

PLAN FOR IMPROVING EARLY INTERVENTION SERVICES FOR CHILDREN AND YOUTH AND THEIR FAMILIES IN MARION COUNTY

2008

Marion County Early Intervention Planning Council

Prepared by:



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Without Appendices

This document outlines recommendations and action steps for improving the capacity of Marion County to provide delinquency prevention and early intervention services to children, youth, and their families. The plan was developed by the Marion County Early Intervention Planning Council for the City-County Council of Indianapolis and Marion County Indiana. The document was prepared under contract by Dr. Eric R. Wright and staff at the Indiana University Center for Health Policy, 334 N. Senate Ave., Suite 300, Indianapolis, IN 46204. An electronic copy of this document is available at www.healthpolicy.iupui.edu/eipc.htm.

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Christina Ball	Judge of Juvenile Court	Probation Department
Rhonda Allen	Director of County Department of Child Services	Marion County Department of Child Services
John Brandon	Director of County Department of Child Services	Either: an interested resident of the county or a representative of a social service agency
VACANT	Superintendent of the largest school corporation	The largest school corporation in the county
Patricia Jones	City-County Council	The remaining school corporations in the county
Doris Clark	City-County Council	Community mental health centers
VACANT	City-County Council	Experience or training in public accounting or public finance
VACANT	City-County Council	The minority leader or designee who must also be a member of the city-county council
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Taren Duncan	Director of County Department of Child Services	Marion County Department of Child Services
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Contents

Early Intervention Planning Council Members	2
Contents	3
Plan for Improving Early Intervention Services for Children and Youth and Their Families in Marion County	4
Overview of the Problem	5
Issue: Significant numbers of children at risk are entering the system.....	6
Mentoring Programs	7
Model Programs.....	8
Relative Effectiveness of Interventions	10
Challenges.....	12
Action Steps	13
Issue: Many children who need services are not identified early enough	16
Action Steps.....	16
Issue: More mental health services are needed.....	18
AACAP Recommendation 3.....	18
AACAP Recommendation 11.....	19
AACAP Recommendation 12.....	20
Model Programs.....	20
Mental Health Providers Roundtable.....	21
Medicaid Funding	21
Hard to Find Staff	23
Schools.....	23
Funding for Children Who Fall Through the Gaps.....	23
Early Diagnosis.....	24
Mental Health Center Budgets.....	24
Budget Trends.....	26
Medicaid Rule Changes	28
Challenges.....	28
Action Steps	30
Issue: Children are falling through the cracks in the system	31
American Psychological Association Task Force.....	31
Education	31
Social Services	32
Juvenile Justice	32
Mental Health.....	33
APA Task Force Conclusions.....	33
A Successful System.....	33
Action Steps	34
Conclusion	35
References.....	36

PLAN FOR IMPROVING EARLY INTERVENTION SERVICES FOR CHILDREN AND YOUTH AND THEIR FAMILIES IN MARION COUNTY

The Early Intervention Planning Council (EIPC) was appointed by the City-County Council of the city of Indianapolis and Marion County, Indiana, in May 2006, to develop a comprehensive plan for early intervention that will provide services tailored to the needs of children who have been either adjudicated or delinquent, and children and adolescents who have been identified by the Office of Family and Children as substantially at risk of becoming delinquent children, or have been referred to the Marion County Office of Family and Children Services. As outlined in City-County General Ordinance No. 70, 2005, the EIPC is chaired by the director of the Marion County Office for Family and Children and includes representatives of the major child-serving systems as well as other organizations serving children, youth, and their families.

Under the City-Academic Partnership agreement between the City-County Council and Indiana University–Purdue University Indianapolis (IUPUI), Professor Eric R. Wright and staff at the Center for Health Policy at IUPUI provided logistical and technical support under contract to the EIPC.

Following a period of careful study, the analysts have outlined the EIPC’s 2008 plan in this document. Specifically, we have highlighted four major goals and recommendations. The EIPC plan includes four goals:

- Expand access to and improve the quality, coordination, and range of early intervention programs available in local neighborhoods, communities, and faith-based organizations.
- Provide in-depth training to primary care medical providers, childcare workers, preschool teachers, and public and private school teachers in the assessment of childhood and adolescent risk factors and to help them develop procedures to refer identified children, adolescents, and families to the appropriate community services.
- Expand access to mental health services for children and families in need.
- Improve coordination of information and resources for children and adolescents entering the “system” (e.g., first contact with special education, child welfare, mental health, or juvenile justice).

These goals address major objectives outlined in the ordinance, including: increase permanency and self-sufficiency among families at risk of abuse and neglect; reduce the number of abuse, neglect, and delinquency cases requiring juvenile court intervention; promote the coordination of available resources and minimizing unnecessary duplication of services; and minimize the cost of addressing the needs of delinquent children.

OVERVIEW OF THE PROBLEM

Currently, there are more than 3,000 children in need of services (CHINS) in Marion County. Of those now in the care of DCS, approximately half are in foster care, with the remainder in residential care, relative care, in their own home, or in other. Within the Juvenile Justice system in 2006, there were 8,439 delinquency cases and 2,384 status offenses. Research conducted by the IUPUI Support Staff estimated that there are approximately 38,000 youth under age 25 who exhibit four or more risk factors for contact with either DCS or Juvenile Justice. This number is significantly larger than the current number of youth being served by DCS and Juvenile Justice, suggesting a potential for significant growth in these systems in the future. *This growth can be prevented, children can stay out of the system, and taxpayer money can be saved by implementing this plan.*

Research indicates that our best hope for creating public programs that deter child abuse, neglect, and delinquency is to create a comprehensive system of care that focuses not only on intervention, but also on prevention. Such systems are both coordinated and integrated, and they involve both the interests and input of the children and families involved. Efforts to address the needs of vulnerable children and families before they are deemed at risk or in need of services have been proven effective in multiple studies. Researchers studying prevention in a variety of fields have also concluded that isolated services are less effective than coordinated systems of care in addressing the needs of vulnerable children. In a system of care model, the education, juvenile justice, mental health, and child protection subsystems work together with families and other community agencies through a unified approach to deal with the problems of child abuse, neglect, and delinquency—and their precursors—together. Communication, teamwork, and shared goals and philosophies are vital for the system to work effectively. Coordination of services is essential to deliver services in an effective manner. Researchers studying prevention research in a variety of fields have also concluded that isolated services are less effective than coordinated systems of care in addressing the needs of vulnerable children.

To achieve the comprehensive approach needed to prevent children from entering the system, more coordinated and strategic efforts are needed to assist community and neighborhood organizations and formal service providers in identifying prevention programming needs.

Youth programs have shown great promise in addressing the key risk factors for delinquency. A great deal of literature point to the evidence-based practices of effective mentoring programs. Mentoring programs should be guided by theory and research that emphasize a focus on positive youth development, youth-driven activities, and the development of core competencies and skills (e.g., decision-making, problem-solving, and accessing community resources).

ISSUE: SIGNIFICANT NUMBERS OF CHILDREN AT RISK ARE ENTERING THE SYSTEM

Goal One: Expand access to and improve the quality, coordination, and range of early intervention programs available in local neighborhoods, communities, and faith-based organizations.

Research indicates that our best hope of creating public programs that deter child abuse, neglect, and delinquency is to create a comprehensive system of care that focuses not only on intervention, but also on prevention [1, 2]. Such systems are both coordinated and integrated, and involve both the interests and input of the children and families involved. Efforts to address the needs of vulnerable children and families *before* they are deemed at-risk or in need of services have been proven effective in multiple studies [3, 4]. Researchers studying prevention research in a variety of fields have also concluded that isolated services are less effective than coordinated systems of care in addressing the needs of vulnerable children [5]. Comprehensive and coordinated systems also show improvement over the continuum of care model [6].

Part of the paradigm shift involved in a system of care approach is the recognition that problems once seen as independent issues are actually intricately related and are often risk factors for subsequent social problems. Children who are at risk of failing in school, for example, are more likely to become delinquent in future years. Children who face abuse or neglect at home are at greater risk of both academic failure and delinquency [7]. The challenges faced by vulnerable children and families are interrelated and systemic; the response must also be interrelated and systemic. In a traditional care model, issues such as neglect, drug use, academic failure, poverty, chemical imbalance, and delinquency might be treated by separate agencies; in a system of care model, appropriate elements of each subsystem are brought together to treat each problem currently or potentially faced by a vulnerable child and family.

A preventive system of care also focuses on the treatment of problems before they begin. Some issues faced by a child or family are recognized not solely as isolated problems, but also as risk factors for related issues [8]. Common root problems, including poverty, adverse family history, mental, emotional and physical illness, and lack of social support, are treated at the earliest recognizable onset, but also—by recognizing related vulnerabilities that may be precursors of these problems—before they occur [9, 10]. Risk factors for any kind of social problem are addressed and early intervention measures taken to keep risk factors from blossoming into actual problems.

Numerous studies and analyses have shown that prevention and early intervention are more effective [11, 12] and less expensive than treatment of more progressive social problems [13, 14]. Early intervention for families and children displaying risk factors is good, but not good enough; a true preventive system of care is also focused on enhancing the strength and resiliency

of children and families, giving them a greater advantage in overcoming risk factors they may face. Just as risk factors exist that make a child and family more vulnerable to future problems, protective factors exist that can help strengthen the resilience of child and family to those ills [15].

This preventive approach is based on the belief that all children and families have needs which must be met in order for them to be successful. These needs comprise the conditions for success. Risk factors generally compromise or eliminate the fulfillment of these needs, making children and families more susceptible to problems. Conversely, by instituting programs that promote and support the conditions of child and family success, children and families can become more resilient to the stresses and challenges they face and better equipped to overcome those challenges in a healthy and productive way.

Researchers at the Center for the Study of Social Policy identified nine conditions for child success—conditions that must be met for all children if they are to be successful. These conditions must be met regardless of a child and family’s race, socioeconomic status, educational background, or other factors (see Table 1) [16]. A wide range of additional research has identified additional protective factors that contribute to child and family resiliency.

Table 1: Conditions for Child Success

<ul style="list-style-type: none"> • Economic and physical security • Environmental and public safety • A nurturing, stable family environment • Adult mentors and role models in the community • Positive peer activities • Opportunities to exert effort and achieve success • Health care for medical needs • Positive educational experiences and acquisition of useful skills • Access to professional services to treat conditions or needs that may require professional care

Source: Center for the Study of Social Policy. (1996). *The Case for Kids. Community Strategies for Children and Families: Promoting Positive Outcomes*. Washington, D.C.

Mentoring Programs

A great deal of literature suggest that there is solid value in the evidence-based practices of effective mentoring programs. Mentoring programs should be guided by theory and research that emphasize a focus on positive youth development, youth-driven activities, and the development of core competencies and skills (e.g., decision-making, problem-solving, and accessing community resources) [17]. The success of a mentoring program depends largely on the program’s ability to foster a trusting relationship between a mentor and a mentee. From a number of studies published by Public/Private Ventures, a national nonprofit organization whose mission is to improve the effectiveness of social policies, programs, and community initiatives, especially as they affect youth and young adults, it is clear that this can be accomplished through recruiting adult mentors who are mature, empathetic, excellent listeners, passionately committed, and able to serve as positive role models, thus engendering trust. Mentors must be offered training to

develop a clear understanding of the needs of the youth they will mentor and the expectations of the role of the mentor. Mentor training should prepare mentors to set realistic expectations for the relationship and to manage mentee resistance.

Evidence suggests that one-on-one mentoring leads to better outcomes than group mentoring approaches. Success also appears to depend upon regular, scheduled contact, over a period of at least one year, with weekly in-person contact, supplemented with regular phone contact. Match is critical: same-sex, samerace mentoring relationships tend to be more successful. Gender, race, and ethnicity are especially important since African American and Hispanic youth make up a disproportionate number of incarcerated youth [18] and a growing number of girls are involved in the juvenile justice system [19]. Research clearly shows that structured activities for mentors and mentees can be beneficial [17]. Such activities ideally expand the worldview of the youth, are low cost, and integrate the mentor and mentee into the larger program, all of which increases the rate of retention of the youth and the mentors in the program.

Mentoring programs must be able to effectively recruit, screen, train, and supervise staff and mentors [20, 21]. Sufficient infrastructure means lower staff-to-mentor ratios; systems to monitor the mentor/mentee relationship and progress; group support systems; and performance evaluations and supervision. It is critical that mentoring programs set boundaries on the scope of the mentoring relationships so that mentors understand the appropriate limitations of their role. Such systems help prevent mentor frustration and drop-out and ensure successful mentee outcomes [22].

Model Programs

The largest mentoring organization in the United States is Big Brothers/Big Sisters. A national evaluation of this program [23] has furnished evidence that mentoring is a best practice. Using a randomized experimental design to evaluate the program in many sites across the United States, Grossman and Garry found that youth who were mentored were less likely to start using drugs and alcohol, less likely to use violence against others, less likely to be truant from school, more likely to feel better about school and academic work, and more likely to report stronger relationships with parents and peers. Formal mentoring has been used as an intervention to address risk factors as diverse as early and persistent antisocial behavior, alienation, family management problems, and lack of commitment to school. The prototypical one-on-one mentoring approach is geared at enhancing such protective factors as healthy beliefs, opportunities for involvement, and shaping appropriate behavior (see the OJJDP website on Model Programs for more detail related to risk and protective factors addressed by formal mentoring programs).

The bulk of the evidence on the effectiveness of formal mentoring comes from evaluations of either school-based or community-based mentoring programs [24]. In general, school-based mentoring has been shown to be effective in enhancing academic performance, but is typically a less expensive approach that provides lower levels of contact between the mentor and mentee. The community-based programs contribute more to influencing behaviors and can be used to reach youth who are not effectively engaged in the school setting.

Mentoring is often incorporated as a strategy within programs with many components. For instance, CASA START (Striving Together to Achieve Rewarding Tomorrows), has been shown to have strong evidence of reducing future drug use, violent crime, and drug dealing. This program has been implemented and evaluated in cities across the country—Austin, TX; Bridgeport, CT; Memphis, TN; Savannah, GA; and Seattle, WA were part of the largest evaluation of the program. However, in addition to mentoring, the program also provided (for all participants): case management, family services, afterschool and summer activities, and educational services, making it difficult to identify the specific effects of mentoring [25].

Another example of a multi-dimensional program that includes mentoring as a key component is the Movimiento Ascendencia (Upward Movement) program in Colorado. This program targets girls at risk for substance use and gang involvement. All girls are assigned to a female mentor who is expected to spend 2 hours each week with her mentee over a period of 9 months. Results showed the program to be effective in reducing involvement in delinquency, but again it was not clear how much of a role the mentoring played in the positive outcomes [26].

A third example is the Supporting Adolescents with Guidance and Employment (SAGE) program in North Carolina. This program has three key components: a cultural pride and ethnic identity component geared at African American youth and delivered by mentors, a job training and placement program, and an entrepreneurial experience [27]. The evaluation provided preliminary evidence that this program can reduce the likelihood of violence and other problem behaviors for African American males, but again, it is not clear how important mentoring was to the outcomes.

One program that provided experimental evidence isolating the effects of mentoring within a multi-dimensional strategy is the Across Ages program. This program used intergenerational mentoring (older adults with preteens) and found that mentoring was important for the success of the program. The youth who received mentoring (in addition to life skills instruction in the school, community service projects, and parent workshops) were most likely to deal effectively with peer pressure to use drugs or alcohol, to have more positive attitudes about school and their future, to have stronger feelings of self-worth, to have fewer reports of depression, and to be less likely to use drugs and alcohol [28]. The evidence from the evaluation would at least put this program in the category of “adequate evidence.”

Mentoring also has been shown to make a difference in influencing educational outcomes. In the program Career Beginnings, the focus was on providing career-shaping mentoring for disadvantaged high school students [29]. Mentors focused on exploring college and career options. The evidence of effectiveness is adequate for this program. Participants in the program (that involved mentoring and a service package that was built from a partnership between the high school, the community, and the university) reported higher aspirations after the program and were more likely to go to college.

In terms of positive youth development, there have historically been a number of community-based civic youth programs for youths to get involved in. The best known programs include Boy Scouts, Girl Scouts, the YMCA, the Boys and Girls Clubs, Girls, Inc., and 4-H. These programs

have been important in the development of healthy attitudes and values and for learning life skills and leadership development. Recently these programs have become particularly important as evidence has shown that significant numbers of adolescents are unsupervised for hours each day after school, and that youth involvement in delinquency and high-risk activities is most likely to occur after school hours when adult supervision is lacking.

Relative Effectiveness of Interventions

Many of these programs have not yet been subject to quality evaluations. We can infer some conclusions about the potential of these programs to have an impact with youths from related activities in other community-based programs. As summarized in the Model Programs section of the OJJDP website, we can point to the following key lessons we have learned to date:

- Quality programs involve mentoring, and life prep types of activities. Examples are college awareness and preparation, employment preparation/training, volunteer and community service opportunities, and youth leadership activities.
- Quality programs also provide access to cultural enrichment and supervised recreation.
- The most effective programs have clear goals, are staffed effectively, pay attention to safety, draw on the diverse resources of the community, create learning experiences for the youth, and encourage the involvement of the family.

In general, these programs address a number of protective factors related to the involvement in positive activities with other peers, and several targeting the individual youth, such as social competencies and problem-solving skills, healthy positive beliefs, the perception of social support from adults and peers, positive expectations for the future, and a positive temperament. These programs are appropriate to address risk factors from several domains: the community in which they live, their experiences in school, the context of the family, the influence of negative peers, and their own individual characteristics.

Adequate evidence exists that the SMART Leaders program of the Boys and Girls Clubs of America is an effective strategy [30]. This program is geared toward prevention of drug use and sexual activity among adolescents age 13-15. The actual content of the program includes a curriculum that focuses on teaching social and personal competence skills geared at resisting peer and social pressure to engage in problem behaviors. The program also encourages the youth to take on roles to help other youth benefit from the program. An evaluation of the implementation of the program in 14 different clubs in cities across the country found that the program was effective in changing attitudes about drug and alcohol use and reducing the likelihood of eventual involvement in substance use.

Preliminary evidence is available for another program of the Boys and Girls Clubs of America: Gang Prevention Through Targeted Outreach. This program targets youth from 6-18 and was evaluated with samples from 24 clubs across the country [31]. This program uses the interest-based programming at the Boys and Girls Clubs to facilitate positive youth development and engagement in positive youth activities. The evaluation results showed that the strategy was successfully delayed the onset of some gang-related behaviors and contributed to lower levels of

involvement in delinquency and the juvenile justice system. There were also benefits in terms of school outcomes and engagement of youth in positive activities.

There have been a few evaluations of the programs provided by 4-H. One example is an evaluation of the Living Interactive Family Education (LIFE) Program that was established in 1999 at the Potosi Correctional Center, a maximum security prison in Missouri. This program seeks to increase the amount of visitation between incarcerated fathers and their children, while involving the youth in 4-H activities. At the 4-H meetings, children and their fathers work together on curricula-based activities focused on the development of life skills, such as conflict resolution, substance abuse resistance, teamwork, and character development. Preliminary evidence is available at this point from the evaluation [32]. The results indicate that LIFE does increase the life skills of the youth participating in the program, although there was less improvement in the communication skills. However, the sample size was small and in only one geographic location.

Boy Scouts is another national civic organization that provides youth development programs. Boy Scouts are provided with opportunities to build character, explore the differences between right and wrong, take part in service projects to help others, set goals and then go about achieving them, be exposed to positive role models, be encouraged to spend more time with family, learn new skills, and use time constructively. A national assessment of programming was organized according to six “critical elements of healthy youth development”: strong personal values and character, a positive sense of self-worth and usefulness, caring and nurturing relationships with parents and peers, desire to learn, productive use of time, and social adeptness. Results found positive outcomes in each of these areas [33]. Since the results of this study come from a survey of scouts and their parents across the country, they offer preliminary evidence, at best, of the impact of these programs.

Similarly, there has been a national evaluation of programming by the Girl Scouts of America. Traditional troop activities in Girl Scouts take place after school and in the early evening. They involve organized play and learning activities supervised by positive adult role models, and interaction between the girls and their parents. The organization has proposed the following outcomes for girls: self-reliance, self-competence, social skills (ability to make friends), respect for others, feelings of belonging, values and decision-making, helpfulness/concern for the community, teamwork, and leadership. Results of the evaluation found that regardless of age, compared to other school activities, troop activities gave them more opportunities to experience all nine outcomes. It appears that troop activities also enhance the relationships the girls have with their parents. As with the results from the assessment of Boys Scouts programming, these results come from a survey of girls involved in the program, their parents, adult leaders, and others outside of Girl Scouts. As such, they offer, at best, preliminary evidence of the effectiveness of programming [34].

There is also preliminary evidence from other initiatives not being provided by national civic organizations described so far. One program, described before in the section on mentoring, is Movimiento Ascendencia (Upward Movement), a program that targets girls at risk for substance use and gang involvement. Girls are exposed to organized sports and recreational activities,

cultural activities, and case management. Results showed the program to be effective in reducing involvement in delinquency [26].

Another program, BUILD (Broader Urban Involvement and Leadership Development), from Chicago, is a gang prevention program that incorporates a number of elements from quality programs: afterschool sports programs, recreational activities, career training, and college counseling. This program also draws upon the participation of corporate sponsors, community leaders, and parents. A recent evaluation of the program focus on an implementation of the program with youth released from a detention center in Chicago. The results showed that the youth who actually participated in BUILD were less criminally involved thereafter [35]. These results offer preliminary evidence of the effectiveness of the program.

Challenges

One challenge noted is that the programs are often trying to accomplish too many disparate goals, and not doing anything really well [36]. Another concern is that these programs often receive funding through competitive opportunities, but then the staff members of the programs have not bought into the logic models laid out in the grant proposal [37]. Staffing of these programs is also a challenge in that turnover is often high—the pay for these positions is relatively low, so the best staff move on to other opportunities. Finding ways to retain highly-skilled staff members is also important because continuity impacts the ability of the program to retain youths, as they have trouble building relationships with staff members when turnover is high [36]. Retention of youth for a significant length of time is a challenge and it is important because the evidence shows that the longer the involvement of the youths in the programming, the more positive the results. For youth to get the most out of the programming, it is also critical for them to attend the activities several times each week. Program staff need to work to encourage participation at this level. Many of the youth who are interested in the services being offered are not the youth who need the services most. In contrast, a critical challenge is that the demand for services is too high, overwhelming the programs and lowering the effective adult-youth interactions [38]. Programs need to specifically target the high-risk youth who do not have effective adult supervision and support in place. Partners may also create challenges in that they may not make referrals as expected, meaning the programs are undersubscribed by the youth who most need the services—low utilization may also challenge the ability of the programs to sustain themselves or to attract additional funding [37].

Sherk [39] catalogues the issues that programs must be wary of when implementing mentoring programs that work (see also [40]). First, programs must have enough resources and sufficient staffing. The staff must understand their role in recruiting and nurturing volunteers. It is critical, as well, that the program managers are passionate and committed about mentoring and good role models for the volunteers. Many ineffective programs suffer from lack of a clearly defined mission and goals. It is also problematic when the programs have not developed partnerships and relationships with schools, faith-based organizations, social clubs, corporations, and universities. Problems have also been found when programs do not provide ongoing monitoring and support of the mentoring relationships. Initial training and ongoing training must also be in place to avoid

some of the problems that many mentoring programs face. It is also critical that effective practices are in place to recruit, screen, and train volunteers.

Action Steps

To address these issues, we recommend expanding access to and improving the quality, coordination, and range of early intervention programs available in local neighborhoods, communities, and faith-based organizations. This can be accomplished by:

- expanding the number, capacity, and variety of youth development programs available in local neighborhoods through existing community centers, youth service agencies, and faith-based organizations;
- expanding the number, capacity, and variety of mentoring programs for “at risk” children and adolescents (i.e., children and adolescents who have not touched the special education, child welfare, mental health, or juvenile justice systems); and
- strengthening the network of youth development agencies through establishment of a single interagency coordination body that facilitates coordinated inter-agency service planning and staff training.

The EIPC recommends the development of a Nonprofit Coordinating Agency. The Nonprofit Coordinating Agency would serve both as a liaison to state child serving agencies (Department of Children’s Services [DCS], education, and juvenile justice) and a source of infrastructure support to youth-serving agencies and organizations. A representative from the coordinating agency would serve on the larger Early Intervention Planning Council.

The Nonprofit Coordinating Agency’s primary mission would be to coordinate and enhance prevention and intervention efforts to reduce the number of children and families who enter the child welfare and juvenile justice systems. The coordinating agency would serve several key functions in pursuit of this mission:

- Facilitate collaboration between youth serving agencies through strategic partnerships, sharing of information, and services. These responsibilities include:
 1. identify and facilitate opportunities for joint ventures between organizations that might increase the eligibility for certain performance-based grants,
 2. conduct ongoing research on best practice and information dissemination, and
 3. create a comprehensive report profiling early intervention services and programs available in Marion County.
- Promote the integration of early intervention services with formal services provided within education, mental health, DCS, and juvenile justice to improve the quality of services and reduce costs of service provision. Critical roles of the coordinating agency would be to:

1. identify gaps in service provision and provide stakeholders with information on available community resources to address those gaps; and
 2. serve as a liaison to coordinate the various systemic reform efforts.
- Coordinate the resource development to bring in public, private, and philanthropic dollars to support the expansion of early intervention programming. These activities would include:
 1. provide technical assistance for fundraising including proposal writing seminars and prospect research;
 2. develop an online database outlining potential funding sources for youth-serving agencies, including foundation grants and federal and state social services grants; and
 3. research the financing processes of other/neighboring states/communities to identify innovative practices.
 - Lead the effort to enhance prevention and intervention efforts to reduce the number of children and families who enter the child welfare and juvenile justice systems. This may include expansion of substance abuse treatment programs; accessibility/availability of quality child care; parenting training and support programs.

In its second year, the coordinating agency would employ a full-time director of research and evaluation to develop a series of outcome indicators to measure key performance targets set by members of the Early Intervention Planning Council. These indicators will measure efficiency of spending, monitor sources of funding, and evaluate the relative success of early intervention efforts measured by numbers of children served and what levels of services received. The coordinating agency would:

- convene a service provider's outcome/data results group;
- establish a baseline of current child welfare expenditures by type of services and the relative success of those efforts;
- aggregate and analyze data from all Early Intervention Planning Council stakeholders to develop common indicators related to specific time phased performance targets;
 - develop a centralized data base to providing ongoing tracking of data; and
 - develop methods of data sharing between public service providers, DCS, juvenile justice, and the City-County Council.

The director of research and evaluation would outline procedures to conduct annual internal audits of costs and services to ensure effective use of public dollars to provide services to children and families. The coordinating agency would provide assistance to all major stakeholders on data collection and evaluation methodology. These results would be published in

an annual state of the children report and be used to demonstrate a return on investment and to facilitate ongoing community engagement and dialogue.

ISSUE: MANY CHILDREN WHO NEED SERVICES ARE NOT IDENTIFIED EARLY ENOUGH

Goal Two: Provide training to primary-care medical providers, childcare workers, preschool teachers, and public and private school teachers in the assessment of childhood and adolescent risk factors and help them develop procedures to refer identified children, adolescents, and families to the appropriate community services.

In community surveys, the prevalence of one or more psychiatric disorders among children and adolescents ranges from 17.6 to 22.2%. The estimated number of affected children with serious emotional disturbance in the United States is 6-9 million children (9 to 13% of the population); however, 70% of all children needing mental health services do not receive these services. Children with mental health problems do not self-identify, as many adults do. Rather, they must be suspected of having a mental health issue by those who live with, educate, or otherwise care for them. Many times, emotional and behavioral problems are severe before parents will acknowledge that their child's problems are beyond the scope of normal development and seek professional consultation.

One way to address this is with utilization of a risk factor prevention model imported from medicine and public health. By intervening with public programs at certain points in a child's life, the development of risk factors can be avoided or delayed. These programs can also curtail the process by which these factors cause more serious risk factors to develop [41].

There are many points of possible intervention with at-risk youth, but very early intervention at ages 3 to 5 has been shown to decrease the numbers of children who later drop out of school, become teenage parents, abuse drugs and alcohol, and become involved in delinquency or serious crime. Researchers are not sure if this is due to the avoidance of risk factors or the strengthening of protective factors which thereby lessens the impact of risk factors or a combination of the two [42].

Action Steps

To address this issue, we recommend providing training to primary-care medical providers, childcare workers, preschool teachers, and public and private school teachers in the assessment of childhood and adolescent risk factors and help them to develop procedures to refer identified children, adolescents, and families to the appropriate community services. This can be accomplished by:

- initiating a mass media “Healthy Families” social marketing campaign to:
 1. improve public attitudes and knowledge about parenting, child and adolescent development, and available resources and services for families, and
 2. de-stigmatize help-seeking in vulnerable communities;
- increasing the number of parenting education programs offered in local community centers, family agencies, and faith-based organizations;
- providing in-depth training to primary-care medical providers in the assessment of childhood and adolescent risk factors and help them to develop procedures to refer identified children, adolescents, and families to the appropriate community services;
- providing in-depth training to childcare workers, preschool teachers, and public and private school teachers in the assessment of childhood and adolescent risk factors and help them to develop procedures to refer identified children, adolescents, and families to the appropriate community services;

ISSUE: MORE MENTAL HEALTH SERVICES ARE NEEDED

Goal Three: Expand access to mental health services for children and families in need.

Before establishment of the Child and Adolescent Service System Program initiative (CASSP) in the late 1980s, child mental health resources were fragmented into various factions: the remnants of the child guidance clinics which emphasized individual and family-driven therapy versus the modern medical model which placed children in institutions and emphasized pharmacotherapy without community supports. As government funding shifted away from talk therapies and toward medical treatments, fewer resources were available to help children succeed in their home environments. Since the early 1990s, the systems of care model (an outgrowth of the CASSP) has been adopted as the standard philosophy for treating children and adolescents, which maintains that the best place for a child to be treated is in his/her community, preferably at home, with decisions driven by the culture, resources, and guidance of the child's family, coordinated by some central agent, and funded by a nonspecific and flexible funding source. Although these principles are meant to be applied to every child, by no means have adequate systems of care been created to meet the needs of most children. Funding sources, staffing issues, training, oversight, infrastructure, leadership, coordination, and effective communication all remain significant obstacles to successful establishment of systems of care in Indiana.

The American Academy of Child and Adolescent Psychiatry (AACAP) routinely establishes and publishes practice parameters for its members through the work of expert panels who utilize evidence-based studies and expert consensus in delineating minimal standards, clinical guidelines, and options for a particular area of child and adolescent psychiatry. One such "practice parameter" is on "Child and Adolescent Mental Health Care in Community Systems of Care," currently available to Academy members and soon to be in print.

When comparing several of the recommendations for minimal standards and clinical guidelines for practice as advanced by the AACAP in this document with the current local status, we found several areas where improvement could yield benefits. These benefits are supported by the most recent research data. These will be delineated below:

AACAP Recommendation 3

"Mental Health interventions should be actively coordinated with services by other providers, including primary care providers, and whenever possible, integrated with interventions provided by other social agencies. This can occur at the case, program and larger system level." [minimal standard]

Due to constraints of HIPAA (Health Insurance Portability and Accountability Act) and the physical and logistical boundaries that separate agencies, communication across providers is a

difficult accomplishment. This is essential, however, for youth who require multiple services in the community.

The primary care physician is crucial to this equation, but is often left out of the picture until the child or adolescent runs into major problems at home, school, or in the community. Helpful in ruling out disease processes that may be causing or contributing to the youth's mental or behavioral symptoms, the primary care physician is an important and trusted point of contact for many families. Linking primary care physicians more broadly to local mental health centers for referrals or mental health information might facilitate entry into mental health treatment and/or systems of care at a more appropriate time.

Active coordination requires that someone actually attends to the coordination of the unique set of services provided by the various agencies which may involve child welfare, juvenile justice, education, community mental health, and private providers for each individual patient. This is further complicated by wraparound services from the community such as volunteers for transportation, instructors of leisure activities, mentors, afterschool programs, etc. Active coordination implies accessibility, so that providers know whom to contact for initial referral and ongoing problems. Although not specified in this standard, active coordination would also mean coordinating the stream of funds that would enable the youth to benefit from services integrated across agencies without duplication of effort and expense. The political and logistical aspects of such coordination are daunting. The benefits of this "case management," if one were to reframe it as such, since the position entails managing resources both human and financial in the most efficient manner, are well documented in terms of reduced hospitalizations, fewer foster placement changes, decreased numbers of runaway episodes, and increased adjustment of youth, among other positive outcomes [43].

AACAP Recommendation 11

"Services should be delivered in the most normative and least restrictive setting that is clinically appropriate. Children should have access to a continuum of care with assignment of level or intensity of care determined by clinically informed decision-making." [minimal standard]

At the present time, access to a continuum of care seems to hinge on whether a child has a source of funding and/or is affiliated with a mental health center that actually has developed an operational system of care. Currently, Medicaid will pay for certain services but not others, and community mental health centers find themselves short on staff, and therefore must choose which cases they will serve with home-based services and case management. While all counties in Indiana must endorse the presence of a system of care, some counties in Indiana have so little funding for children's mental health that their system is a skeleton at best. When pressed, a case manager can give a vague description of services. One system we encountered hinged on a local barber. Some cases which should qualify as severe enough to engage systems of care, therefore, do not, simply because the resources are not there.

Some counties do have services, but finding a funding source becomes the issue. As mentioned above, Medicaid does not cover all services suggested by systems of care, but will pay for many

important ones such as case management. If the child has the option of a severely emotionally disturbed (SED) waiver but deteriorates, she/he may be admitted to a hospital for acute care, but must forfeit the waiver if placement at a residential treatment facility or state-operated facility is needed. The waiver must be applied for again at the time of discharge, and this can delay services for weeks.

Recently, Medicaid has agreed to pay certain qualified private hospitals and other facilities as residential treatment facilities (PRTFs) as an alternative to more expensive state hospitalization. The payment is for a maximum 90-day period, approved in 30-day blocks, after which the youth is meant to return to the community. Traditionally, a child could not be placed at a residential treatment facility unless paid for by his/her county's DCS or probation department. This might occur after a series of acute hospitalizations or other failed intensive treatment experiences or else as a step-down placement after state hospitalization when that level of care was no longer required, but the child was not yet ready for the transition home. It is not yet clear whether residential treatment as an alternative to state hospitalization for some children is cost effective since the state hospital is receiving applications for children who have reached their limit of 90 days in a PRTF but who continue to need intensive services. This is where a systematic approach to needs assessment would be helpful.

AACAP Recommendation 12

“Significant attention should be paid to transitions between levels of care, services, agencies, or systems to ensure that care is appropriate, emphasizing continuity of care.”
[clinical guideline]

As mentioned in previous sections, early identification by those most closely in contact with troubled children should be the standard, and primary care physicians and teachers are good choices. A seamless process of referral to a mental health provider for evaluation should follow, who would then designate the intensity of services needed. A “seamless process” implies that primary care physicians need better connections to community mental health centers, and community mental health centers need to have a presence in our schools and juvenile detention centers.

When the needs of the youth are complex and multiple agencies are involved, it is essential that case management be the central organizing element that coordinates services, connects providers, assesses family/patient needs, and utilizes available funding wisely. As mentioned before, there are many transitions at the present time that are troublesome—from state-operated facility to home, from no SED Waiver to waiver status—and others, such as the juvenile who turns 18 while receiving youth services and must be “admitted” to the adult side of the mental health center (and is sometimes lost in the system).

Model Programs

From reviewing the studies about mental health care for youth, no true comprehensive model programs currently exist. There are elements, however, that stand out as essential for the success

of community-based care. This list includes school-based mental health services of a wide array; day treatment as an alternative to acute hospitalization; case management of “brokered” services, especially if provided in the home; therapeutic foster care when the home is not an option; wraparound services funded by a flexible funding source; psychosocial interventions offered at school, in the home, and in community mental health centers to include parent training, multisystemic therapy, and cognitive behavioral therapy; and assessment and treatment by a qualified child and adolescent psychiatrist who is an integrated member of the treatment team.

Mental Health Providers Roundtable

The Center for Health Policy convened a meeting of representatives from four major mental health centers that provide child mental health services in Marion County, including Adult and Child Center, Behavior Corp, Midtown, and Gallahue. The meeting was a round table discussion during which the representatives shared their concerns about child mental health services in Marion County. The discussion revealed some strengths and weaknesses of these services. Several key concerns arose during the discussion.

The key concerns can be summarized as:

- a reduction in Medicaid reimbursement, leading to fewer children being served, fewer services per child, and a related lack of funding for prevention and screening;
- a change in Medicaid’s definition of *case management* which will require either new funding sources for case management or fewer case management services;
- difficulty finding qualified staff, particularly clinical nurse specialists (CNSs) and child psychiatrists;
- insufficient resources for early intervention programs in schools, particularly in the Indianapolis Public Schools (IPS);
- more resources needed to expand the early diagnosis services offered in Marion County; and
- insufficient sources for mental health care for individuals from families with household incomes above 200% of the federal poverty level who either have no health insurance or who have insurance with no mental health coverage.

Medicaid Funding

The mental health centers in Marion County operate on a fee-for-service basis. As a result, they have limited capacity to provide services for which they are not reimbursed. Combine this fact with the decrease in Medicaid funding, and it is no surprise that the representatives of the mental health centers report that they are now able to serve fewer children and often must provide fewer services to the children they do treat. Some representatives said their organizations have had to close entire service lines. The problem also extends to services for which Medicaid is approving reimbursement.

The managed care organizations (MCOs) have become strict about the number of treatments they will provide to children. Some children are not approved for additional treatment because

they have shown improvement, even when they are still at risk for future problems. Other children are not approved because they have failed to show significant progress. As one representative said, “What do you do with the ones they declare ‘not treatable’ because in four sessions they haven’t moved forward?”

Representatives also reported problems with the ease and timeliness of reimbursement from the MCOs. CompCare was cited as a particularly difficult MCO with which to work. Magellan, on the other hand, was praised as being much easier to work with.

There are three upcoming Medicaid rule changes that will negatively impact the funding of the community mental health centers. These changes are:

1. the redefinition of targeted case management,
2. revisions to the Medicaid rehabilitation rule, and
3. redefinition of intergovernmental transfer.

The redefinition of case management requires that there be only one case manager per child. This change is an attempt by the federal government to reduce costs, but will ultimately diminish the services provided to children. One representative said that the change in the definition of case management will eliminate half of what her organization does and is likely to dismember the system of care. Services billed to case management include linking children and families to services, monitoring children’s behavior, and working with the family. Without alternative funding sources, these services will not be provided.

The revisions to the Medicaid rehabilitation rule require narrowing the definition of medical necessity, and specific rehabilitation goals, and a demonstration of progress in a short period of time. This focus on the medical model of treatment rules out valuable treatment options that address social and environmental issues, and the time requirements can rule out treatments which are effective but slow.

Finally, the change in the definition of intergovernmental transfers affects the federal matching of Medicaid dollars. A transfer must be an intergovernmental transfer for there to be matching funds. Transfers to the community mental health centers qualified for federal matching dollars under the previous rules, but do not under the new rules. Indiana Senate Bill 350 sidesteps this rule by having the county governments send money to DMHA so that it will qualify for a federal match. This money is then distributed to the community mental health centers by the DMHA.

The first two rule changes will not be so easy to sidestep, and stopping these rules from going into effect would require an act of Congress. As a result, the state and counties face a choice of discounting some services provided by the community mental health centers or finding an alternative source of funding for these services.

Hard to Find Staff

Another key issue mentioned was the difficulty finding qualified staff. There are two key aspects to this problem:

1. a lack of qualified individuals available in the job market, and
2. insufficient funds to hire the necessary staff.

The lack of qualified individuals is, to a large extent, a training problem. One particular problem is that there is a shortage of individuals who are qualified to assess children younger than three. This problem is discussed further in the section on early diagnosis. There is also a shortage of clinical nurse specialists (CNSs) and child psychiatrists.

One representative stated that even if her staff can get a child in the door to see a clinician, it could still be up to four months before the child is able to see a CNS or child psychiatrist. The same representative said that if two CNSs walked in her door, she would hire them both in a heartbeat. Indiana has more child psychiatrist than some states; however, it can take 1 to 1.5 years to find a replacement for a child psychiatrist who leaves. To address these problems requires training for more CNSs and child psychiatrists in Indiana or attracting qualified individuals from out of state.

Schools

The mental health centers operate in the schools with the mission of providing early intervention and preventive care. However, the referrals they receive from the schools are for children who are past the point of early intervention and prevention—they are the kids who are “falling off the cliff.” Part of the problem is a lack of capacity. There is such a large volume of children who need help that the agencies end up treating the children who are already showing the most impairment. However, there is one benefit—some children end up staying in school who would otherwise be expelled.

One representative noted that her organization has been moving out of Indianapolis Public Schools because they cannot break even when they provide services to IPS. She also noted that they are moving into schools that pay, because they can at least break even in these schools. This is occurring despite the need for more capacity at IPS schools. Furthermore, schools are trying to be proactive by identifying pre-kindergarten children who they anticipate will have problems; however, the mental health centers are not receiving funding for these purposes. These facts all validate the need for additional funding to provide early intervention and prevention services at Marion County schools, particularly IPS.

Funding for Children Who Fall Through the Gaps

There is a need for funding to cover middle class children with mental health issues. Some commercial insurance plans do not cover behavioral health. As one representative stated, sometimes the only choice for treatment for these children is to put them in a state hospital because there are no other options.

Early Diagnosis

Because early intervention can be much more effective than treating full-blown problems, there needs to be a focus on early diagnosis of problems. Currently many children are not diagnosed until they either enter school, are declared a child in need of services (CHINS), or enter foster care. Early intervention is possible and could be done in prekindergarten settings such as day care and child care centers.

In order to facilitate effective early diagnosis, there is a need for more individuals who are trained to assess child mental health problems. One representative said she has only four individuals on staff capable of performing a solid assessment on children three years old and younger. It would also be beneficial for pediatricians to receive training in assessing young children, as they are often the only medical professional a young child sees on a regular basis. Trained pediatricians would then be able to refer children with mental health issues to an appropriate mental health professional. One representative said that mental health and primary care professionals do not work well together and need to communicate better. Better communication between mental health and primary care professionals combined with some initial screening by children's primary care physicians could go a long way to identify children with problems at a younger age when issues can be dealt with more efficiently.

Mental Health Center Budgets

The four key mental health organizations in Marion County were also kind enough to share information regarding revenues, expenditures, and the number of children served in Marion County. All of the agencies were gracious enough to reply; however, Adult and Child Mental Health Center was unable to provide the requested data. This is because Adult Child and Behavior does not keep the records for the children they serve in Marion County separate from their records for children in other counties.

Behavior Corp

In 2006 BehaviorCorp spent \$1.98 million on serving children in Marion County (see Table2). The largest portion of their funding (47.19%) was obtained from Medicaid and other revenue; 44.22% of their revenue was state revenue, and the remaining 8.58% of their revenue was from Marion County. Over time, we see that BehaviorCorp has been receiving a smaller share of their revenues from Medicaid while the shares from Marion County and the state have both been increasing.

During 2006, BehaviorCorp served 815 children, an increase of 13% since 2004 when it served 757 children. The average cost for services per child in 2006 was \$2,426, lower than the \$2,556 per child in 2004. It would take further investigation to determine whether the decrease in spending per child can be attributed to efficiency gains, to providing fewer services for each child, or some combination of the two.

	FY 2004	FY 2005	FY 2006
Children Served	757	789	815
Total Estimated Expenses	\$ 1,935,000	\$ 1,980,000	\$ 1,977,000
Estimated Revenue			
Medicaid & Other Revenue	\$ 1,111,900	\$ 1,086,000	\$ 933,000
Marion County Revenue	\$ 119,460	\$ 130,910	\$ 169,680
State Revenue	\$ 703,640	\$ 763,090	\$ 874,320
Total Revenues	\$ 1,935,000	\$ 1,980,000	\$ 1,977,000
Cost Per Child	\$ 2,556	\$ 2,510	\$ 2,426

Gallahue

In 2006 Gallahue spent \$13.6 million for services for children in Marion County (see Table 3). The largest portion of their funding (70.4%) was obtained from Medicaid and other revenue; 7.0% of their revenue was from the Division of Mental Health, 6.5% of their revenue was from Marion County, and the remaining 15.8% was from other sources. The mix of Gallahue's funding has remained stable.

During 2006, Gallahue served 4,471 children, an increase of 22% since 2004 when 3,653 children were served. The average cost for services per child in 2006 was \$3.041, lower than the \$3,533 per child in 2004. It would take further investigation to determine whether the decrease in spending per child can be attributed to efficiency gains, to providing fewer services for each child, or some combination of the two.

	FY2004	FY2005	FY2006
Children Served	3,653	4,150	4,471
Salaries & Benefits	\$4,342,036	\$4,828,728	\$4,674,511
Other Direct	\$8,564,478	\$8,687,033	\$8,922,776
Total Expenditures	\$12,906,514	\$13,515,761	\$13,597,287
Medicaid	\$9,214,513	\$9,386,476	\$9,576,341
Division of Mental Health Grant	\$803,424	\$942,485	\$942,810
Marion County Contracts	\$858,096	\$841,746	\$888,629
Other	\$2,131,941	\$2,211,393	\$2,152,987
Total Funding Sources	\$13,007,974	\$13,382,100	\$13,560,767
Cost Per Child Served	\$3,533	\$3,257	\$3,041

Midtown Community Mental Health Centers

During 2006, Midtown spent a total of \$4.29 million serving children in Marion County (see Table 4). The majority of their funding (68.60%) was received from Medicaid. Additionally, they received 18.45% of their funding from a state Division of Mental Health Grant, 8.71% from Marion County, and the remaining 4.24% from other sources. Midtown's expenditures in 2006 have decreased 8% from the \$4.67 million which it spent in 2004. Midtown has seen an increase in the share of funding from Medicaid and other sources, while revenues from Marion County and the Division of Mental Health Grant have declined.

Midtown Community Health Center served 2,918 children in Marion County during 2006, a decrease of 5% since 2004 when it served 3,056 children in Marion County. The average cost for services per child in 2006 was \$1,774, a decrease of 3% since 2004, when the average cost per child was \$1,834.38. It would take further investigation to determine whether the decrease in spending per child can be attributed to efficiency gains, to providing fewer services for each child, or some combination of the two.

Table 4: Midtown Community Mental Health Center Budget

	FY2004	FY2005	FY2006
Children Served	3,056	3,268	2,918
Salaries & Benefits	\$5,089,390	\$4,008,915	\$4,581,833
Other Direct	\$516,483	\$497,169	\$595,450
Total Expenditures	\$5,605,873	\$4,506,084	\$5,177,283
Medicaid	\$3,005,037	\$2,905,273	\$2,943,647
Division of Mental Health Grant	\$1,155,883	\$976,811	\$791,566
Marion County Contracts	\$511,637	\$230,527	\$373,919
Other	\$0	\$208,556	\$182,010
Total Funding Sources	\$4,672,557	\$4,321,167	\$4,291,141
Cost Per Child Served	\$1,834	\$1,379	\$1,774

Budget Trends

Looking at the data for the three mental health centers, three trends stand out. First, we see a decrease in the cost of services per child at each of the three mental health centers. Whether this is due to efficiency gains, because of fewer services for each child, or some combination of both is unknown. Second, there is an increase in the number of children being served by both BehaviorCorp and Gallahue. The number of children served by Midtown decreased 5% from 2004 to 2006. The number of children served by all three institutions has increased since 2004. A hypothesis consistent with these two trends is that the number of children being served is

increasing more quickly than the capacity at these institutions, thus leading to lower spending per child. The fact that Midtown is serving fewer children yet still has lower spending per child, however, is inconsistent with this hypothesis. Finally, we see that the amount of funding from Medicaid has decreased at Midtown and Behavior Corp. The amount of Medicaid funding at Gallahue has increased slightly; however, the amount of Medicaid spending per child has decreased.

Medicaid Rule Changes

The Medicaid rule changes regarding the optional state plan case management services mentioned by the representatives of the mental health centers are available in the Federal Register [44]. The rules changes were not in effect at the time of the round table, but are scheduled to take effect on March 3, 2008.

There are several issues with the Medicaid rule changes. First, the rules restrict state flexibility in a way that could make Medicaid payments less efficient. Some individuals feel this change violates a central tenant of Medicaid, namely that states must follow federal guidelines but should be allowed broad flexibility over payment rates and policies [45]. Second, the rules prohibit states from making fee for service payments in increments exceeding 15 minutes. This is a significant change from the case rates and per diem rates often used by states. While intended to keep cost down by making providers more accountable, the additional overhead required for billing could reduce efficiency. Finally, the rules require that a state provide no more than one case manager per beneficiary. In most cases, having one case manager is beneficial as it eliminates duplication of effort; however, some beneficiaries with multiple conditions may need the expertise of more than one case manager.

Senator Grassley, of Iowa, has written a letter to HHS Secretary Michael Levitt, in which he states that “[Case management] services, which the Congress intended would be appropriately considered a Medicaid expense, are particularly important to children in foster care [46].”

Challenges

Children and adolescents across the state are underserved when it comes to their mental health needs, and Marion County is not immune to this deficiency. Community Mental Health Centers do not get reimbursement commensurate with the services they provide, and some are therefore very limited in scope. Children who need services are not always identified early, or when identified, are sometimes unable to negotiate through the system to get their needs met due to the still-fragmented state of inter-agency communication. Systems of care are either understaffed or underfinanced, and in any case, are underutilized in Marion County due to a combination of financing and frustrations with the waiver system. Coordinated case management and invested cooperation of stakeholders, namely, Juvenile Justice, Department of Children’s Services, Department of Education, Community Mental Health Centers, and Division of Mental Health and Addictions, are essential for successful growth of systems of care in Marion County. Expanded reimbursement by Medicaid would also go a long way toward improving access to services for children.

As for acute services, there is a definite need for child and adolescent inpatient psychiatric beds in Marion County. Often physicians are unable to get a patient admitted to a hospital in this county due to various barriers. Unfortunately, due to the inability to deliver the required intensity of community-based care, patients are admitted to residential treatment facilities and state hospitals with longer stays than are probably necessary for most youth.

Indiana is in the midst of an anticipated shortage of psychiatrists and a current shortage of child and adolescent psychiatrists. If the number of trainees in these fields does not increase in the next ten years, there will be a real crisis in meeting the psychiatric needs of the state, particularly for children. At the same time, the training stipends for psychology interns continually decline, leading to fewer professionals who can evaluate children and adolescents and even fewer who have the requisite skills to provide expert psychosocial therapies such as cognitive behavioral therapy.

Availability and coordination of funding seem to be two of the biggest hurdles to the implementation of programs to identify and evaluate children, to administrate and pay for systems of care services, and to pay for needed services such as residential treatment and therapeutic foster care which are not currently available to many deserving youth.

When discharging adolescent patients from a state-operated facility, “placement” sometimes becomes the most difficult accomplishment of a hospitalization. Often the adolescent’s psychosocial circumstances are part of the reason for his/her admission, and returning directly home is not a reasonable option. Unless the Department of Education will sponsor the individual to a residential facility due to his/her overwhelming developmental/educational needs, the youth’s local probation department (if the youth is on probation) is willing to pay for therapeutic foster care, residential treatment, or a group home, or the Department of Children’s Services (if the child is a ward) is willing to do likewise, there is no funding for these types of placements. In addition, there are shortages of group homes and therapeutic foster care in general.

There are additional concerns for which there are no easy answers associated with added expense to the community, There are concerns for children and adolescents who have parents with serious psychiatric disturbances, for youth who have suffered severe abuse of multiple forms and have been perpetrators themselves, for youth who have two or more serious psychiatric disorders, and for youth who have substance abuse problems in addition to a psychiatric disorder. These youth are likely to need an intensity of services much higher than anticipated based on usual community expectations. They often require inpatient stabilization at a state-operated facility before consideration of maintenance in the community, and may require step-down placement in a residential treatment facility as mentioned above. These youth may not have the option of community-based care, no matter how intensive, in the active phases of their illnesses.

Furthermore, there are youth on probation whose behavior cannot be controlled safely in the state hospital, but who do not receive adequate treatment in the Department of Corrections due to inadequate formularies and lack of therapeutic programming. Sometimes a hard decision must be made in the interest of safety (of staff and other patients) to return them to probation. There are youth who have no family due to the ravages of parental psychiatric disturbance, substance abuse, and/or abuse/neglect, and no facilities to receive them due to the youths’ past behaviors in less restrictive settings. (Some have been in the “system” for as long as 10-11 years.) There are youth who have serious mental illness and nowhere to go for lack of the kinds of facilities available to adults with similar mental illnesses (i.e., group homes for patients with bipolar disorder or schizophrenia). These youth often remain “institutionalized” for lack of a better alternative. Many challenges remain if we are to adequately serve our children.

Action Steps

To address these issues we recommend expanding access to mental health services for children and families in need. This can be accomplished by advocating for:

- expanding school-based mental health services programs (including direct service for children and for families);
- expanding the pool of high-quality, Medicaid-eligible mental health providers both in and outside of the existing community mental health center system;
- improving the number of qualified child/adolescent mental health providers, including child/adolescent psychiatrists, social workers, psychologists, faith community leaders, and paraprofessionals and volunteers;
- expanding the number of emergency psychiatric inpatient beds, therapeutic group home, and therapeutic foster home placements for children in Marion County; and
- improving reimbursements for children/adolescent mental health services, particularly within Medicaid (and address proposed changes).

ISSUE: CHILDREN ARE FALLING THROUGH THE CRACKS IN THE SYSTEM

Goal Four: Develop a community-based prevention and early intervention-focused case management program to provide direct assistance in accessing social services for children, youth, and their families “at risk” of entering the formal systems, including special education, child welfare, mental health, or juvenile justice.

Research shows that service models that involve integration of services offered by education, social services, mental health, and juvenile justice at the individual case level are most effective in preventing delinquency, abuse, and neglect than those that coordinate only at the departmental or agency levels or that do not coordinate at all [47]. Children and families that are served by integrated systems of care fare better than those who receive individual services separately. Various system of care models exist—and development of a system of care depends on several factors, including the community context, the background and history of the current system model, the philosophy and goals of the organizations involved, and the strengths and weaknesses of the system’s current infrastructure (see Table 3) [48]. System integration often occurs through implementation of innovative approaches, including on-site service delivery, intensive case management, wraparound services, and other service delivery models that involve case-level integration and coordination of services. Various agencies or departments may alternately take the lead, provide services, or perform an advisory role during interactions with children and families [49]. Many such models are school-based, with mental health and social services professionals, law enforcement officers, parents, and teachers working in case teams to address and prevent a wide range of issues [50-52]. Schools are the predominant source of programs implemented as preventive measures where children and families can learn methods of effective social interaction, conflict resolution, and problem solving [53].

American Psychological Association Task Force

The American Psychological Association (APA) created a task force on innovative models of mental health services for children, adolescents, and their families. The task force identified three key areas in which innovative approaches could improve the wellbeing of children: education, social services, and juvenile justice [54]. These findings have implications for the member agencies of the EIPC.

Education

The APA task force on innovative models of mental health services for children, adolescents, and their families identified several ways in which behavioral approaches in early education

could be enhanced to improve outcomes. For example, parents should be invited to participate in rewarding the positive behavior of their children. Children should be taught effective behavioral strategies in addition to being corrected for inappropriate behavior. Parents should be taught how to positively encourage effective and appropriate behavior and social interaction. Schools are also a potential location for on-site, multiagency wraparound care models wherein integrated services center around the child and his or her individual needs. This type of model is effective when school-based, but also flexible enough to include home-based visits or care when needed.

Table 5: Elements to consider in developing a system of care

-
- The community context
 - Background and history of the current system model
 - Philosophy and goals
 - Target population
 - System organization
 - System care components
 - System-level coordination mechanisms
 - Client-level coordination mechanisms
 - System of care activities
 - System financing
 - Evaluation
 - Major strengths and challenges
 - Technical assistance resources
-

Source: Stroul, B. A., et al., (1992). *Profiles of Local Systems of Care for Children and Adolescents with Severe Emotional Disturbances*, Rockville, MD: National Institute of Mental Health (DHHS).

Social Services

The APA task force on innovative models of mental health services for children, adolescents, and their families determined that a wide array of interventions and intensive family preservation strategies are the healthiest methods for preventing exacerbation of social problems. Crisis intervention should be employed when necessary; however, a family preservation approach involving intensive family services has been found effective in preserving the family unit and improving its function. This is accomplished through behavioral, cognitive, and environmental interventions focused on the whole family. Effective programs include parent training, coping skills training, and concrete services and the availability of flexible discretionary funds (for furniture, clothing, rent, etc.).

Juvenile Justice

For children and families involved with the juvenile justice system, the APA Task Force on Innovative Models of Mental Health Services for Children, Adolescents and Their Families determined that individualized wraparound care and intensive case management are the most effective strategies for helping to prevent further issues of delinquency. The wraparound model

involves a commitment to developing care based on the needs of the individual child/youth, surrounding the child and family with workers from a variety of community agencies. Consensus about treatment and case management is maintained among the key decision makers for a cohesive and child/family-centered plan of intervention. Intensive case management includes a commitment to low worker caseloads and 24/7 case coverage for families. Effective intervention plans generally involve multisystemic therapy focusing on multiple inputs and environments.

Mental Health

The clear consensus of the APA task force on innovative models of mental health services for children, adolescents, and their families was that child- and family-centered systems of care, including assistance from education, juvenile justice, social services, and mental health, are the most effective way to assure the positive mental and emotional development of children and families. The task force recommended that mental health organizations reduce the use of restrictive services and increase availability of home- and community-based services and partnerships with other agencies and stakeholders.

APA Task Force Conclusions

In addition to the recommendations for education, juvenile justice, social services, and mental health, the APA Task Force on Innovative Models of Mental Health Services for Children, Adolescents and Their Families recommended innovations to whole systems of care for children and their families. These recommendations included an increase in provider accountability, more service integration, reform in mechanisms for financing of services, and training of direct service providers in the delivery of cost-effective services. The services themselves should be comprehensive, empower families, and be flexible and individualized to the needs of the individual children or families.

A Successful System

The goal of the Early Intervention Planning Council is to create a successful system of prevention, intervention, and treatment measures that will improve the wellbeing of children and families in Marion County. Research suggests that a successful system focuses not only on areas where problems exist, but also on strengths that can be enhanced for problem prevention. A successful system is multifaceted but coordinated, creating a system of care that is responsive to the individual needs of the child and family, being flexible and sensitive to their needs and environments [55]. Such a system functions effectively and is well-staffed, capacity-building, accountable to its clients and the public [56], and provides resilience-enhancing programs to all families, with additional support for vulnerable families and children and excellent care for families and children with special needs.

In Marion County, there is a major gap in the system linking children, youth, and families with available social services. Case management services are available currently to families who have entered the formal system of care, but there are precious few case management services

available to children, youth, and families to help them address needs early and voluntarily before they come into contact with the formal service system.

Action Steps

To address this issue, we recommend developing a community-based prevention and early intervention-focused case management program to provide direct assistance in accessing social services for children, youth, and their families “at risk” of entering the formal systems, including special education, child welfare, mental health, or juvenile justice. This can be accomplished by:

- establishing (or expanding) a single agency (or small set of agencies) to provide centralized, cross-system program coordination and case management/resource coordination services for children, youth, and families; and
- establishing training programs for youth development staff in conjunction with local colleges and universities.

CONCLUSION

If Marion County is going to reduce the number of children entering care in the Department of Child Services and the Juvenile Justice system, the EIPC believes that we must take a longer term view and begin by expanding access to and strengthening the existing network of community-based and neighborhood agencies already providing services to the citizens of Marion County. Marion County can support the development of more resilient children, youth, and families if we make a significant commitment to building a system of early intervention and problem prevention that can reach every child, youth, and family in need in the county.

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