INDIANA STATE BOARD OF EDUCATION

To: Indiana State Board of Education
From: Timothy Schultz, General Counsel
Date: May 2, 2018
RE: Social, Emotional, and Behavioral Health Plans

Indiana Code 20-19-5-1 reads:

IC 20-19-5-1 Department duties

Sec. 1. The department of education, in cooperation with the department of child services, the department of correction, and the division of mental health and addiction, shall:

(1) develop and coordinate the children's social, emotional, and behavioral health plan that is to provide recommendations concerning:

(A) comprehensive mental health services;

(B) early intervention; and

(C) treatment services;

for individuals from birth through twenty-two (22) years of age;

(2) **make recommendations to the state board, which shall adopt rules under IC 4-22-2 concerning the children's social, emotional, and behavioral health plan**; and

(3) conduct hearings on the implementation of the plan before adopting rules under this chapter.

As provided in the above statute, the Indiana Department of Education (IDOE) is required to develop and coordinate a children's social, emotional, and behavioral health plan. IDOE is then required to provide recommendations to the Indiana State Board of Education (Board), which the Board shall use as the basis for administrative rulemaking.

In 2006, IDOE participated in the drafting of a “Children’s Social, Emotional, & Behavioral Health Plan” that was submitted to the General Assembly. The Board is requesting that IDOE provide specific recommendations, based on the published plan, to the Board in order to initiate rulemaking.

Children's Social, Emotional & Behavioral Health Plan

Originally Submitted June 1, 2006

Updated August 2006
Revised December 2018

Required By
Senate Enrolled Act 529 / Indiana Code 20-19-5

Table of Contents

Introduction

In the 2005 legislative session, Indiana's elected officials saw the need for a comprehensive children's mental health plan and passed Senate Enrolled Act 529, which includes a chapter regarding children's mental health services. The legislation calls for the State of Indiana (with the Indiana Department of Education as the lead agency) to complete three tasks:

1. Develop a Children's Social, Emotional, and Behavioral Health Plan, containing short-term and long-term recommendations to provide comprehensive, coordinated mental health prevention, early intervention, and treatment services for children from birth (0) through age 22;
2. Adopt joint rules under IC 4-22-2, concerning the children's social, emotional, and behavioral health plan; and
3. Conduct hearings on the implementation of the plan before adopting joint rules under this chapter.

The SBOE in May, 2018 reintroduced a document for review called the Social, Emotional, and Behavioral Health Plan. The document was originally created in 2006 by a multi-agency team of State-level child serving organizations, and was approved by legislation for implementation. However, it was never implemented, and lay dormant until May of this year. The SBOE has required IDOE to convene a review of this document for relevance and updated information, which will be reviewed by the SBOE in early 2019.

IDOE partnered with the State Child Interagency Collaborative which includes members from IDOE, Department of Child Services, Department of Correction, Division of Mental Health and Addiction – Family and Social Services Administration, Commission on Improving the Status of Children, Department of Workforce Development, Bureau of Developmental Disabilities Services, Vocational Rehabilitation, Office of Medicaid Policy Planning, and Department of Family Resources. This collaborative group provided a community approach and a broader perspective.

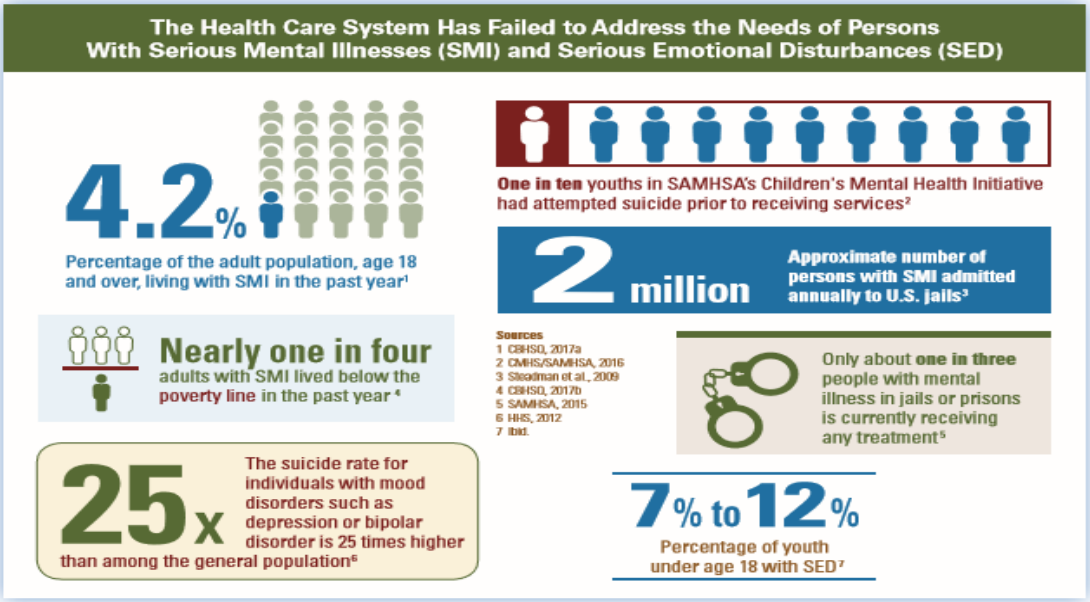
Indiana's focus on mental health services follows President Obama's 2015 Every Student Succeed Act (ESSA). Funding was created within ESSA for social and emotional supports within schools. This funding was called the Student Support and Academic Enrichment (SSAE) program. In addition, more recent developments include Governor Holcomb's "2018 Indiana School Safety Recommendations" which included heavy emphasis on mental health and the recommendation from the Commission on Improving the Status of Children that each district in the State designate a professional to coordinate the Social and Emotional Learning (SEL) and mental health wellness programming for their district. As of September 2018, IDOE and DMHA have both created positions that serve as the point person for all SEL and mental health wellness for students. We hope the other state agencies will look at establishing a point person to focus on social and emotional wellness.

The Bush Commission's findings address unmet needs and barriers that impede care for people with mental illnesses. Mental illnesses are very common and affect the majority of American families. Mental illness can happen to a child, a co-worker, a brother, or a grandparent--someone from any background[1]. Mental illness can also occur during any stage of life, childhood to old age. Communities, schools, and the workplace are all affected by mental illnesses. It is important to note that whenever the terms *child* or *children* are used, it is understood that parents or guardians should be included in the process of making choices and decisions for minor children. This allows the family to provide support and guidance when developing relationships with mental health professionals, community resource representatives, teachers, and anyone else the individual or family invites. In addition this shows the importance of family member's participation in a child's treatment for mental health and wellness.

In 2003, the President's New Freedom Commission on Mental Health concluded that America's mental health service delivery system was in shambles. The Commission's final report stated that "for too many Americans with mental illnesses, the mental health services and supports they need remain fragmented, disconnected and often inadequate, frustrating the opportunity for recovery." A number of the recommendations of the President's New Freedom Commission on Mental Health were not implemented or have only been partially realized. Since then, quality of life has not fundamentally changed for adults with serious mental illnesses (SMI), children and youth with serious emotional disturbances (SED), and their families in the United States (Figure 1). In response, the 21st Century Cures Act (Public Law 114-255) authorized the Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC) to enhance coordination across federal agencies to improve service access delivery of care for people with SMI and SED and their families.

[1] US Department of Health and Human Services, 1999.

Figure 1. Estimates and Unmet Needs of Persons With Serious Mental Illnesses and Serious Emotional Disturbances



Defining SED: *Serious emotional disturbance (SED) refers to children and youth who have had a diagnosable mental, behavioral, or emotional disorder in the past year, which resulted in functional impairment that substantially interferes with or limits the child's role in family, school, or community activities. The members of the ISMICC have concerns about the term "serious emotional disturbance." The use of the word "emotional" does not capture the reality that mental disorders experienced by children and youth often have cognitive or behavioral aspects. The word "disturbance" also does not seem fitting for diagnosable disorders that are just as important to address in young people as disorders experienced by adults. As a result, ISMICC members plan to examine this issue and propose alternative language as the group moves forward.*

SAMHSA estimates prevalence of SED ranging between 6.8 and 11.5 percent of all children. About 4 in 10 (40.9%) of youth ages 12 to 17 with major depressive episodes (1.2 million youth) received treatment of any kind in 2016. In Indiana, 13% of children received treatment or counseling from a mental health professional in 2017. The Division of Mental Health and Addiction (DMHA) served 32,765 children ages 0-12 and 21,259 youth ages 13-17 in Indiana.[2]

Expectations and Outcomes of the Plan

The Children's Social, Emotional, and Behavioral Health Interagency Task Force envisions a comprehensive and coordinated children's mental health system comprised of prevention, early intervention, and treatment across all state systems (mental health, substance use, child welfare, juvenile justice, schools, Medicaid, and primary healthcare). With gubernatorial, legislative, state and community support, this plan can make a difference. Specifically, there are seven areas of expectations that the Indiana Department of Education, the Department of Child Services, the Department of Correction, the Division of Mental Health and Addiction, Medicaid, and the Indiana State Department of Health have for this plan.

1. Early Identification and Assessment

- Participate in early identification initiatives (state agencies, community agencies, health care providers, child care providers, parents, and schools).
    - such as Help Me Grow (partnership between ISDH and DCS)
- Encourage parental involvement in noting early signs of possible need for assessment.
- Establish one assessment for fair measurement of preliminary information needed to help a child and improve the child's situation.

[2] IYI Kids Count Data Book (2019)

2. **Accountability and Outcome Measurement**
    - Evaluate the strengths and needs of Indiana's Behavioral Health Network across child service agencies.
    - Establish benchmarks to measure accountability of the system.
    - Determine outcomes for agency accountability.
    - Establish and operationalize common definitions.
3. **Best Practices**
    - Reduce stigma as a barrier for help seeking behavior.
    - Improve the quality of services.
    - Make effective models of care available to all young people with mental health issues and/or substance use problems, and their families.
4. **Finance and Budget**
    - Communicate and collaborate between agencies to use dollars and resources wisely.
    - Fund services that produce positive outcomes.
    - Use State dollars to maximize federal dollars.
    - Address fiscal constraints.
5. **Obtaining Services and Referral Networks**
    - Organize and coordinate service delivery models across systems.
    - Coordinate children's mental health services at the State agency level.
    - Prevent duplication of services to those in need.
    - Families should have access to services and supports in a timely manner.
    - Formulate a process for how to obtain services and recommend a referral network by which children are treated fairly and equally because of the process and not in spite of it.
    - Engage Managed Care Organizations (MCOs), Community Mental Health Centers (CMHCs), and providers in referral and delivery planning.
    - Increase public awareness of agencies' services available.
    - Reduce stigma around mental health.
6. **Learning Standards**
    - Increase focus on reviewing requirements and allowances in existing state education laws and make recommendations for change where appropriate.
    - Incorporate the social and emotional development of children as an integral component to the mission of schools.
7. **Workforce Development and Training**
    - Build a qualified and adequately trained workforce with a sufficient number of professionals to meet the needs of children and families. Increase the capacity of existing programs and providers who work with children.
    - Train frontline providers and make recommendations regarding appropriate training. Using models such as Mental Health First Aid training.
    - Strengthen parent education and support services, especially for new and at-risk parents.

*Currently in 2018 the Commission on Improving the Status of Child has numerous task forces who are addressing the above expectations and outcomes. https://www.in.gov/children/

Barriers to Mental Health Service Provision for Children

In most states and communities, significant barriers to mental health care services exist, including fragmentation of services, high service costs, insufficient resources including provider and workforce shortages, a lack of availability of services, and stigma associated with mental illness. Barriers to mental health care exist for all children with mental health needs. Most children and youth with SED do not receive treatment. Identifiable mental health problems are common, but few children receive services for those problems. The lack of services received by these young, multi-challenged children is a services systems and social policy failure (McCue Horwitz et al., 2012). About 4 in 10 (40.9 percent) of youth ages 12 to 17 with major depressive episodes (1.2 million youth) received treatment of any kind (CBHSQ, 2017j). This is similar to the findings from the NCS-A study, that 36.2 percent of adolescents with mental disorders received treatment across diagnostic groups. For children and youth, fragmentation of services is compounded by the fact that this population is seen and served by multiple systems.

There are a number of known risk factors for developing emotional problems and disorders: biological factors (premature births, traumatic brain injury, prenatal exposure to alcohol, tobacco, opioids, and other drugs), family factors (resources, capacity, toxic stress), and parenting factors (responsiveness, sensitivity, and parental mental health).[3] Poverty is known as an indirect risk factor because it can lead to behavioral problems among parents, facilitate chronic stressful environments, and increase the risk of child abuse.[4]

Adverse Childhood Experiences (ACEs) in childhood are major risk factors for illness and a poor quality of life. Research further indicates that ACEs can impede a child's social, emotional, and cognitive development. They are the best predictor of poor health and the second best predictor of academic failure.[5] [6] Based off of data from the 2011-2012 National Survey of Children's Health (NSCH), Child Trends found that: [7]

34% of children ages 0-17 in Indiana have 1-2 ACEs
21.3% of Indiana high school students have a parent who served time in jail [8]
11.1% or more than 1 in 10 Hoosier children ages 0-17 have lived with someone who was mentally ill or suicidal [9]
51.3% of Indiana high school students live in a family that argues repetitively[10]

Identifying the emotional or behavioral problem or disorder can also be difficult. Evidence suggests that pediatricians, usually the first non-family members to assess a child's health, have an early opportunity to identify these children. According to the American Academy of Pediatrics (AAP), there are a number of tools that pediatricians can use to identify children through age eight that can identify 70 to 80 percent of children with problems. But an AAP study conducted in 2003, found that only 15 percent of pediatricians always use a screening tool[11]. In addition, some parents may not follow up on problems that are identified. One major study of primary care physicians found that 59 percent of children referred to a mental health specialist never went for treatment.[12]

Of all sectors, schools play the largest role in serving youth with mental and emotional disorders, ranging from mild to severe. According to National Center for School Mental Health, "Of youth who receive mental health services 70-80% access these services in schools." In addition to access "Youth are 8x more likely to complete mental health treatments in schools than in other settings." While schools are by no means serving all children with mental disorders, they are a prominent source of care for two reasons. First, under the federal special education law, schools are mandated to help children with emotional disturbance. However, the special education criteria are narrow enough so that only those with the most serious dysfunction qualify. The Individuals with Disabilities Education Act of 2004 (IDEA) requires that all school districts provide a free appropriate public education (FAPE) to students with one or more of the 13 disabilities identified by the law and are thereby in need of special education services.[13]

Second, over the last 20 years, leaders have focused on the connection between emotional well- being and school performance, and as political pressure for academic achievement has mounted, there has been a striking growth in the number and variety of mental health services offered by schools for students with problems not severe enough to warrant, or qualify for, special education. These services are for students at risk for or diagnosed with mild to moderate disorders. In some cases, funding can be used for prevention programs for the entire student body. Although the special education system is mandated to serve children with serious mental disorders, they are frequently unidentified or mislabeled as learning disabled and miss the opportunity to receive care early on.[14] As highlighted by the Collaborative for Academic, Social, and Emotional Learning (CASEL), "A study estimating the relative influence of 30 different categories of education, psychological, and social variables on learning revealed that social and emotional variables exerted the most powerful influence on academic performance."

For a review of the existing funding sources for mental health services for children in Indiana, please refer to Appendix A.

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[3] Koppelman, J. National Health Policy Forum, Issue Brief No. 799, 2004.
[4] US Department of Health and Human Services, 1999.
[5] Aces Too High. (2012, February).
[6] Felitte, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., & . . . Marks, J.S. (1998).
[7] Child Trends.(2014, July).
[8] Indiana Prevention Resource Center. (2016).
[9] National Survey of Children's Health. (2011/12).
[10] Indiana Prevention Resource Center. (2016).
[11] Dunkle & Louis, 2003.
[12] United States Department of Health and Human Services, (2000).
[13] Gilliam, Walter S., The Achiever, 2005.
[14] Koppelman, J. National Health Policy Forum, Issue Brief No. 805, 2005.

Research on Barriers in Indiana

In 2018, a third statewide System of Care Implementation Survey (SOCIS) assessed state and local system of care (SOC) development to support planning and to monitor progress. Over 770 survey respondents represented diverse perspectives: behavioral health (27%), education (16%), primary health (7%), youth (1%), juvenile justice (5%), faith-based community (2%), child welfare (5%), advocates (3%), families (4%), other human service providers (13%), and other community partners (18%). On average, the level of SOC development at the state and across 55 participating counties fell into a mid-level range, an action implementation level. Respondents recognized developing resources: *Individualized, Comprehensive, and Culturally Competent Treatment*, *SOC Values and Principles*, *Family Choice and Voice*, *Transformational Leadership*, *Theory of Change*, *Interagency and Cross-system Collaboration*, and *Management or Governance*. Areas clearly needing further developing were improving *Outreach and Access to Care*, developing a *Comprehensive Financial Plan*, building and sustaining a *Skilled Provider Network*, improving the *Performance Measurement System*, assuring *Provider Accountability*, updating *the Implementation Plan*, identifying the *Population(s) of Concern*, and monitoring *General System Performance.*[15]

Comparison to national SOC development. Indiana's SOCIS results were consistent with a national SOCIS study regarding resources and identified challenges in local SOCs nationally that had received federal SOC implementation funding[16]. In contrast to the national study, Indiana reported higher inter-agency, cross-system collaboration. The State shared commonly identified challenges needing further planning and improvement to better manage resources and access to an effective array of behavioral health services and supports for children, youth, and their families.

Implications of the survey include building and sustaining developing cross-system resources, and focused planning and action to address underdeveloped factors. To assist focused planning, detailed information about key elements of each SOCIS factor is available. For example, the *Service* factor asked about existence of IEPs for youth in treatment and the frequency of educational staff participation in family care coordination meetings. *Implementation Plan* included the extent that the SOC implementation plan reflected input of decision makers from the education system. *Collaboration* questioned the existence of written agreements between the Education and Behavioral Health to have behavioral health agencies provide services in schools. SOC Values and Principles queried the extent that services were community-based, with services delivered, as well as managed with decisions made at the local community level. *Comprehensive Financial Plan* rated the extent to which mental health and schools pool or braid funds (or used any other collaborative funding mechanisms) to deliver behavioral health services in schools to children and youth with mental health and substance use needs**.** The *Skilled Provider Network factor* asked if educational and local behavioral health staff were trained together regarding service delivery. Consideration of suggested strategies and SOCIS factor, including specific questions', ratings, could support planning and help improve services and outcomes for youth and families.

Barriers Identified by the State Child Interagency Collaborative Task Force

In addition to these issues identified by Indiana Systems of Care study, the Interagency Task Force identified several barriers that exist in how mental health services are delivered in Indiana.

1. Funding for mental health services is a barrier. Funding sources are multiple and each has specific requirements for eligibility and services.

- Medicaid and private insurance are the most common funding sources for children's mental health services, yet not all children have access to these programs.
- Different funding sources and different mandates for agencies cause duplication of services.
- Agencies have differing definitions for same concept for funding purposes; if the agency does not use their definition, they do not receive the funding.
- Disparate funding sources exist and there are inconsistent, disparate budgets throughout counties.
- Most private insurance has extremely limited mental health coverage and generally does not cover intensive, community-based services.
- The Affordable Care Act (ACA) provided expansions of mental health and substance use disorder coverage, building on the Mental Health Parity and Addiction Equity Act. Mental health and substance use disorder benefits are now included in the Essential Health Benefits package available to all Americans in non-grandfathered plans in the individual and small group markets as of January 1, 2014.[17]

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[15] Walton, B.W., Karikari, I., & Garry, C. (2018).
[16] Kutash K., Greenbaum P., Wang W, Boothroyd, R. A., Friedman, R. M. (2011).
[17] ASPE.hhs.gov (2018)

- The Indiana Kids Count Data book shows that the percentage of children under 19 without health insurance has decreased significantly over the past decade. In 2008 9.8% of children under 19 at all income levels were uninsured, compared to 5.8% in 2016. The reduction is even more significant for those children at or below 200% of poverty, decreasing from 15.5% uninsured in 2008 to 7.8% in 2016.[18]
- The public mental health system (DMHA) has increased its budget allocation for children from 10% to 24%.
- The Hoosier Assurance Plan, which is a program of the FSSA/DMHA that helps eligible individuals who qualify for assistance pay for some of their mental health treatment, is matched by local dollars through the Community Mental Health Centers. An analysis of the state's 2003 budget showed that only 1% of funds spent for children were allocated for mental health services. When Medicaid reimbursement was added, the total rose to 7% of the children's budget.
- During SFY 2003 1% of state expenditures related to children's services were allocated to community-based mental health; when Medicaid reimbursement was added, it became 7% of the budget.
- Funding drives the service delivery system, such as providing group services instead of individualized care. Group services may be more appropriate in some instances; however the business plan was the impetus for some design features of the service delivery system.

2. Coordination between agencies is a barrier. Sharing information among providers is challenging because of the Health Insurance Portability and Accountability Act (HIPAA) and the Family Educational Rights and Privacy Act (FERPA), distrust among agencies, and the complexity of the release of information processes.

- Multiple agencies serve the same child.
- Multiple agencies evaluate the same child.
- The system is fragmented and difficult to navigate.
- There is no systemic coordination to make sure the same or similar services exist from county to county.
- Services offered/received are dependent upon which system youths enter.
- Assessment/treatment planning information does not follow the child.
- There is a lack of integrated treatment of substance abuse/mental health.
- Families are reluctant to seek help because of concerns of loss of custody.
- There is a lack of community-based services.
- There is a lack of culturally and linguistically competent services.
- There are insufficient self-help and peer/family support groups.
- There is a lack of communication among agencies and mistrust among agencies

*However there has been progress on interagency collaboration: Commission on Improving the Status of Indiana children was legislatively created in 2013, the Commission includes 18 members and more than 100 volunteers serving on Task Forces and Committees.

3. The lack of adequate support for groups involved in the delivery and receipt of mental health services in Indiana is a barrier.

- There is a need for more appropriately trained workforce.
- There is a need for additional support for children inside and outside the school setting.
- There is a need for more support in schools and child care providers.
- Despite the proven value of community-based services, those services are not widely, nor equally, distributed throughout the state.
- Therapeutic foster care, respite, and family support services can be effective, and prevent institutionalization; however, they are limited, or unavailable in many communities.
- The Children's Home and Community-Based 1915(i) State Plan Amendment served over 1100 children in SFY2017.
- There is limited availability of intensive community based behavioral health services. Case managers often have large caseloads (8-10 cases is ideal).

[18] IYI Kids Count Data Book (2019)

4. The stigma associated with mental illness is a barrier.

- The child's needs and not their label should drive services. For children with disabilities, the barrier is the eligibility label. Needed services should be offered to the child despite the child's label/eligibility category. It is recommended that service systems develop ways to offer services to children and families that are having difficulties but do not reach the level of a mental health diagnosis (e.g., interventions such as counseling, support groups, or skill-building classes).
- Stigma negatively impacts families/caregivers and prevents them from seeking help for mental health problems.
- Many youth feel that it is preferable to receive treatment for addiction rather than mental health treatment.
- Families/caregivers are reluctant to seek help because of their concern about a diagnostic label following their child.
- There is a racial/ethnic-based belief that mental health intervention is not acceptable.
- Some believe that childhood mental health problems are the result of poor parenting.
- Some believe that troubled youth just need more discipline. The prevailing public understanding regarding the cause of troubled youth behavior is poor or ineffective parenting and is historically not linked to medically treatable illness.
- There is a belief that families cannot afford the necessary treatment.

5. Lack of early recognition of mental health problems in young children, and the lack of accessible early childhood mental health interventions is a barrier.

- Head Start reports an increasing number of children are referred because of behavioral problems. Behavior Management is on the Top 10 list for consultation requests.
- As of September 2018, First Steps has one LCSW and eight psychologists.
- There is a commonly held belief that young children cannot be impacted by violence, trauma, or have emotional problems.
- Primary health care providers have limited time to address mental health issues.
- Medicaid-funded screen, EPSDT (early, periodic screening, diagnosis and treatment) is not accessed for mental health.
- There is a lack of early childhood trained mental health professionals.
- 16% of Hoosier children age birth to five have at least two or more ACE's.
- To be a licensed early childhood provider, a requirement is to have a training on the early childhood foundations which includes social emotional development. This does not include schools who service early childhood.

In most states and communities, significant barriers to mental health care services exist, and Indiana is no exception. The Interagency Task Force focused on several key areas in order to address the barriers in Indiana: early identification and assessment, accountability and outcome measurement, finance and budget, best practices, obtaining services and referral networks, early learning foundations and Indiana Academic Standards, and workforce development and training.

Early Identification and Assessment

Most children in this country do not suffer from mental health problems. Their development from birth through adolescence is healthy. As they grow and develop, children typically become resilient in dealing with multiple challenges. However, for some children and adolescents, mental illnesses are very real. A complex interaction of biological, behavioral, and environmental factors place certain children and youth at greater risk than others for emotional and behavioral disorders that can range from mild to severe, some long lasting. Prevalence studies indicate that almost 21% of children, ages 9 to 17, meet the criteria for a mental health diagnosis.[18] Adding a criterion for mental health symptoms with a *significant* functional impairment, the rate is 11%. These children experience significant impairments at home, at school, and with peers. When *extreme* functional impairment is the criterion, the estimates are 5% of all children. Childhood, beginning from birth, is the time to support children's social and emotional development as a means of preventing development of challenging behaviors.[19] Early detection through screening can help parents identify emotional or behavioral problems and assist them in getting appropriate services and supports before problems worsen and have longer term consequences.[20]

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[18] HHS, 1999; Shaffer et al., 1996.

[19] Hemmeter, et al, 2003.

[20] Substance Abuse and Mental Health Services Administration (SAMHSA) policy statement, 2005. Recommendation number one in Governor Holcomb's School Safety report is to "direct FSSA to identify and

provide schools with a universal and effective mental health screening tool, which would evaluate a student on an individual basis and allow the school to take personalized preventive action." According to the Substance Abuse and Mental Health Services Administration (SAMHSA), between 13 and 20 percent of children in the United States experience a serious emotional disturbance in a given year. However, only about half of all children in need of behavioral and emotional services receive them. It is recommended that FSSA (has this been fully referenced?) be directed to evaluate available universal screening tools for students and identify and implement the selected tool in Indiana schools. Universal screenings are preventive tools that use evidence-based methodology to identify individual students, particularly those who internalize emotions and those who need extra support in the area of mental health. This could be a student who is struggling socially, emotionally, or behaviorally. After a screening is completed, a support team that could include administrators, counselors, psychologists, social workers, special education staff, and teachers would meet regularly with schools to implement a multi-tiered approach of providing support and services, regardless of a family's ability to pay.

The State of Indiana understands that parents are the decision-makers in the care for their children, including screening, early identification, and treatment. Involving parents and caregivers in the planning and organizing of early identification and ongoing treatment is imperative. **Screening must be voluntary, active parental consent must be obtained, and clear procedures must be in place for notifying parents of the screening.** When sharing the results with parents, they must be made aware that the results are an important tool to use when helping and working with their child. It is also important to note that screening for children and youth must take into account child development stages.

Goal and Strategies

The following goal and strategies have been developed by the Interagency Task Force:

Goal: Establish standards for early identification and behavioral health assessments for children in all state systems.

- **Strategy 1:** Differentiate between assessment and screening.
- **Strategy 2:** Ensure active parental consent for all early identification processes and assessments.
- **Strategy 3:** Ensure early identification of behavioral health needs of children with high risks including those in the child welfare and the juvenile justice systems.
- **Strategy 4:** Improve access to effective, appropriate behavioral health services through the use of evidence based assessment tools and related outcome quality management processes.
- **Strategy 5:** Implement a follow-up policy to longitudinally evaluate the value of early identification and assessment activities.

Assessment versus Screening

It is important to define the difference between assessment and screening. "Most definitions of screening for mental health and substance use problems describe a relatively brief process designed to identify youth that are at increased risk of having disorders that warrant immediate attention, intervention, or more comprehensive review."21 Screening in child service settings, such as primary health care, child welfare, juvenile court/probation, and detention centers can quickly identify youth who may have mental health or substance use needs. When possible, behavioral health needs are identified and if necessary, further assessment through a mental health specialist is recommended. **Parental involvement and approval is essential in the screening, assessment, and treatment processes.**

Assessment is a more comprehensive, individualized examination that is lengthy and labor intensive (i.e. multiple interviews, record reviews, collateral contacts, and sometimes, psychological testing). Assessments are usually administered by trained mental health professional to evaluate the type and extent of mental health or addiction disorders in order to make treatment recommendations, level of care determination, and establish outcome measures.

It should be noted that screening instruments, with active parental consent and permission of the youth, have been used in schools across the United States. Longitudinal studies conducted on these sites over a nine year period have shown conclusively that these screens save lives (reduce suicidality), identify needs for assessment of youth at risk for depression and other emotional and behavioral disorders, and inform parents of referral recommendations.[22]

Screening and Assessment in Indiana

Over the past 10 years, a number of screening and assessment instruments have been used across the United States and by Indiana's child service agencies and providers in cooperation with their parents or caretakers to identify and assess the social, emotional, and mental issues of children. The instruments have changed to improve the quality of services. Information is used by families and to inform intervention plans, to determine the appropriate level of care, to determine eligibility for public funding, and to measure outcomes.

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[21]Grisso & Barnum, 2000 & Grisso & Underwood, p. 6, 2004
[22]Mann, et al., 2005; Shaffer, et al., 2004

Within the Indiana Division of Mental Health and Addiction, the HAPI-C was replaced by the Child and Adolescent

Needs and Strengths (CANS) Assessment. The CANS was implemented as a common assessment tool and quality outcome management process across Indiana's child service systems. The CANS ensures clear interagency communication through a common language and uses information obtained by the tool to inform policy and planning decisions on a statewide interagency level. All accredited community mental health centers or hospitals are required to complete psychosocial assessments of children and adolescents who enter treatment. A level of care assessment is required to determine eligibility for intensive community based services through a Medicaid Rehabilitation Option (MRO) package or possible admission to a state hospital. Eligibility for developmental assessments by IDEA Part C programs include social, emotional, and behavioral health concerns. Medicaid EPSDT screens completed by primary health care providers include a behavioral health domain. The public school systems assess children who have learning, behavioral health needs, and possible special education needs. The Department of Correction uses a number of instruments to evaluate the needs of children in their facilities.

Screening children and youth with higher risks of social, emotional, or behavioral health issues, such as those in the child welfare or juvenile justice systems, has been recommended by researchers, advocates and national policy as early identification and effective intervention has been demonstrated to result in better outcomes for children and their families.[23] Upon completion of a two year study, the Indiana Bar Association recommended screening of youth in detention and on probation. [24] Department of Child Services recognizes how abuse and neglect impact the functioning of children, and strives to help mitigate these effects and enhance resiliency by identifying children who have experienced trauma and providing them with services designed to facilitate safety, stability, healing for the child.

Recommendation Regarding Assessment

The fragmentation of Indiana's child service systems, like most across the country, is reflected in the multiple assessment processes. The quality and scope of behavioral health assessments for youth with mental health or substance abuse needs vary widely; recommendations for treatment vary by community, profession, and service system. Some children and families experience repeated assessments, retelling their story, and still have difficulty accessing effective services that fit their needs.

To improve the quality and effectiveness of behavioral health services for children and their families in Indiana, uniform assessment tools and related quality outcome management processes are recommended that meet the following criteria:

- meaningful to the children and families
- inform care planning
- inform decisions about the appropriate level of care
- measure outcomes
- identify training needs and gaps in services

The assessment process would help families and children identify and communicate needs and possible resources. The information would help families, clinicians, probation officers, child welfare family case managers, and judges develop intervention plans and measure outcomes. Information could be aggregated to identify successful services, training needs, and gaps in services. Real time data could be used to make decisions for individual care, workforce development, and resource allocation. When aggregated, such data are important for accountability and improving the quality of services, as discussed in the following sections.

The CANS was adopted as an assessment tool due to its communimetric properties. This tool has also been adopted by other child serving systems in order to improve communication between systems regarding children's behavioral health.

Next Steps

The Children's Social, Emotional, and Behavioral Health Plan Interagency Task Force recommends using the Commission on Improving the Status of Indiana Children to continue to work towards the establishment of cross-system assessments in Indiana.

[23] President's New Freedom Commission on Mental Health, 2003.
[24] Indiana State Bar Association, 2005.

Accountability and Outcome Measurement

Senate Enrolled Act 529 Chapter 16 (IC 20-19-5) calls for a plan that includes guidelines for creating a children's

social, emotional, and behavioral health system with shared accountability among state agencies in order to conduct ongoing needs assessments, use outcome indicators and benchmarks to measure progress, and implement quality data tracking and reporting systems.

Goal and Strategies

The overarching goal for accountability is to ensure that resources are provided to children and families in need of social, emotional and behavioral health services with specific focus on the children being served by the system and those in need of services who are not currently being served. The following goal and strategies have been developed by the Interagency Task Force:

Goal: Responsible systems (mental health, substance use, child welfare, juvenile justice, schools, Medicaid, and primary healthcare) are accountable to provide a network of collaboration that assures that children and families receive needed social, emotional and behavioral health services.

- **Strategy 1:** Establish procedure to evaluate the strengths and needs of Indiana's Behavioral Health Network across child service agencies.
    - Research existing assessments and use existing data to compile for needs assessment baseline.
    - Include an analysis of strengths.
    - Include fiscal analysis in the evaluation.
    - Conduct a literature review for best practices.
    - Create final report with the results of the assessment.
    - DMHA has fostered Systems of Care in most Indiana counties as well as developed a state-level System of Care. The primary purpose of Systems of Care is to address access to and broaden the array of behavioral health services for all Indiana children. The Indiana System of Care Evaluation Subcommittee has gathered data on accessibility, family engagement, and SOC infrastructure implementation.
- **Strategy 2:** Utilize indicators, outcomes and benchmarks to measure progress and continuously improve quality.
    - Build consensus on outcomes.
    - Convene a public forum to determine indicators, outcomes, and benchmarks. A uniform assessment tool, as described under the Early Identification and Assessment section, should be used as a primary source of outcome data to measure progress. If used across child service systems, this tool will be a primary part of the outcomes measurement system.
    - DMHA has adopted ongoing Quality Improvement Evaluation plan (see Appendix F).
- **Strategy 3:** Implement quality data tracking and reporting systems.
    - Identify data sources and review process by which we collect data. Make recommendations for process improvements.
    - Data tracking and reporting systems must cover all relevant privacy laws affected by this project including but not limited to Health Insurance Portability and Accountability Act (HIPAA) and Family Educational Rights and Privacy Act (FERPA) issues.
    - Develop a shared database across all involved agencies with a standard identifier for each individual using an enterprise data warehouse model.
    - Legally mandate sharing of information with parental consent.
    - The data collected using such a system should include sufficient data on the type of services provided (to whom, when, under what conditions and at what cost) as well as outcome data so that effective models of care that are already being used in Indiana can be identified. Please refer to the Best Practices section for more information.
- **Strategy 4:** Functionalize consistent nomenclature (common language) across systems.
    - Identify disparate nomenclature.
    - Develop shared nomenclature.

Needs and Strengths Assessment of Indiana's Behavioral Health Network

Needs and strengths assessments are important in order to ensure that resources are available for children who require services based on a number of factors. First, the cost of providing services is rising and at the same time the resources available for care are limited. Second, many people have inequitable access to adequate services, and many governments are unable to provide such care universally. Third, there is a large variation in availability and use of services by geographical area. Availability tends to be inversely related to the need of the population served. Finally, the expectations of members of the public have led to greater concerns about the quality of the services they receive from access and equity to appropriateness and effectiveness.[25] A needs assessment collects data on each of these four points and allows policy makers to ensure that requirements are being met in the community.

[25] Wright, J., et al, 1998.

It is essential for an ongoing Indiana needs and strengths assessment, although resources to conduct such an

assessment are limited. Successful needs assessments require a practical understanding of what is involved, the time and resources necessary to undertake assessments, and sufficient integration of the results into planning and commissioning of local services. We need to be conscious of the fact that there are several existing studies and assessments that should be taken into consideration prior to conducting a formal assessment. These existing studies include the Evaluation of Systems Reform in the Annie. E. Casey Foundation Mental Health Initiative for Urban Children: Summary of Findings and Lessons Learned, The Indiana State Bar Association's Civil Rights of Children Committee Report and the Indiana Consortium for Mental Health Services Research Sixth Annual Evaluation Briefing of the Dawn Project Evaluation Study.

Outcome Indicators and Benchmarks

Given the increasing focus on accountability, it follows that clinicians, providers and administrators are interested in determining the outcomes of care delivered to children with social, emotional, and behavioral health issues.[26] Outcomes, benchmarks and data reporting are all related to the assessment tool that is chosen (refer to Assessment and Screening section of the plan). These variables are linked fundamentally to the assessment discussion as the tool is more than a tool for direct service planning. The tool is for decision support and data can be aggregated for utilization and quality management within an organization and at the state level.

In order to effectively measure outcomes, the state must build consensus on outcomes through a public forum. State agencies must work with community partners to establish appropriate indicators, outcomes, and benchmarks.

Data Tracking and Reporting Systems

There are many issues surrounding data in Indiana. The data are not consistent, not readily available, may not contain all encounters, and primarily collect financial information on an individual. Wide variance in different geographic regions, variability in nomenclature, and variance in expenditures for particular services also have been identified as issues across databases.

The following example illustrates several of these concerns. Through Indiana's experience with the child welfare screening, assessment and treatment initiative, the limitations of the current systems have become apparent. No one state database included the data needed to evaluate the implementation or outcomes of this initiative. Using a unique identifier to link information from DCS, Medicaid, and DMHA, de-identified information was matched and then shared for evaluation. This allowed the use of outcome data to improve the quality of care and helped identify the limitations of the current fragmented databases. Each has been designed for specific purposes and involves different state technology systems and contractors. Each is limited in its information.

Moreover, there are many federal data requirements that drive agency database requirements. State programs interact with federal counterparts to address issues requiring access to data. Federal agencies need this information for better planning and budgeting. This interaction is also required for reporting and auditing purposes. It is important to note that each program usually maps to a separate information system that in turn maps to several databases[27]. It will be difficult to modify data collections based on these requirements. Any modifications must ensure that federal reporting requirements continue to be fulfilled.

In many cases, agency systems have child information collected on an individual basis but there is no aggregate data collection. Each agency has information by individual and there may or may not be comparable indicators and benchmarks across systems. These indicators supply several critical data sets that are required to ensure the individual is viewed holistically. It is important for these similarities to be identified and for shared databases to be developed. The data collected using such a system should include sufficient data on the type of services provided (to whom, when, under what conditions, and at what cost) as well as outcome data so that effective models of care that are already being used in Indiana can be identified.

Nomenclature

Nomenclature refers to a system or set of terms for a particular discipline, in this case, social, emotional, and behavioral health services for children. Every state agency involved in providing services to children uses their own set of terms for diagnoses and services. In order to ensure we are providing a continuum of services we need to identify the disparate nomenclature and establish a common language across agencies.

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[26] Hoagwood, K., et al, 1996.
[27] Bouguettaya, A., et al, no year.

Next Steps

The Children's Social, Emotional, and Behavioral Health Plan Interagency Task Force recommends establishing a procedure for a statewide needs and strengths assessment of the behavioral health network across child service systems. Successful needs assessments require a practical understanding of what is involved, the time, and resources necessary to undertake assessments, and sufficient integration of the results into planning and commissioning of local services. This assessment should utilize indicators, outcomes, and benchmarks to measure progress, implement quality data tracking and reporting systems, and functionalize consistent nomenclature across systems (mental health, substance use, child welfare, juvenile justice, schools, Medicaid, and primary healthcare).

The Interagency Task Force also recommends creating a subcommittee to identify the existing data sources, review the process by which we collect data in each agency and make recommendations for process improvements. The end result should be an enterprise data warehouse model for use by all agencies involved in the delivery of services for children with social, emotional and behavioral health needs.

Finance and Budget

Senate Enrolled Act 529 Chapter 16 (IC 20-19-5) calls for a state budget for children's social, emotional, and mental health prevention and treatment; and recommendations as to how state agencies and local entities can obtain federal funding and other sources of funding to implement a children's social, emotional, and behavioral health plan.

The cost of mental illness is devastatingly high. The United States annual, economic, indirect cost of mental illnesses is estimated to be $79 billion. Most of that amount—approximately $63 billion—reflects the loss of productivity as a result of illnesses. But indirect costs also include almost $12 billion in mortality costs (lost productivity resulting from premature death) and almost $4 billion in productivity losses for incarcerated individuals and for the time of those who provide family care (President's New Freedom Commission Report).

In 1997, (latest year comparable data are available), the United States spent more than $1 trillion on health care, and that includes $71 billion on treating mental illnesses. 57% of mental health expenditures are predominately publicly funded, and 46% of overall health care expenditures are funded. From 1987 through 1997, less was spent on mental health funding because of cutbacks in hospital expenditures and declines in private health spending under managed care (President's New Freedom Commission Report).

The current system of mental health care must rely on many sources of financing. Many of the funding streams are tightly restricted in who can use them and how they can be used. Providing access to effective treatments and services that are easy to navigate and that use flexible funding streams is crucial to transforming mental health care. Currently, eligibility requirements for receiving services or supports and reimbursement policies vary widely, and states must rely on waivers to provide treatments and supports that federal standards deem optional[28].

Financing services for children's social, emotional, and mental health requires state and local officials to use all relevant resources effectively. Mental health systems for children and youth are supported by a range of financing sources that support elements within each comprehensive mental health system. The federal government provides much of the funding for children with emotional and mental disorders, unfortunately, the sources of federal funds are numerous and complex resulting in a web of programs that is hard to understand in the context of service delivery[29].

Medicaid finances the majority of children's mental health services. Although over two-thirds of children have private insurance coverage, less than half of children's mental health treatment is paid by this source. Federal grants provide some support for prevention and early intervention, including through Head Start, Maternal and Child Health, Part B and Early Intervention under the Individuals with Disabilities Education Act. Federal grant support for treatment comes from mental health, child welfare, and juvenile justice funds. Federal grant funds also support system development and coordination. Additionally, states invest funding in children's mental health, primarily for treatment services, and increasingly as Medicaid matching funds[30].

The interagency task force explored Indiana's funding options for mental health services which can be found in Appendix A, the inventory of public systems, services, and programs serving Indiana children. The Task Force then turned the focus to improving the funding structure and making recommendations for ways to improve the system.

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[28] President's New Freedom Commission on Mental Health, 2003.
[29] Bazelon Center, 2003.
[30] National Institute for Health Care Management, 2005.

Goals and Strategies

The overarching goal for finance and budget is to ensure that resources are provided to children and families in need of social, emotional and behavioral health services. The two broad categories are systems issues and equity issues. The following goal and strategies have been developed by the Interagency Task Force:

Goal: SYSTEMS: Maximize current investments and leverage available funds to ensure children receive the services they need.

- **Strategy 1:** Ensure families and parents have access to information regarding eligibility and available services.
- **Strategy 2:** Create a central reimbursement entity to ensure collaborative funding involving DMHA, DCS, IDOE, DOC, OMPP, ISDH (and any other relevant agency).
    - Explore consolidation of all rate-setting and licensing for residential treatment facilities to a single state agency.
    - Identify funds from multiple state and local agencies, including those that can be braided or pooled, to support children's mental health prevention, early intervention and treatment efforts at the community, local, regional, and state levels.
    - Explore a fee for service model.
    - Explore a capitated rate and/or managed care.
    - Explore a "flex-fund" model that can provide necessary services and items for children and families that no service system is able to provide.
    - Work with counties to ensure access to local funding. Start with a review of the early intervention plans (both community and individual) at the county level.
- **Strategy 3:** Examine a tiered approach to services based on levels of intensity
    - Establish how children are entering the system
    - Define populations
- **Strategy 4:** Maximize access to federal funds.
    - Explore the use of various federal programs (e.g., Title V Maternal and Child Health Services Block Grant, Juvenile Justice, 1915C Medicaid Waiver) to support children's mental health programs and services.
    - Advocate for increased federal funding to support comprehensive children's mental health programs and services.
- **Strategy 5:** Maximize education funding.
    - Explore expanding provision of mental health services in schools.
    - Explore development of a program to place licensed clinical social workers and mental health professionals in schools to provide services for students who are enrolled in Medicaid. (Note: The schools must be eligible and certified to bill Medicaid for services.)
    - Promote expanded use of federal funding for early intervening services through the reauthorized Individuals with Disabilities Education Improvement Act of 2004 (IDEIA) for students who are not in special education.
    - Determine opportunities for social and emotional learning and student support in Title IV, Part A funds.
    - Provide school based mental health services in collaboration with local community mental health provides.
- **Strategy 6:** Explore use of Medicaid to ensure that children receive appropriate mental health services.
    - Explore expanding Medicaid reimbursement for children's mental health services on a continuum for children with moderate to severe mental health disorders.
    - Explore modifying the State Medicaid Plan to expand the number and type of providers (e.g., licensed clinical social workers and psychologists, licensed clinical professional counselors, nurse practitioners, and nurses) who are eligible to receive reimbursement for assessment and treatment services under Medicaid.
    - Explore various Medicaid waiver options to maximize the availability of federally matched mental health services for Indiana children including an early intervention waiver. See Appendix A
    - Re-engineer Medicaid eligibility – participate in process so issues are represented
- **Strategy 7:** Identify necessary legislative changes.

Goal: EQUITY: All children should receive services based on individual needs and strengths regardless of availability of funding.

- **Strategy 1:** Examine eligibility and determine if state-imposed eligibility can be changed and/or broadened.
    - Focus on financial and individual needs.
    - Examine eligibility determination process.
- **Strategy 2:** Focus on non-Medicaid eligible kids who do not have private insurance and explore mechanisms and strategies for increasing private insurance coverage of children's mental health services (parity).
- **Strategy 3:** Focus on Early Intervention (0-5).
- **Strategy 4:** Identify necessary legislative changes.
- **Strategy 5:** Improve access to quality care that is culturally competent.
- **Strategy 6:** Improve access to quality care in rural and remote areas.

Systems

The broad goal of improving systems related to funding includes maximizing Indiana's current investments and leveraging available funds to ensure children receive the services they need. Numerous federal programs provide Indiana with funds that are either directly targeted to children's mental health or could be used to support an array of services in some capacity. Many of these federal resources offer flexibility in the use of funds and program design, within federal parameters. Efforts that maximize and coordinate federal program funds, state general revenue funds, and local and private funds can result in better ways of using scarce resources and create new investments for children's mental health.

One of the most important strategies is to create a central reimbursement entity to ensure collaborative funding involving DMHA, DCS, IDOE, DOC, OMPP, ISDH and any other relevant agency. Blending or braiding funding allows the decisions for the child to be made by the family and those working closely with the family. Both strategies offer flexibility and allow the provider to focus on outcomes. Systems that are set up to allow this type of funding must track, document and account for funds that are spent. Blending funding into a central reimbursement entity, even on a small scale, has advantages over braiding funding because it offers flexibility for state and local agencies and reduces the administrative burden. Blended funding can also allow systems to fund activities that are not reimbursable through specific categorical programs. As a result blended funds can help plug funding gaps in the service continuum[31].

Braided funding may be more applicable to federal funds because funds from various sources are used to pay for a service package for an individual child. Tracking and accountability for each pot of money is maintained at the administrative level[32]. The child and family would still see a seamless funding source for the services they receive. The recommendation to create a central reimbursement entity would need to include some combination of blended and braided funding based on the requirements of each revenue source.

It is also important to note that the way the State provides mental/behavior health services to its Medicaid (Hoosier Healthwise) recipients is changing. In the 2007 re-procurement of the Hoosier Healthwise Managed Care Organizations (MCOs), the Office of Medicaid Policy and Planning (OMPP) will be requiring the MCOs to provide and pay claims for all Hoosier Healthwise behavioral health services except for Medicaid Rehabilitation Option (MRO) services. The Hoosier Healthwise population consists of children, pregnant women, and low-income families. These members qualify for Medicaid based on income rather than disability and it is assumed that women and children enrolled in Hoosier Healthwise are free from serious mental illness and other chronic medical conditions that would qualify them for Medicaid Disability.

The current Hoosier Healthwise program "carves" behavioral health services out of managed care. This means that while MCOs reimburse providers for all physical health care, prescription medications, and inpatient hospitalization, mental health providers bill their claims to the Medicaid fiscal agent. This results in fragmentation and a lack of continuity and coordination between patients' physical and mental health care. Despite the MCOs paying for mental health medications, they do not receive record of the mental health treatment the patient is receiving.

Carving behavioral health services into the managed care organizations communicates the connectivity of mental and physical health. In so doing, there is a reduction of the stigma for pursuing and receiving mental health services and promoting recognition of these services at the same level of concern as other medical services. The following are Medicaid's goals for the transition and implementation of the behavioral health carve-in:

1. **There will be no disruption of current/pre-carve-in medication regimes.**
    - The pharmacy benefit will not change due to the carve-in. Presently, Hoosier Healthwise members obtain all medications through their MCO. HEA 1325-2005 created a Mental Health Quality Advisory Committee to standardize authorization requirements for mental health medications for fee-for-service Medicaid and the MCOs.
    - The MCO is required to have a process for appealing restrictions of needed medication. Currently, requests for medications that are not on the formulary are reviewed by the MCO for medical necessity. This team includes representation by a psychiatrist.
    - Monitoring of the consistency of prescribing practices for behavioral health will be monitored through the Mental Health Quality Advisory Committee.

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[31] Bazelon Center, 2003.
[32] Bazelon Center, 2003.

2. **There will be access to any medically necessary behavioral health care**
   - The MCOs are required, by contract, to provide medically necessary treatment. If they are not providing care, they are out-of-compliance with their contract.
   - The RFP requires MCO's to have Behavioral Health Care Managers to oversee the more complex cases, ensuring medically necessary services are provided.
   - The RFP will require the MCO's to implement the use of the CANS as a universal tool to assist with service and level of care determination. This tool is currently endorsed by DMHA.
   - The carve-in may actually increase consultation with and referrals to mental health providers due to the contractual partnerships that have been encouraged.
   - Participants who require intensive, ongoing behavioral health services for chronic conditions can apply for Medicaid Disability to ensure appropriate eligibility and levels of service need are met.

3. **Access to emergency services will not be adversely impacted**
   - Hospitals are required by the federal Emergency Medical Treatment and Active Labor Act (EMTALA) to screen everyone that comes to the emergency room regardless of ability to pay. MCOs are required by the federal managed care rules to pay for all emergency services that meet the "prudent lay person standard".
   - MCOs are encouraged to contract with CMHCs to provide behavioral health services. All CMHCs are required to have crisis services available to Consumers.

4. **Children will have access to behavioral health specialists for diagnosis and treatment and this care will be coordinated and shared with primary medical providers.**
   - Hoosier Healthwise participants can self-refer to behavioral health services with in the MCO network.
   - The primary medical provider (PMP) may serve as the first contact, but if he or she cannot treat the member, the member will be referred to a specialist. The benefit is that the PMP will be able to track the referral, know the patient's behavioral health treatment plan, and can work with the mental health practitioner to ensure compliance and coordination with the member's physical health care.
   - MCO's are encouraged to contract with CMHCs who have the expertise providing care for behavior health disorders of varying severity and impairment. Formal contracts may actually lead to increased referrals to mental health providers.
   - OMPP acknowledges that the Hoosier Healthwise Managed Care Organizations are designed to care for healthy, low-income individuals. Participants who meet criteria for SED and SMI may request a review from their local DFR for eligibility and enrollment in Disability Medicaid to ensure they have access to needed services. During this eligibility review, these members will have full access to their MRO services without requiring an authorization from their MCO.
   - As Participants reach recovery, they will be able to maintain needed medications through their PMP without dependence on a second set of appointments with a specialist. The PMP will already be informed of the course of care, making this transition seamless. There is a great advantage to children and families to have this link in place.
   - The MCOs will be required to adhere to IC 12-15-12-9 and allow members to obtain care from any Medicaid-enrolled psychiatrist through self-referral.

5. **Efforts will be made to decrease the possibility consumers will have to change providers.**
   - Contracts between MCOs and CMHC are being encouraged as the CMHCs have been the primary provider of behavioral health services in most communities. Members will be educated on the entire provider network of MCOs in their region, including the behavioral health providers. If their mental health provider is in only one, the member can select the plan in which their provider is enrolled.
   - If the current behavioral health provider is not a part of any Hoosier Healthwise HMO, the member will have to work with his or her primary medical provider to determine if an out-of-network referral is medically necessary.
   - The new regions that MCOs will bid on and be required to provide all covered services are smaller, which fosters care in the local community.
   - MCOs and Providers can contract across regions, not just within regions.

6. **Needed inpatient services will be available and this information will be available to PMPs.**
   - The MCOs are presently required to pay for inpatient behavioral health treatment.
   - Carving behavioral health into managed care will allow them access to the patient's full medical and mental health care history to make medically necessary admissions.
   - The carve-in will allow the MCO to assist in discharge planning. Presently the mental health patient

can be discharged from the hospital without follow-up coordination with the PMP or other health providers. Coordinated efforts among all those involved with a Participant's care may lead to decreases in recidivism rates.

7. **Community Mental Health Centers (CMHCs) reimbursement for serving the Hoosier Healthwise population will not be adversely impacted.**
   - MRO services will remain carved out of Hoosier Healthwise and will be billed to Medicaid FFS.
   - Clinic option billing will be sent directly to the MCO for reimbursement.
   - The carve-in does not decrease the ability to bill for service but changes to whom those services are billed.

8. **Consumers will benefit from the encouraged relationships established between MCOs and behavioral health providers**
   - Data suggest that a mental health consumer benefits from a centralized, coordinated source of care. Coordinating service delivery is the primary aim of this.

9. **Administrative costs related to the changes will be kept to a minimum**

   - There will only be two MCOs per region (except potentially the Marion County region).
   - If a mental health provider contracts with the MCO, it can bill electronically.
   - This is no different than billing multiple versions of private insurance.

Equity

The broad goal of ensuring equity in the state's mental health systems means that all children should receive services based on individual needs and strengths regardless of availability of funding. Barriers to mental health care exist for all children with mental health needs but they are more pervasive for some groups. According to research, racial and ethnic disparities are evident in children's access to and receipt of mental health services. While the prevalence of mental disorders in racial and ethnic minorities is similar to that of their white counterparts, minorities are less likely to have access to mental health services, less likely to receive needed care, and more likely to receive poor quality of care than whites. In children, Hispanics are the most likely of all racial/ethnic groups followed by African-Americans to have the highest rates of unmet need for mental health services.[33]

One strategy is to focus on non-Medicaid eligible children who do not have private insurance and explore mechanisms and strategies for increasing private insurance coverage of children's mental health services. Over three quarters of children and youth who are publicly- or privately-insured or uninsured report unmet needs for mental health care. Moreover, uninsured children are more likely to have unmet needs for mental health care. Nearly 90% of uninsured children report unmet needs for mental health care as compared to 73% of publicly-insured children and 79% of privately-insured children.[34] By applying what we know about social determinants of health, we can not only improve individual and population health but also advance health equity.

Next Steps

As stated earlier, Senate Enrolled Act 529 Chapter 16 (IC 20-19-5) calls for a state budget for children's social, emotional, and mental health prevention and treatment; and recommendations as to how state agencies and local entities can obtain federal funding and other sources of funding to implement a children's social, emotional, and behavioral health plan. Because the goals and strategies outlined in this section are complicated, the recommendation is that a subcommittee be formed with the State Budget Agency as an integral member agency to explore each of the strategies listed.

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[33] National Institute for Health Care Management, 2005
[34] National Institute for Health Care Management, 2005

Best Practices

Senate Enrolled Act 529 Chapter 16 (IC 20-19-5) called for recommendations for procedures concerning the positive development of children and recommendations on how to facilitate research on best practices and model programs for children's social, emotional, and behavioral health.

The President's New Freedom Commission (2003) calls for the use of evidence based interventions and the ongoing development of this knowledge base. More people could recover from serious mental illnesses if they have access in their communities to supports and effective treatments tailored to meet their needs. The Commission also discovered the following, that: new, relevant research findings need to be systematically conveyed to front-line mental health providers and applied to practice; treatment offered must be sensitive to the commonalities, differences, and diversity of Americans; and services and treatment based on consumer preference and proven effectiveness must be the basis for reimbursements.

Although prior to 1990, there was no mention of evidence based practice related to children's behavioral health[35], the research literature has increased at a fast pace. Evidence based practices refer to programs that meet some specified research criteria for effectiveness. In actual practice, these evidence-based practices are often not available.[36] For a listing of children's mental health evidence base practices that are available refer to www.NREBP.org.

A large percentage of the behavioral health services received by children occur in schools and services outside clinical settings. Because children are involved in multiple systems (mental health, substance use, child welfare, juvenile justice, schools, Medicaid, and primary healthcare) a wide range of providers will need to be trained in evidence-based or effective practices.[37]

The gap between science and practice includes limitations in the evidence base, implementation issues, and limited capacity for outcome based quality management. Much research has focused on specific behavioral symptoms in controlled settings. Real people have complex needs and adaptations may be needed in the interventions, settings and service systems to effectively implement research based practices.[38] Furthermore, some best practices may not have been studied and documented in the research literature.

Practice based evidence is the use of information from actual practice to inform the research base.[39] Practice based evidence can identify best practices. When the evidence indicates the need to improve practice, the existing evidence base can be used to suggest more effective interventions. The availability and use of real-time data regarding outcomes and practice is central to identifying best practices and to effectively implementing evidence based practices.[40] The following issues must be addressed in order to identify, develop, and implement effective models or best practices of care in Indiana:

- Identify effective models of care (best practices)
- Assess readiness for change
- Apply implementation research
- Measure fidelity to the model
- Track outcomes
- Use data for quality management.

The following goal and strategies for the identification and dissemination of best practices include using the emerging evidence-based in research and practice-based evidence to integrate effective social, emotional, and behavioral health practices in Indiana's child service systems.

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[35]Hoagwood, et al, 1996.
[36]Burns, et al, 1999.
[37]Hoagwood, et al, 2001.
[38]Schoenwald & Hoagwood, 2001.
[39] Newman, Kellett & Beail, 2003.
[40] Effland & McIntyre, 2005.

Goal and Strategies

The goal and strategies in this section were adapted from the Technical Assistance Center for Systems of Care and Evidence Based Practices for Children and Families.[41] The TA Center is funded through a contract with the Family and Social Services Administration Division of Mental Health and Addiction and supports statewide transformation efforts.

Goal: Create, implement, and sustain an accountable system that uses real-time process and outcome data to continuously improve the quality of services and that makes effective models of care available to all young people with mental health issues and/or substance use problems and their families.

- **Strategy 1:** Advance evidence-based practices through dissemination of a combined knowledge base and demonstration projects. Create a public-private partnership to guide their implementation.
    - Identify State and Local Partners - Identify key state and local partners (including public and private agencies and community members) involved in transforming the mental health system in Indiana.
    - Assessment - Assist in conducting an assessment of local and state readiness to adopt new structure for shared accountability, quality improvement and implementing effective models of care.
    - Services and Resources - Through participation in appropriate workgroups and subcommittees, written communication and personal contacts, educate key partners about the services and resources available in the State to meet the shared accountability, quality improvement and implementation of effective model of care objectives of statewide initiatives.
    - Issue Papers - Develop brief and timely summaries of research, issues and theories to disseminate key policy decisions.
    - Training - Provide training to public and private partners, community members, and other individuals as requested on relevant topics.
- **Strategy 2:** Make an informed decision regarding best practices for Indiana.
    - Design the following components (and others as appropriate) of a structure: Implementation Plan, Measurement of Fidelity to Identified Practice Models, Outcome Management System, and Quality Improvement Process.
- **Strategy 3:** Implement best practices model for Indiana.
    - Training - Design and conduct trainings to: provide information on shared accountability, quality improvement and implementation of effective models of care structure; build statewide and local enthusiasm; give guidance on how to manage the implementation process; and clarify the goals and objectives.
    - Coaching - Provide individualized coaching to local communities and the state as they work through the stages of the implementation process. Coaching will be based on the latest implementation research and experience working with system of care communities.
    - Monitoring Implementation Outcomes - Collect data necessary to ensure that the best practices are implemented as planned.
- **Strategy 4:** Maintain best practices model.
    - Consultation - Provide consultation in (1) using fidelity and outcome data for quality improvement purposes; (2) assessing outcomes; and (3) use the findings to improve the quality of implementation of the best practices model(s).
    - Training - Provide ongoing training to the workforce to sustain the best practices model(s). Trainings in this step would be designed to: acknowledge the challenges associated with implementing and sustaining change; generate improvements in practice based on fidelity and outcome data collected; support, motivate, and challenge existing workers; educate new workers on best practices.
- **Strategy 5:** Implement quality data tracking and reporting systems.
    - Develop shared data bases with standard identifier for each individual.
    - The data collected using such a system should include sufficient data on the type of services provided (to whom, when, under what conditions, and at what cost) and outcome data so that effective models of care that are already being used in Indiana can be identified. Please refer to the Accountability and Outcome Measurement section for more information.

Next Steps

The first step in creating best practices and model programs for children is to initiate a process to disseminate knowledge about best practices and outcomes quality management to stakeholders. The second step is to develop an action plan. The third step is to create an infrastructure for data collection and quality management. After the action plan is complete, a business plan focused on funding to support the dissemination of best practices (effective implementation of evidence-based practices and use of practice-based evidence to identify new best practices) should be developed. The final step is to implement targeted best practices considering the strategies listed in the previous section.

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[41] Effland & McIntyre, 2005

Obtaining Services and Referral Networks

Social, emotional, and behavioral health is a critical component of a child's health, well-being, and learning. Yet stigma attached to mental health concerns and misinformation about mental health are some of the most significant barriers to ensuring that children and their families have access to a quality mental health system. The President's New Freedom Commission defined stigma as "a cluster of negative attitudes and beliefs that motivate the general public to fear, reject, avoid, and discriminate against people with mental illnesses." According to the Commission, stigma leads to the avoidance of socializing, living, working with, employing, or renting to people with mental disorders—especially severe disorders, such as schizophrenia.

Not only does mental illness lead to low self-esteem, hopelessness, and isolation, but it deters the public from seeking care. People with mental health problem internalize public attitudes, conceal symptoms, and become so embarrassed or ashamed that they do not seek treatment. The Commission found that when individuals understand the facts, they are less likely to view mental illness as a stigma and more likely to seek treatment for mental health problems.[42] Reducing stigma involves increasing awareness and encouraging treatment.

Early prevention and intervention efforts can help assure that children who have mental health needs are identified early and provided with appropriate services. Systems that serve children must be equipped with knowledge and skills to identify early warning signs of problems in social and emotional development.

Senate Enrolled Act 529 Chapter 16 (IC 20-19-5) calls for recommendations concerning procedures to assist a child and the child's family in obtaining necessary services to treat social, emotional, and mental health issues; procedures to coordinate provider services and interagency referral networks for an individual from birth through twenty-two (22) years of age; how to implement a public awareness campaign to reduce the stigma of mental illness; and educate individuals about the benefits of children's social, emotional, and behavioral development; and how to access children's social, emotional, and behavioral development services.

In order to improve services for people with mental illnesses, the collaboration among mental health care and general medical care systems must be reviewed. Mental health and physical health are clearly connected, and call for a collaborative system in order to help primary care providers effectively treat common mental disorders. Primary care providers can also help reduce stigma by informing and helping the public recognize and identify their own symptoms and the symptoms of their children. They can also help those in need with the identified problems.[43]

Goals and Strategies

Goal: PROCESS: Develop procedures to assist a child and the child's family in obtaining necessary services to treat social, emotional, and mental health issues including procedures to coordinate provider services and interagency referral networks for an individual from birth through twenty-two (22) years of age.

- **Strategy 1:** Identify gaps in the existing processes for each State agency.
- **Strategy 2:** Create master flow chart for the entry point into the mental health system for children and make recommendations for process improvements.
- **Strategy 3:** Create a multi-tiered system of support framework within schools to support children who do not need to enter the mental health system but do need some services.
- **Strategy 4:** Integrate social and emotional development practices into existing academic settings by using Indiana's PK-12 Social Emotional Learning Competencies as a road map.
- **Strategy 5:** Disseminate information and referral procedures of state and local programs serving children with social and emotional concerns and their families to stakeholders.

Goal: PUBLIC AWARENESS: Develop a comprehensive, culturally inclusive, and multi- faceted public awareness campaign to reduce the stigma of mental illness, educate families, the general public, and other key audiences about the importance of social, emotional, and behavioral health development.

- **Strategy 1:** Address mental health with the same urgency as physical health. The epidemiological data is supportive of treating the children's mental health issues as a serious public health challenge.

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[42] President's New Freedom Commission on Mental Health, 2003, page 10.
[43] President's New Freedom Commission on Mental Health, 2003.

- **Strategy 2:** Focus on dissemination of information regarding mental health in schools in order for students to

accept other students with mental illness. School-based prevention programs for suicide are ideal because the school provides an environment with the highest likelihood of exposure to a prevention program for adolescents.
    - Identify existing school programs and evaluate for effectiveness.
    - Increase resources for evaluations in schools.
    - Focus on public service announcements in schools.
    - Educate teachers about mental illness including how to identify youth at risk.
    - Encourage mentoring relationships in schools.
    - Focus prevention programs on suicide prevention and bullying.
- **Strategy 3:** Create support for building the capacity of the mental health system to serve infants and toddlers, young children, and adolescents. Ensure that families/caregivers, providers, and others are informed of availability of services and programs in order for them to recognize issues, use early identification opportunities, and seek help.
- **Strategy 4:** Look at existing public awareness packages (e.g. public awareness packages provided by the Federal Substance Abuse and Mental Health Services Administration (SAMSHA) (full name already referenced) and the Mental Health Association for Community Mental Health Awareness Week to determine if we can replicate them or utilize them in Indiana.
    - Ensure that the chosen public awareness campaign is based on research and information regarding knowledge and perceptions about areas including: stigma; importance of promoting mental health in children and adolescents; the prevalence of mental health disorders in children and adolescents (including as it relates to youth in the juvenile justice system and the importance of providing mental health treatment rather than placement in correctional settings); the factors that can cause and/or contribute to mental health disorders; the availability of services and resources among the target audience(s); and understanding of concepts relating to mental health versus mental illness.
    - Utilize the momentum created by the Annual Children's Mental Health Awareness Day, to be held May 10, 2019, sponsored by NAMI, National Federation of Families, National Association of Social Workers, National Mental Health Association, and SAMSHA.
- **Strategy 5:** Provide policymakers with regular communication about children's mental health including key aspects of the public awareness campaign and efforts to improve the mental health system. Build political will around the issue including identification of a representative for the cause.
- **Strategy 6:** Measure the impact of the public awareness campaign on the target audiences (e.g., families/caregiver, educators, health and mental health providers, and juvenile justice system officials) knowledge, perceptions, and relevant behavior change.
- **Strategy 7:** Educate the public regarding the prenatal/environmental factors that can influence mental health for infants and toddlers and the risk factors that predispose an individual to mental illness.
- **Strategy 8:** Educate children about mental health and promote social, behavioral, and emotional health through wellness programming.
- **Strategy 9:** Promote parents teaching parents as a significant opportunity for public awareness and education. Several programs in this regard exist and are of proven value.
- **Strategy 10:** Develop a plan for ongoing strategies to support and sustain the public awareness campaign efforts.
- **Strategy 11:** Celebrate successes by telling positive stories as personal experience is the most powerful connection.

Process

The goal of developing a process and creating procedures to assist a child and the child's family in obtaining necessary services to treat social, emotional, and mental health issues is of pressing concern for the State of Indiana. This is also a national concern. In its *Interim Report to the President*, the President's New Freedom Commission stated that "…the mental health delivery system is fragmented and in disarray…leading to unnecessary and costly disability, homelessness, school failure and incarceration.[44]" The report described unmet needs and barriers to care, including gaps and fragmentation in mental health care for children. Indiana has many services available for children with mental health concerns but the system is difficult to navigate. Indiana first needs to identify the gaps in the existing services and then create a point of entry into the system that is easy to understand.

Public Awareness

The goal of developing a public awareness campaign to reduce the stigma of mental illness, educate families, the general public, and other key audiences about the importance of social, emotional, and behavioral health development is a key recommendation. When the public is informed about mental illness they are less likely to stigmatize it and more likely to seek treatment.

[44] President's New Freedom Commission on Mental Health, 2003.

Indiana needs to have a public awareness campaign based on research and information regarding knowledge and

perceptions about the following areas: stigma; importance of promoting mental health in children and adolescents; the prevalence of mental health disorders in children and adolescents (including as it relates to youth in the juvenile justice system and the importance of providing mental health treatment rather than placement in correctional settings); the factors that can cause and/or contribute to mental health disorders; the availability of services and resources among the target audience(s); and understanding of concepts relating to mental health versus mental illness. This list is not intended to be all inclusive. It is important to note that the recommendation does not necessarily involve Indiana creating its own public awareness campaign. Existing public awareness packages should be reviewed to determine if Indiana can replicate the campaign and/or use it in Indiana.

Next Steps

The first step in developing a public awareness campaign is to develop an action agenda and an operational business plan. This can be accomplished through a cross-agency team/interagency coordinating council such as The Commission on Improving the Status of Indiana Children.

Early Learning Foundations and Indiana Academic Standards

Recent research points to public schools as the major providers of mental health services for school-aged children. According to the report, School Mental Health Services in the United States 2002-2003, more than 80 percent of schools provided assessment for mental health problems, behavior management consultation, and crisis intervention, as well as referrals to specialized programs. A majority also provided individual and group counseling and case management. Findings from this report indicate that schools are responding to the mental health needs of their students, but there is an increasing need for mental health services. Schools face multiple challenges in addressing these needs. The report also indicates that further research is needed to explore issues identified by the study, including training of school staff delivering mental health services, adequacy of funding, and effectiveness of specific services delivered in the school setting.[45]

Indiana Academic Standards have been developed from kindergarten through twelfth grade to promote excellence and equity in education. The standards provide a framework of the essential content every student needs in order to have a basis for understanding each subject area at each grade level and can be found at https://www.doe.in.gov/standards. The Foundations to the Academic Standards for children birth to five are aligned to the Academic Standards. The Foundations outline specific early childhood skills and concepts in a developmentally appropriate perspective and give examples of instructional strategies that support teachers, parents, and caregivers as they develop the types of experiences and interactions early learners need to develop each foundation. They can be found at https://www.doe.in.gov/earlylearning.

Beginning at birth, children's social and emotional development is an essential component to school readiness and academic achievement. Research indicates that critical foundations for learning, school success, and general well-being occur long before a child enters kindergarten.[46] When children's social and emotional development and mental health concerns are not addressed early, the cost to families and the State increases. When an adult such as a teacher, caregiver, parent, family member, or service provider engages in interactions that help the young child develop strong interpersonal relationships and social and emotional skills, more intensive interventions later on in life will be reduced. For young children, early childhood mental health is healthy social and emotional development.[47] Early childhood is a critical period for the onset of emotional and behavior impairments. Significant progress has been made in the United States to establish Social Emotional Learning as a component of education policy. On December 10, 2015, President Obama signed the bipartisan Every Student Succeeds Act (ESSA), which reauthorizes the Elementary and Secondary Education Act of 1965 (ESEA). ESSA contains several elements that support social and emotional learning and provides flexibility for states and local school districts to define and assess student success.

Schools play a central role in promoting children's social and emotional development because most children ages 5-18 attend school, and because social and emotional well-being is integral to children's ability to learn and succeed in school. By integrating an emphasis on social-emotional learning in schools, students are better able to resolve interpersonal problems and prevent antisocial behavior, as well as to achieve positive academic outcomes.

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[45] Foster, S., et al, 2005.
[46] Shonkoff & Phillips, 2000.
[47] Zero to Three, Infant and Early Childhood Mental Heatlh, 2004.

"In this era of accountability and school reform, the mental health community should be aware that their interventions must align with the major concern of the schools academic achievement. Likewise, the education community must be aware that mental health professionals do have strategies to improve instruction and achievement as well as improving social and emotional function in children. The convergence of these two perspectives is the hallmark of "school-based mental health.[48]"

Goals and Strategies

Goal: YOUNG CHILDREN BEGINNING AT BIRTH: Incorporate the social and emotional development of young children as a critical component to the development of the whole child and the well-being of families.

- **Strategy 1:** Provide parents and families with learning opportunities related to the importance of their children's social and emotional development.
- **Strategy 2:** Train mental health providers, health care service providers, social service agencies, and public school preschool programs for children with/without disabilities on Indiana Early Learning Foundations which lists social emotional development as one of the domains. https://www.doe.in.gov/sites/default/files/earlylearning/foundations-2015-august-12.pdf
- **Strategy 3:** Develop and strengthen parent education and support services for all parents of young children, especially new and at-risk parents.
- **Strategy 4:** Review developmental screening practices across early childhood programs and health care services. Provide consultation and training to individuals conducting screenings to ensure an appropriate and culturally competent assessment of young children's social and emotional development with the use of a standardized tool.
- **Strategy 5:** Assure earlier identification and intervention of mental health disorders in infants and toddlers and young children by providing practitioners with mental health consultation and training to increase their capacity to identify and assist families with infants and young children whose behavior has begun to deviate from the normal range of development.

Goal: STUDENT SERVICES: Increase focus on requirements and allowances within 511 IAC 4-(Article IV). Use this language to better identify and effectively guide provision of student assistance services to children in Indiana schools including prevention, assessment, referral, and intervention services.

- **Strategy 1:** Revisit the ratio of student services personnel as outlined in Article IV (511 IAC 4-1.5-2). Examine the fiscal impact of changes to the ratios. The following ratios are recommended for providing student services:
    1. For elementary educational and career services, one (1) school counselor for every six hundred (600) students enrolled in grades one through six in the corporation.
    2. For secondary school educational and career services, one (1) school counselor for every three hundred (300) students enrolled in grades seven through 12 in the corporation.
    3. For student assistance services, one (1) school counselor, school psychologist, or master's level school social worker for every seven hundred (700) students enrolled in the corporation.
    4. For health services, one (1) registered nurse for every seven hundred fifty (750) students enrolled in the corporation.

  However National Organizations recommend:

    1. The American School Counselor Association recommends a ratio of 1:250
    2. School Social Worker Association of America recommends a general ratio of 1:250 students depending on the characteristics and needs of the student population served. Students with intensive needs would require a lower ratio.
    3. National Association of School Psychologist recommend ratio for school psychologists is 500-700:1 (NASP Model for Comprehensive and Integrated School Psychological Services)
- **Strategy 2:** Consider policies to encourage schools to utilize their credentialed student service professionals to provide appropriate services rather than clerical, disciplinary, administrative, etc. tasks. Encourage a minimum percentage of time spent providing direct service to students and appropriate services for each discipline (school counseling, psychology, social work – specific).
- **Strategy 3:** Change wording in Article IV to "shall" instead of "should." Examine the fiscal impact of the proposed changes. Refer to the following sections:
    - 511 IAC 4-1.5-4 Sec.4.(b) – "should provide" to "shall"
    - 511 IAC 4-1.5-8 Sec.8.(a) – "may be" to "shall"

[48] Kutash, Duchnowski, & Lynn, 2006.

- **Strategy 4:** Frequently there is no comprehensive, cohesive and consistent method of student service delivery. Develop a process for student services including funding.
- **Strategy 5:** Increase the provision of student service delivery in the early grades when interventions could be most effective.
- **Strategy 6:** Encourage schools to identify a staff person or team to: serve as liaison to families and community agencies; define roles and functions of personnel providing support services to avoid duplication of services; establish appropriate referral mechanisms for students with social, emotional, and mental health needs; develop a network of community resources that meet student needs; and educate students and families about the availability of school-based and school-linked mental health services.
    - Was an approved recommendation by the CISC on 8/15/18.

Goal: SCHOOLS: Incorporate the social and emotional development of children as an integral component to the mission of schools, critical to the development of the whole child, and necessary to academic readiness and school success.

- **Strategy 1:** Link evidence to outcomes through demonstration projects in schools.
    - IDOE will be working with pilot school corporations through Project AWARE funding.
- **Strategy 2:** Establish formal partnerships between schools and community mental health providers to support families and caregivers. Establish guidelines for schools on how to develop partnerships with diverse community agencies, including non-traditional organizations, to ensure a comprehensive, coordinated approach to addressing children's mental health, and social and emotional development.
    - Develop partnerships between CMHC services and schools or use existing Systems of Care partnership with a focus on mental wellness, not illness.
- **Strategy 3:** Maximize Medicaid funding for schools.
- **Strategy 4:** Work with local school districts, educators, and others to ensure implementation of school policies and administrative procedures that promote social and emotional development.
- **Strategy 5:** Help schools develop a process for a system of triage. Disseminate sample policies and administrative procedures to guide development of policies for incorporating social and emotional development into educational programs as well as protocols (i.e., guidelines) for responding to children with social, emotional, and mental health problems.
- **Strategy 6:** Support DCS in order to prevent child abuse and neglect by making appropriate referrals to community based agencies when children and/or parents indicate they need assistance.
    - Develop process for referrals by trained mental health professionals to appropriate services.
- **Strategy 7:** Educate parents about options. Parents may be unaware of their rights regarding the legislation governing access to mental health services in schools (Section 504, Article 7, Article 4).
- **Strategy 8:** Recommend that school districts, schools, and other relevant entities implement policies, programs, and services that support social and emotional competencies, promote mental health, and prevent risky behaviors (e.g., substance abuse, bullying, violence).
- **Strategy 9:** Develop and enhance mentoring programs.
- **Strategy 10:** Strengthen advisor/advisee programs at the middle school level.
- **Strategy 11:** Provide professional development to school personnel, including administrative, academic, and staff, in social and emotional competencies and learning standards and how to integrate them across disciplines. Train schools on restructuring systems to include a multi-tiered systems of support (MTSS) framework for all students.
- **Strategy 12:** Promote opportunities for multi-disciplinary school personnel (e.g., social workers, psychologists, counselors, and school nurses) to develop consistent protocols and coordinated approaches for providing mental health services in schools (i.e., prevention, early intervention, and treatment) for children ages 3 - 22.
- **Strategy 13:** Develop and support a common language. Use Indiana School Mental Health Initiative document.
- **Strategy 14:** Teachers and school staff should be trained as part of the mental health services system. Involve parents and families in in-service training and planning of training for teachers.

Goal: TRAINING AND CURRICULUM: Ensure development and implementation of a plan to incorporate social emotional learning standards as part of the Indiana Academic Standards.

- **Strategy 1:** Support dissemination and training efforts on the Foundations to the Academic Standards for families and early childhood practitioners that interact with children from birth to age five.
- **Strategy 2:** Teach social skills in the early years. Enhance curriculum at the elementary level.
- **Strategy 3:** Improve and strengthen guidance curriculum at middle and high school levels.
- **Strategy 4:** More effectively integrate social and emotional learning competencies into existing academic standards and standards delivery.
- **Strategy 5:** Training required for administration and analysis of universal screeners; further assessment; referral; and collaboration of community providers.
- **Strategy 6:** training on MTSS (social-emotional included, along with academic services and supports); social-emotional development; impact of trauma; mental illness, and how to identify youth at risk; funding options for mental health services;

- **Strategy 7:** Parent-specific training on recognizing signs of mental health.

Young Children Beginning At Birth

The emotional and social competence of young children is a strong predictor of academic performance in elementary school. Social and emotional development is just as important as literacy, language, and number skills in ensuring young children are ready for school.[49]

An Illinois study found that 42% of child care programs asked families to withdraw their infants and toddlers because of social-emotional problems.[50] Indiana early care and education providers frequently identify training on addressing challenging behaviors as a priority training need. Infant and early childhood mental health must be integrated into all child-related services and systems. Cost- benefit analyses confirm that providing young children with social, emotional, and behavioral skills through quality early educational experiences produces an economic return to society.[51] Children with healthy social and emotional skills are capable of developing lasting friendships and intimate relationships, effectively caring for their own children, holding a job, and becoming productive citizens.[52]

Student Services

The broad goal of increasing the focus on requirements and allowances within the rule for Student Services will allow better use of the language to identify and effectively guide provision of student assistance services to children in Indiana schools including prevention, assessment, referral, and intervention services. Student assistance services (511 1AC 4-1.5-5) are required to address those barriers to learning which impede a student from accomplishing academic success. Certified school counselors, school psychologists, and school social workers are to provide prevention, assessment, intervention, and referral services in a comprehensive and coordinated manner. Such services will promote the social, emotional, and behavioral health of students. Needs assessments are to be conducted at the macro (school, community) and micro (student, family) levels. Assessment results will prompt timely and best-practice interventions which may include individual/group counseling and/or referral to a community resource.

Schools

It is important for schools to incorporate the social and emotional development of children as an integral component to their mission. Social and emotional development is critical to the development of the whole child and necessary to academic readiness and school success. Mental health is primarily discussed as if the term were synonymous with problems (e.g., emotional disturbance, violence, and substance abuse) thereby countering efforts to pursue the school's role in promoting positive social and emotional development.[53]

According to the Mental Health in Schools: Guidelines, Models, Resources, & Policy Considerations Report, the well-being of young people can be substantially enhanced by addressing key policy concerns in the school setting. In this respect, policy must be developed around well-conceived models and the best available information. Policy must be realigned to create a cohesive framework and must connect in major ways with the mission of schools. Attention must be directed at restructuring the education support programs and services that schools own and operate. School owned resources and community owned resources must come together into comprehensive, integrated approaches for addressing problems and enhancing healthy development. In doing all this, more must be done to involve families and to connect the resources of schools, neighborhoods, and institutions of higher education.[54]

Training and Curriculum

Nationwide, schools have begun to direct resources to school-wide and/or curriculum-based programs intended to reach the broader student population, and not just those individual students identified with mental health problems. Many schools have curriculum-based programs and classroom guidance to enhance social and emotional functioning. Topics for such programs can include anger management, prevention of violence and bullying, conflict resolution, resisting peer pressure, communication skills, substance abuse, and character education (e.g., developing citizenship skills, responsibility, honesty, fairness, patience).[55]

In Indiana, it is important to ensure development and implementation of a plan to incorporate social emotional learning standards as part of the Indiana Academic Standards. School curricula incorporating social skills training and activities of daily living has been identified as a critical part of preparation for transition to independent living.

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[49]Shonkoff & Phillips, 2000.
[50] Cutler & Gilkerson, 2002.
[51]Heckman & Masterove, 2004.
[52]Weissbourd, 1996.
[53]Policy Leadership Cadre for Mental Health in Schools, 2001.
[54]Policy Leadership Cadre for Mental Health in Schools, 2001.
[55]Foster, et al,2005.

Next Steps

Senate Enrolled Act 529 Chapter 16 (IC 20-19-5) calls for guidelines for incorporating social, emotional, and behavioral development into school learning standards and education programs. Because the goals and strategies outlined in this section are complicated, the recommendation is that a subcommittee be formed with the Indiana Department of Education as an integral member agency to explore each of the strategies listed. This includes early care and education as well as school-aged education.

Workforce Development and Training

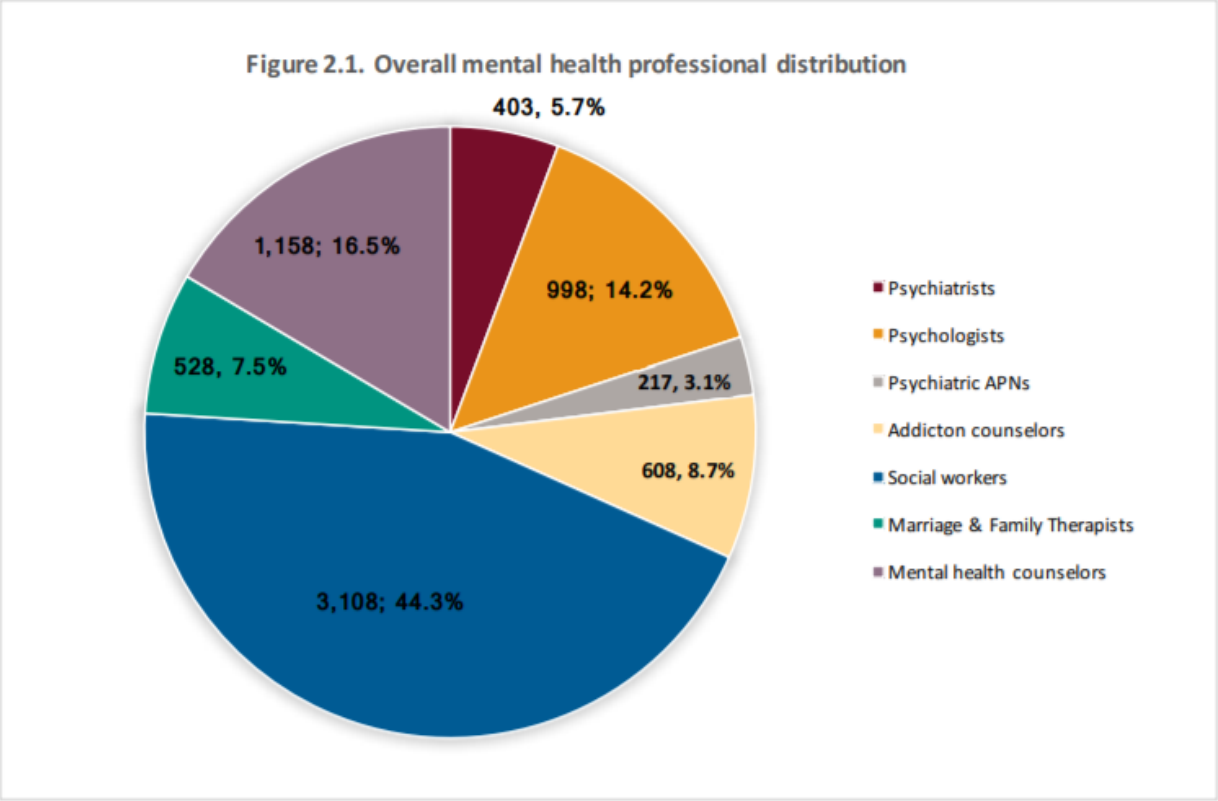
The report from the President's New Freedom Commission on Mental Health in 2003 described the need for "significant changes in practice models and in the organization of services to improve access, quality and outcomes in mental health." The Commission recognized that substantial changes are needed in both who does the work in mental health and how that work is done (President's New Freedom Commission).

Workforce issues, including training for the delivery of mental health services for children and adolescents, are particularly critical for many reasons. Children and adolescents change constantly as they grow through largely predictable developmental stages. Their mental health needs are complex and because children and adolescents live in families a "whole family" approach is needed for services and supports to be effective. In addition, children and adolescents with mental health needs often interact with multiple service systems[56] making it difficult to combine services across systems.

SEA529 Chapter 16 (IC 20-19-5) calls for the plan to make recommendations on how to maintain and expand the workforce to provide mental health services for individuals from birth through twenty-two (22) years of age and families; and how employers of mental health professionals may improve employee job satisfaction; and retain employees.

Indiana Child Mental Health Workforce Statistics

According to the 2016 Indiana Mental Health Professionals Licensure Survey data report, "The greatest proportion (44.3%) of Indiana's mental health professional workforce are trained as social workers or clinical social workers. The lowest proportion of professionals is found in the realm of psychiatry: psychiatrists (5.7%) and psychiatric APNs (3.1%)." Figure 1 illustrates the proportional distribution of the seven mental health professions. See individual profession sections for details by profession.



[56] National Technical Assistance Center for Children's Mental Health, 2005.

According to Bowen Center for Health Workforce, “Workforce Supply When examining the supply of the mental health professional workforce, the scarcity of practicing professionals is brought into sharp focus. Overall, two counties (Ohio and Warren) had no mental health professionals reporting working in those counties. Thirty-seven (37) counties have no reported psychiatric coverage (including psychiatrist or psychiatric APN), and 24 (64.9%) of those are designated as rural counties. The supply of psychologists is similar: 31 counties do not have any reported psychologist FTE, and 22 (71%) of those counties are rural counties. Half (46) of Indiana counties have no reported addiction counselor FTE (including clinical addiction counselors), and 30 (65.2%) of those counties are rural. With social work being the largest mental health profession, it is no surprise that a greater number of counties have social work coverage. Twenty-five (25) counties had no reported social worker FTE, and only seven (7) counties have no reported FTE for clinical social workers. Additionally, clinical social workers had the highest reported total county FTE (383.6 FTE in Marion) than any other mental health profession. Mental health counselors are the next most common practicing profession, with 76 counties having reported mental health counselor FTE; 39 (51.3%) of these counties are rural. Thirty-seven (37) counties have no reported marriage and family therapist (MFT) FTE, and 27 (73%) of those counties are designated as rural.”[57]

“Regarding access to care, mental health services are most readily available in Indiana through social workers and mental health counselors. Over one-half of Indiana counties lack access to psychiatry (at both the MD and APN levels), psychology, addiction counseling or marriage and family therapy. Consistent with national trends, mental health providers are found most often in populous, urban areas. With this disproportionate distribution of mental health professionals, 68 counties, 45 of which are rural, meet the minimum qualifications for mental health professions shortage area designation per US Health Resources and Services Administration guidelines.1 These shortage areas affect 2,669,719 Indiana citizens. Geographic and racial/ethnic disparities in Indiana’s mental health workforce point to the need not only to recruit and retain mental health professionals in areas of greatest need but also diversify the mental health professional workforce to better serve Indiana’s underserved populations.”[58]

Please refer to Appendix E for the Indiana Mental Health Professional Shortage Areas (MHPSAs)

*The Indiana Department of Education released a Student Services Survey to the field obtain a baseline data of the professionals in Indiana schools providing students services. The results from this survey in addition with The Division of Mental Health and Addictions current community local mental health survey, will provide data to identify gaps in school based mental health services. This data should be released in January 2019.

Indiana Specific Issues

In 2005 a Federal Children's Mental Health Care Relief Act (S537/HR1106) was introduced to increase the number of well-trained mental health service professionals (including those based in schools) by providing incentives such as paying educational loans and awarding scholarships to students who are prospective professionals.

While Indiana continues to experience a shortage of child mental health professionals, a new workforce is being developed. Parents, caregivers, and family members of children with serious emotional and behavioral challenges are being identified as an important resource to other families. Several Systems of Care sites provide families entering their system with family mentors. These mentors offer support and share the knowledge they have gained through their experiences. This linkage can be a critical piece in supporting families and caregivers as they negotiate the challenges and complexities of caring for a child with exceptional needs.

Family support groups are developing throughout the State to offer support, guidance, and respite for families with challenged children. Families and caregivers can offer exceptional insight to policy making bodies, however, their participation in policy setting is often blocked by lack of transportation, child care and incurred expenses. Resources need to be deployed to overcome these barriers and to acknowledge their valuable input.

[57] Bowen Center for Health Workforce Data Report (2016)
[58] Bowen Center for Health Workforce Data Report (2016)

Goals and Strategies

Goal: RECRUITMENT (BUILD NEW CAPACITY): Build a culturally-competent, qualified, and adequately trained workforce with a sufficient number of professionals to serve children and their families, and develop natural supports and tap into the core competencies of families and caregivers.

- **Strategy 1:** Encourage and expand partnerships with universities to recruit students enrolled in social work programs into the mental health field.
    - Expand the Department of Child Services (DCS) Indiana Partnership for Social Work Education in Child Welfare. The goal is to enhance regional social work programs to offer courses that reinforce the DCS core staff competencies, develop an available resource of qualified BSW graduates for Family Case Manager positions, and to reduce the recidivism rate of new hires through university educational experience and practical experience offered at DCS offices.
    - Increase resources for those who want to further their education in the mental health area.

- **Strategy 2:** Identify barriers in Indiana that prevent a more diverse workforce from entering the children's mental health field.
- **Strategy 3:** Increase the capacity of early care and education programs to promote social and emotional development and serve the mental health needs of children and their families. Explore training early care and education providers (licensed and legally license exempt) about early childhood social-emotional development and children's mental health and offer mental health consultation to providers.
    - Include training on early identification.
    - Build upon the work of Head Start, First Steps, public school special education services, Healthy Families, Parents as Teachers, and Building Strong Families.
    - Develop consensus on competencies to be included in early childhood social- emotional development training.
    - Maximize opportunities to offer mental health consultation to early care and education professionals.
- **Strategy 4:** Boost training of school staff for identification of social, emotional, and behavioral need of students.
- **Strategy 5:** Determine the number of higher learning institutions that offer coursework and specialized tracks in early childhood mental health within psychology, clinical social work, and other counseling programs. Review the university curriculum (long-term strategy) and make recommendations for information that should be included in formal education.
- **Strategy 6:** Build and strengthen efforts that use video technology for training purposes particularly to underserved areas of the state, including web-based distance learning for natural support caregivers.
- **Strategy 7:** Focus on on-site training, consultation, and monitoring including personalized coaching.
- **Strategy 8:** Focus training on prevention with less focus on remediation including common sense parenting training and training of community partners for child safety in each of the 18 identified DCS regions.
- **Strategy 9:** Promote training for community health workers for public health (for example, prenatal care coordination). Some services are reimbursable.
- **Strategy 10:** Develop incentives to attract professionals and paraprofessionals, particularly those from diverse backgrounds and underrepresented groups, to enter the mental health field.
    - Encourage service for underserved populations and in underserved areas.
    - Encourage recruitment of Spanish speaking professionals.
    - Encourage use of professional guilds for this promotion, including but not limited to the American Academy of Pediatrics, Professional Nurse Practitioners, and the American Academy of Family Physicians.
- **Strategy 11:** Work with the academic community to recruit behavioral health professionals.
- **Strategy 12:** Use the evidence base of effective behavioral health interventions in training.
- **Strategy 13:** Develop a finite capacity for those who have experience in the mental health system (such as peers, family members, and mentors) to be providers.
- **Strategy 14:** Promote careers in children's mental health at the high school level. Many high schools are moving toward the concept of "small learning communities" focused on a particular career track.
- **Strategy 15:** Increase the focus on and availability of vocational training for increasing employment opportunities for individuals interested in pursuing careers in mental health services.

Goal: RETENTION: MAINTAIN AND INCREASE EXISTING CAPACITY: Increase the capacity of existing programs and providers who work with children (e.g., early childhood, health care, education, families, mental health, education, child welfare, juvenile justice) to promote and support the social and emotional development and mental health needs of children and their families.

- **Strategy 1:** Promote cross-training and collaboration between disciplines and agencies (mental health, developmental delays, substance use, child welfare, juvenile justice, schools, Medicaid, and primary healthcare) with a common family theme.

- **Strategy 2:** Promote programs staffed by qualified mental health professionals including: psychiatrists, psychologists, counselors, and social workers in juvenile detention/confinement.
- **Strategy 3:** Base credentialing on education and experience.
- **Strategy 4:** Look at non-traditional ways to obtain training (especially for the de-facto mental health workers including pediatricians, nurses, and primary care physicians).
    - Need to leverage family knowledge and experience.
- **Strategy 5:** Promote training for better dialog between pediatricians, primary care settings, and parents. When a child's developmental levels are off course these groups need to participate in a discussion (for example, the Bright Futures curriculum, www.brightfutures.org).
- **Strategy 6:** Need an identified workforce for referrals once a problem is identified. Develop a resource guide for parents, schools, and mental health workers.
- **Strategy 7:** Need appropriate and adequate supervision of existing mental health staff.
    - Must have adequate number of supervisors across all agencies and train them properly.
- **Strategy 8:** Increase resources to support existing initiatives.
- **Strategy 9:** Expand Indiana's existing specialized technical assistance, training, and educational infrastructure to train and retain individuals in the mental health field.
- **Strategy 10:** Develop the capacity of school systems, school administrators, and staff to promote social and emotional development and serve the mental health needs of children and their families.
- **Strategy 11:** Use the evidence base of effective behavioral health interventions in retention.
- **Strategy 12:** Work with the Bureau of Health Care Professionals to assure that all mental health professionals, including psychiatrists, register in the county or counties where they practice as opposed to the counties where they reside.
- **Strategy 13:** Increase resources for those who want to further their education in the mental health area.
    - Outline a career path for those in the mental health field so they are more inclined to stay in the discipline.

Goal: TRAINING: Train frontline providers in a core team environment on the development and implementation of a tiered intervention approach in order to provide a continuum of care.

- **Strategy 1:** Engage professional organizations in educating new frontline providers in various systems (e.g., teachers, families, physicians, nurses, hospital emergency personnel, early care and education providers, probation officers, school staff, and other child healthcare providers).
- **Strategy 2:** Train and educate mental health providers about scientifically-proven prevention and treatment services in the framework of effective practice.
- **Strategy 3:** Train professionals on all services available in Indiana through Indiana's existing network of resources.
- **Strategy 4:** Train providers on the basics of mental health through the use of professional guilds. (This should be included in the public awareness campaign.)
    - Encourage professional guilds for mental health specialists (e.g., psychiatry, psychology, social work, and nursing) to require training in mental health for children.
- **Strategy 5:** Facilitate training of providers by building knowledge in the following areas:
    - Systems of care
    - Portal to services
    - Tiered interventions
    - Effective interventions
    - Effective practice
    - Outcome based supervision - supervisors use data
    - Children's mental health issues and implications for their ability to function in school
        - Resilience/recovery for kids
        - Special education and eligibility categories
        - Course of the illness and interventions
    - Positive behavioral supports
    - Share models of success
    - Resilience
    - Parenting skills
    - Evaluation of services received

Recruitment

Recruitment is defined as the process of adding new individuals to the pool of existing mental health providers. It is important to build a culturally-competent, qualified and adequately trained workforce with a sufficient number of professionals to serve children and their families.

Families are increasingly involved as partners with professionals in care planning for their children. Families are considered the "silent army" waiting to partner with professional providers in mental health care for their children.[59] Partnerships with families is not readily understood or accepted by some professionals, however this must be addressed when considering the recruitment of new individuals to the pool of existing mental health providers.

Retention

Retention is defined as keeping individuals who work in mental health employed as mental health service providers. The challenges of retaining people in the children's mental health workforce are complicated by the fluid nature of the workforce and the fact that mental health care for children is often addressed by multiple systems including but not limited to, primary health care, child protection, education, and juvenile justice. Often, frontline workers in child welfare, childcare, education or juvenile justice are not considered part of the mental health workforce.[60]

In order to effectively retain this broad spectrum of children's mental health care workers from all fields, it is important to increase the capacity of existing programs and providers who work with children to promote and support the social and emotional development and mental health needs of children and their families.

Training

Education and training programs often do not keep pace with the policy and practice changes in delivery of services to children and families. Many in the children's mental health field are concerned that pre-service academic training does not prepare students for the changing models of service delivery or for actual work in communities. The concern extends to a lack of training on the comprehensive approaches necessary to meet the needs of families. In order to prepare human service workers for the changing role they must play, education must align with mental health reforms[61]. Workforce development initiatives must train new providers and re-train existing providers to improve their ability to provide effective community-based care. A much larger set of people must be trained to take on new roles including paraprofessionals, family members, home- and school- based staff, pre-school staff, and early childhood consultants.[62]

Next Steps

SEA529 Chapter 16 (IC 20-19-5) calls for the plan to make recommendations on how to maintain and expand the workforce to provide mental health services for individuals from birth through twenty-two (22) years of age and families; and how employers of mental health professionals may improve employee job satisfaction; and retain employees. Because the goals and strategies outlined in this section are complicated, the recommendation is that a subcommittee be formed with the Indiana Department of Workforce Development (IDWD) as an integral member agency to explore each of the strategies listed.

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59 Huang, L., et al, 2004.
60 Huang, L., et al, 2004.
61 Huang, L., et al, 2004.
62 Huang, L., et al, 2004.

Appendix A: Inventory of public systems, services, programs serving Indiana children

The Interagency Team took an inventory of public systems, services, and programs serving Indiana children. The inventory lists agencies and the programs and mental health services offered. The intent of the inventory is to show what Indiana currently offers to use as a benchmark for improvement.

The Commission on Improving the Status of Indiana *Children*
Mission: To improve the status of children in Indiana.
Vision: Every child in Indiana will have a safe and nurturing environment and be afforded opportunities to grow into a healthy and productive adult.

Overview: The multi-branch statewide Commission is aimed at improving the status of children in Indiana. In cooperation with other entities, members of the State Commission on Improving the Status of Children will study issues concerning vulnerable youth, review and make recommendations concerning legislation, and promote information sharing and best practices. https://www.in.gov/children/

Health Insurance for Children

Children's Health Insurance Program (CHIP) (A part of Hoosier Healthwise)
Agency: Office of Medicaid Policy and Planning – Family Social Services Administration (FSSA)
Ages served: Birth-18
Mission: CHIP offers health care coverage to eligible children ages 0-18 whose family income is between 150%-200% of the federal poverty level (FPL). As part of the Federal Balanced Budget Act of 1997, Congress created the Children's Health Insurance Program (CHIP) as a way to encourage states to provide health insurance to uninsured children.
Specific covered mental health services include: Inpatient and outpatient mental health and substance abuse services are covered when the services are medically necessary for the diagnosis or treatment of the member's condition in the same manner as Hoosier Healthwise below except for the following limitations: 1) Inpatient services are not covered when provided in an institution for mental diseases with more than 16 beds. 2) Outpatient office visits are limited to a maximum of 30 per rolling twelve months per member without prior approval for a maximum of 50 visits per year. 3) Reimbursement is not available for reservation of beds in psychiatric hospitals and 4) Community mental health rehabilitation services are not covered by the program. On June 12, 2018, the Committee on Energy and Commerce amended title XXI of the Social Security Act "to ensure access to mental health services for children under the Children's Health Insurance Program" for all States. It specifically directed all states' CHIP programs to cover mental health benefits including substance use disorder services for pregnant women and children. "H.R. 3192, the CHIP Mental Health Parity Act, would require all Children's Health Insurance Program (CHIP) plans to cover mental health and substance abuse treatment. In addition, states would not be allowed to impose financial or utilization limits on mental health treatment that are lower than limits placed on physical health treatment." https://www.congress.gov/congressional-report/115th-congress/house-report/734/1
Funding: [*education, state, county]: Title XXI and dedicated state funds; $73 million federal;
$30 million state.
For more information: http://www.in.gov/fssa/programs/chip/index.html

Hoosier Healthwise (Medicaid)
Agency: Office of Medicaid Policy and Planning– FSSA
Ages served: Pregnant women and children 0-18 years from families with incomes of 150% federal poverty level (FPL) or less; families with children that have incomes of less than approximately 25% FPL; individuals under the age of 18 who are legally in the custody of or supervision of the County Departments of Public Welfare or the Indiana Family Social Services Administration; individuals between the ages of 16 and 64 who meet the state's definition of disability; aged, blind, and disabled individuals in domiciliary facilities or other group living arrangements as defined under supplemental security income (SSI); individuals under the age of 21 who are receiving active treatment as inpatients in psychiatric facilities or programs; individuals who have been in institutions for at least 30 consecutive days; and recipients of adoption assistance and foster care under Title IV-E of the Social Security Act.
Mission: Medicaid is a health insurance program provided by the state and federal government. Medicaid eligibility is based on need.
Specific covered mental health services include: Inpatient Services
Medicaid provides inpatient hospital services and physician services. Inpatient services provided included mental health and substance abuse treatment in a specialized wing of an acute care hospital or an inpatient psychiatric facility. Covered inpatient substance abuse services include inpatient detoxification, rehabilitation, and aftercare for chemical dependency. All admissions, except emergency admissions, must be pre-approved by the Medicaid agency and reviewed every 60 days. Each patient admitted must have an individually developed plan of care developed
by the physician and an interdisciplinary team. The plan must be reviewed and updated every 30 days. Emergency admissions are covered only in cases of a sudden onset of a psychiatric condition manifesting itself by acute symptoms of such severity that the absence of immediate medical attention could reasonably be expected to result in danger to the

individual, danger to others, or death of the individual.
Outpatient Hospital including Rural Health Center (RHC) and Federally Qualified Health Center Services (FQHC): Substance abuse and mental health services that would be covered if provided in another setting may be provided in an outpatient hospital setting. Services must be physician or psychologist directed;
Mental health and substance abuse services provided in an outpatient hospital setting must meet the same requirements as those provided in another setting.
Physician Services:
Physicians may provide mental health and substance abuse services as described under Rehabilitative Services. The service must be within the scope of the practice of medicine, as defined by State law. Mental health or substance abuse services provided in a physician's office must meet the same requirements as those provided in another setting.
Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Services to Children Under 21:
Indiana does not identify any specific service as a mental health or substance abuse service that is provided only under EPSDT. The federal criteria to cover any service that (1) can be covered under federal Medicaid regulations, and (2) that is needed to treat or ameliorate a condition identified in an EPSDT screen continues to apply.

Optional State Plan Services
Inpatient Psychiatric Services for persons under the age of 21:
Inpatient psychiatric services are services provided in an inpatient psychiatric hospital facility or residential treatment facility that is devoted to the provision of inpatient psychiatric services for persons under the age of 21. All admissions must be pre-approved by the Medicaid agency.
Services may only be provided by facilities that maintain a current license as a hospital or a residential treatment center and accreditation by the Joint Commission on Accreditation of Healthcare Organizations.
Rehabilitation (community mental health rehabilitative services): Includes three types of services: mental health clinical services (including but not limited to diagnostic assessment, pre- hospitalization screening, individual counseling/psychotherapy, conjoint counseling/ psychotherapy, family counseling/psychotherapy, group counseling/psychotherapy, crisis intervention, medication/somatic treatment, and training in activities of daily living); partial hospitalization services; and case management services. Services may be provided by a psychiatrist, physician, psychologist, or qualified individual with at least a master's degree and two years of supervised clinical experience.
Outpatient mental health services are conducted in an office or outpatient setting and services may include: group, family, or individual psychotherapy; and evaluation, neuropsychological, and psychological testing.
Services may not include day treatment, hypnosis, biofeedback, partial hospitalization, and missed appointments. Services must be provided as part of a plan of care developed by a qualified mental health professional and approved by a supervising physician or service provider in psychology (HSPP). An initial treatment plan must be developed and approved within seven days, and the treatment plan must be reviewed by the supervising physician/HSPP at least every 90 days.
Services must be provided by a licensed physician, psychiatric hospital, psychiatric wing of an acute care hospital, outpatient mental health facility, or psychologist endorsed as a health service provider in psychology (HSPP). Prior reauthorization by the Medicaid agency is required before the beneficiary may receive more than 20 units of service within a rolling 12 month period, more than four units per month, or more than two diagnostic interviews during a 12 month period. A physician, psychiatrist, or HSPP must certify the diagnosis and supervise the plan of treatment.
All services provided by a physician must be within the scope of practice defined in state law. **Substance abuse prevention** Includes services provided by physicians, psychiatric wings of acute care hospitals, outpatient mental health facilities, and psychologists endorsed as Health Services Providers in Psychology. Specific opioid treatments such as methadone and or LAAM are not covered. Prior authorization by the Medicaid agency is required before the beneficiary may receive more than 20 units of service within a rolling 12 month period or more than four units per month.
Targeted Case Management (TCM) services are goal-oriented activities that locate or create, facilitate access to, and coordinate and monitor the full range of basic human needs, treatments, and service resources. Allowable activities include identification and outreach, individual assessment, service planning, implementation, monitoring of service delivery, and utilization and reassessment. The individual receiving the service must be identified as seriously mentally ill or seriously emotionally disturbed.
Funding: $1,131,950,000 state; $2,411,346,264 federal; $52,157,229 dedicated; $188,696,758 transfer; $41,044,168 other; $3,825,194,419 total
For more information: https://www.in.gov/fssa/ompp/2544.htm

Medicaid School Based Services Agency:
Agency: Indiana Department of Education
Ages served: ages 3-22
Mission: Medicaid reimburses Medicaid-enrolled Indiana public school corporations for covered health care services provided to individuals who are enrolled in Medicaid and who are eligible for special education. The services reimbursed are those medically necessary special education services that are provided by Medicaid-qualified personnel and are specified in the student's individualized education program (IEP).
Specific covered mental health services include: The program allows Medicaid-enrolled school corporations to claim reimbursement for certain psychologists' services necessary for the development of the student's IEP and for treatment

intended to address the student's physical or mental condition. Medicaid will reimburse for these services when provided by a physician or health service provider in psychology (HSPP), or by one of the following practitioners under the supervision of a physician or HSPP: licensed psychologist, licensed independent practice school psychologist, licensed clinical social worker, licensed marital and family therapist, a licensed mental health counselor, a person holding a master's degree in social work, marital and family therapy or mental health counseling, a licensed advanced practice Registered Nurse with a master's degree in nursing with a major in psychiatric or mental health nursing from an accredited school of nursing.
Funding: Public school corporations may enroll as Medicaid providers and claim reimbursement for covered, IEP-required health services provided to eligible special education students. Medicaid reimbursements are jointly funded with federal and state funds. The state matching funds are contributed by the state education agency.
For more information:
https://www.doe.in.gov/specialed/school-based-medicaid

Children's Mental Health Services

Division of Mental Health and Addiction (DHMA)
Agency: FSSA
Ages served: all ages
Mission: DMHA ensures that Indiana citizens have access to quality mental health and addiction services that promote individual, family and community resiliency and recovery. DMHA provides funding support for mental health and addiction services to target populations with financial need and administers federal funds earmarked for substance abuse prevention projects. The division certifies all community mental health centers and addiction treatment services providers and operates six psychiatric hospitals.
Specific covered mental health services include: DHMA provides addiction and mental health services to uninsured and underinsured Hoosiers; informs the public about addiction and mental health services; and sets standards of quality care for the provision of addictions and mental health services.
Funding: State appropriation, federal grants, and grants from other state agencies.
For more information: https://www.in.gov/fssa/dmha/index.htm

Family Social Services Administration (FSSA)
Ages served: low income individuals and families; children; senior citizens; people with mental illness, addictions, and physical and developmental disabilities
Mission: FSSA is a health care and social service funding agency. Ninety-four percent (94%) of the agency's total budget is paid to thousands of service providers ranging from major medical centers to a physical therapist working with a child or adult with a developmental disability. The six care divisions in FSSA administer services to over one million Hoosiers.
Division of Family Resources (DFR) - Receives applications and approves eligibility for Medicaid, Supplemental Nutrition Assistance Program (SNAP), Cash Assistance (TANF) and childcare; implementing a modernized application process using internet, document imaging and call-in services. DFR operates in all 92 counties.
Office of Medicaid Policy and Planning (OMPP) - Administers Medicaid programs for the state of Indiana, including Hoosier Healthwise, Hoosier Care Connect and the Healthy Indiana Plan.
Division of Disability and Rehabilitative Services (DDRS) - Manages the delivery of services to children and adults with developmental disabilities. DDRS oversees the First Steps rehabilitation program for children from birth to age three.
Division of Mental Health and Addiction (DMHA) - Supports network of mental health care providers. DMHA operates six psychiatric hospitals and funds addiction prevention and treatment programs.
Division of Aging - Funds long-term care through Medicaid programs. The Division of Aging supports the development and utilization of alternatives to nursing home care, as well as coordinates and funds services through network of Area Agencies on Aging.
Office of Early Childhood and Out-of-School Learning (OECOSL)- Oversees early care and education and out-of-school time programs. OECOSL administers the childcare licensing and inspection program.
Specific covered mental health services include: helping uninsured or underinsured people with mental illness or addiction receive treatment and re-integrate into the community.
Funding: State, federal and local dollars
For more information: www.in.gov/fssa/

Indiana Department of Child Services (DCS)
Ages served: Children and families
Mission: The Indiana Department of Child Services engages with families and collaborates with state, local, and community partners to protect children from abuse and neglect and to provide child support services. DCS was established in January 2005, by an executive order of the Governor to better care for children by providing more direct

attention and oversight in two critical areas: protection of children and child support enforcement. The department is located in the Indiana Government Center South at 402 West Washington Street, Room E306.
Specific covered mental health services include: DCS protects children and strengthens families through services that focus on family support and preservation. The department administers child support, child protection, adoption and foster care throughout the state of Indiana. In addition, the Department provides services to children in both the child welfare and delinquency systems.
Funding: State, federal and local.
For more information: www.in.gov/dcs/ or the Child Support Hotline 800-840-8757

Indiana Criminal Justice Institute (ICJI)
The Indiana Criminal Justice Institute (ICJI) is the State planning agency for criminal justice, juvenile justice, traffic safety and victim services. ICJI is designated as the State Administering Agency for distribution of federal funds, and as the State Statistical Analysis Center for research.
ICJI develops long-range strategies for the effective administration of Indiana's criminal and juvenile justice systems and administers federal and state funds to carry out these strategies. Through the use of evidence-based decision making, ICJI works to improve the efficiency of criminal justice system, from call for service through post-conviction. The agency accomplishes this by bringing together key leaders from the criminal justice system at the state, local, and national levels to identify critical issues facing
Indiana. The agency evaluates policies, programs, and legislation designed to address these issues.
In fiscal year 2018, ICJI provided nearly $93 million in funding for organizations throughout Indiana
Entities receiving funding include:
· Nonprofits,
· Local governments,
· Local service providers,
· State agencies, and
· Statewide organizations (coalitions, etc.)
Division of Youth Services:
Mission of the Youth Services Division: is to improve the juvenile justice system, promote positive youth development through community-wide collaboration and support initiatives that aim to prevent and/or reduce juvenile offending. The Youth Services Division support programs for at-risk youth as well as those involved in the justice system, funds training for agencies and schools who work with these youth and facilitates system-wide collaboration and improvement efforts. Staff serve as liaisons between federal, state and local agencies, provide technical assistance, and implement the goals outlined in the state's Juvenile Justice and Delinquency Prevention Three-Year plan
School Safe Haven is two pronged program. SHH first support the School Safety Specialist Academy operated by the Department of Education. Second, SSH grants provide funding to public school corporations and charter schools to support evidence-based prevention and intervention programs to students. SSH grants run on the state fiscal calendar and the request for proposals is typically released in early spring. SSH grants are 100% state funded. Through the 2018-2019 school year, SSH grants also supported School Resource Officers in collaboration with the Secured Schools grant program administered by the Indiana Department of Homeland Security.
JJDPA Title II grants assist state, county and local governments with delinquency prevention, diversion, and juvenile justice intervention programs. Title II grants may be used to support direct service programs for at-risk youth and/or for justice system involved youth. The priority/program areas for Title II grants are determined annually by the state Juvenile Justice State Advisory Group and are approved by the federal Office of Juvenile Justice and Delinquency Prevention. Title II grants run on a calendar year schedule and the RFP is released in the fall. Title II grants are 100% federally funded.
Division of Victim Services:
The Victim Services Division administers funding to programs throughout the state that provide a variety of direct services to crime victims based on specific needs. Services are defined as efforts that respond to the emotional and physical needs of crime victims, assist primary and secondary victims of crime to stabilize their lives after victimization, assist victims to understand and participate in the criminal justice system, and provide victims of crime with a measure of safety and security. The division awards federal dollars to these programs from the Office for Victims of Crime (OVC) and Office on Violence Against Women (OVW).

The following is a list of funding streams administered by the Victim Services division:
· Family Violence Prevention and Services Act (FVPSA)
· Domestic Violence Prevent and Treatment (DVPT)
· Domestic Violence portion of the Social Services Block Grant (SSBG through the Department of Child Services)
· Sexual Assault Victims Assistance Fund (SAVAF)
· Sexual Assault Services Program (SASP)
· Sexual Assault Services portion of the Public Health and Human Services Block Grant (SAS through the Indiana State Department of Health)
· Services, Officers, Training, Prosecution (STOP)
· Victims of Crime Act (VOCA)

Funding: Administers $75 million in annual state, US Department of Justice and US Department of Transportation grants.
For more information: **https://www.in.gov/idoc/dys/2380.htm**
Indiana Department of Correction (IDOC)
Mental Health Services/ Division of Youth Services
Intake: LaPorte (girls); Logansport Intake (boys)
Treatment Facilities: Pendleton; Logansport; LaPorte
Agency: Indiana Department of Correction/Division of Youth Services
Ages served: 12-18 (committed students can be kept until age 21 if necessary)
Mission: All students arriving at an intake unit (LaPorte or Logansport) are screened on the date of arrival for mental health issues (self-harm, harm to others, depression, delusions, etc). This screening is conducted by trained staff. Referrals to psychologists and/or psychiatrist are made as needed. A student arriving at an intake unit with psychotropic medication is assessed for the necessity of continuing the medications.
Specific covered mental health services include:
Trained staff complete a suicide screener upon receiving a transferred youth.During a student's stay with DOC, treatment is provided by clinicians and mental health professionals. Treatment progress reviews are held at no more than 30 day intervals by a multi-disciplinary team of staff. Referrals to psychologist can come from any staff person or the student. The facility psychologist is the gatekeeper for referrals to the adolescent psychiatrist. Individual treatment is provided by psychologist and psychiatrist as needed. Medications used as needed and reviewed regularly.
Acute mental health episodes are managed at the facility if possible. If needed, a short-term in- patient placement may be authorized. Students deemed in need of a transfer to the Department of Mental Health are referred for temporary commitment as needed. Civil commitments to DMH for youth 17 years of age or older are pursued as needed. Continuity of services upon release from the facility is coordinated by facility staff and juvenile parole staff.
Process for IDOC Juvenile Facilities, Mental Health Services:
1) Commitment to DOC by County Juvenile Court
2) Intake Facility
· Assessments
· Acute risk management
· Medication review
3) Treatment Facility
· Individualized treatment plans
· Treatment and crisis management
· Programming to develop coping skills
· Education services
· Family engagement
· Team reviews
· Referral for services
· Medication/follow-up
· Transition to community
4) Aftercare
· Referrals to community providers
· Monitoring and adjustments
· Discharge from supervision
Funding: Budget of $43.7 million general state funds annually for Division of Youth Services ; an additional $3.3 million in grant funds for juvenile services.
For more information: **https://www.in.gov/idoc/**

Education

Alternative Education
Agency: Indiana Department of Education
Ages served: grades 6-12
Programs must complete an Individual Service Plan for each child that identifies academic and behavioral goals as well as services including mental health services that they need to be successful. Several programs partner with their local mental health agencies to ensure students get services.
Funding amount: $6.3 million/year; source of funding-state budget.
For more information: https://www.doe.in.gov/cte/alternative-education

Special Education
Office of Special Education: Indiana Department of Education
Ages served: 3-22
Mission: Special education and related services are provided to students identified in accordance with Article 7 as having a disability that adversely affects the students' educational performance and who by reason of the disability require special

education and related services. Student with a disability means a student who has been identified as having a disability listed in Article 7 and who needs special education and related services because of that disability. Special education is specially designed instruction, provided at no cost to the parent, designed to meet the unique needs of a student who has been determined eligible for special education and related services. Related services means transportation and such developmental, corrective, and other supportive services as are required to assist a student with a disability to benefit from special education. Article 7 is based on the federal Individuals with Disabilities Education Act (20 USC §§1400 *et seq.*) and the federal regulations (34 CFR Part 300). It is made up of 18 rules describing how special education and related services are to be determined and provided by Indiana's public schools. Rule 41 lists the eligibility categories and the criteria for each category. The eligibility categories for special education and related services include: autism spectrum disorder; blind or low vision, cognitive disability, deaf or hard of hearing, deaf-blind; developmental delay (early childhood); emotional disability; language or speech impairment; multiple disabilities; orthopedic impairment; other health impairment; specific learning disability, and traumatic brain injury.

Specific covered mental health services include: Article 7 defines emotional disability as an inability to learn or progress that cannot be explained by cognitive, sensory, or health factors. The student exhibits one or more of the following characteristics over a long period of time and to a marked degree that adversely affects educational performance: a tendency to develop physical symptoms of fears associated with personal or school problems; a general pervasive mood of unhappiness or depression; an inability to learn that cannot be explained by intellectual, sensory, or health factors; an inability to build or maintain satisfactory interpersonal relationships; inappropriate behaviors or feelings under normal circumstances; and episodes of psychosis (511 IAC 7-41-7(a)). The case conference committee (CCC) is the group of individuals, including school personnel and the parents, that decides whether a student is eligible for special education, and if eligible, decides what special education and related services will be provided, based on the student's needs. For those children deemed eligible for special education services, the CCC develops a written plan called an individualized education program (IEP) which describes the special education and related services to be provided to a student with a disability. Although one may be more likely to think of mental health services for a student with an emotional disability, services are not to be determined based on the student's identified category of disability but rather based on the individual needs of the student. Therefore, if required by the student's needs, the CCC could specify that mental health services be provided to students with autism, other health impairments, or any other category of disability.

Funding: State Adjusted Pupil Count (APC) and State Preschool Count funding for expenditure on students with disabilities: $569,266,472 (FY18). Part B federal funding passed to local education agencies for expenditure on students with disabilities: $259,371,476 (FFY18).

For more information: https://www.doe.in.gov/specialed

High Ability Education

Office of High Ability, Office of School Improvement

Ages served: K-12

Specific covered mental health services: Per 511 IAC 6-9.1-2(c)(3), high ability programs in Indiana must have a counseling and guidance plan.

Counseling and Guidance Plan

Each child, regardless of ability, has his/her own personality characteristics that lead to certain social and emotional needs. In addition, each child has needs that arise because of the situation or environment in which he/she lives. Children with high abilities, however, may have additional affective needs resulting from their increased capacity to think beyond their years, greater intensity in response, combinations of unique interests, personality characteristics, and conflicts that are different from those of peers of similar age. It is important to provide a systematic and differentiated program of affective services, K-12, for these students; this proactive approach will facilitate development of their high potential and promote their positive adjustment. This differentiated affective curriculum plan should include the following*:

- A K-12 scope and sequence documenting coverage of common social/emotional issues faced by high ability students
- College and career readiness topics and activities
- Description of how the high ability affective curriculum interfaces with the Indiana guidance and counseling standards

Social and Emotional Issues

The social and emotional issues below are common among high ability students and, as such, would be important to include in the affective curriculum. Some topics may be covered in multiple years with an increasing degree of sophistication or through addressing a different facet of the same issue.

Overexcitabilities

Gifted students may have "intensities" that could manifest themselves in one or more of these areas (Dabrowski's Theory):

- Intellectual intentness and focus on a particular topic
- Greater sensitivity to environment (appreciation for music or art, sensitivity to loud noises or bright lights, more allergies, etc.)
- Surplus of physical energy
- Vivid imagination and creativity
- Heightened emotional sensitivity (reaction to criticism, perfectionism, empathy, attachment)

Asynchronous Development
Physical, cognitive, and emotional development may be at different places within the same child:
- Presents a number of problems for the child with exceptional abilities
- In general, the greater the level of ability, the greater the discrepancies.

Perfectionism
- High ability students may place unrealistically high standards for performance on themselves. This may result in anxiety, frustration, or self-blame for less-than-perfect performance.
- High Ability students may feel as though others (parents or teachers) have unrealistically high expectations. This may result in fear of failure, avoidance of challenges, depression, and connection of self-worth to performance.
- High ability students may develop unrealistically high standards for the performance of others.

Self-esteem/Identity Issues
High ability students may experience difficulty constructing their identities, which may lead to lowered self-esteems.
(space) Difficulty with identity development may result from any of the following:
- Lack of understanding of higher abilities and their implications
- Feeling different from one's same-age peers
- Behaviors inconsistent with gender role expectations (e.g., sensitivity in gifted boys, assertiveness in gifted girls)
- Being identified as learning disabled as well as having high abilities
- Differences resulting from cultural, linguistic, or SES differences

College and Career Readiness
High ability learners are often multi-talented, and this can cause more difficulty in making career decisions. Special care should be taken to ensure students the opportunity to explore career possibilities and to assist them in aligning these possibilities with interests and abilities. Assistance is often needed to recognize where interests and abilities might be used in college planning and career decision-making.
This list was adapted from a list on topics for affective education found in Cohen, L. & Frydenberg, E. (1996). *Coping for Capable kids: Strategies for parents, teachers, and students.* Waco, TX: Prufrock Press. www.prufrock.com
Funding:$12,548,096.00 (FY 18-19) Identification Grant: $500,000 (FY 18-19)
Additional Resources: https://www.doe.in.gov/highability

Services for Infants and Toddlers with a Disability or Developmental Delay

First Steps
Agency: Division of Disability and Rehabilitation Services, Bureau of Child Development Services
Ages served: 0-3
Mission: To serve infants and toddlers with or at-risk for special developmental needs by providing a family-centered, comprehensive, coordinated, neighborhood-based system of services for them and their families. This is accomplished through the implementation of a comprehensive, coordinated statewide system of local interagency councils called First Steps. **Specific covered mental health services include:** Indiana's First Steps Early Intervention System is a family-centered, coordinated system to serve children from birth to age 3 who have disabilities and/or who are developmentally vulnerable. First Steps brings together families and professionals from education, health and social service agencies. By coordinating locally available services, First Steps is working to give Indiana's children and their families the widest possible array of early intervention services.
Funding: Indiana First Steps Early Intervention System facilitates and coordinates federal, state, local, and private resources for the payment of early intervention services for Hoosier families.
The Indiana General Assembly passed legislation requiring the First Steps System to implement Cost Participation (cost sharing) for families with incomes over 350% of poverty on April 1, 2003. During the 2003-2004 grant year, the First Steps System provided services to more than 19,000 children and their families, at an average cost of $2,900.00 per child, well within national averages for early intervention services.
For more information: https://www.in.gov/fssa/ddrs/4655.htm

Head Start and Early Head Start Ages served: birth to 5
Mission: Head Start and Early Head Start are comprehensive child development programs that serve children from birth to age 5, pregnant women, and their families. The Head Start philosophy is based on three key points: 1) comprehensive child development services; 2) parent involvement; 3) community partnerships and community-based services.
Specific covered mental health services include: Head Start is a comprehensive health, nutrition, education, and social services program that promotes school readiness in low-income children.
Funding: Federal funding from the Department of Health and Human Services, Administration for Children and Families has enabled Head Start programs to provide comprehensive services for low-income Hoosier children and their families for over 35 years. In 2004, Indiana allocated
$95,093,413 for Head Start and served 14,234 children. The Head Start programs serve all 92 Indiana counties while Early Head Start programs serve 22 counties.
For more information: www.in.gov/fssa/children/headstart/overview.html

Maternal and Child Health Division (MCH)
Agency: Indiana State Department of Health
Ages served: Birth to 45 but emphasis is placed on ensuring services to childbearing women, infants, children, and adolescents, low-income populations, those with poor nutritional status and those who do not have access to health care. MCH provides preventative and primary care for the Maternal and Child Health population through programs that provide direct and enabling services to families such as: Indiana's Early Start program, Baby and Me Tobacco Free and Group Prenatal Care.
Mission: The ISDH mission supports Indiana's economic prosperity and quality of life by promoting, protecting, and providing for the health of Hoosiers in their communities with a vision of a healthier and safer Indiana.
Funding: The Maternal and Child Health Bureau's Title V Maternal and Child Health Block Grant in Indiana exemplifies the importance of supporting coordinated, comprehensive and family-centered systems of care at the state and local levels, especially for children and youth with and without special health care needs. Title V programming guides major state initiates that impact all MCH populations and program staff serve on numerous internal and external boards and councils addressing this work. Some of the state initiatives Title V funds include pregnancy care coordination and home visiting programs that support the family throughout the baby's first year of life.
For more information: https://www.in.gov/isdh/19571.htm

Medicaid Waivers
Ages served: Individuals under the age of 21
Community Integration and Habilitation Waiver (CIH): This waiver provides Medicaid Home and Community-Based Services (HCBS) to participants in a range of community settings as an alternative to care in an intermediate care facility for individuals with developmental disabilities(ICF/IID) or related conditions. The waiver serves persons with a developmental disability, intellectual disability or autism and who have substantial functional limitations, as defined under the paragraph for "Persons with related conditions" in 42 CFR 435.1010. Participants may choose to live in their own home, family home, or community setting appropriate to their needs. Participants develop an Individualized Support Plan (ISP) using a person centered planning process guided by an Individualized Support Team (IST). The goal of the CIH Waiver is to provide access to meaningful and necessary home and community-based services and supports, seeks to implement services and supports in a manner that respects the participant's personal beliefs and customs, ensures that services are cost-effective, facilitates the participant's involvement in the community where he/she lives and works, facilitates the participant's development of social relationships in his/her home and work communities, and facilitates the participants independent living.

- Community Integration and Habilitation Waiver - Effective August, 1 2018

Family Supports Waiver (FSW): This waiver provides Medicaid HCBS waiver services to participants in a range of community settings as an alternative to care in an intermediate care facility individuals with developmental disabilities (space) (ICF/IID) or related conditions. The waiver serves persons with a developmental disability, intellectual disability or autism and who have substantial functional limitations, as defined under "Persons with related conditions" in 42 CFR 435.1010. Participants may choose to live in their own home, family home, or community setting appropriate to their needs. Participants develop an Individualized Support Plan (ISP) using a person centered planning process guided by an Individual Support Team (IST). The IST includes the participant, their case manager and anyone else of the participant's choosing but typically family and/or friends. The participant, with the Team selects services, identifies service providers of their choice and develops a plan of care and is subject to an annual waiver services cap of $17,300. The FSW provides access to meaningful and necessary home and community-based services and supports, implements services and supports in a manner that respects the participant's personal beliefs and customs, ensures that services are cost-effective, facilitates the participant's involvement in the community where he/she lives and works, facilitates the participant's development of social relationships in his/her home and work communities, and facilitates the participant's independent living.

- Family Supports Waiver - Effective August 1, 2018

Community Health Center Program
Agency: Indiana State Department of Health
Ages served: All ages
Mission: The goal of the CHC's is to increase primary and preventive health care services and access throughout the state by supporting efforts to improve the health status of uninsured working families and underserved populations. This program assists with planning, start up and operations of community health centers that establish medical homes for the uninsured as well as insured people within medically undeserved areas within Indiana.
Specific covered mental health services include: Sites participate in the local health system including referral systems for local specialists, local primary care providers and hospitals; mental health providers; dental health providers; emergency services provisions; and coordination and referral with public health programs (e.g. WIC, EPSDT, family planning, HIV, immunization and communicable disease). Components of Comprehensive Primary Care include primary health care services by physicians and/or mid-level practitioners including treatment for acute disease and management of chronic disease; preventive health services; case management and outreach; pharmacy services needed to complete

treatment; referrals to supplemental service providers; health education and counseling; cultural competence employing an understanding of emotional and social factors in assessment and intervention for each individual client.
Funding: The Indiana Legislature allocates CHC funding. Funding for this program has been supported through Indiana's portion of the Tobacco Settlement Account. CHCs have used state funding to help leverage other funding from foundations, businesses, the federal level, and other fundraising. The use of these funds in combination with state funding and the billing of Medicaid, Medicare, and third party payers has established financially solvent centers that provide quality health care services.
For more information: https://www.in.gov/isdh/20544.htm

Women, Infants, and Children (WIC)
Agency: Indiana State Department of Health
Ages served: Pregnant women, infants, children to age 5
Mission: The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) was established through the Child Nutrition Act of 1966 with a mission to improve access to nutritious foods and promote healthier eating and lifestyles.
Specific covered mental health services include: A specific function of the WIC certification process is to make referrals for medical and social service programs. Although WIC does not provide health care, WIC will refer all applicants to health care providers as appropriate. Thus, the WIC Program is often referred to as the "gateway" into health care.
Funding: Congress funds the WIC Program through the U.S. Department of Agriculture, Food and Nutrition Services Division (USDA/FNS). These funds are distributed to states and territories based on the number of participants served. The Indiana State Department of Health receives funding through the regional USDA/FNS office in Chicago, IL to administer the WIC Program in Indiana. The funds provided by USDA/FNS for the WIC Program are classified as discretionary funds and are divided into administrative dollars and food dollars. Funds for FY2017 were: $36,558,155 for Administrative Dollars and $74,463,012 in food dollars. WIC's annual budget totals $111,021,167 with additional infrastructure grant monies awarded for special projects. **For more information: https://www.in.gov/isdh/19691.htm**

Help Me Grow (HMG) Indiana (1-844-624-6667, option 3)
Agency: Indiana State Department of Health
Ages served: Families of children birth to age 8
Mission: The mission of HMG Indiana is to promote optimal development of Indiana's young children. This model is a system approach to designing a comprehensive, integrated process for ensuring developmental promotion, early identification, referral, and linkage to early childhood resources and services. It reflects a set of best practices for designing and implementing a system that can optimally meet the needs of young children and families. It is specifically designed to help states organize and leverage existing resources in order to best serve families with children at-risk for developmental delay. The model does not change or reinvent these programs and services, rather, it ensures collaboration among multiple systems to ensure access to services and seamless transitions for families.
Specific services include:
- **Free, standardized developmental screening**: HMG Indiana can work with your program to provide standardized developmental screening. This will include pathways to have children screened by a HMG-Indiana Care Coordinator **or** provide resources if the program has already provided the screening. HMG will use the Ages and Stages Questionnaire (ASQ), for children ages 0-65 months (approx. 5.5 years).
- **HMG is a resource for you:** HMG will have information on general child development and parenting topics**.** In addition, do you need assistance with sharing results with families from a recent developmental screening? Do you need a reference for resources to give to families? HMG can help!
- **Care Coordination**: HMG Indiana provides free, specialized care coordination for families of young children that you serve. This means that if we have the family's permission, we will connect with resources and share information with you as the provider so we can all be on the same page. Care Coordinators will provide referrals to local community resources that support child development, and ensure that families successfully connect with those resources. HMG is open and can be reached through phone Monday through Friday from 7:30 a.m. to 4:30 p.m. (EST), with the exception of state holidays.

Website: Early Childhood Comprehensive Impact: **https://www.in.gov/isdh/27274.htm**
Funding: Funding is provided by the Early Childhood Comprehensive Systems (ECCS) and Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Innovations grants through the Health Resources and Services Administration (HRSA)

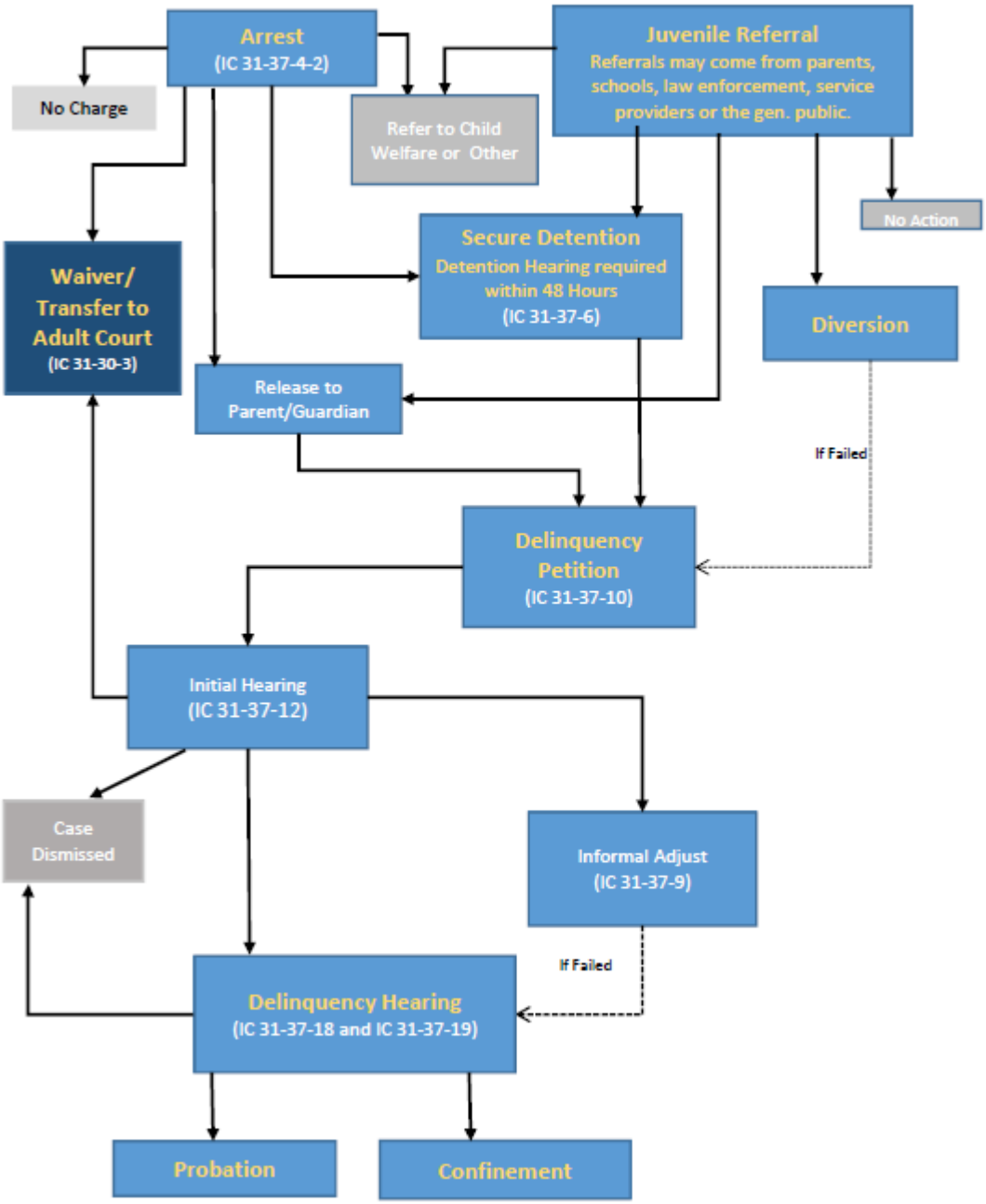
MOMS Helpline (1-844-624-6667)
Agency: Indiana State Department of Health
Ages served: Women of child bearding age, parents and children under 18
Mission: On March 1, 2016, the Indiana State Department of Health, Maternal and Child Health Services, launched the MCH MOMS Helpline. The MCH MOMS Helpline mission is to reduce the infant mortality rate in Indiana by connecting families with access to available resources focused on improving the health of mothers and their children. The primary focus of the helpline is to reduce infant mortality by raising awareness and getting families connected to resources. Some of the resources include health care providers, mental and behavioral service providers, baby programs, immunizations,

baby items, transportation providers, free testing centers, housing and financial assistance, nutrition assistance, educational assistance, and others that address the broad spectrum of the social determinants of health. In addition, the helpline provides health insurance navigation and enrollment. The helpline has received 6,446 calls from the launch date to September 1, 2018. It has also formed different partnerships with multiple entities including Indiana 2-1-1. In addition, it provides support to the Help Me Grow Indiana by serving as the centralized access point. Furthermore, services are made easily accessible to Hoosiers through the pregnancy mobile application Liv. The helpline manages and maintains all the resources on the Liv mobile application.
Specific services include: The MOMS Helpline has communication specialists that provide information and referral resources to Hoosiers, as well as, identifies and reports the community needs. The top three needs identified from the calls received between March 2016 and September 2018 include: transportation (57%), dental care (13%), and primary care provider (5%). In addition to the Bilingual specialists, the Helpline utilizes a language line, providing advocacy to community members that have limited English speaking capability. In the case the call requires extensive assistance, the Helpline's follow-up coordinator works closely with the family to connect them with resources. The resources provided by communication specialists and the follow-up coordinators are managed and maintained by the resource database specialists. The resource database specialists seek and gather statewide resources identified to influence maternal and child health from different health providing agencies. The Helpline partners with internal and external health care agencies to ensure every resource is identified. The helpline is open and can be reached through phone, text, and email Monday through Friday from 7:30 am to 5:00 pm (EST), with the exception of state holidays.
Website: MCH MOMS Helpline: **https://www.in.gov/isdh/21047.htm**
Funding: Funding is provided by the Maternal and Child Health Bureau's Title V Block Grant. For more information: https://mchb.tvisdata.hrsa.gov/

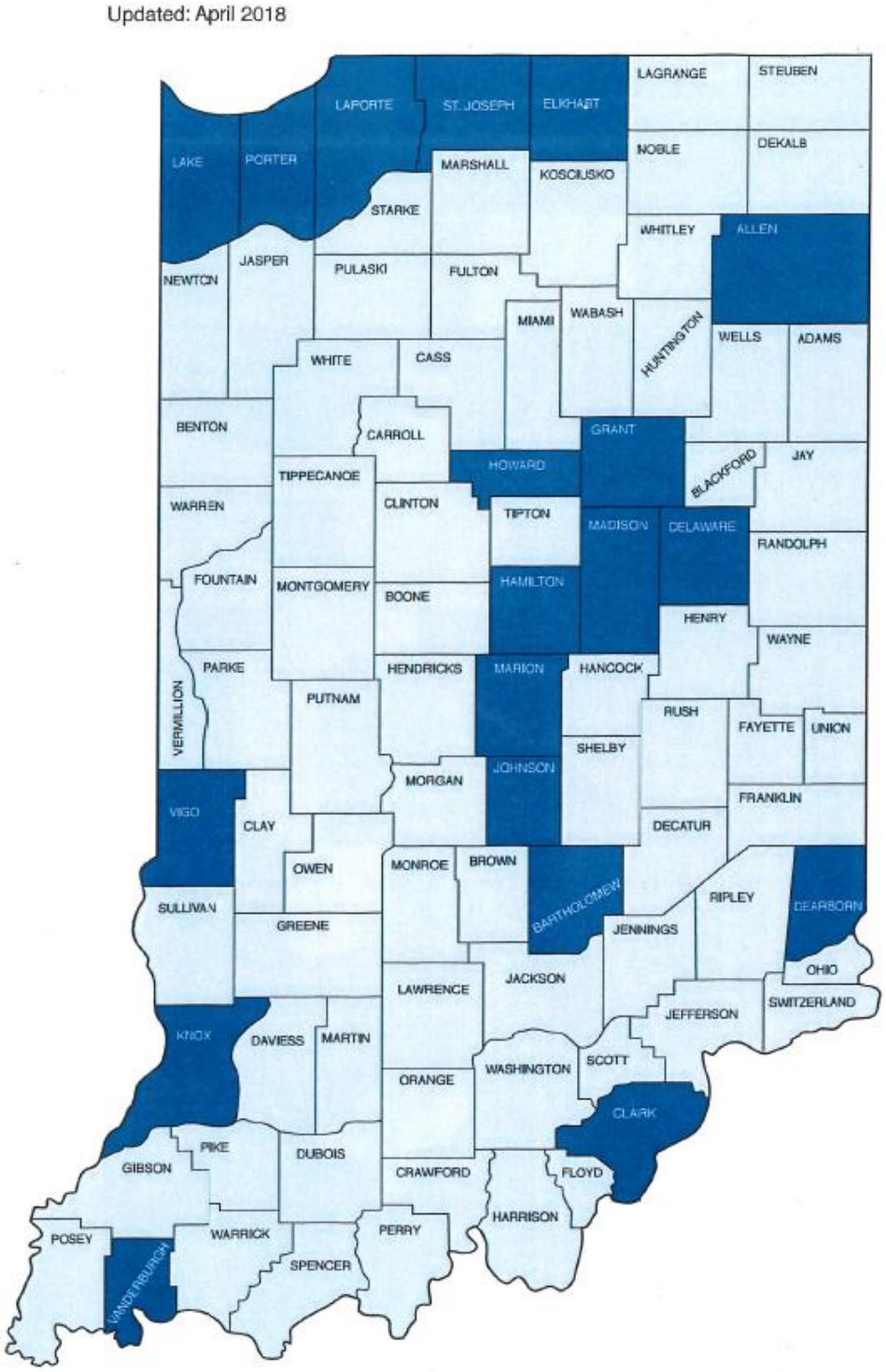
Indiana Family Helpline (1-800-433-0746) Agency: Indiana State Department of Health **Ages served:** Indiana families
Mission: On May 2, 1988, the Indiana State Department of Health, Maternal and Child Health Services, launched a statewide comprehensive Indiana Family Helpline. During fiscal year 2004, the Indiana Family Helpline responded to 28,115 calls; 1,210 advocacy calls resulting in 58,763 referrals. The primary focus of the Indiana Family Helpline is to address questions relating to Maternal and Child Health Services, Children with Special Health Care Services, WIC Services, and other concerns of callers throughout the state of Indiana. Callers' needs are assessed by trained Communication Specialists who refer callers to the appropriate community resource(s) accessed through the county-specific computer resource database that contains over 9,500 resources.
Specific mental health services include: Communication Specialists provide information, referrals, consumer education, advocacy, and follow-up to individual callers on a variety of topics including obtaining early prenatal and child health care; accessing Medicaid and WIC providers; locating emergency housing, food pantries, utility assistance; and getting callers in contact with literacy, vocational, and GED programs. The Family Helpline staff may become advocates for those callers who require this assistance. This advocacy sometimes takes the form of a conference call between the client, provider, and an Indiana Family Helpline Communication Specialist, especially for high-risk clients in areas of limited resources. The Indiana Family Helpline service also enables Maternal and Child Health Services and Children's Special Health Care Services staff to keep a "pulse" on the challenges facing families trying to obtain care with limited resources. Many potential crises have been averted in local counties by the Indiana Family Helpline staff providing families, agencies or providers with resources unknown to them. Communication Specialists are on duty from 7:30 a.m. to 5:00 p.m., Monday through Friday.
Each Communication Specialist is specially trained in Maternal and Child Health Services programs and issues and has access to consultants from the Public Health Services commission in solving complex problems.
Funding: Funding is provided by the Maternal and Child Health Bureau's Title V Block Grant. For more information: https://mchb.tvisdata.hrsa.gov/

Appendix B: Indiana Juvenile Justice System

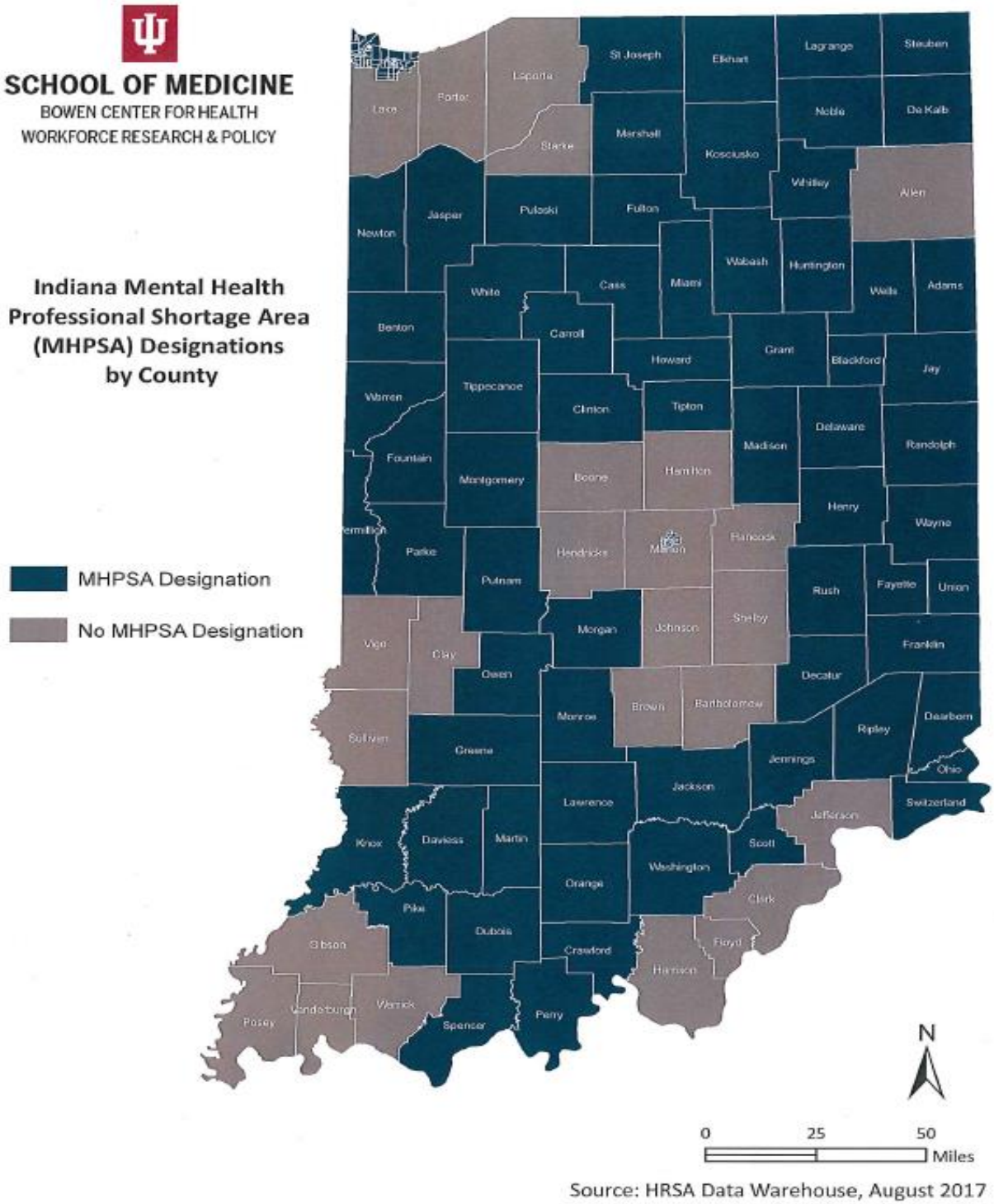
This chart is for information purposes only and was designed to provide a simplified, high-level overview of the juvenile justice system. It does not identify every step in the process. It does not supercede any state or federal law, policy or guidelines or the advice of legal counsel.
Last updated May 2018.



Appendix C: Juvenile Detention Centers



Appendix D: Mental Health Professional Shortage Areas (MHPSAs)



Appendix E: Division of Mental Health and Addictions ongoing Quality Improvement Evaluation

Sustainable Quality Improvement /Evaluation Plan

Look for differences by age, gender, race/ethnicity, & geography	How often?	Populations of concern	Data Sources	Responsible Party
Wraparound Fidelity – adherence to the practice model	Every 6 months	Wraparound enrolled youth	WFI-EZ	Wraparound Evaluation & Research Team
Service Utilization & Costs	Annual Financial Toolkit	Youth with mental health or SUD needs; youth eligible for wraparound; minorities	Medicaid Toolkit _ Medicaid Claims; federal block grant reports; COGNOS	TBD
Outcomes CANS Outcome Reports	Quarterly	Youth with mental health or SUD needs; youth enrolled in wraparound; minorities	CANS, WFI-EZ, YSS	TBD
Dashboard – key outcomes across systems	TBD	Youth with mental health or substance use disorder (SUD) needs	Management Performance HUB	Commission on the Status of Children
Estimated CMHW Eligibility & Enrollment	Quarterly	Youth with complex behavioral health needs	DARMHA diagnostic, CANS, & Medicaid eligibility TOBi – CMHW enrollment	TBD

Appendix F: Areas of Concern in Indiana

Note: There are several areas of concern in Indiana listed in this plan including suicide, incarceration, suspensions, and expulsions. These subjects have been identified as particular areas of concern through the public forum process for the development of this plan. This is in no way intended to minimize the importance of other concerns related to social, emotional, and behavioral health for children.

Children Who Are Abused or Neglected

Child abuse and neglect continues to be a serious area of concern in Indiana. The Department of Child Services "Child Abuse and Neglect State Fiscal Year (SFY) 2016 Annual Fatality Report" states that there were 59 abuse and neglect fatalities substantiated in SFY 2016, which reflects a decrease of 24% (18 deaths) from SFY 2015.[63]

Prevent Child Abuse Indiana identifies several characteristics of communities that take prevention seriously:

- Support parents and caregivers before there is a crisis.
- Provide primary prevention activities and programs for all parents regardless of ethnic, cultural, racial or economic backgrounds because they understand that child abuse and neglect happens in all segments of our communities.
- Invest in prevention because they understand that their investment will ultimately reduce juvenile delinquency rates, drug and alcohol abuse, domestic violence and crime.
- Understand that prevention requires leadership and involvement from all sectors of the community including civic, business, education, clergy, health, and human services.
- Understand that preventing child abuse and neglect is everyone's problem.[64]

Suicide

Suicide is a serious public health challenge that has not received the attention and degree of national priority it deserves. Many Americans are unaware of suicide's toll and its global impact. It is the leading cause of violent deaths worldwide, outnumbering homicide or war-related deaths.[65] One of the most distressing and preventable consequences of undiagnosed, untreated or under-treated mental illnesses is suicide.

In March 2017, the Indiana State Legislature passed House Enrolled Act 1430 requiring (1) all school corporations to adopt a policy addressing measures intended to increase child suicide awareness and prevention; (2) Teachers and staff that interact with the student body within grades 5th through 12th are required to have at least two hours of in-person suicide awareness and prevention training every three school years. Senate Bill 230 identifies Indiana Suicide Prevention Network Advisory Council as the decision authority for identifying acceptable trainings to meet this requirement. The Education sub-committee has reviewed the curriculum for many different suicide prevention training programs; however, has only approved the following due to the demonstration of being effective: (1) Question, Persuade, Refer (QPR); (2) ASIST; and (3) Kognito program for high school educators with an additional hour of suicide prevention training. As more programs are submitted for review and approval, it is expected that the list of acceptable suicide prevention programs will grow.

In the U.S., suicide claims approximately 30,000 lives each year. Overall, suicide was the 10th leading cause of death among Americans in 2016. The vast majority of all people who die by suicide have a mental illness, often undiagnosed or untreated.[66] According to the Center for Disease Control's 2016 report, suicide has become the second leading cause of death for ages 14-39. This has changed since 1999 where suicide was the fourth cause of death among youth aged 10-14, third among those between 15 and 24, second among 25- to 34-year olds, and fourth among those 35-44 years of age. The rate of teen suicide (for those from ages 15 to 19) has tripled since the 1950s.[67]

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[63] Indiana Department of Child Services, 2016
[64] Prevent Child Abuse Indiana, 2006
[65] President's New Freedom Commission, 2003.
[66] President's New Freedom Commission on Mental Health, 2003
[67] President's New Freedom Commission on Mental Health, 2003

According to the Indiana State Department of Health, suicide is the second leading cause of death for young people in **Indiana** ages 12 to 22, second only after accidents. In addition, the most recent Indiana State Department of Health Youth Risk Behavior Survey reports that in 2005 almost 1 in 5 Indiana youth had seriously considered attempting suicide (18% overall, 22% of girls and 14.3% of boys).[68] Furthermore, the Indiana Youth Institute's survey results in 2016 continued to show that 1:5 high school students have experienced a suicide ideation. This survey suggests that in each high school classroom across Indiana, there are five to six students per class that have or are experiencing suicide ideations.

Given that the vast majority of those who die by suicide give warning signs prior to their death, the tragedy of suicide is preventable if we know how to recognize warning signs and get distressed youth the help they need and build resiliency/coping skills so that distressed youth are able to seek help themselves. There are a variety of suicide prevention education programs that have been proven effective at raising awareness of suicide and reducing suicidal behavior.

There are three approaches to suicide prevention that are commonly accepted: case finding (with appropriate referral and treatment); risk factor reduction; and building or promoting protective factors. Ideally all three should be addressed when conducting suicide prevention activities. Case finding strategies include: school-based suicide awareness curricula, screening, gatekeeper training, and community crisis centers and hotlines. Risk factor reduction strategies include: restricting lethal means to suicide (e.g., pills and guns), media education on proper reporting of suicides, postvention (helping survivors after a loss due to suicide) and crisis intervention.[69] Support groups for survivors (people who have lost loved ones to suicide) are also helpful in risk factor reduction as survivors are at increased risk of suicide themselves. Promotion of protective factors commonly includes skills training related to problem solving, self-esteem, decision making, conflict resolution, anger management, and help-seeking skills. Data show that building these skills can help reduce risk behaviors, including suicidal behaviors.[70]

Universal strategies for youth suicide prevention are usually implemented in schools and youth serving organizations, as well as with parents. Selective strategies are typically implemented in schools, youth serving organizations, juvenile justice centers, group homes, physicians' offices, emergency departments, mental health facilities, and crisis centers. Indicated strategies are typically implemented in youth serving organizations, juvenile justice centers, mental health centers, physicians' offices, and crisis centers/lines. A number of these strategies are currently being implemented in Indiana or other states with success.[71]

It should be noted that screening instruments have been developed that are confidential, computer based and are being broadly used with efficacy in identifying children who may be at risk for suicide or have other mental health issues. In one study, Shaffer[72] noted that only 31% of those with major depression, 26% of those with recent suicide ideation, and 50% of those that had made a past suicide attempt were known by school personnel to have significant problems. In addition, these screens have identified needed interventions that have improved adolescent functioning. Dr. Shaffer has found in his research that 90% of the teens that committed suicide had a psychiatric disorder at the time of their deaths.[73] Screening instruments for teen suicide prevention should be evaluated to assess the advantages and risks of broader use in Indiana.

In addition to the strategies listed in this appendix, other sections of this plan list recommendations that are related to suicide prevention such as early identification and intervention and access to effective services. Please refer to the sections on obtaining services and referral networks, early learning foundations and Indiana's academic standards, and workforce development and training for more information.

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[68] Indiana State Department of Health Youth Risk Behavior Survey, 2005.
[69] Silverman, no date.
[70] American Association of Suicidology, 1999.
[71] Carpenter, 2006.
[72] Shaffer, D. and Craft, L., 1999.
[73] Shaffer, D., Gould, M., et. al., 1996.

Incarceration

Growing evidence indicates that a lack of mental health care services leads to the incarceration of thousands of mentally ill youth each year in the United States. Studies consistently show that youth in the juvenile justice systems have a much higher rate of mental health needs than in the general population. Experts in both the mental health and corrections systems believe many children with mental disorders would be better served in the community with a range of therapies and family supports.[74]

Department of Corrections has enhanced their mental health supports by training all staff on a suicide screener. The suicide screener is used to assess every transferred youth for any concerns. During a student's stay with DOC, treatment is provided by clinicians and mental health professionals. Treatment progress reviews are held at no more than 30 day intervals by a multi-disciplinary team of staff. Referrals to psychologist can come from any staff person or the student. The facility psychologist is the gatekeeper for referrals to the adolescent psychiatrist. Individual treatment is provided by psychologist and psychiatrist as needed. Medications used as needed and reviewed regularly.

Acute mental health episodes are managed at the facility if possible. If needed, a short-term in-patient placement may be authorized. Students deemed in need of a transfer to the Department of Mental Health are referred for temporary commitment as needed. Civil commitments to DMH for youth 17 years of age or older are pursued as needed. Continuity of services upon release from the facility is coordinated by facility staff and juvenile parole staff.

Process for IDOC Juvenile Facilities, Mental Health Services:

1. Commitment to DOC by County Juvenile Court
2. Intake Facility
    a. Assessments
    b. Acute risk management
    c. Medication review
3. Treatment Facility
    a. Individualized treatment plans
    b. Treatment and crisis management
    c. Programming to develop coping skills
    d. Education services
    e. Family engagement
    f. Team reviews
    g. Referral for services
    h. Medication/follow-up
    i. Transition to community
4. Aftercare
    a. Referrals to community providers
    b. Monitoring and adjustments
    c. Discharge from supervision

See Appendix B and C for additional information of the Juvenile Justice System.

Suspension and Expulsion

In March 2014, the U.S. Department of Education Office for Civil Rights released the results of the latest national Civil Rights Data Collection (USDOE, 2014). Those data show Indiana to have the second highest rate of out-of-school suspension for Black males, and tied for the fourth highest rate of out-of-school suspension for Black females. Indiana was one of five states in the nation with male rates of Out of School Suspension (OSS) higher than the national average for all racial/ethnic groups.

In light of these national and state concerns, the Equity Project at Indiana University at Center for Education and Evaluation Policy conducted a preliminary analysis of the state's suspension and expulsion data for all schools and school corporations in the state. Based on an analysis of all suspensions and expulsions in the State for the 2012-2013 school year, the purpose of the report was to provide a more in-depth analysis of the status of suspension and expulsion in Indiana, and to use those data to frame preliminary recommendations. The analyses were designed to address the following three questions:

[74] Koppelman, 2005.

1.) What is the status of the use of in-school suspension (ISS), out-of-school suspension (OSS), and expulsion in Indiana's schools?
• How widely are those procedures used?
• What offenses are most likely to result in suspension or expulsion?
• To what extent is there racial/ethnic disproportionality in the use of suspension and expulsion?

2.) What do we know about instructional time lost to suspension, and about students who may be subject to multiple suspensions and expulsions?
• How much time out of school is lost to ISS, OSS, and expulsion?
• Are certain individuals or groups more likely to lose instructional time as a result of being out of school for a suspension or expulsion?

3.) What recommendations could be made to improve data collection or disciplinary practice regarding suspension and expulsion in Indiana?
• What further analyses would need to be conducted to gain a more complete picture of suspension and expulsion in Indiana?
• What changes or improvements could be made with respect to the way in which Indiana collects data on suspension and expulsion?
• What resources could be provided to Indiana schools and school corporations seeking to restructure or reform their disciplinary systems?
• What state and national resources could be leveraged in order to further support improved disciplinary practices in Indiana?

Feel free to review the report and their findings:

Suspensions and Expulsions in Indiana-

In order to improve Indiana's discipline models in 2018, House Enrolled Act 1421 was put into place. Per HEA 1421, IDOE shall conduct a survey of school corporation school discipline policies to determine the extent to which positive discipline and restorative justice practices are being utilized. The results from this survey will be shared in early 2019 in addition to a mode plan that will: (1) reduce out-of-school suspension and disproportionality in discipline and expulsion; (2) limit referrals to law enforcement and arrests on school property to cases in which referral to law enforcement or arrests necessary to protect the health and safety of students or school employees; and (3) include policies to address instances of bullying and cyberbullying on school property of a school corporation. This model plan will be made public in early 2019.

Appendix G: Existing Studies Related to the Needs Assessment of Indiana's Behavioral Health Network

Evaluation of Systems Reform in the Annie E. Casey Foundation Mental Health Initiative for Urban Children: Summary of Findings and Lessons Learned.
Authors: Gutierrez-Mayka, M., Joseph, R., Sengova, J., Uzzell, J., Contreras, R., Friedman, R., Hernandez, M.

May 2000

http://www.aecf.org/publications/data/mhisysref.pdf

In 1993, the Annie E. Casey Foundation launched the Mental Health Initiative for Urban Children (MHI). The overall goal of this five year, neighborhood-scale program was to improve community mental health services to achieve positive outcomes for children, and, in the long run, avoid significant public expenditures. Specifically, the MHI sought to demonstrate new ways of delivering culturally appropriate, family sensitive, mental health services to children in high poverty, urban communities, and to work with states to improve the policies and practices supporting these services.

A key aspect of the MHI design was its focus on high poverty inner-city neighborhoods. The life experiences of children in these communities places them at a much higher risk for involvement with systems (e.g., mental health, juvenile justice, child welfare, special education) that are unprepared to give them and their families the support they need to succeed. According to the 1999 Kids Count Report produced by the Annie E. Casey Foundation, there are 9.2 million children nationally who are growing up with multiple risk factors including absence of a parent, low parental education, low socio-economic status, unemployed or underemployed parents, welfare assistance, and lack of health insurance coverage. A demographic look at these children reveals they are mostly from minority groups (i.e., 30% of all Black and 25% of all Hispanic children are considered at high risk) and they live in poor central city neighborhoods. In addition to the environmental stressors, in the United States today, increasing numbers of children are experiencing some type of emotional, behavioral or developmental problem. For children living in low income communities, the combination of more acute mental health problems and inadequate services results in disproportionate numbers of them spending time in foster care, special education, psychiatric hospitals, and juvenile justice facilities—all at public expense.

Another key aspect of the MHI design was to target a broad population of children at-risk, while incorporating features from system reform initiatives, specifically targeted at children with serious emotional disturbances and their families.

The MHI's reform agenda called for simultaneous efforts on a variety of fronts (e.g. community involvement and governance, service design and delivery, MIS, systems integration, and sustainability) making it almost impossible to dedicate the time, energy and commitment that each one required to succeed. However, clear successes were claimed in the area of partnerships. The MHI's mixed governing entities modeled new types of relationships between state and local agencies, and neighborhood residents, and created new networks whose potential impact is yet to be seen. In terms of reforms related to service delivery, the main contribution of the MHI is the idea that a service strategy (i.e., Family Resource Centers) which emphasizes supporting families' basic needs for housing, employment, education, recreation, spirituality and cultural identification can be an effective mechanism to address children's mental health needs and prevent their future involvement with formal systems. This idea has implications for how community-based mental health services are marketed and packaged, and ultimately, for the achievement of positive child and family outcomes. The notion that trained community residents can make important and unique contributions to a family's mental health is another legacy of the MHI. Finally, the success in promoting policy and fiscal reforms and in the development of

management information systems (MIS) to support the service strategy can be considered small compared to what the Foundation expected to see in this area.

The Indiana State Bar Association, Children, Mental Health and the Law Summit: Official Report on Summit Findings with Recommendations.
Fall, 2005
http://www.inbar.org/content/pdf/Mental Health Report%20.pdf

The Indiana State Bar Association's Civil Rights of Children Committee, in partnership with the Indiana State Bar Association (ISBA) Family and Juvenile Law Section and ISBA Criminal Justice Section, organized an interdisciplinary summit on August 27, 2004, to address concerns regarding the unmet mental health needs of children in the juvenile justice system. A lack of prompt identification, diagnosis and treatment of children before their mental health problems lead them into the juvenile justice system, and inadequate screening, assessment and care once they do enter the system are creating a crisis that the legal profession and others cannot ignore. The juvenile justice system is ill-suited, as a matter of sound public policy and children's civil rights, to be the primary provider of mental health service to children.

This report outlines specific recommendations developed as a result of the Summit, including steps local communities, mental health officials and the juvenile justice system can take to provide appropriate services to more children with mental health needs in order to return them safely to their communities and schools, and reduce their risk of future incarcerations. Indiana has made progress in these areas, but more needs to be done.

Recommendations for the children with mental health needs as they enter the juvenile justice system:

- Develop and implement a standardized, integrated, statewide program for screening in conjunction with a validated risk assessment instrument to treat youth upon entry of the juvenile justice system.
- Safeguard youths' constitutional right against self-incrimination through screening and assessment programs.
- Divert low-risk children to community-based treatment.
- Educate attorneys, judges, county, and local officials on the mental health needs of the youth and the benefits of prompt screening, assessment, and treatment of mental health disorders.
- Encourage earlier intervention by using appropriate screening and assessment methodologies to detect mental health disorders of children in Child in Need of Services (CHINS) cases.
- Determine and treat the mental health needs of the family when treating the child.
- Strengthen special education advocacy within the legal community to build and support community-based systems of care protecting critical rights of children and parents.
- Reduce school expulsions and out-of-school suspensions by increasing the availability of prevention, early intervention, and special education alternatives.
- Increase the use of IDEA and Medicaid entitlements to generate comprehensive community-based mental health systems that are integrated in schools to provide mental health services for school-age children through early intervention efforts.
- A collaborative, interdisciplinary committee, to be appointed by the Indiana Supreme Court, should recommend processes for: (1) determining competency to stand trial in juvenile delinquency proceedings; (2) restoring children to competency; and (3) determining what to do with children who cannot be restored.
- An Indiana juvenile competency model should be based on the same legal standard for competency required in criminal court, as set forth in Re K.G. (Court case: 808 N.E.2d 631, 635 (Ind. 2004)).
- Require competency evaluations, unless waived by the child's counsel, in cases where the State is seeking waiver to adult criminal court.

- Appoint legal counsel in every juvenile delinquency case to ensure juveniles are not subjected to delinquency proceedings if incompetent to stand trial.
- Refer children incompetent to stand trial, (incompetent due to mental health issues rather than due to age and development) to the county office of the Department of Child Services to receive services as a CHINS or pursuant to I.C. 31-34-1-16, which allows for services without parents relinquishing custody of their child.
- Implement, at the local level, inter-agency funding that is service driven, and ease the accessibility of mental health services for families.
- Identify additional revenues for children's mental health services.
- Maximize Medicaid eligibility by limiting placements of children in secured settings to those who cannot be appropriately treated through community-based services.
- Maximize mental health care benefits for low income children through Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Medicaid funding.
- Provide sufficient funding for building greater capacity of community-based services and for dissemination of information on evidence-based, best practices.
- Develop within local communities and counties, inter-disciplinary alternatives to encourage cross-coordination of services for youth in the juvenile justice system.
- Adopt or change policies and laws to improve collaboration, coordination and information sharing among education, mental health, medical, juvenile justice, foster care, residential treatment programs, and public/private child welfare professionals.
- Consider legislation that requires timely and appropriate mental health treatment and services for juveniles and their families secured or incarcerated in the juvenile justice system.
- Develop policies to remedy the negative impact that inadequate insurance and Medicaid reimbursement levels have on the availability of mental health services in the private sector.
- Extend the jurisdiction of the juvenile court to allow monitoring of children with disabilities who are placed in state correctional facilities.
- Continue the work of the Summit.

Indiana Consortium for Mental Health Services Research

Sixth Annual Evaluation Briefing of the Dawn Project Evaluation Study

Author: Wright, E., Anderson, J.

September 2005

http://www.urbancenter.iupui.edu/healthpolicy/dawnproject/BriefingReports/DPES%202005%20Public%20Briefing%20Report%20-%20Final.pdf

Since 1997, the Dawn Project has provided an interagency system of care for youth with emotional and behavioral challenges and their families in Marion County. Dawn is responsible for creating and maintaining a coordinated, community-based system of services; developing supports for children and youth with the most serious emotional and behavioral challenges; and placing families at the center of decision-making in the provision of services.

September of 2005, Eric Wright and Jeff Anderson completed a study of the impact of the Dawn Project on the Marion County Children's Social Service System. The study was conducted to understand how key stakeholders in the children's service arena in Marion County perceived the impact that the establishment of the Dawn Project had on the social services community over time. To understand how the Dawn Project has impacted the community, study findings related to positive community level impact fell into the following groups: increased collaboration and service coordination, importance of family involvement, lessening fiscal constraints, enhancing strengths approaches, and ecological responses.

Data for this study were collected primarily through interviews with stakeholders—system and agency leaders and parents who were involved in the children's social services system at the inception of the Dawn Project through the first five years of its existence.

Respondents reported an increase in recognition among stakeholders that children served by the Dawn Project tend to be involved in many different systems, thus making service coordination a useful approach. They also reported that the Dawn Project is helping the community become aware of the importance of building on family strengths by viewing the family as a resource in the treatment program, and by asking them what they need rather than telling them what services they will receive. At the county level, traditional power structures have been challenged because of the creation of the Dawn Project, some of the financial barriers have been "loosened," there is more discussion on wraparound and the use of "flex" funds, and that the use of costly residential services has been reduced and the nature of residential treatment is changing. The Dawn Project has had an overall impact in the adoption, use, and proliferation of strengths-based approaches, and has pushed the systems to move beyond just treating children to also working with their environments. Respondents also mentioned the importance of multi-system treatment plans that are used to ensure that all domains of a child's life are addressed.

Appendix H: Glossary

Active Parental Consent –The term "active parental consent" means collecting a signature and/or permission from the parent or guardian of each child authorizing an agency to give the child a screening or assessment.

CANS- Child and Adolescent Needs and Strengths Assessment- a common assessment tool and quality outcome management process across Indiana's child service systems. For more information, www.praedfoundation.org

Child-Serving Agencies - Addressing the needs of young people in the service population requires the resources of multiple public agencies, including education, mental health, child welfare, corrections, and juvenile justice, along with private providers and community organizations (e.g., faith, family support, and youth organizations).

Effective Models of Care - Definitions of evidence-based practices (or effective models of care) have been developed by many national organizations, including the Institute of Medicine[75] and American Psychological Association.[76] Additionally, states, such as Hawaii,[77] have created definitions of effective models of care that reflect the values of their system of care. The importance of effective models of care in a transformed mental health system is highlighted by the creation of New Freedom Commission on Mental Health Subcommittee on Evidence-Based Practices.[95] In Indiana, the following issues must be addressed in order to identify, develop, and implement effective models of care:

- Defining effective models of care
- Assessing readiness for change[78] [79]
- Applying implementation research[80]
- Measuring fidelity
- Tracking outcomes
- Using data for quality improvement

Multi-tiered Systems of Support (MTSS) - An educationally equitable framework characterized by a continuum of evidence-based practices for academics, behavior, and social-emotional development.

This framework includes:

1. Universal Screening
2. Core curriculum for all students with tiered supports for the unique needs of each student
3. Data-informed decision making and problem solving
4. High quality instruction
5. Purposeful and intentional implementation

Population of Concern - The vision articulated above is for young people ages 0 to 22 with identified mental health issues and/or substance use problems and their families. The population of concern includes individuals at the beginning of their life span; a comprehensive plan that includes adults and the elderly, although beyond the scope of this goal statement, would help insure social, emotional, and behavioral health for all citizens of Indiana.

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75 Chambless, D L., et al. 1998.
76 Evidence Based Services Committee, 2004.
77 Godbole, A., et al, 2005.
78 Prochaska, J. O., et al, 1994.
79 Rogers, E. M., 2003.
80 Fixsen, D. L., et al, 2005.

Quality Improvement - Given the complexity of issues faced by young people in Indiana and the unique socioeconomic, geographic, and cultural characteristics of the population of concern, the

fit between available services and individual consumers must be continuously monitored. Effective innovations that come from clinical expertise and family voice and choice should be applied locally, assessed using outcome data, and disseminated throughout the state.

Real-Time Process and Outcome Data - Currently, more than 30 community mental health centers, other contracted providers, and a countless number of private providers, deliver services to young people in 92 counties throughout Indiana. Understanding what services are being delivered, to whom, and with what result, is critical to transforming the mental health system and achieving social, emotional and behavioral health for children and their families. An infrastructure is needed that would allow data on both the services being provided (i.e., process data) and the results of those services (i.e., outcome data) for young people to be collected on a regular, if not continuous, basis. With this data, effective services currently being provided in Indiana could be identified and supported, ineffective services could be improved or stopped, and gaps in services could be met by implementing nationally and locally recognized effective models of care.

Recovery - Refers to the process in which people are able to live, work, learn, and participate fully in their communities. For some individuals, recovery is the ability to live a fulfilling and productive life despite a disability. For others, recovery implies the reduction or complete remission of symptoms. Science has shown that having hope plays an integral role in an individual's recovery.

Resilience - The personal and community qualities that enable us to rebound from adversity, trauma, tragedy, threats, or other stresses—and to go on with life with a sense of mastery, competence, and hope. We now understand from research that resilience is fostered by a positive childhood and includes positive individual traits, such as optimism, good problem-solving skills, and treatments. Closely-knit communities and neighborhoods are also resilient, providing support for their members.

Shared Accountability - Fiscal, workforce and training resources for children's services are limited in Indiana and throughout the country. As a result, everyone in the system of care must provide cost efficient services (i.e., services that result in positive outcomes while effectively managing costs). Mechanisms must be in place to insure that service providers are delivering services appropriately (including maintaining fidelity to established treatment protocols) and using available resources wisely.

Systems of Care-– A comprehensive spectrum of services. Systems of Care (SOC) builds community networks which include families, policy makers and workers in child welfare, juvenile justice, education, mental health, primary healthcare and community based organizations who gather around a child and provide needed services. In 2000, Indiana Division of Mental Health and Addiction (DMHA), part of the Family and Social Services Administration (FSSA) initiated implementation of the statewide Systems of Care (SOC) network to better meet the mental health needs of Indiana children.
About 75% of the state's youth populations live in the areas served by a System of Care. By 2006, 51 of Indiana's 92 counties will have identified SOC with new counties being added yearly. Currently (2018) over 70 counties have an identified local SOC.

In Indiana and nationally, communities are working to develop and implement a system of care consistent with the following definition: "A comprehensive spectrum of mental health and other necessary services which are organized into a coordinated network to meet the multiple and changing needs of children and their families." [81] To effectively promote children's social, emotional and behavioral health, however, the concept of a system of care must be viewed more broadly to include coordination of services and supports across all of the agencies, organizations and individuals that work to improve outcomes for children and families at the state, regional, county, and community levels. The system of care includes the full continuum of services, including services delivered in the community, by child-serving agencies in residential treatment settings and state hospitals.

[81] Stroul, B., & Friedman, R., 1986.

Appendix I: Task Force Members

DCS	Don Travis-Deputy Director
DCS	David Reed-Deputy Director
DCS	Sarah Sailors-Deputy Director
DMHA	Sirrilla D. Blackmon-Deputy Director
DMHA	Gina Doyle-Assist. Deputy Director
DMHA	Bethany Ecklor – School & Community Based Programs Director
DWD	Leslie Crist-Associate Chief Operating Officer of Workforce Development
DOE	Jeff Wittman-School Social Work & Foster Youth Specialist
DOE	Christy Berger – Assistant Director of Social, Emotional, and Behavioral Wellness
DYS	Chris Blessinger-Executive Director
JDAI	Nancy Wever–Executive Director
CISC	Julie Whitman–Executive Director
DFR	David D Smalley-Deputy Director – Policy
DFR	Suzanne Tryan-Policy
VR	Johnathan Kraeszig
OMPP	Carol Sutton
ISDH	Shirley Payne- CSHCS Director
BDDS	Cathy Robinson- Ed Director Bureau of Developmental Disabilities Services

ICJI	Elizabeth Crist Darby- Youth Division Director

Appendix J: Enabling Legislation/Indiana Code Citation

http://www.ai.org/legislative/ic/code/title20/ar19/ch5.html#IC20-19-5-1

IC 20-19-5
Chapter 5. Children's Social, Emotional, and Behavioral Health Plan

IC 20-19-5-1
Department duties
Sec. 1. The department of education, in cooperation with the department of child services, the department of correction, and the division of mental health and addiction, shall:
(1) develop and coordinate the children's social, emotional, and behavioral health plan that is to provide recommendations concerning:
(A) comprehensive mental health services;
(B) early intervention; and
(C) treatment services;
for individuals from birth through twenty-two (22) years of age;
(2) make recommendations to the state board, which shall adopt rules under IC 4-22-2 concerning the children's social, emotional, and behavioral health plan; and
(3) conduct hearings on the implementation of the plan before adopting rules under this chapter.
As added by P.L.234-2005, SEC.79.

IC 20-19-5-2
Plan recommendations
Sec. 2. The children's social, emotional, and behavioral health plan shall recommend:
(1) procedures for the identification and assessment of social, emotional, and mental health issues;
(2) procedures to assist a child and the child's family in obtaining necessary services to treat social, emotional, and mental health issues;
(3) procedures to coordinate provider services and interagency referral networks for an individual from birth through twenty-two (22) years of age;
(4) guidelines for incorporating social, emotional, and behavioral development into school learning standards and education programs;
(5) that social, emotional, and mental health screening be included as a part of routine examinations in schools and by health care providers;
(6) procedures concerning the positive development of children, including:
(A) social, emotional, and behavioral development;
(B) learning; and
(C) behavioral health;
(7) plans for creating a children's social, emotional, and behavioral health system with shared accountability among state agencies that will:
(A) conduct ongoing needs assessments;
(B) use outcome indicators and benchmarks to measure progress; and
(C) implement quality data tracking and reporting systems;
(8) a state budget for children's social, emotional, and mental health prevention and treatment;
(9) how state agencies and local entities can obtain federal funding and other sources of funding to implement a children's social, emotional, and behavioral health plan;
(10) how to maintain and expand the workforce to provide mental health services for individuals from birth through twenty-two (22) years of age and families;
(11) how employers of mental health professionals may:
(A) improve employee job satisfaction; and
(B) retain employees;

(12) how to facilitate research on best practices and model programs for children's social, emotional, and behavioral health;

(13) how to disseminate research and provide training and educational materials concerning the children's social, emotional, and behavioral health program to:

(A) policymakers;

(B) practitioners; and

(C) the general public; and

(14) how to implement a public awareness campaign to:

(A) reduce the stigma of mental illness; and

(B) educate individuals:

(i) about the benefits of children's social, emotional, and behavioral development; and

(ii) how to access children's social, emotional, and behavioral development services.

As added by P.L.234-2005, SEC.79.

Plan Endnotes

Aces Too High. (2012, February). Spokane, WA, Students' Trauma Prompts Search for Solutions. Retrieved from https://acestoohigh.com/2012/02/28/spokane-wa-students-child-trauma-prompts-search-for-prevention/

American Academy of Child and Adolescent Psychiatry Work Group on Systems of Care and American Association of Community Psychiatrists. (2003). Child and Adolescent Level of Care Utilization System (CALOCUS) User's Manual, Version 1.3. Washington, DC: Authors.

American Association of Suicidology. (1999). Guidelines for School Based Suicide Prevention Programs. Prevention Division. Retrieved from http://www.suicidology.org/associations/1045/files/School%20guidelines.pdf

ASPE.hhs.gov (2018). Retrieved from https://aspe.hhs.gov/report/affordable-care-act-expands-mental-health-and-substance-use-disorder-benefits-and-federal-parity-protections-62-million-americans

Bazelon Center. (2003). *Mix and Match: Using Federal Programs to Support Interagency Systems of Care for Children with Mental Health Care Needs.* Washington D.C.: Bazelon Center for Mental Health Law.

Burns, B. J., Hoagwood, K., Mrazek, P. J. (1999). Effective treatment for mental disorders in children and adolescents. *Clinical Child and Family Psychology Review, 2*(4), 199-244.

Bouguettaya, A., Ouzzani, M., Medjahed, B. & Elmagarmid A.. Supporting Data and Services Access in Digital Government Environments. Department of Computer Science, Virginia Tech & Department of Computer Sciences, Purdue University. (http://wwwpersonal.engin.umd.umich.edu/-brahim/mypublications/chapter elmagarmid. pdf)

Bowen Center for Health Workforce. Data Report 2016 Indiana Mental Health Professionals. Licensure Survey. Retrieved from https://scholarworks.iupui.edu/bitstream/handle/1805/13295/2016%20Mental%20Health%20Data%20Report.pdf?sequence=4&isAllowed=y

Carpenter, Colleen. MA*, MPH. Indiana Suicide Prevention Coalition's Recommendations on Integrating Suicide Prevention into the Indiana's Children's Social, Emotional, Behavioral Health Plan.* May 22, 2006

Chambless, D L., et al. (1998). Update on Empirically Validated Therapies, II. *The Clinical Psychologist,* 51.

Child Trends. (2014, July). Adverse Childhood Experiences: National and State-Level Prevalence. Retrieved from: https://www.childtrends.org/wp-content/uploads/2014/07/Brief-adverse-childhood-experiences_FINAL.pdf

Cutler, A. & Gilkerson, L. (2002). *Unmet needs project: A research, coalition building and policy initiative on the unmet needs of infants, toddlers and families.* Chicago, IL: University of Illinois at Chicago and Erikson Institute.

Dennis, M. L., Titus, J. C., White, M. K., Unsicker, J. I., Hodgkins, D. (2002). Global Appraisal of Individual Needs (GAIN): Administration guide for the GAIN and related measures. Bloomington, IL: Chestnut Health Systems. Retrieved from www.chestnut.org/li/gain.

Dunkle, M. and Louis, V., "A Different Kind of Test." *Education Week,* September 24, 2003.

Effland, V.S. & McIntyre, J. (2005). *Promoting children's social, emotional, and behavioral: Shared accountability, quality improvment and implementation of effective models of care in Indiana*. Indianapolis, IN: Technical Assistance Center for Systems of Care and Evidence Based Practices for Children and Families, Choices, Inc.

Evidence Based Services Committee, Biennial Report (2004). Hawaii: Department of Health Child and Adolescent Mental Health Division, Retrieved from: www.hawaii.gov/health/mental- health/camhd/library/pdf/ebs/ebs011. pdf

Felitte, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., & . . . Marks, J.S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. American Journal of Preventive Medicine, 14(4), 245-258.

Foster, S.(M.S.S.W., M.P.H.), Rollefson, M. (Ph.D.), Doksum, T. (Ph.D., M.P.H.), Noonan, D. (Ph.D.), Robinson, G. (Ph.D.), Teich, J. (A.C.S.W.) (2005). *School Mental Health Services in the United States 2002-2003.* Washington, D.C.: US Department of Health and Human Services.

Fixsen, D. L., Naoom, S. F., Blase, K. A., Friedman, R. M., Wallace, F. (2005). "Implementation Research: A Synthesis of the Literature," *FMHI Publication #231* Florida: University of South Florida, Louis de la Parte Florida Mental Health Institute, The National Implementation Research Network.

Gilliam, Walter S.(2005) "Prekindergartners Left Behind: Expulsion Rates in State Prekindergarten Programs," *The Achiever," 5,(4),* 5/06. Foundation for Child Development. *FCD Policy Brief Series* No. 3, U.S. Department of Education, Washington, D.C., May 2005.

Godbole, A., M.D., Goldman, H., M.D., Ph.D. (2005). *Subcommittee on Evidence-Based Practices: Background Paper.* DHHS Pub. No. SMA-05-4007. Maryland: New Freedom Commission on Mental Health.

Grisso & Barnum. (2000) - Massachusetts Youth Screening Instrument-Second Version: Users Manual and Technical Report. Worcester: University of Massachusetts Medical School

Grisso, T. & Underwood, L. A. (2004). *Screening and Assessing Mental Health and Substance Use Disorders Among Youth in the Juvenile Justice System. A Resource Guide for Practitioners.* Washington, D.C.: U.S. Department of Justice.

Heckman, J. & Masterove, D. (2004) The Productivity Argument for Investing in Young Children, Invest in Kids Working Group Working Paper No. 5. Washington, DC: Committee on Economic Development. Retrieved from www.ced.org/docs/report/report ivk heckman 2004.pdf.

Hemmeter, M.L., Ostrosky, M., Gail, J. (2003) *Promoting Children's Success: Building Relationships and Creating Supportive Environments.* Illinois: University of Illinois at Urbana-Champaign: Center on the Social and Emotional Foundations for Early Learning.

Hoagwood, K. (2001). Effectiveness, Transportability, and Dissemination of Interventions: What Matters When? *Psychiatric Services, 52,* 1190-1197.

Hoagwood, K., Burns, B., Kiser, L., Ringeisen, H., Schoenwald, S. K. (2001). Evidence-Based Practice in Child and Adolescent Mental Health *Services_ Psychiatric Services,* 52(9), 1179-89.

Hoagwood, K., Jensen, P.S., Petti, T., & Burns, B. (1996). Outcomes of Mental Health Care for Children and Adolescents: A Comprehensive Conceptual Model. *Journal of the American Academy of Child & Adolescent Psychiatry,* 35(8), 1055-1063.

Hodges, K, (1994). *The Child and Adolescent Functional Assessment Scale (CAFAS), Self-*

Training Manual. Ypsilanti: Eastern Michigan University, Department of Psychology.

Huang, L., MacBeth, G., Dodge, J., and Jacobstein, D. (2004). Transforming the Workforce in Children's Mental Health. 32(2), 167-187.

Indiana Department of Child Services. (2016). Child Abuse and Neglect SFY 2015 Annual Fatality Report,.

Indiana Division of Family and Children. (2002). 2001 SFY Demographic Trend Report. Retrieved from http:l/www.pcain.org/index.asr)?action=stats

Indiana Family and Social Services Administration. (2003). Child Abuse/Neglect Summary by County SFY 2003. Retrieved from http://www. in.gov/dcs/pdf/protection/2003%20statistics. pdf

Indiana Prevention Resource Center. (2016). Indiana Youth Survey. Data Request.

Indiana State Bar Association. (2005). *Children, Mental Health and the Law Summit: Official Report on Summit Findings with Recommendations.* IN: Indiana State Bar Association.

Indiana State Department of Health Youth Risk Behavior Survey. (2005). Retrieved from http://www. in.gov/isdh/dataandstats/vrbsNiolenceFS2005. pdf.

Indiana Youth Institute Kids Count Data Book. (2018). Retrieved from https://datacenter.kidscount.org/data/tables/5644-children-under-19-without-health-insurance?loc=16&loct=2#detailed/2/any/false/870,573,869,36,868,867,133,38,35/1536,1537/12236.

Institute of Medicine. (2001). *Crossing the quality chasm: A new health system for the 21St century.* Washington, DC: Institute of Medicine.

Kutash, K., Duchnowski, A., Lynn, N. (2006). *School-based Mental Health: An Empirical Guide for Decision-Makers.* Florida: University of South Florida, The Research & Training Center for Children's Mental Health.

Kutash K., Greenbaum P., Wang W, Boothroyd, R. A., Friedman, R. M. (2011). Levels of system of care implementation: A national study. *Journal of Behavioral Health Services and Research, 38*(3), 342-357.

Kirk, R. S., and Reed-Ashcraft, K, (1998). *North Carolina Family Assessment Scale for Intensive Family Preservation Services (NCFAS), Version 2.*

Koppelman, J. (2004). *Children with Mental Disorders: Making* Sense *of Their* Needs *and the* Systems *That Help Them, NHPF* Issue *Brief, No. 799.* Washington, D.C.: The George Washington University.

Koppelman, J. (2005). *Mental Health and Juvenile Justice: Moving Toward More Effective Systems of* Care. *NHPF* Issue *Brief, No. 805.* Washington, D.C.: The George Washington University.

Mann, J. J. et al. (2005). Suicide prevention strategies: A systematic review. *Journal of the American Medical Association,* 294(16), 2064-2074.

National Survey of Children's Health. (2011/12). Child Ever Lived with Anyone Who Was Mentally Ill or Suicidal. Retrieved from http://www.nschdata.org/

National Technical Assistance Center for Children's Mental Health (2005). Issue *Brief. Transforming the Workforce in Children's Mental Health.* Washington, D.C.: Georgetown University Center for Child and Human Development.

Newman, D. W., Kellett, S., & Beail, N. (2003). From research and development to practice- based evidence:

Clinical governance initiatives in a service for adults with mild intellectual disability and mental health needs. *Journal of Intellectual Disability Research, 47,* 68-74.

Newman, F. L., McGrew, J. H., DeLiberty, R. N., Anderson, J. A., Smith, T., & Griss, M. E. (2002). *Psychometric properties of the HA PI-Child: An instrument developed to determine service eligibility and level of functioning in a state mental health and substance abuse service system. Indiana Division of Mental Health and Addiction.* Retrieved from http://www.in.gov/fssa/servicemental/pdf/HAPI-Child.pdf [2002.

Pavkov, T. (2004). *Indiana local systems of care assessment project.* Hammond, IN] Purdue-Calumet.

Policy Leadership Cadre for Mental Health in Schools. (2001). *Mental Health in Schools: Guidelines, Models, Resources, & Policy Considerations.*

President's New Freedom Commission on Mental Health (2003). *Achieving the promise: Transforming mental health care in America.* DHHS Publication No. SMA-03-3831. Rockville, MD: U.S. Department of Health and Human Services.

Prevent Child Abuse Indiana. (2006). How Does Primary Prevention Work? Retrieved from http:l/www.r)cain.org/index.asp?action=howdoespreventionwork.

Prochaska, J. 0., Norcross, J. C., DiClemente, *C. C. Changing for Good: A Revolutionary SixStage Program for Overcoming Bad Habits and Moving Your Life Postively Forward.* (New York: HarperCollins 1994).

Rogers, E. M. (2003). Diffusion of Innovations. New York: Free Press.

Shaffer, D., Gould, M., Fisher, S., Trautman, P., Moreau, D., Kleinman, M., Flory, M. (1996) Psychiatric diagnosis in child and adolescent suicide. *Archives of General Psychiatry,* Vol. 53, No. 4, April 1996 New York: State Psychiatric Institute, Division of Child Psychiatry, Schoenwald, S. K.,

Substance Abuse and Mental Health Services Administration (SAMHSA) (2005). *Screening and Early Detection of Mental Health Problems in Children and Adolescents, SAMHSA policy statement.* Maryland: SAMHSA

Schoenwald, S. K., & Hoagwood, K. (2001). Effectiveness, transportability, and dissemination of interventions: What matters when? *Psychiatric Services,* 52, 1190-1197.

Shaffer, et al. (2004). The Columbia Suicide Screen: validity and reliability of a screen for youth suicide and depression. *Journal of the American Academy of Child and Adolescent Psychiatry,* 43(1), 71-79.

Shaffer, D.,Craft, L. (1999) Methods of Suicide Prevention. *Journal of Clinical Psychiatry,* 60 (Suppl. 2): 70-74.

Shaffer, D., Fisher, P., Dulcan, M. K., Davies, M., Piacentini, J., Schwab-Stone, M. E., Lahey, B. B., Bourdon, K., Jensen, P. S., Bird, H. R., Canino, G., & Regier, D. A. (1996). The NIMH Diagnostic Interview Schedule for Children Version 2.3 (DISC-

2.3): Description, acceptability, prevalence rates, and performance in the MECA Study. Methods for the Epidemiology of Child and Adolescent Mental Disorders Study. *Journal of the American Academy of Child and Adolescent Psychiatry,* 35, 865-877.

Shonkoff, J. & Philips, D. (Eds.) *From Neurons to Neighborhoods: The Science of Early Childhood Development.* National Academy Press, 2000, Washington, D.C.

Silverman, Morton M. (no date). Suicide Assessment, Intervention, and Prevention.

Retrieved from www.thedoctorwillseeyounow.com/articles/behavior/suicide 13/.

Skiba, R., Rausch, M.K., Ritter, S. "Children Left Behind: Series Summary and Recommendations," *Education Policy Briefs, 2(4),* Summer *2004, p. 3.*

Stroul, B., and Friedman, R. (1986). *A system of care for children and youth with severe emotional disturbances (rev. ed).* Washington, DC: Georgetown University Child Development Center, National Technical Assistance Center for Children's Mental Health.

U. S. Department of Health and Human Services (HHS). (1999). *Mental Health: A Report of the Surgeon General.* Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Mental Health. http://www.surgeongeneral.gov/library/mentalhealth/home.html.

U. S. Department of Health and Human Services. (2000) *Report of the Surgeon General's conference on children's mental health. A national action agenda.* Retrieved from http://www.hhs.gov/surgeongeneral/topics/cmh/childreport.htm

Walton, B.W., Karikari, I., & Garry, C. (2018). *Indiana system of care development: System of Care Implementation Survey (SOCIS) 2018 overview*. Indianapolis, IN: Indiana University School of Social Work

Weissbourd, R. *The Vulnerable Child: What Really Hurts America's Children and What We Can Do About It. (* Massachusetts, Addison Wesley Publishing Company 1996).

Wright, J., Williams, R., Wilkinson, J. R. (1998). Health Needs Assessment: Development and Importance of Health Needs Assessment. *BMJ,* 316, 1310 - 1313.

ZERO TO THREE. (2004). Infant and Early Childhood Mental Health: Promoting Healthy Social and Emotional Development. Washington DC: ZERO TO THREE Policy Center.

End of Report.