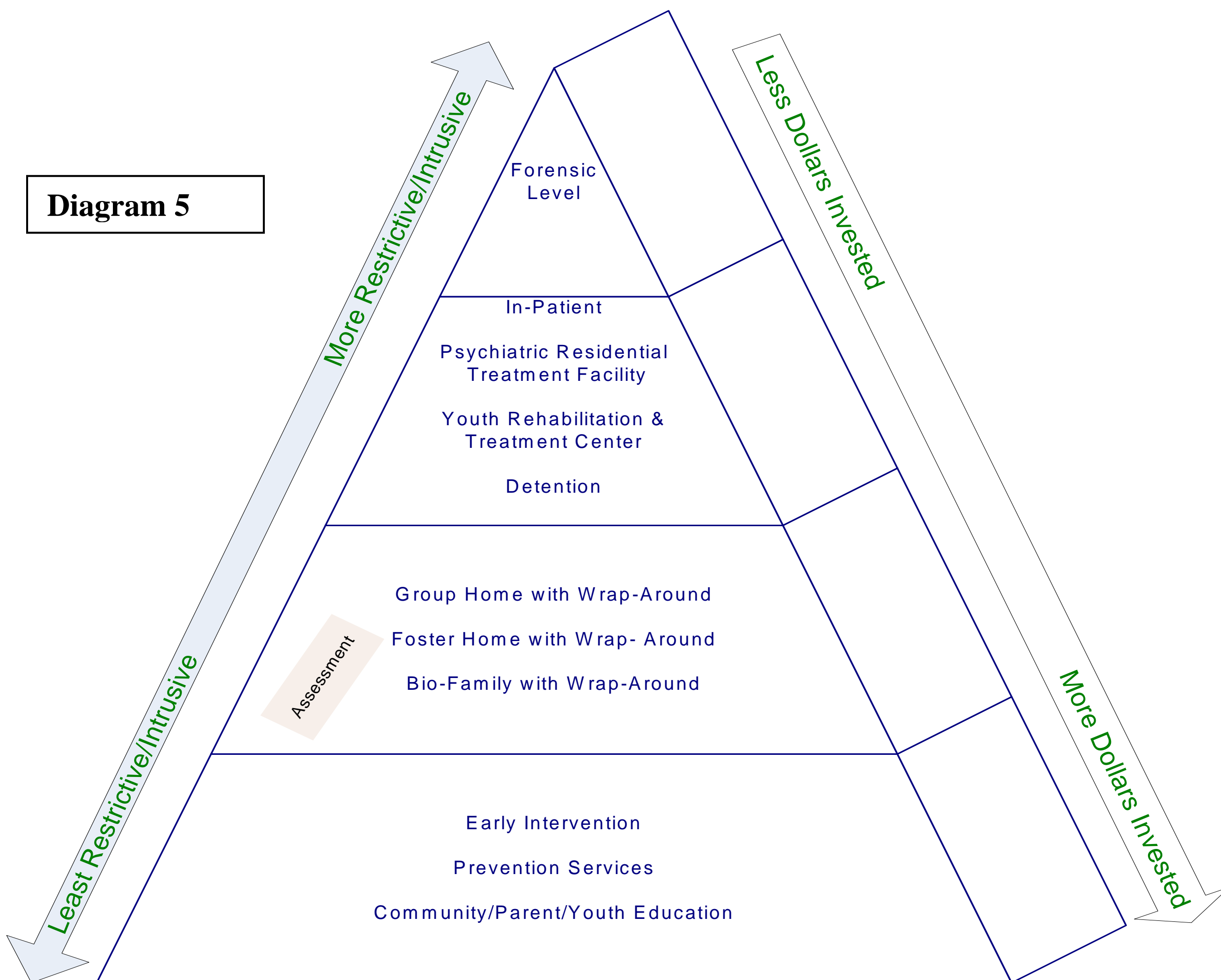
A true system of care includes building and offering a focused array of services. This service array must encompass a diverse array of mental health, substance abuse and prevention services, and needs to maximize community resources that may be considered non-traditional in the context of children's behavioral health service delivery. Through an accessible, coordinated, and collaborative network, children, adolescents and their families receive the right service, in the right amount, at the right location, for the right length of time, at an affordable, sustainable cost.

Currently, in comparison to other states, Nebraska has a high proportion of children and adolescents in state care and in out-of-home placements. A service array project was initiated as a first step to rebalance the system from currently serving the majority of children and adolescents in out-of-home care to safely serving the majority of children and adolescents while they live at home. Diagram 4 shows the potential benefits of a balanced service array.



The Department identified the rationale and a current listing of the service array that can be found in Appendices 4 and 5. The current service array is confusing, results with children being served out of their home and with parents feeling helpless and out of control. It is no easier for providers of care.

Diagram 5 describes the preferred Array of Services in which there are fewer sub-services within major domains of care in order to simplify the system. Further, Diagram 5 demonstrates the Department's intention to place greater emphasis on earlier, in-home care and less on expensive, intensive and out-of-home treatment services.



Office of Juvenile Services (OJS)
A subset of children and adolescents who may need behavioral health services are those who have committed a crime. In Nebraska, juvenile and district courts have authority for these youth and may order treatment. The Youth Rehabilitation Centers (YRTC) are an option, but in-home and in-community care also may be ordered.

The law directs courts to place such wards in the care and custody of DHHS, but frequently courts order particular treatment placements largely because of lack of trust with the system. One goal of this plan is to correct this improper balance in the system.

Youth Rehabilitation and Treatment Center (YRTC)
DHHS-Office of Juvenile Services (OJS) uses the Youth Level of Services/Case Management Inventory (YLS/CMI) risk and needs assessment instrument in determining the level of treatment for juveniles. The YLS/CMI risk and needs score is used in the DHHS-OJS initial classification process to determine the appropriate level of treatment, custody, and services that are recommended to the court.

The DHHS-OJS classification process will determine whether the juvenile's act is sufficiently severe, or the risk of continued criminal behavior is sufficiently high, as to justify a placement at the YRTC's. The YRTC's accept only those juveniles who have been adjudicated delinquent under Nebraska Revised Statutes. Reasons for commitment may include, but are not limited to assault, theft, possession of drugs, criminal mischief, burglary, auto theft, concealed weapon, and sexual assault.

The YRTC's level of care is currently considered the highest level for youth to be placed by the court. Therefore, by the time the youth is committed to YRTC, they usually have been unsuccessful in less restrictive community-based treatments or in out of home placements.

- Youth are committed to YRTC's because they present a community safety risk and thus need the type of structure, programming and security that the YRTC's can offer. Youth are committed to the YRTC facility initially by a juvenile court based upon a judicial review of the circumstances and considering the best interest of the youth.
- Some estimates indicate as many as 78% of youth in the YRTC's have substance abuse and/or mental health treatment needs.
- Both the Geneva and Kearney YRTC facilities currently assess the behavioral health needs of youth placed in their facilities. According to the 2007 Chinn report
  - 73% of the girls and 27% of the boys committed to the YRTC's have serious mental health problems
  - 73% of the boys and 27% of the girls have behavior-based disorders
  - 77% of the boys and 83% of the girls have substance abuse/dependency problems

The Hastings Regional Center (HRC)
Providing youth with chemical dependency treatment can be effective in reducing crime and recidivism in juvenile services. Treatment for youth incarcerated in juvenile justice facilities is crucial to address the human needs and financial costs of some young persons in the juvenile justice system. Research indicates that treatment has a positive impact on youth and that the majority of these youth respond well to treatment. For example, a meta-analysis of treatment services for juvenile offenders found substantial improvement for treated offenders in comparison to offenders who were incarcerated. Garret (1985) and Cohen (1998) found that treatment services for juvenile offenders result in long-term cost savings when including the costs of recidivism, unemployment and social costs.

While the LB542 Children's Behavioral Health Task Force encouraged closing the Hastings Regional Center and privatizing services across the state, the Department disagrees with the second part of that recommendation because of the unique nature of this population. These

youth can be violent, experience mental illness, abuse substances and engage in criminal behavior. Additionally, the adolescents at the Hastings Regional Center have generally had previous community-based treatment experiences prior to their placements in Kearney and Hastings. The Department also rejects an “as-is” strategy of providing the same service in the same facility with the same capacity as is currently provided.

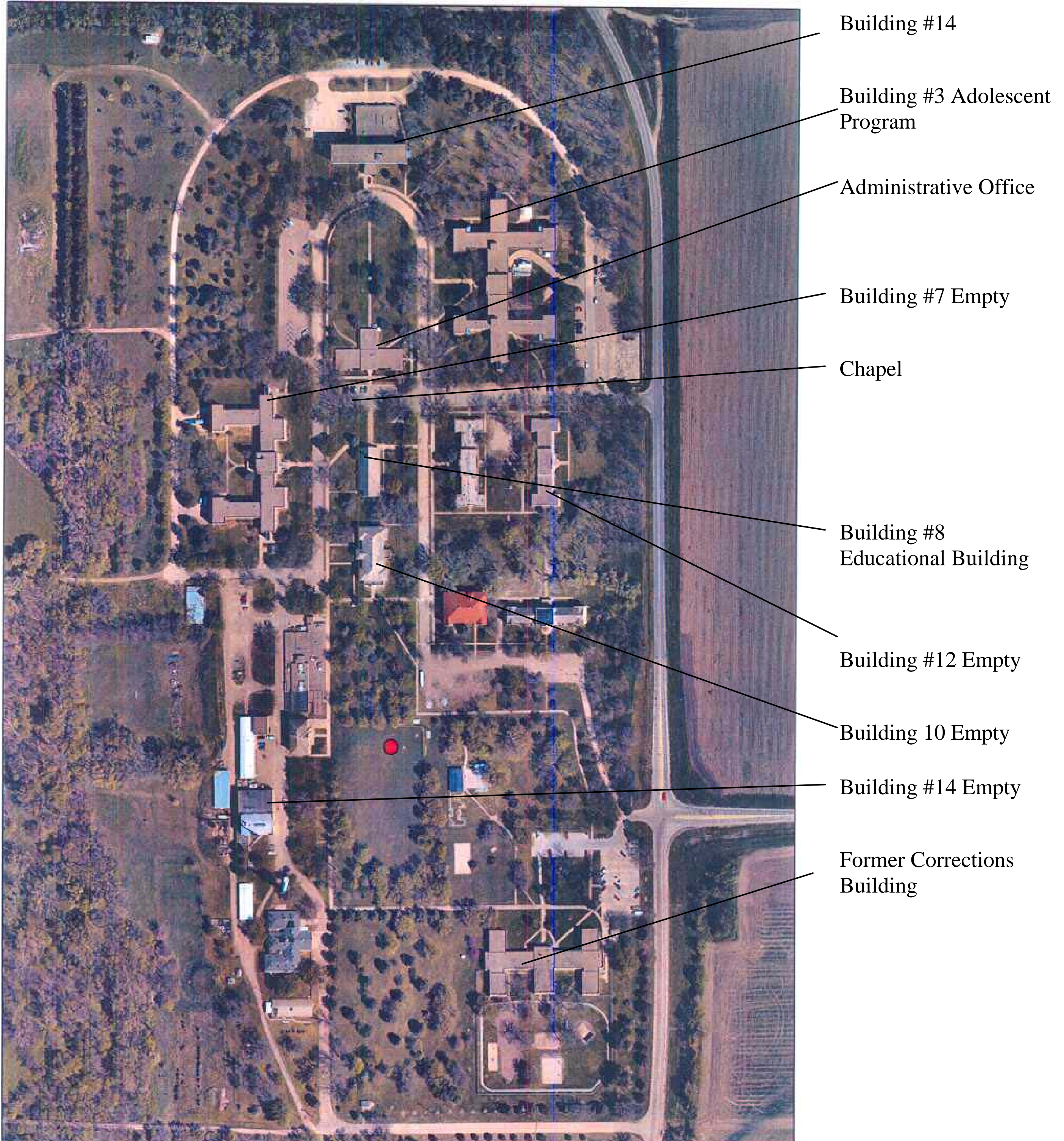
Youth from YRTC-Kearney who have specialized chemical dependency treatment needs have an opportunity to receive treatment at the Hastings Juvenile Chemical Dependency Program (HJCDP). This program serves 40 youth who have been approved for residential treatment by Magellan prior to being paroled to the facility. These youth still require a high level of security, structure and behavioral intervention in order to maintain positive behaviors and ensure community safety. The HJCDP program has worked closely with YRTC-Kearney since 1999 to develop a program that addresses both the security and treatment needs of the youth they serve. Many of these youth have had multiple previous community treatment experiences for their chemical dependency issues and have not been able to be successful at lower level community-based programs. Youth in community-based programs are in less secure facilities and frequently have a higher incidence of running away or committing further criminal acts while being served. In addition, many of these high-risk, high-need juveniles are currently served in out of state placements.

Balanced Array of Services
Implementation Strategies:

- Develop service capacity that will increase in-home placements for specific populations of children and adolescents.
- Ensure that services are individualized and provide supports to families that will allow children and adolescents to live in a safe, stable, permanent family environment.
- Develop expanded capacity for chemical dependency treatment.
- Develop a more cost efficient residential program to replace the existing chemical dependency program.
- Provide training to workforce and stakeholders on the array of services.
- The Department will work with communities and private philanthropic organizations to explore development of needed infrastructure and facility construction through a public/private partnership.
- Develop a Level 5 (highly secure) facility to serve high-risk, violent juvenile offenders.
- Closed the mental health unit for adolescents at the Hastings Regional Center effective January 1, 2008.

Diagram 6 is of the Hastings Regional Center and the buildings on campus. None of the current buildings on this campus would be cost efficient or programmatically adequate for the proposed chemical dependency or high security unit.

Diagram 6



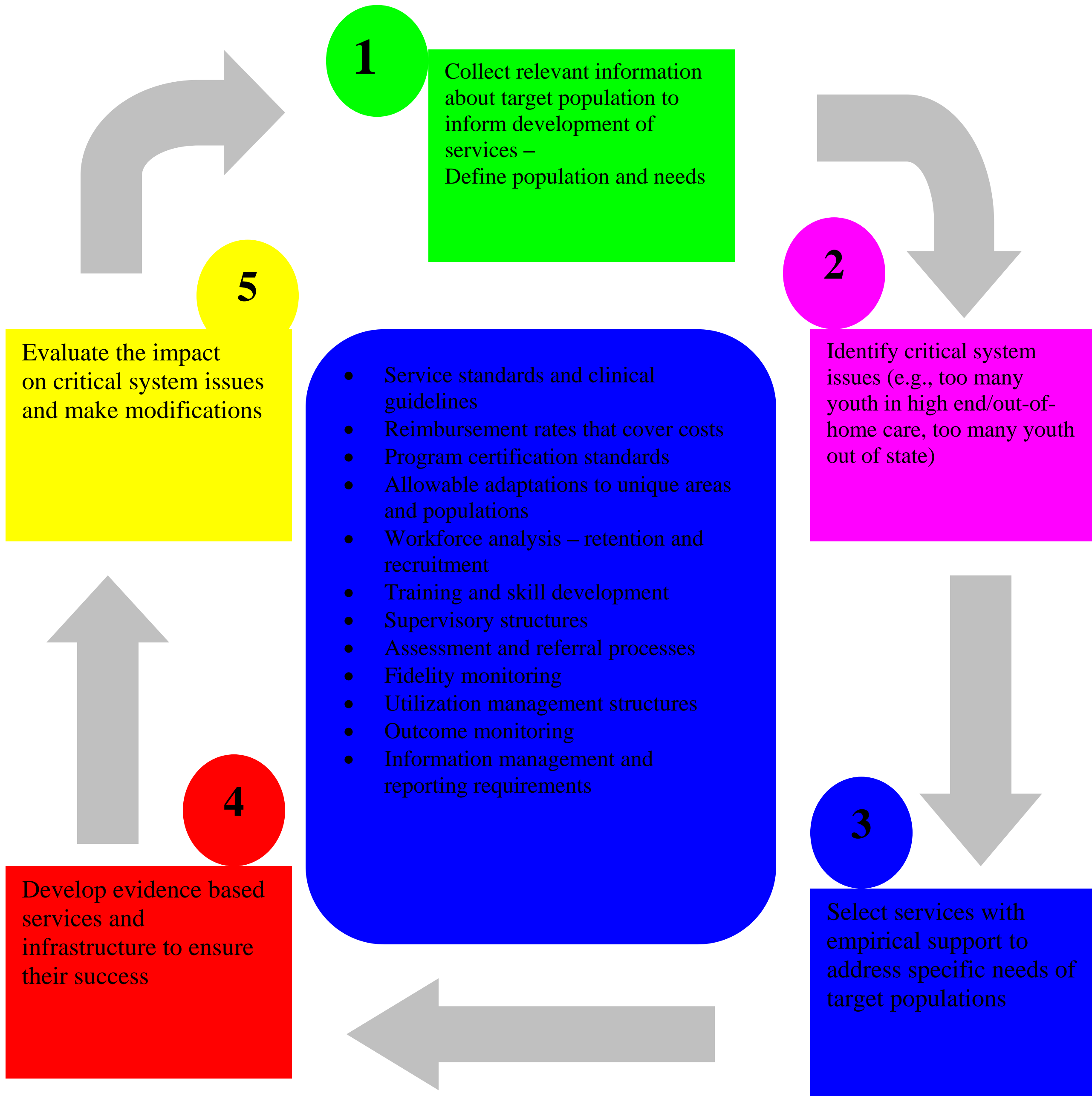
4. Utilize Evidence Based Practices

Behavioral health professionals use a variety of terms when describing best practices. Terms such as: Promising Practice, Evidence-Based Practice, and Science-Based Practice, are often used interchangeably and can often confused professionals. Best practices are not an attempt to simply standardize practice, but aim to adapt practice in ways that suit the particular person and their context and share stories, tools, and understanding. "Best" practice is a continuum of practices/programs ranging from promising, to evidence-based to science-based. The American Psychological Association conceptualizes the need for effective treatment as a three-pronged approach. Evidence based practice requires a combination of services with demonstrated research support, expertise by the practitioner delivering the service and congruence between the service and the unique needs and characteristics of the individual client.

Evidence-Based Practices: Determining the types of evidence-based practices should follow a strategic process based on the specific system level needs to be addressed. Some of the critical system level issues in Nebraska include youth sent out of state to access services, too many youth in out-of home care, and youth who have difficulty transitioning to adulthood. The evidence-based practices selected for implementation should be those that will effectively address the needs of the target populations and be reasonably expected to achieve desired system outcomes. Development of evidence-based practices requires a sophisticated infrastructure to ensure appropriate support of service development. For example, an assessment and referral process need to be established to ensure youth appropriate for the service are identified and linked to the service; reimbursement rates must be structured to adequately cover the costs for service delivery as well as program certification, training, fidelity monitoring and program evaluation; essential data must be collected and reported to ensure services are delivered as designed and result in the anticipated outcomes. Diagram 7 describes a process for developing evidence-based practices.

Another population of children and adolescents that have presented service challenges consists of transition-aged youth. Youth with serious emotional disorders and substance abuse problems have high rates of dropping out of school, unemployment, and criminal activity. Some pilot efforts have been made involving vocational rehabilitation, schools and mental health to provide prevocational training, treatment and an engaging educational environment to keep youth in school and prepare them for employment and independent living. A pilot program has recently been implemented to provide transitional services to youth in the Omaha area. This collaborative pilot has experienced initial planning success with ensuring that youth have a smooth transition to adult living.

Diagram 7



Utilize Evidence Based Practice
Implementation Strategies:

- Examine current models of transition services that are consistent with evidence based practice and review for statewide application.
- Develop clinical criteria and standards for services that are supported by evidence.
- Identify specific evidence-based practices that match the needs of specific populations of children and adolescents.
- Strengthen the training for the behavioral health workforce with emphasis on evidence-based practice models.
- Provide training to the behavioral health workforce on specific evidence-based models designed to reduce out-of home and out-of-state placements and to transition adolescents to successful adult living.
- Establish reimbursement mechanisms that fit these services.

5. Effective Care Coordination, Management and Evaluation

Children and adolescents with behavioral health disorders, particularly those with serious disorders, often are involved or at risk for involvement with multiple service providers and multiple child-serving systems. This system can often be difficult and overwhelming to navigate. Care coordination, management and evaluation is important from the standpoint of both quality and cost of care, as well as family satisfaction. Evaluating data (process and outcome) will be priorities for continuous quality improvement and increasing accountability. Initially, the system will rely heavily on existing data either maintained on automated information systems or manually collected.

Currently there are various case review processes at the local, regional and state levels specifically intended to prevent youth from unnecessarily being placed out of home, out-of-community or out-of-state. These processes have not been formalized and often lack the flexible resources to prevent youth from entering restrictive and high-cost levels of care.

Team Approach: Children and adolescents with behavioral health needs can benefit from supports and relationships that naturally occur within communities, such as team sports, church-based activities, and connections with local business and trades people. Many times these organizations do not work together. The coordination of these teams is vital in developing the care or treatment plan based on child/family needs, goals and formal and informal resources available or needed to support the family. Families might not receive the support they need to care for their children, or may not even know where to go to ask for help.

In system of care, children, adolescents, families and local public and private organizations work in teams to plan and implement a tailored set of services for individual's physical, emotional, social, educational and family needs. Teams may consist of representatives from mental health, substance abuse, health, education, child welfare, juvenile justice, family and youth advocacy, or other organizations, as well as other people who play an important or supportive role in the child, adolescent and family's life. Teams find and build upon the strengths of the individual and his or her family rather than focusing solely on their problems. Teams work with individual families,

including the children and adolescents, and with other caregivers as partners when developing a plan for the families and when making decisions affecting the individual's care.

Centralized Coordination at the State Level: Historically, children's behavioral health services within the Department of Health and Human Services have been fragmented across Divisions, with no single entity responsible for the statewide coordination of the child and adolescent behavioral health system.

In an effort to reduce fragmentation and increase statewide coordination, the Department has recently hired the position of a Children's Behavioral Health Administrator. While this position is located within the Division of Behavioral Health, this administrator will cross division lines and work collaboratively with each of the Divisions within the Department to coordinate the statewide integration of a system of care specifically for children and adolescents. This state level integration will then be translated to the local level through leadership, policy development, and by providing the state with a single point of contact for systemic issues.

Developing Statewide Coordination: The infrastructure of a system of care requires inter-agency collaboration and coordination as well as the active involvement of a broad array of stakeholders. Infrastructure development is a critical first step in our process of developing an integrated system of care for children and adolescents, with input from stakeholders, including and others that utilize the services. The Division of Behavioral Health, in partnership with the Divisions of Children and Family Services and Medicaid and Long-Term Care, will tap the expertise of the already existing SIG Steering Committee to develop a statewide coordination/integration plan for children's behavioral health. This state-community partnership will ensure statewide input, statewide system coordination and statewide problem solving. The coordination/integration plan will provide a single document outlining the vision and strategies for a comprehensive system of care for children, adolescents, and their families in Nebraska. This plan will be updated annually, report on progress made in system of care development and identify future activities to move the system forward.

Effective Care Coordination, Management and Evaluation
Implementation Strategies:

- Review existing case review procedures at both the community and state levels and develop strategies and resources to enhance review processes to ensure children and adolescents are served in the least restrictive manner and as close to home as is possible.
- Examine if current practices allow for ample communication and collaboration among agencies.
- The Children's Behavioral Health Administrator will assume the management of the SIG and SOC Grants and all activities related to these grants.
- Continue to evaluate the appropriate role of front-end care coordination and management.
- Designate the SIG Steering Committee as the interagency working group for statewide input, coordination and problem solving.
- The membership of the current SIG Steering Committee will be reviewed to ensure that this Steering Committee is appropriate in size and composition to function most effectively as the interagency working group.

6. Data Driven Decision Making

How we are doing in our Child and Adolescent Behavioral Health System is a challenging question to answer. In recent years there have been efforts at the federal level to capture standard data on youth and family outcomes. For example, the federal government conducts comprehensive reviews of state child welfare programs (The Division of Children and Family Services), for conformance with federal requirements under Titles IV-B (general child welfare program operation) and IV-E (out-of-home care placement). The Children and Family Services Review (CFSR) examines 14 aspects of the state program, including 7 outcome measures relating to safety, permanency and well being and 7 systemic factors relating to the overall capacity of the state program to serve children, adolescents, and their families. A synopsis of the CFSR can be found in Appendix 6 of this report. The Children's Health Act of 2000 established federal requirements for outcome measurement referred to as the National Outcome Measurement (NOMS) for the Block Grants (mental health and substance abuse). These measures encompass 10 domains that embody meaningful, real life outcomes for people, who are striving to attain and sustain recovery, build resilience, and work, learn, live, and participate fully in their communities.

Nebraska currently does not have the capacity to collect and analyze routinely and effectively much of the data required to inform policy decisions, system development and evaluation of its public behavioral health system. There is no standard set of information that is uniformly collected about all children and adolescents served by the system. Of the information that is collected, some exists only as paper records and are never entered into an automated database. The items of information that have been automated reside on a number of computer systems, developed for different purposes, with different capabilities, file structures and operating systems. A listing of the current data system collection is located in Appendix 7 of this report.

The Department will provide leadership in developing a uniform system to collect and evaluate data across systems regarding youth served, the quality of services provided and the outcomes produced by those services. The system will consist of uniform, cross-system data collection, storage, analysis and reporting to evaluate the children's behavioral health system. The system will have the capacity to evaluate both process data and outcome data thereby creating the infrastructure for continuous quality improvement and increasing accountability. Initially, the system will rely heavily on existing data either maintained on automated information systems or manually collected. The Divisions are working together to put out for bid a renewed and enhanced request for an Administrative Services Only provider in the Medicaid and Long-Term care, Behavioral Health and Children and Family Services divisions to improve data acquisition and management capacity.

Through the efforts of the SIG grant, a "data dictionary" has been developed related to children and adolescents with mental health and substance abuse disorders. The "data dictionary" identifies various data elements within the file structure of the Department's NFOCUS database, the Medicaid database (MMIS), and Magellan's interface with Medicaid (Advantage Suite).

The Department has also identified additional data stored in other special purpose databases or kept manually. A key strategy within the SIG grant has been the establishment of an accountability evaluation work team, comprised of representatives from the Divisions of Behavioral Health, Children & Families, and Medicaid & Long-term Care, who have the

capacity to gather the existing data into a single unified data base, identify a standard set of process and outcome indicators to be collected across systems, determine whether barriers and gaps exist between the desired data and current data collection protocols, and develop a plan for addressing any identified barriers.

Data Driven Decision Making
Implementation Strategy:

- Develop a uniform system to collect and analyze data across systems regarding youth served, the quality of services provided, and outcomes.
- Place the Administrative Services Organization (ASO) contract out for bid.

7. Coordinated Funding Structures

Categorical funding silos can limit the success of a system of care, with each funding source having specific eligibility requirements, service delivery requirements, data collection mandates, assessment procedures, co-payment requirements, and flexibility.

Funding: A component critical to the Children's Behavioral Health System of Care will include the ability of Nebraska to facilitate "blending" or "coordinating" available monies in creative and flexible ways. Currently, our flexibility is limited; some of this is compounded by regulations for the Federal funding. Because of the potential infusion of federal funds, private resources, and the realignment of funds from costly out of home placements to earlier interventions, this plan does not call for additional state funds.

Over the last several months, representatives from the Department have been exploring how other states have attempted to move from categorical funding to a more blended funding system while retaining accountability for funds. The SIG Finance Work Team identified the fragmentation of the public funding structures in Nebraska as a problem for providing high quality uniform and effective services for children and adolescents with behavioral health disorders and their families. Ideally, funding should be invisible to the consumer. Whether a youth receives behavioral health services funded through the Divisions of Medicaid and Long-Term Care, Behavioral Health or Children and Family Services, the services and standards of care should be consistent. The specific features of coordinated funding structure that could be implemented may include the following principles:

- ❖ Ensure that finances across systems support Family Centered Practices
- ❖ Develop structures to support blended funding
- ❖ Develop structure for flexibility
- ❖ Ensure funding is targeted to behavioral health services that have evidence for being effective with specific populations
- ❖ Tie funding to outcomes that are consistently measured across funding streams and include performance indicators to measure success

Coordinated Funding Structure
Implementation Strategies:

- Develop a coordinated and accountable funding model.
- Ensure accountability for all funds.
- Implement performance based contracting.

Summary and Conclusions

The purpose of this report was to develop an implementation plan for the Governor and Legislature to consider based upon the LB 542 Children's Behavioral Health Task Force Report. The key elements and action steps included in the Department's plan include:

- Uniform assessment process
- Balanced array of services
- Accessible services
- Strategic use of evidence-based practices
- Strengthen training to behavioral health workforce
- Ensure cultural and linguistic competence at all levels of practice
- Coordinated responses for families involved in multiple systems
- Focus on community based services
- Develop highly secure facility to serve violent juvenile offenders

This plan is intended to provide direction as we move forward with developing a system of care across Nebraska. Our goal is to provide children, adolescents and their families with the right service, in the right amount, at the right location, for the right length of time, at an affordable, sustainable cost. Through partnership with communities, we will together provide for the safety, permanency and well being of children, adolescents and their families.

References

Ace Study on Findings on Alcoholism, (2003). The ACE Reporter. 1:2, 1-5.

American Psychiatric Association. (1992). *APA online public information. Childhood disorders* [On-line]. Available: http://www. psych.org

Cohen, M. C., (1998). Monetary value of serving high-risk youth and potential benefits to addressing drug and alcohol use with delinquents. Journal of Quantitative Criminology. Vol. 14 (1).

Family Centered Services. Retrieved from: http://www.answers4families.org/ifspweb/family_services.html on July 7, 2006.

Felitti, V. J. (2004). *The Origins of Addiction: Evidence from the Adverse Childhood Experiences Study*. The ACE Reporter. 1: 1-4.

Garrett, C. J., (1985). Effects of residential treatment on adjudicated delinquents: A meta-analysis. *Journal of Research in Crime and Delinquency, Vol. 22(4), 287-308.*

Kadzin, A. (1993). Premature termination from treatment among children referred for antisocial behavior. *Journal of Clinical Child Psychology, 31*(8), 415–425.

Nebraska MHSIP: Prevalence, Utilization and Penetration," WICHE Mental Health Program (October 30, 2001).

Nebraska: Prevalence Estimates for Serious Mental Illness (SMI) and Serious Emotional Disturbance (SED), WICHE Mental Health Program (January 5, 2007).

Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda, Washington, DC: Department of Health and Human Services, 2000. Stock No. 017-024-01659-4: ISBN No. 0-16-050637

Improving the mental/psychosocial health of US children and adolescents: Outcomes and implementation strategies from the national KySS summit (2003)**.** *Melnyk, B. M., Brown, H. E., Jones, D. C., Kreipe R., Editors and Novak, J.*

Appendix 1

Major Childhood Disorders

The consequences of mental and emotional disorders can be severe and may include family disruption, poor school performance and attendance, assaultive behavior, withdrawal, anxiety, addiction, commission of status offenses, self harm, risky behaviors, illegal activities, and in some situations, death. Behavioral health disorders in childhood are caused by a combination of biological and environmental factors and encompass a broad spectrum of symptoms and behaviors that occur in a variety of different contexts and many of these disorders exist in combination with other disorders. Some of the major types of disorders include the following:

1. Depression. Studies show that 2 of every 100 children may have major depression, and as many as 8 of every 100 adolescents may be affected (National Institutes of Health, 1999). Symptoms include the child feeling worthless or hopeless, losing interest in school or activities, and withdrawing from friends and family. Some children with depression may not value their lives and are at high risk of suicide.

2. Conduct Disorder. Youth with conduct disorder usually have little concern for others and repeatedly violate the basic rights of others and the rules of society. Conduct disorder causes children and adolescents to act out their feelings or impulses in destructive ways. Often children with conduct disorders end up in the juvenile justice system for status offenses such as ongoing truancy, running away, or more serious offenses such as assault, theft, and arson.

3. Bipolar Disorder. Children who demonstrate large mood swings that range from extreme highs (intense excitement or manic phases) to extreme lows (depression) may have bipolar disorder. During manic phases, children may talk nonstop, need very little sleep, and show unusually poor judgment. At the low end of the mood swing, children experience severe depression.

4. Anxiety Disorders. Youth who experience excessive fear, worry, or uneasiness may have an anxiety disorder, which affects as many as 13 of every 100 adolescents. Anxiety disorders include phobias (unrealistic and overwhelming fear of objects or situations); panic attacks, which may include rapid heartbeat or dizziness; obsessive-compulsive disorders which cause children to be trapped in a pattern of repeated thoughts or behaviors; and post-traumatic stress disorder, caused by a psychologically distressing event such as abuse or witnessing violence.

5. Attention-Deficit/Hyperactivity Disorder. Youth with attention-deficit/hyperactivity disorder are unable to focus their attention and are often impulsive and easily distracted. Many of these children have difficulty in school and are at high risk of dropping out, leading to negative outcomes in adulthood.

6. Eating Disorders. Children who are intensely afraid of gaining weight and do not believe that they are underweight may have eating disorders. Eating disorders can be life threatening.

7. Autism. Children with autism have problems interacting and communicating with others. Autism appears before the third birthday, causing children to act inappropriately, often repeating behaviors over long periods of time. Children with autism may have a very limited awareness of others and are at increased risk for other mental disorders.

8. Schizophrenia. Youth with schizophrenia have psychotic periods that may involve hallucinations, withdrawal from others, and loss of contact with reality. Other symptoms include delusional or disordered thoughts and an inability to experience pleasure.

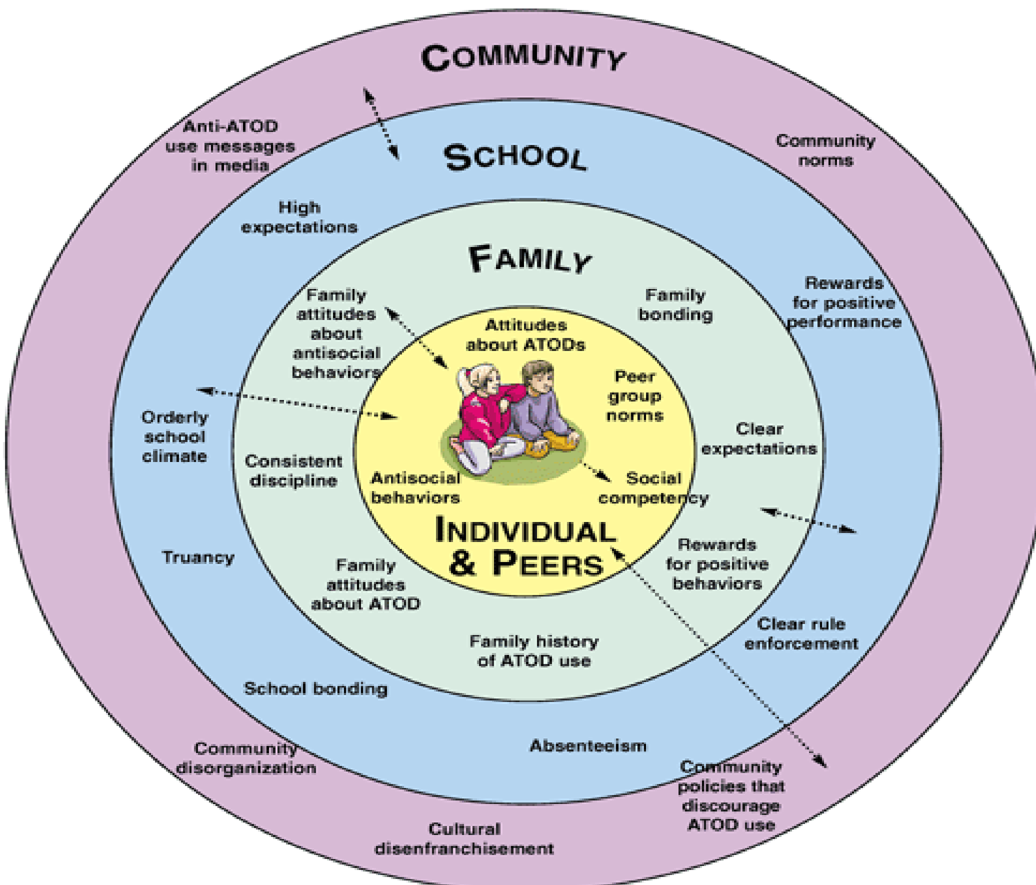
9. Substance Abuse. Children may use and become dependent on alcohol and other drugs such as over-the-counter medications; inhalants, including glue or paint; or illegal drugs, including marijuana, cocaine, methamphetamine, or heroin. Substance abuse often leads to physical, family, school, financial, and social problems. In some cases, a child may have both a substance abuse disorder and another mental health disorder. These multiple disorders are referred to as “co-occurring” disorders.

Appendix 2

Risk & Protective Factors

While mental illness affects children and adolescents from all walks of life, there are certain populations that are at higher risk for behavioral health disorders. For example, while behavioral health challenges can occur in families at all income levels, many -- such as depression, domestic violence, and child abuse -- are disproportionately frequent among low-income families. In 2005, more than 28.5 million US children lived in low-income households, in which the annual incomes were up to twice the federal poverty level, or about $40,000 for a family of four. Whether these challenges are associated with low income or a result of other factors, they are likely more difficult to cope with when a household has fewer resources. Also, because many of these risks occur in tandem, vulnerable families may require multiple services to achieve stability and security.

Prevention Wheel:



Uri Bronfenbrenner's Ecological Model of Human Development is helpful in understanding the interrelationship interplay of risk and protective factors in designing Alcohol Tobacco and Other Drugs (ATOD) prevention programs. As indicated in the graphic below, forces impact on a developing child at levels that include the individual, family, school, and community. In the graphic, the concentric circles surrounding the individual represent the sources of risk or the

sources of protection. Each circle is nested within the others. Note that individual risk and protective factors cluster around personality or psychosocial characteristics, attitudes, knowledge, and behaviors. Family factors may include a family history of ATOD abuse; school-related factors include the youth's sense of connectedness to the school; and community risk factors include the availability of ATOD and norms related to ATOD use.

Risk Factors: These elements in a child's life increase the likelihood that there will be substance use and mental health disorder sometime in their lives.

- Community Domain
  - Low neighborhood attachment
  - Community disorganization
  - Transitions and mobility
  - Laws and norms favorable toward drug use
  - Perceived availability of drugs
  - Perceived availability of guns
- Family Domain
  - Poor family management
  - Family conflict
  - Family history of antisocial behavior
  - Parental attitudes favorable toward drugs
  - Parental attitudes favorable toward antisocial behavior
- School Domain
  - Academic failure
  - Low commitment to school
- Peer/Individual Domain
  - Rebelliousness
  - Early initiation of antisocial behavior
  - Early initiation of drug use
  - Attitudes favorable toward drug use
  - Perceived risks of drug use
  - Interaction with antisocial peers
  - Friends who use drugs
  - Rewards for antisocial behavior
  - Depressive symptoms
  - Gang involvement
  - Intentions to use drugs

Protective Factors – These factors present in a person's life buffer risk influences

- Community Domain
  - Opportunities for prosocial involvement in the community
  - Rewards for prosocial involvement in the community
- Family Domain
  - Family attachment
  - Opportunities for prosocial involvement in the family

- Rewards for prosocial involvement in the family

- School Domain
  - Opportunities for prosocial involvement at school
  - Rewards for prosocial involvement at school
- Peer/Individual Domain
  - Religiosity
  - Social skills
  - Belief in the moral order
  - Interaction with prosocial peers
  - Prosocial involvement
  - Perceived rewards for prosocial involvement

Appendix 3

Family/Person Centered Practice
Based on a set of values, beliefs and principles that ensure it is:

- **COMPASSIONATE**
  Every effort to communicate with consumers, colleagues and families embodies compassion and is distinguished by good manners. The hopes of the individual and family are cherished, nurtured and held dear.

- **INDIVIDUALIZED**
  People are unique; their problems are as well. Simple logic dictates that the best solutions to their problems are those that are uniquely tailored to them.

- **FAMILY/PERSON DRIVEN**
  Families are the experts on what they need. This process produces a new level of individual and family input and eventually, investment in plans intended to alleviate distress and respond to troubling circumstances.

- **STRENGTHS BASED**

  A thorough discovery of individual and family strengths, cultures, preferences, and values is where this process starts. Meetings begin with a description of the strengths, culture and values of the individual/family.

- **CULTURALLY COMPETENT**

  We set out to learn each individual's and family's unique culture. These are among the cornerstone strengths and assets on which the plan is based

- **TEAM DEVELOPED AND SUPPORTED**

  The people who are involved with the family – both formally and informally – come together in a Family Team. This team, which changes as it's developed, forms a circle of support around the person in need.

- **OUTCOME FOCUSED**

  Accountability is encouraged because planned outcomes are defined in advance and monitored throughout the process. Outcome statements identify specifically what is to be produced by the plan.

- **NEEDS DRIVEN**

  Unmet needs, when met, become the bridges between the desired outcomes and the current reality.

- **FLEXIBLE**

  The integrity of the individual and family is the concern, not the integrity of the program. We don't try to shove square pegs into round holes. Unique supports and resources are developed to best fit a particular person or family and meet their needs.

- **UNCONDITIONAL**

  Plans are supposed to work, to produce desired outcomes. If the plan does not work, we change the plan. *The only thing we don't do is give up.*

- **NORMALIZED**

  Plans are created that feel so familiar and comfortable to their intended beneficiaries that they claim them as their own. People have access to the activities that typify daily life for children and adults of the same age, stage and culture.

- **COMMUNITY BASED**

  We should help people remain in their neighborhoods and communities and still get their unmet needs met.

Adapted from:
The Wraparound Process Curriculum
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E.M. Grealish

Appendix 4

Rationale for Service Array Project

ACCOUNTABILITY

- Aligns the three Divisions for shared responsibility to meet the needs of all children served by DHHS. Shared vision and strategies between the Divisions.
- Increases the ability to meet federal outcome measures (CFSR) related to safety, permanency and well-being for children
- Increases accountability for outcome achievement by DHHS, the providers, and the managed care organization.
- Increases accountability for families.

QUALITY

- Creates a "continuum of care" for children and family services from least intrusive/restrictive to most intrusive/restrictive
- Establishes clear criteria for service delivery and movement through the continuum of care based on individual and family needs
- Simplifies and condenses levels of care and offers "Wrap-Around" services

EFFICIENCY

- Coordinates the service delivery system between the Divisions of Children and Family Services, Medicaid and Behavioral Health
- Decreases duplication and overlapping of services
- Decreases the "silos" within DHHS (services, funding)
- Moves the service delivery system from high cost, high-end out-of-home services to low cost community-based and in-home services

EFFECTIVENESS

- Increases the number of children served in their own homes and in their own communities
- Decreases residential and institutional care, therefore decreasing number of state wards
- Decreases the number of court cases
- Increases the number of families served without unnecessary court involvement

SUSTAINABILITY

- Establishes a service delivery structure that can be sustained in the future

Appendix 5

Current Array of Services

Children and Family Services	Medicaid and Long-Term Care	Behavioral Health
Adoption Support	23:59 Observation	Assessment/Evaluation ONLY MH
Agency Based Foster Care	Acute Inpatient Hospitalization	Assessment/Evaluation ONLY SA
Child Care	Assertive Community TX (ACT)	Community Support SA
Clothing	Behavior Health Drugs and Injections	Crisis Inpatient
Day Reporting	Case Conferences	Day Treatment
Detention	Client Assistance Program (CAP)	Home Based Therapy
Education Support	Community Support	Intensive Outpatient
Education/Training Vouchers	Community Treatment Aide	Intensive Outpatient SA
Electronic Monitoring	Comprehensive Child/Adolescent Assessment	Med Mgmt
Emergency Shelter Center	Comprehensive Family Assessment	Outpatient Therapy MH
Emergency Shelter Foster Care	Day Rehabilitation	Outpatient Therapy/Assessment SA
Escort	Day Treatment / Partial Hospitalization	Prof Partner/School Wraparound
Family Group Centering	Electro Convulsive Therapy	Professional Partner
Family Support	Emergency Treatment Group Home (ETGH)	Respite Care
Foster Care	Evaluation Management by Psychologist or Psychiatrist	Therapeutic Community/Community Support
Group Home A	Family Assessment	Therapeutic Consultation
Group Home B	Family Therapy	
Intensive Family Preservation	Group Therapy	
Interpreter	Individual Therapy	
Legal	Initial Diagnostic Interview	
Maintenance Ward's Child	Intensive Outpatient	

PALS	Intensive Psychological Residential Rehabilitation
Parent Education	Medical Interpreters
Personal Needs	Medical Transportation
Rent/Utilities & Furniture	Medical Wrap Services
Respite	Medication Management
Subsidy Payments	Mental Health Home Health
Tracker	Pretreatment Assessment (PTA)
Transitional Living Programs	Provider Mileage
Tutoring	Psychological Residential Rehabilitation
Visitation Supervision	Psychological Testing
YRTC	Residential Treatment Center (RTC)
ADC	SA Ambulatory Detoxification
Adult Family Home	SA Assessment
Adult Protective Services	SA Community Support
Child Care	SA Dual Diagnosis Therapeutic Community
Child Support Enforcement	SA Family Therapy
Chore Services	SA Group Therapy
Emergency Assistance	SA Halfway House
Employment First	SA Individual Therapy
Energy Assistance	SA Inpatient Detoxification
Every Woman Matters	SA Intermediate Residential
Food Stamps	SA IOP
Home delivered meals	SA Partial Hospitalization
Home Health	SA Residential Social Detoxification

Nutrition	SA Residential TX dual Diagnosis Enhanced
Personal Assistance	SA Short Term Residential Dual
Refugee Program	Treatment Foster Care (TFC)
Respite	Treatment Group Home (TGH)
TANF	SA IOP
Transportation	SA Partial
WIC	Short Term Residential Dual
	Transportation

Appendix 6

Child and Family Service Review Summary

About the Review

The Child and Family Services Review (CFSR) is a federal review of performance-based outcomes for children and families. The review examines the delivery of child welfare services and the outcomes for children and families served by child protective services, foster care, adoption and other related programs.

Why are these reviews done?

In addition to measuring compliance with federal legislation, the review provides an opportunity for states to engage in quality improvement of the services to children and families throughout the state.

Who does these reviews?

The reviews are conducted by the federal Department of Health and Human Services (DHHS). During the onsite portion of the review, teams of DHHS staff and consultants and State representatives review a small sample of case records and interview stakeholders. The DHHS Regional Administration ultimately completes the report for Children and Families (ACF) office.

How often are they done?

This is the first time the federal government has reviewed state child welfare services using performance-based outcomes. DHHS is just completing the first round of reviews for each state. Once a state completes the review, they have two years to work on a program improvement plan before they are reviewed again.

What does the review look at?

The review looks at outcomes for children and families in the three main areas of safety, permanency, and child and family well-being.

The review also examines each state's infrastructure or 'system' that supports the delivery of child welfare services. These systemic factors include such things as staff training, evaluation of a state's computer data systems to track cases, and the state's efforts to license and recruit foster parents.

How are the reviews conducted?

The primary elements of the review include:

- State's self-assessment
- Statewide data collection and analysis
- Week-long onsite review

The review assesses what is actually happening to children and families who are receiving child welfare services in each state. The review takes many different aspects of child welfare into considerations. A small sample of case records is examined to analyze how the child welfare system responds to help both the child and the family. Children and families are interviewed, as are representatives of other child welfare agencies and the courts.

Is there a report?

A final report is developed following the onsite portion of the review. The report summarizes the state's performance during the specified time period on seven child welfare outcomes pertaining to safety, permanency and well-being and on seven systemic factors. Six data outcome measures and information from the case review process and stakeholder interviews result in findings and a determination of whether or not the state achieved conformity with federal requirements and standards. The report also details strengths and areas where improvements are needed.

Are all states reviewed?

Yes, All 50 states are reviewed as well as Puerto Rico and Washington D.C.

Are mental health and substance abuse part of this review?

States are required to work with a variety of systems, including mental health and substance abuse service agencies, to ensure positive outcomes for children. In addition to using the CFSRs as a learning tool, mental health and substance abuse representatives may participate directly in the CFSR process in a variety of ways, such as participating as a consultant on a review team to help review cases and conduct interviews; serving on Statewide Assessment or PIP development teams; or being interviewed during stakeholder interviews conducted at each review site. Representatives may include persons from the State health program, Medicaid program, or State mental health and substance abuse agency, and behavioral health treatment providers. The CFSRs assess State efforts to address the mental/behavioral health needs of children through exploration of the following core questions:

- Assessment: Did the agency conduct an assessment of the children's mental/behavioral health needs initially and on an ongoing basis to inform case planning decisions?
- Services: Did the agency provide appropriate services to address the children's mental/behavioral health needs?

Appendix 7

Collected Data Sets

Evaluation Question	Examples of Types of Data	Examples of Specific Instrument/ MIS Systems	Populations					
			State Wards				Non-wards	
			Abuse & Neglect		Delinquents			
			P & S	ICCU	ICCU	P & S	Probation	Professional Partners
Who are the children and families served by the public behavioral health system?	Demographics (age, race, gender)	NFOCUS	X	X	X	X		
		DIQ		X	X			X
	Diagnosis	DIQ		X	X			X
	Level of Functioning	CAFAS		X	X[1]			X
		PECFAS[2]		X	X			
	Behavior Problems	Ohio Scales		X	X			X[3]
		Eyberg/ Sutter-Eyberg						X[3]
	M. H. Symptoms	CBCL/TRF/ YSR						X[3]
	Degree of Substance Abuse	CASI			X	X	X	
		SUS						X[3]
	Living Environment	Ohio Scales		X	X			X[3]
		ROLES						X[3]
	Risk of Continued Delinquent Behavior	YLS/CMI			X	X	X	X[4]
	Delinquent Behavior	DS						X[3]
	Developmental Stage	PEDS[5]		X	X			
	Child Strengths	BERS						X[3]
	Caregiver Strain	CGSQ						X[3]
How are they served?	Medicaid service utilization (type,	MMIS	X	X	X	X		X

	length and cost of service)							
	Non-Medicaid service utilization (type, length and cost of service)							
	Fidelity to treatment protocol (Wraparound)	WFI		X	X			X
What difference does it make?	Changes in symptoms, problems or functioning	CAFAS/ PECFAS[5]		X	X			X
		Ohio Scales		X	X			X[3]
		CBCL						X[3]
		WAI						X
	Changes in Substance Abuse Behavior	CASI			X	X	X	
		SUS						X[3]
	Changes in Living Environment	Ohio Scales		X	X			X[3]
		ROLES						X[3]
	Changes in Risk of Continued Delinquency	YLS/CMI			X	X	X	X[4]
	Changes in Delinquent Behavior	DS						X[3]
	Changes in School Attendance or Performance							