Children's Social, Emotional & Behavioral Health Plan

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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.

An Interagency Task Force was formed with these goals in mind, and includes members from the Department of Education, Department of Child Services, Department of Correction, Division of Mental Health and Addiction – Family and Social Services Administration, Medicaid – Family and Social Services Administration, Indiana State Department of Health, a parent advocate and the Governor's Office. Medicaid/State Children's Health Insurance Program (SCHIP), the Indiana State Department of Health, the parent advocate and the Governor's Office, were not required by legislation but were added to the Interagency Task Force in order to provide a broader perspective.

Indiana's focus on mental health services follows President George W. Bush's 2002 New Freedom Commission on Mental Health (called *the* Commission in this document) which was initiated to address the problems in the current mental health service delivery system. The President directed the Commission members to study the gaps and problems in the mental health system and make recommendations for improvements to be implemented by the federal government, state governments, local agencies, and public and private health care providers.

The 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.

The Commission defined a serious emotional disturbance as "a mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified in the DSM-III-R that results in functional impairment that substantially interferes with or limits one or more major life activities in an individual up to 18 years of age. The landmark Surgeon General's 1999 report on mental health found that nearly 14 million children—one in five—have a diagnosable mental disorder. Half of this group lives with a disorder that is significantly impairing. One in 20, or approximately 5 percent of all children, has serious dysfunction[2]. Serious mental illness is a term defined by

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

[2] Koppelman, J., National Health Policy Forum, Issue Brief No. 799, 2004, page 2.

federal regulations that generally applies to mental disorders which interfere with some area of social functioning. The disorders range from mild to severe, and if left untreated—can be life-limiting or crippling[3]. Yet most of these children, even those with the most severe impairments, do not receive care. For those children who do not receive treatment, the repercussions can significantly impact the rest of their lives: suicide, adverse affects on school performance, impaired relationships and incarceration. In Indiana it is estimated there are 857,854 youth aged 9-17 who have emotional difficulties; of those youth, 31,639 may be eligible for public mental health services (200% of federal poverty level) ; 79% of those youth are currently being served (May, 2006). During the same time period, 6% of youth estimated to be in need of and eligible for public substance abuse treatment were receiving services[4].

Expectations and Outcomes of the Plan

The Children's Social, Emotional, and Behavioral Health Interagency Task force envisions a comprehensive, 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).
- 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) Accountability and Outcome Measurement

- Evaluate the strengths and needs of Indiana's Behavioral Health network across child service agencies.
- Establish of 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.

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

[4] Indiana Division of Mental Health and Addiction, 2005 US Census data.

- 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.
- Strengthen parent education and support services, especially for new and at-risk parents.

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 and lack of availability of services, and stigma associated with mental illness. Barriers to mental health care exist for all children with mental health needs and four out of five children do not receive needed mental health services[5]. Access to mental health services can be so inadequate that in some cases families are driven to place their children in child welfare or juvenile justice systems in order to obtain care for severe mental health needs. 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 and other drugs), family factors (resources, capacity, stresses), and parenting factors (responsiveness, sensitivity, and parental mental health)[6]. 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[7].

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[8]. 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[9].

[5] National Institute for Health Care Management, 2005.
[6] Koppelman, J. National Health Policy Forum, Issue Brief No. 799, 2004.
[7] US Department of Health and Human Services, 1999.
[8] Dunkle & Louis, 2003.
[9] United States Department of Health and Human Services, (2000).

Of all sectors, schools play the largest role in serving youth with mental and emotional disorders, ranging from mild to severe. "For the majority of children who received any mental health care, the education sector was the sole source of care," Burns' 1995 study concluded[10]. 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[11].

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

Research on Barriers in Indiana

Thomas Pavkov led the Indiana System of Care Assessment Project which assessed local systems of care within 92 Indiana counties for children and youth with serious emotional disturbances. Over 1,500 respondents from five different stakeholder groups participated in the study: parent/family member/consumer, education, child welfare, juvenile justice, and mental health. The project survey assessed four areas including "problems encountered" or barriers to service, adequacy of service, quality of service, and system of care performance. Analysis of participants' responses indicated five "barrier" groupings in descending order of concern; barriers related to accessing services through the educational system, barriers related to accessing services in the community, barriers to accessing basic services, barriers accessing restrictive treatment settings, and barriers accessing foster care. Similarly, participants' ratings related to service system performance indicated high levels of concern about system performance issues related to strategic planning and collaboration along with service system performance issues that impede access to services. Based on these and other findings, Pavkov's study suggests policymakers examine the following: systemic barriers encountered by parents in the educational setting and in the community; how state policies effect the provision of services to children with behavioral disorders within the classroom setting; and excessive use of punitive methods—suspensions and expulsions—by schools[13].

Barriers Identified by the Interagency Task Force

In addition to these issues identified by Pavkov's 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.

[10] Koppelman, J. National Health Policy Forum, Issue Brief No. 799, 2004, page 9.
[11] Gilliam, Walter S., The Achiever, 2005.
[12] Koppelman, J. National Health Policy Forum, Issue Brief No. 805, 2005.
[13] Pavkov, 2004.

- 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.
- In Indiana's public mental health system in State Fiscal Year 2005, 5% of all children served were uninsured, 79% were covered by Medicaid, and 16% had some insurance at time of enrollment. The benefits were not tracked.
- Most private insurance has extremely limited mental health coverage and generally does not cover intensive, community-based services.
- The Medicaid reimbursement rate has not increased in 12 years and many private resources refuse Medicaid.
- The public mental health system (DMHA) allocates 10% of its budget for children. 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 reluctant to seek help because of concerns of loss of custody.
- Families are sometimes advised to seek their child's arrest to secure services.
- 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.

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 lack of appropriately trained workforce.
- There is a lack of family respect and support.
- There is a lack of support for children inside and outside the school setting.
- There is a lack of support for 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 Systems of Care (SOC) in Indiana serve only 3% of all the children enrolled in the public mental health system.
- The children's Home and Community-based 1915 9(c) Medicaid waiver served 44 children in SFY2006. The program has difficulty handling a higher volume of children because of a lack of community-based services and match.
- There is limited availability of intensive community based behavioral health services. Case managers often have large caseloads (8-10 cases is ideal).

4) **The stigma associated with mental illness is a barrier.**
   - The child's needs should drive services and not their label. 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.
   - First Steps has 36 mental health providers to serve entire state.
   - 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.
   - There is a lack of knowledge of the numbers of children who experience trauma.
   - There is a lack of training in early childhood social-emotional development among early care and education workers, parents, and health care professionals.

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.[14] 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[15]. 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[16].

The Substance Abuse and Mental Health Services Administration (SAMHSA), US Department of Health and Human Services (DHHS), and the President's New Freedom Commission on Mental Health do not recommend mandatory, universal screening. The State of Indiana understands that parents are the decision-makers in the care for their children, including screening and early identification as well as 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, parents 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

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

[15] Hemmeter, et al, 2003.

[16] Substance Abuse and Mental Health Services Administration (SAMHSA) policy statement, 2005.

designed to identify youth that are at increased risk of having disorders that warrant immediate attention, intervention, or more comprehensive review"[17]. 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[18].

Screening and Assessment in Indiana

Over the past ten 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.

Within the Indiana Division of Mental Health and Addiction, the CAFAS (Hodges, 1994) was replaced by the Hoosier Assurance Plan Instrument for Children (HAPI-C) (Newman, et al., 2003). 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 special Medicaid waiver 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[19]. Upon completion of a two year study, the Indiana Bar Association recommended screening of youth in detention and on probation[20]. The Department of Child Services and juvenile court judges often refer children for assessment to help identify needs and plan appropriate services. Indiana's child welfare system began screening children placed into substitute care or adjudicated CHINS in January 2005. For about 30% of the children, possible mental health needs were identified,

[17] Grisso & Barnum, 2000 & Grisso & Underwood, p. 6, 2004
[18] Mann, et al., 2005; Shaffer, et al., 2004
[19] President's New Freedom Commission on Mental Health, 2003.
[20] Indiana State Bar Association, 2005.

indicating a need for further assessment. Preliminary evaluation of this initiative indicate that children and families already receiving mental health treatment have less disrupted placements and less repeated abuse or neglect[21]. Children whose mental health needs are identified in the screening; however, appear to be at higher risk for disrupted placements. Identifying this need and intervening may reduce the risk.

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.

Current Agency Processes for Assessment

Current processes have been identified and can be found in Appendix B.

Next Steps

The Children's Social, Emotional, and Behavioral Health Plan Interagency Task Force recommends establishing partnerships with existing work groups that are currently working towards the establishment of cross-system assessments in Indiana.

[21] Lawson, et al, 2006.

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.
- **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.
- **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 data base 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[22]. 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.

There is a need 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[23]. 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

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

[23] Hoagwood, K., et al, 1996.

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. For example, DCS has not recorded whether or not an assessment was done for a particular child in an accessible form than can be aggregated.

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[24]. 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.

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.

[24] Bouguettaya, A., et al, no year.

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[25].

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[26].

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[27].

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

[26] Bazelon Center, 2003.

[27] 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, DOE, 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 the reauthorized IDEIA.
- **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.
    - 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, DOE, 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[28].

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[29]. 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

[28] Bazelon Center, 2003.
[29] Bazelon Center, 2003.

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.

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[30].

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[31].

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

[30] National Institute for Health Care Management, 2005.
[31] National Institute for Health Care Management, 2005.

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.

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[32], 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[33]. 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[34].

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[35]. Futhermore, 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[36]. 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[37]. 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

[32] Hoagwood, et al, 1996.
[33] Burns, et al, 1999.
[34] Hoagwood, et al, 2001.
[35] Schoenwald & Hoagwood, 2001.
[36] Newman, Kellett & Beail, 2003.
[37] Effland & McIntyre, 2005.

- 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 base in research and practice based evidence to integrate effective social, emotional, and behavioral health practices in Indiana's child service systems.

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[38]. 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.

[38] Effland & McIntyre, 2005.

    - 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) 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 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.

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[39]. 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[40].

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 process for 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 services.
- **Strategy 5:** Disseminate information and referral procedures of state and local programs serving children with social and emotional concerns and their families to stakeholders.

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

- **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.
- **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) 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 Second Annual Children's Mental Health Awareness Day, to be held May 7, 2007, 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, 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[41]." 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.

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 established specifically to develop the action agenda and oversee its implementation.

This cross-agency team should be charged with (1) development of public service announcements (using multiple types of media) that raise public awareness of the importance of recognizing child development issues including social, emotional, behavioral development; (2) development of general educational materials to primary medical care physicians and hospitals, child serving organizations, educational programs, parent groups, etc. regarding "normal development" and signs of potential need to seek screening or assessment; (3) development of more specific materials about specific disorders or challenges of childhood and where to seek assistance; (4) other materials as required or determined by the cross-agency team.

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

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[42].

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 http://www.doe.state.in.us/standards/welcome.html. 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 http://www.doe.state.in.us/primetime/welcome.html#1.

Beginning a 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[43]. 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[44]. Early childhood is a critical period for the onset of emotional and behavior impairments. President Bush's New Freedom Commission on Mental Health Report, *Achieving the Promise: Transforming Mental Health Care in America* includes a recommendation for early detection of mental health problems[45].

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.

"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

[42] Foster, S., et al, 2005.
[43] Shonkoff & Phillips, 2000.
[44] Zero to Three, Infant and Early Childhood Mental Heatlh, 2004.
[45] President's New Freedom Commission Report, 2003.

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[46]."

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 appropriate social and emotional competencies.
- **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 4-1.5 (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.
    - (b) 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 1 through 6 in the corporation.
      (2) For secondary school educational and career services, one (1) school counselor for every three hundred (300) students enrolled in grades 7 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.
- **Strategy 2:** Encourage policies that make the best use of student service providers, i.e., they should be used for student assistance and not clerical or administrative tasks.
- **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"

[46] 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.

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.
- **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 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, 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 multidisciplinary assessment, intervention teams, PBIS, GEI, and SAP Core Teams.
- **Strategy 12:** Promote opportunities for multi-disciplinary school personnel (e.g., social workers, psychologists and counselors, 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.
- **Strategy 14:** Strengthen partnerships and increase communication so every party

shares in the continuum of care. The school doesn't own the issue; it is a community issue and responsibility.

- **Strategy 15:** 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.

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[47]. Infants can experience real depression as early as 4 months of age[48]. An Illinois study found that 42% of child care programs asked families to withdraw their infants and toddlers because of social-emotional problems[49]. 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[50]. 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[51].

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.

[47] Shonkoff & Phillips, 2000.
[48] Luby, 2000.
[49] Cutler & Gilkerson, 2002.
[50] Heckman & Masterove, 2004.
[51] Weissbourd, 1996.

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[52].

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[53].

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, 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)[54].

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.

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.

[52] Policy Leadership Cadre for Mental Health in Schools, 2001.

[53] Policy Leadership Cadre for Mental Health in Schools, 2001.

[54] Foster, et al,2005.

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[55] 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

The following information includes statistics on the child mental health workforce in Indiana. There is no available data to determine the number of mental health professionals with specific child and adolescent mental health training, these statistics represent the workforce for mental health overall.

Psychiatrists

Indiana physicians were surveyed in 2001 to determine specialty areas and other information. The survey was mailed to physicians as part of the license renewal process and there was a 91.8 % response (21,065 of 22,954 license renewals). The full Databook may be accessed at www.in.gov/isdh/publications.

- 465 listed their specialty as "**Psychiatry**" (This is consistent with the Indiana Psychiatric Society Web Page which indicates their membership is "over 400").
- A 16.8% increase over the 398 in the 1997 Survey
- 452 practiced in urban counties (97.2%)
- 24 (8.8%) are African-American and 20 (4.6%) are Hispanic.
- One-third is over 55.

  Source: Indiana Physician Survey Databook, 2001

  Indiana Health Care Professional Development Commission

Psychologists

- Statewide total – 1,580*
- 357 (32%) practice in the Indianapolis metro area
- 27% (304) practice in 2 counties (Marion and Hamilton)

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

- 15 counties have only one licensed psychologist and 9 counties have only 2.

Clinical Social Workers

- Statewide total – 3,626*
- 1,217 (39%) practice in Indianapolis metro area
- 31% (964) practice in 2 counties (Marion and Hamilton)
- 793 (25%) practice in 5 other counties (Allen, Lake, Monroe, St. Joseph, & Vanderburgh)
- 4 counties have only 1 clinical social worker and 5 counties have only 2.

Mental Health Counselors

- Statewide total – 1,461*
- 417 (32%) practice in the Indianapolis metro area.
- 27% (360) practice in 2 counties (Marion 18% and Allen 9%)
- 7 counties have only 1 licensed mental health counselor and 14 counties have only 2

  *as of Jan.30, 2006; percentages based on Sept., 2005 data

Marriage and Family Therapists

- Statewide total: 1,043

  Source: Indiana Professional Licensing Agency (Data as of 9/6/2005)

Health Professional Shortage Areas

- Eighteen (18) counties have been designated as Medically Underserved Areas
- Thirty-two (32) additional counties have designated geographic or facility Medically Underserved Areas within the county.
- Nineteen (19) counties have been designated as Mental Health Professional Shortage Areas.
- Twenty-three (23) counties have been designated as Primary Care Health Professional Shortage Areas.
- Eight (8) additional counties have designated geographic or facility Primary Care Health Professional Shortage Areas within the county.
- Sixty-four (64) of Indiana's 92 counties have one or more of the designated Health Professional Shortage Areas.

  Source: Indiana State Department of Health (Data as of April, 2005)

National comparisons

- In 2000 there were 6.9 psychiatrist, 33.0 psychologists and 167.6 social workers per 100,000 Indiana residents.
- In 2000 Indiana ranked 43rd among states in psychiatrist per capita, 26th for psychologists and 24th in social workers per capita.

  Source: U.S. Dept. of Health and Human Services, Health Resources and Services Administration

Please refer to Appendix C for the Indiana Mental Health Professional Shortage Areas (MHPSAs) and Number of Professional Licenses by Family and Social Services Administration (FSSA) Regions.

Indiana Specific Issues

A federal Children's Mental Health Care Relief Act (S537/HR1106) has been 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, 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.

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, as well as 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, 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 and 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[56]. 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[57].

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[58].

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[59].

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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[56] Huang, L., et al, 2004.
[57] Huang, L., et al, 2004.
[58] Huang, L., et al, 2004.
[59] 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.

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 a 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.
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 Masters 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 7 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 4 units per month, or more than 2 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 4 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: www.in.gov/fssa/servicedisabl/medicaid/

Medicaid School Based Services
Agency: FSSA
Ages served: ages 3-22
Mission: Medicaid reimburses Medicaid-enrolled Indiana public school corporations for some health care services provided to individuals who are enrolled in Medicaid and who are eligible for special education. The services reimbursed are those health-related 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 for reimbursement for certain psychological services necessary for the development of the Student's IEP or active treatments with the intent to reasonably improve the student's physical or mental condition. Mental health services must be provided by a Type 73 School Psychologist or a Psychologist Intern with Indiana State Board of Education (ISBE) approval.
Funding: The School Based Health Services Program allows Local Education Agencies (LEAs) to enroll as Medicaid providers and to claim federal reimbursement for certain health services provided to eligible special education students. Reimbursement for Indiana Medicaid services comes partially from federal funds, approximately 63% in Indiana last year, and partially from state funds, approximately 37 percent in Indiana last year. The 37 percent Indiana state matching funds come from a variety of sources including the budgets of various state and local public entities. Indiana schools that participate in Medicaid receive 100 percent of the Medicaid reimbursement (the federal and state share).
For more information:
www.doe.state.in.us/exceptional/speced/pdf/IndianaMedicaidSchool-BasedServices71405.pdf

Children's Mental Health Services

Division of Mental Health and Addiction (DHMA)
Agency: FSSA
Ages served: all ages
Mission: DHMA ensures that Indiana citizens have access to appropriate mental health and addiction services that promote individual self-sufficiency. DHMA provides funding support for mental health and addiction services to target populations with financial need through a network of managed care providers. DHMA operates six state hospitals and partners with Indiana's Community Mental Health Centers to provide treatment in communities across Indiana.
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: www.in.gov/fssa/servicemental/aboutdmha.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 provides services to help strengthen the ability of families to succeed in their communities by promoting self-sufficiency, independence, prevention, health and safety. FSSA major programs are the following: health care (Hoosier Healthwise); prevention and early intervention services; Temporary Assistance for Needy Families (TANF); food stamps; housing and community services for low-income families; community and regional planning; child development services; community-based services for seniors and people with disabilities; treatment of mental illness or addiction; vocational rehabilitation; blind and visually impaired; deaf and hard of hearing services. The agency has four main divisions: Division of Family Resources; Division of Mental Health and Addiction; Division of Disability and Rehabilitative Services; Office of Medicaid Policy and Planning.
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: Budget of $6.3 billion annually (state, federal and local dollars)
For more information: www.in.gov/fssa/

Hoosier Assurance Plan (HAP)
Agency: Division of Mental Health and Addiction (DHMA) – FSSA
Ages served: Children and adolescents with serious emotional disturbances and persons of all ages with chronic addictive disorders including alcohol, drugs, and gambling.
Mission: Hoosier Assurance Plan (HAP) is the primary funding system used by the Family & Social Services Administration's (FSSA) Division of Mental Health and Addictions (DMHA) to pay for mental health and addiction services.
Specific covered mental health services include: DHMA contracts with managed care providers who provide an array of care for individuals who meet diagnostic, functioning level and income criteria. The managed care providers provide one year of care at the most appropriate levels to all enrollees. Service providers (the general name given to the organizations who provide services funded by HAP) specialize in working with adults; children and adolescents; persons with a drug or alcohol or gambling problem.
Funding: Federal and state funding
For more information: www.in.gov/fssa/shape/hap.html

Indiana Department of Child Services (DCS)
Ages served: Children and families
Mission: The mission of the department is to protect children from abuse and neglect by partnering with families and communities to provide safe, nurturing, and stable homes.
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 legislature authorized the hiring of 400 new child protection case managers as well as additional training. The department is undergoing major changes that will take place over the next five years. On July 5, 2005 the first group of new family case managers will begin training under new standards.
Some of the successes in the first months of the department include a centralized hiring process, regionalization, new training programs, new standards for family case managers, and improved centralized payment processing for child support. The department is temporarily located in Indiana Government Center South at 402 West Washington Street, Room W392.
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.
Funding: State, federal and local.
For more information: www.in.gov/dcs/ or the Child Support Hotline 800-840-8757

Indiana Department of Correction (IDOC)

Mental Health Services/Juvenile Facilities
Intake: Indianapolis (girls); Logansport (boys)
Residential Facilities: Indianapolis; Pendleton; North Central; South Bend; Northeast; Camp Summit
Agency: Indiana Department of Correction
Ages served: 12-18 (committed students can be kept until age 21 if necessary)
Mission: All students arriving at an intake unit (Indianapolis 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 a trained master's level clinician. 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:
During a student's stay with DOC, line level treatment is provided by master's level clinicians. 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 psychologist is the gatekeeper for referrals to the psychiatrist. Treatment is provided by psychologist and psychiatrist as needed. Medications used as needed.
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) Residential Facility
    a. Treatment plans
    b. Team reviews
    c. Referral for services
    d. Medication/follow-up
    e. Transition to community
4) Aftercare
    a. Referrals to community providers
    b. Monitoring and adjustments
    c. Discharge from supervision

Funding: $624 million general state funds; an additional $30 million in grant funds.
For more information: www.in.gov/indcorrection/

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: http://www.doe.state.in.us/alted/welcome.html

Special Education
Division of Exceptional Learners
Agency: Indiana Department of Education
Ages served: 3-21
Mission: Special education and related services are provided to students identified in accordance with Article 7 as having a disability 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, and designed to meet the unique needs of a student who has been determined eligible for special education services. Related services are services, such as physical therapy, counseling, or transportation, that are designed to supplement the student's instructional program and are necessary for the student to benefit from special education. Article 7 is based on the federal Individuals with Disabilities Education Act (IDEA '97) and the federal regulations. It is made up of 15 rules describing how special education and related services are to be determined and provided by Indiana's public schools. Rule 26 lists the eligibility categories and the criteria for each category. The eligibility categories for special education and related services include: autism spectrum disorder; communication disorder; deaf-blind; developmental delay (early childhood); emotional disability; hearing impairment; learning disability; mental disability; multiple disabilities; orthopedic impairment; other health impairment; traumatic brain injury; visual impairment.
Specific covered mental health services include: Article 7 defines emotional disability eligibility criteria as a condition that over a long period of time and to a marked degree consistently interferes with the student's educational performance. An emotional disability may include 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; and inappropriate behaviors or feelings under normal circumstances (511 IAC 7-26-6(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.
Funding: State Adjusted Pupil Count (APC) for Emotionally Handicap (EH) and Learning Disabled (LD) Students Based Upon the 12/01/04 Child Count: EH-Full-time (EH-FT) Amount Generated $57,886,920; EH-AO (part-time/other) Amount Generated $15,867,420; LD Amount Generated $140,564,304.
Average Funding for EH and LD Students Based Upon the 12/01/04 Child Count Multiplied by the FY 2005 "Average Per Child Amount": EH-FT Amount Generated $8,788,505.79; EH-AO Amount Generated $8,858,404.43; LD Amount Generated $78,504,910.05.
The "State average per child amount" is based upon the estimated FY 2006 total Part B Pass-Through grant awards ($218,688,520) divided by the 12/01-04 Federal child count (175,205). The "State average per child amount" for the 2005-2006 school year is $1,248.19.
For more information: http://doe.state.in.us/exceptional/welcome.html

Division of Exceptional Learners Gifted and Talented Program
Agency: Indiana Department of Education
Specific covered mental health services: DEL provides funding for training opportunities in the social and emotional needs of gifted students as well as funding for two "Shared Information Services Centers" or lending libraries, which house materials on the social and emotional needs as well as the counseling gifted and talented students. The gifted and talented grant application requires a guidance and counseling plan under 511 IAC 6-9.1-2(c)(3).
Funding: $5,836,337 for 2005-06 and $5,836,340 for 2006-2007. Approximately $4.8 million is distributed to the schools through grants for their school programming.
For more information: http://doe.state.in.us/exceptional/gt/welcome.html

Services for Infants and Toddlers with a Disability or Developmental Delay

Early Identification and Intervention
Agency: FSSA - Division of Mental Health and Addiction and Division of Families and Children
Mission: To improve the well being of children in the child welfare system by routine, early identification and effective intervention for mental health and addiction needs. All children placed in substitute care will be routinely screened by child welfare Family Case Managers, and, if need is indicated, referred for further assessment and recommendations from a mental health professions. Recommendations will inform care planning and lead to timely, effective interventions.
Specific covered mental health services include: Indiana is implementing routine mental health and addiction screening, assessment, and intervention for children who are placed in substitute care or who become CHINS through the child welfare system. Children identified on the screen as possibly having mental health or addiction issues, are then referred to a master's level qualified mental health professional for assessment and intervention recommendations. Assessments are used in developing individualized services to meet the needs of children and families.
Funding: Federal funding from Substance Abuse and Mental Health Administration $3 million, Indiana State general budge $14 million, Medicaid covers some mental health services.
For more information: www.state.in.us/fssa/dmha

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: http://www.state.in.us/fssa/first_step/index.html or toll free 800-441-7837

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 Children's Special Health Care Services
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 with special health care needs, low-income populations, those with poor nutritional status and those who do not have access to health care. MCSHC provides preventative and primary care for children through 13 infant health projects, 15 grants to agencies that provide direct and enabling services to children and 6 adolescent health care programs.
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. The MCSHC mission is to improve the health status of families in Indiana and to ensure that all children within the context of their family and culture will achieve and maintain the highest level of physical, mental, and emotional health in order to realize their human potential to the fullest. The goal of MCH is to make services available to all residents of Indiana.
Specific covered mental health services include: Local grantees provide preventive, primary health care, and family planning services and/or prenatal and family care coordination to women of childbearing age, pregnant women, infants, children, adolescents, and children with special health care needs depending on what the local communities determine to be their need. Preventive and primary health services include developmental screening, referral for chronic health problems, counseling, psychosocial assessment and intervention. Parenting education is a major focus of MCSHC child health providers.
Funding: The Maternal and Child Health Bureau's Title V Maternal and Child Health Block Grant provide partial funding for 34 projects serving approximately 154,000 infants and children.
For more information: http://www.in.gov/isdh/programs/mch/index.htm

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 3rd party payers has established financially solvent centers that provide quality health care services.
For more information: http://www.in.gov/isdh/programs/community/index.htm

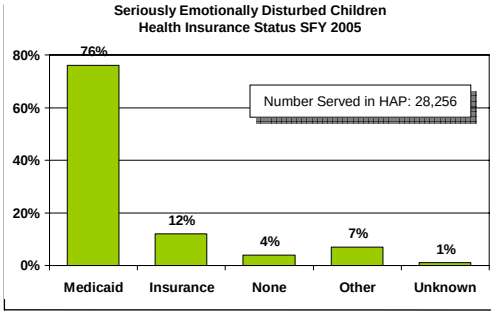
Women Infants Children (WIC)
Agency: Indiana State Department of Health
Ages served: Pregnant women, infants, children to age 5
Mission: The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) was established through the Child Nutrition Act of 1966.
Specific covered mental health 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 FY2004 were: $20,734,705 for Administrative Dollars and $50,372,411 in food dollars. WIC's annual budget totals $100,000,000 with additional infrastructure grant monies awarded for special projects.
For more information: www.in.gov/isdh/programs/wic/wicone.htm

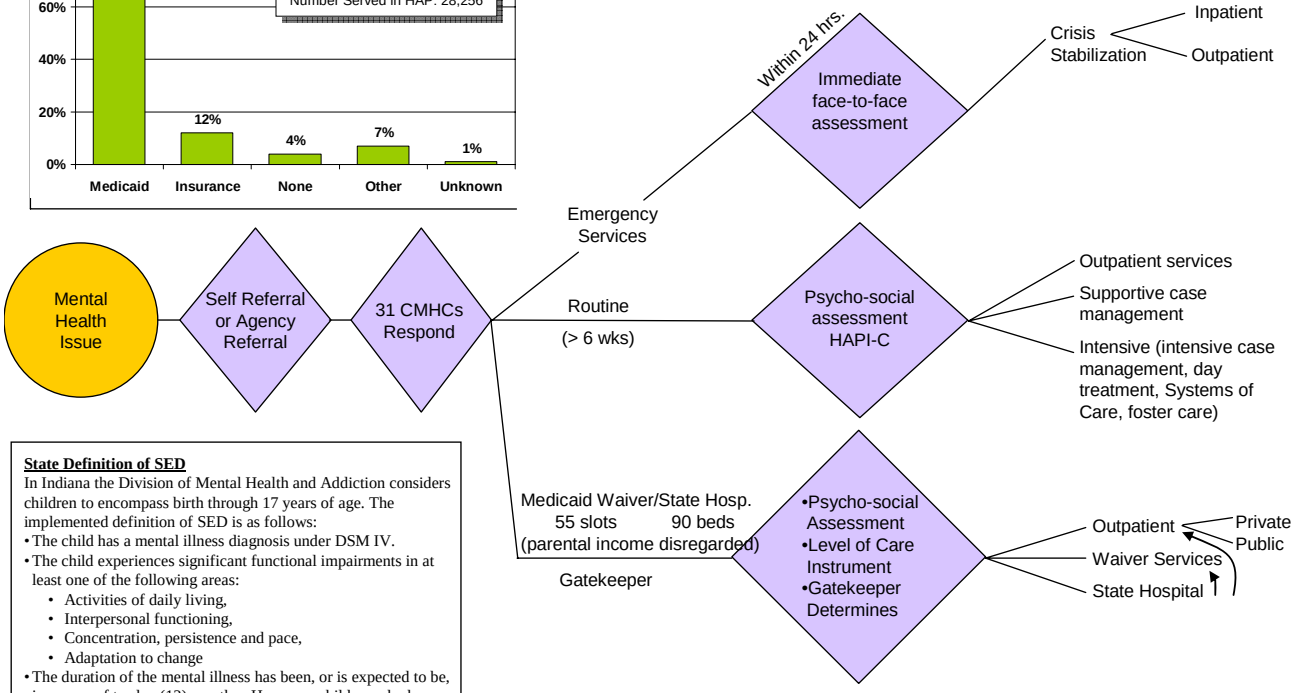
Indiana Family Helpline (1-800-433-0746)
Agency: Indiana State Department of Health
Ages served: Indiana families
Mission: On May 2, 1988, the Indiana State Department of Health, Maternal and Child Health Services, launched a statewide comprehensive Indiana Family Helpline. During fiscal year 2004, the 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 thorough 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: **http://www.in.gov/isdh/programs/mch/ifh.htm**

Appendix B: Current Agency Processes for Assessment

FSSA/Division of Mental Health and Addiction

Accessing Services Through the Hoosier Assurance Plan (HAP)
Children With Serious Emotional Disturbance
FSSA/Division of Mental Health and Addiction





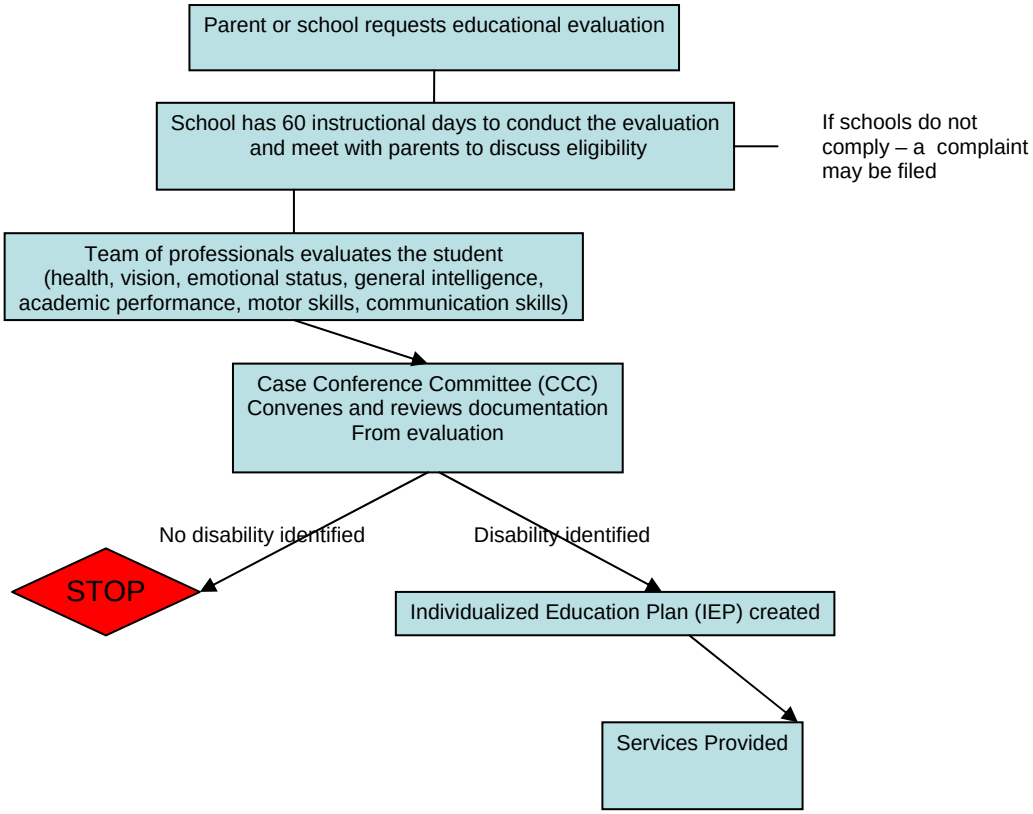
State Definition of SED

In Indiana the Division of Mental Health and Addiction considers children to encompass birth through 17 years of age. The implemented definition of SED is as follows:

- The child has a mental illness diagnosis under DSM IV.
- The child experiences significant functional impairments in at least one of the following areas:
  - Activities of daily living,
  - Interpersonal functioning,
  - Concentration, persistence and pace,
  - Adaptation to change
- The duration of the mental illness has been, or is expected to be, in excess of twelve (12) months. However, children who have experienced a situational trauma, and who are receiving services in two or more community agencies, do not have to meet the duration requirement of this clause.

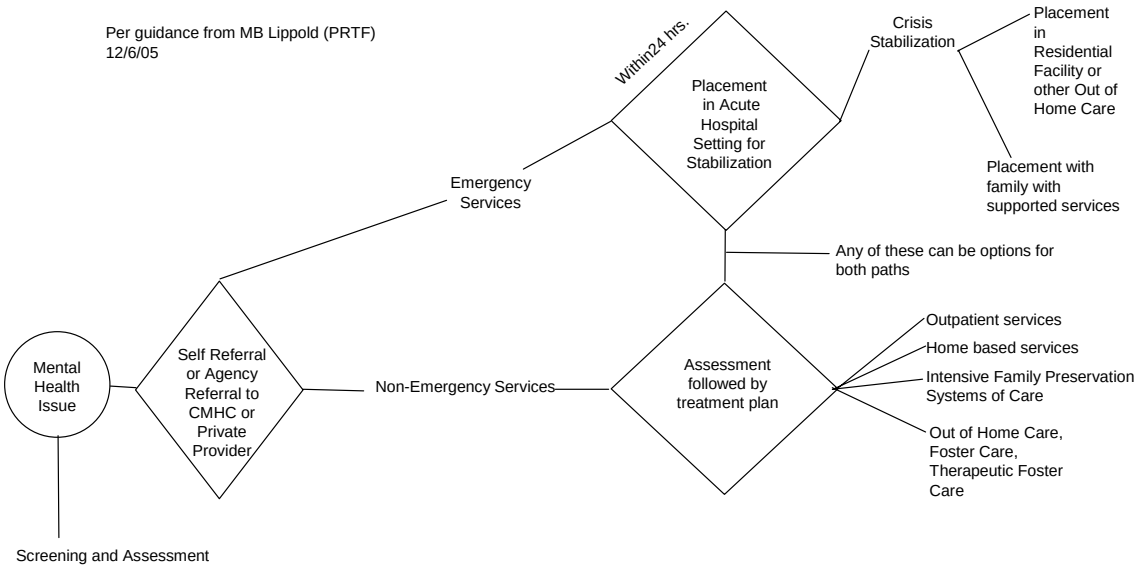
Department of Education, Division of Exceptional Learners

Accessing Services Through the Department of Education

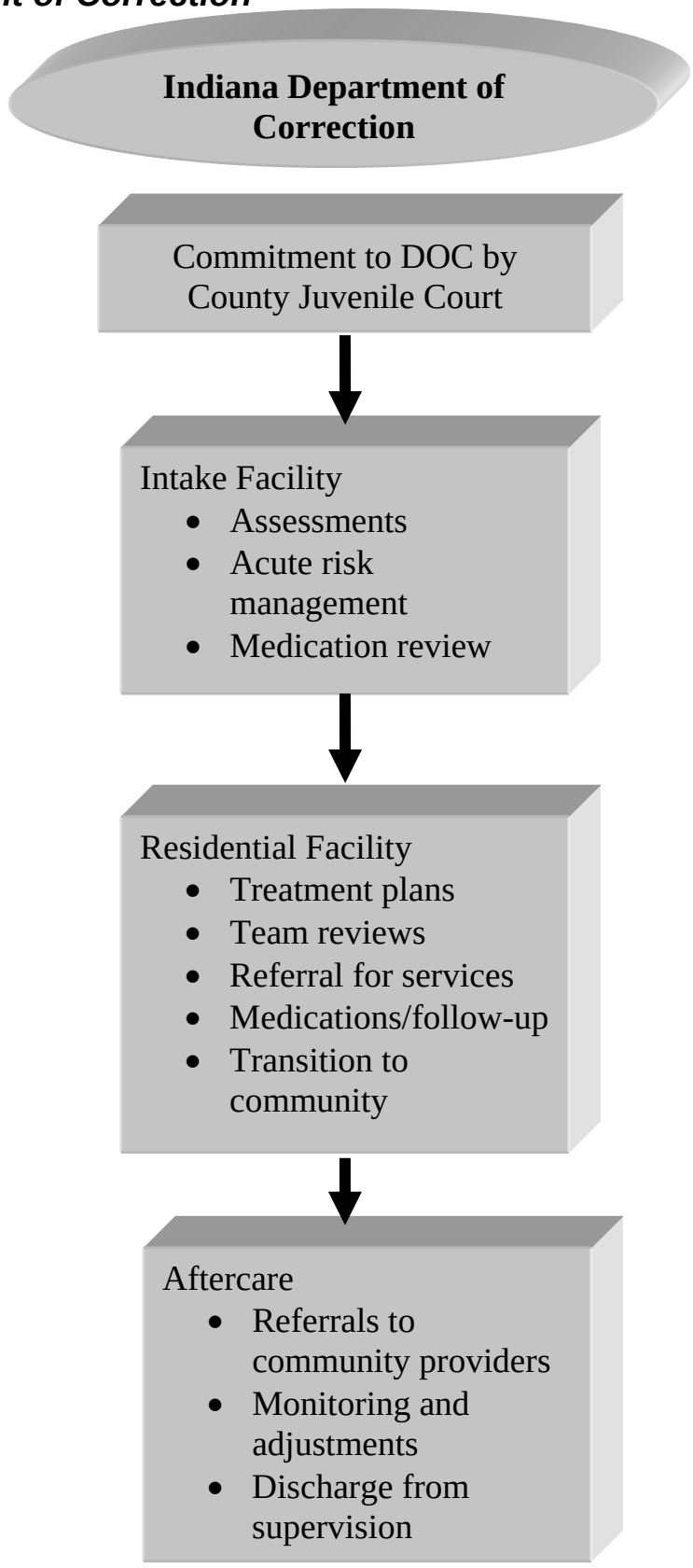


Department of Child Services

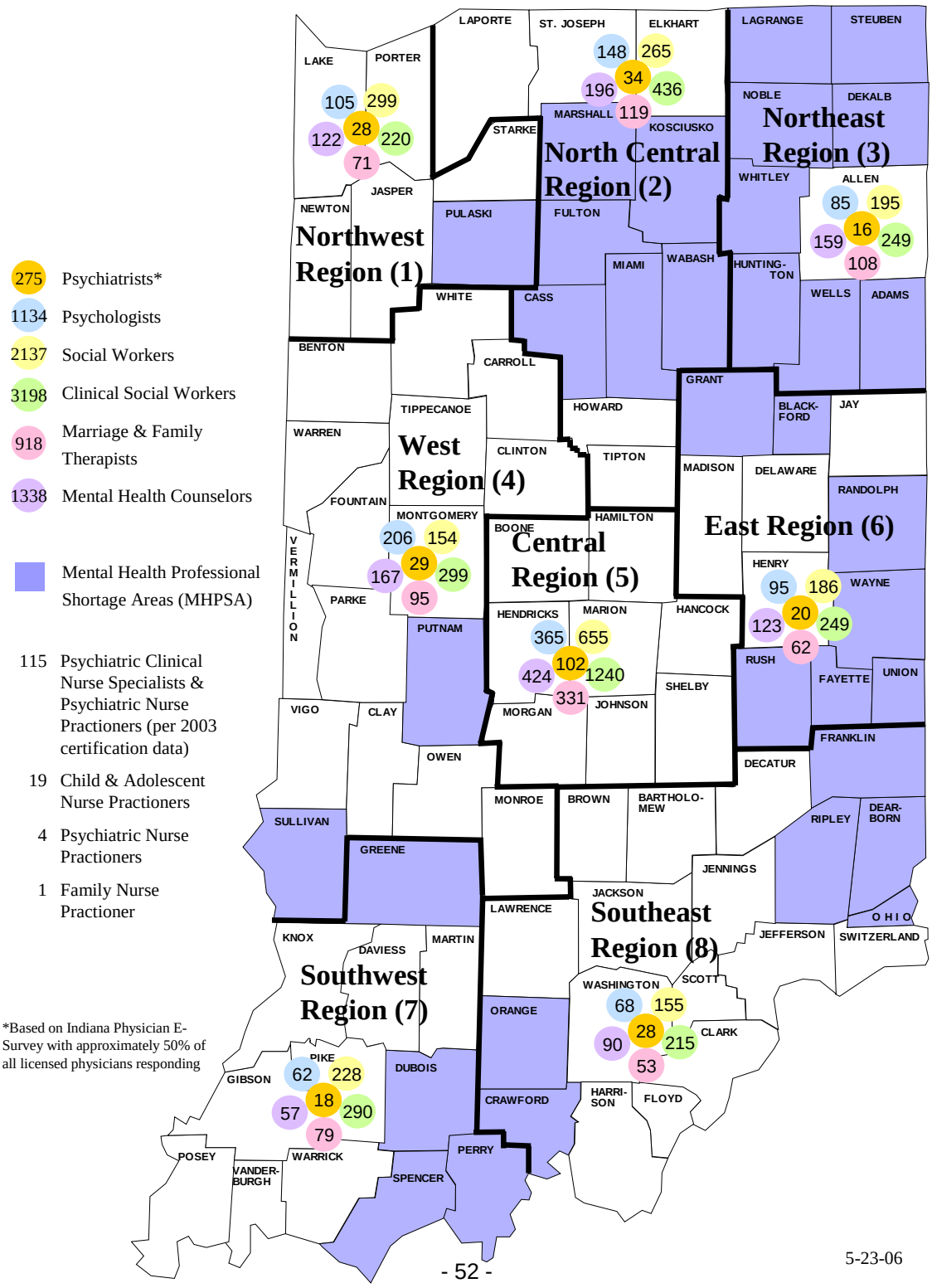
Accessing Services
Division of Child Services (DCS)



Department of Correction



Appendix C: Mental Health Professional Shortage Areas (MHPSAs) and Number of Professional Licenses by Family and Social Services Administration (FSSA) Regions



5-23-06

Appendix D: Areas of Concern in Indiana Based on Public Comment

Note: There are several areas of concern in Indiana listed in this plan including suicide, incarceration and 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) 2004 Annual Fatality Report" states that there were 57 abuse and neglect fatalities substantiated in SFY 2004, which reflects an increase of 6 deaths (12%) from SFY 2003 which reported 51 substantiated fatalities. Of the 57 fatalities, 22 (39%) were due to abuse and 35 (61%) were due to neglect[60].

Over the last five years, over one child per week has died due to child maltreatment in Indiana[61].

The Child Abuse and Neglect Summary by County SFY 2003 reports the number of children with substantiated abuse at 8,060, 4,440 of whom were victims of sexual abuse and 3,620 of whom were victims of physical abuse. 12,308 children were reported to be victims of substantiated neglect[62].

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[63].

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[64]. One of the most distressing and preventable consequences of undiagnosed, untreated or under-treated mental illnesses is suicide.

In the U.S., suicide claims approximately 30,000 lives each year. Overall, suicide was the 11th leading cause of death among Americans in 2000. In 1999, more than 152,000 hospital admissions and more than 700,000 visits to hospital emergency rooms were for self-harming behaviors. The vast majority of all people who die by suicide have a mental illness, often

[60] Indiana Department of Child Services, 2005.
[61] Indiana Division of Family and Children, 2002.
[62] Indiana Family and Social Services Administration, 2003.
[63] Prevent Child Abuse Indiana, 2006.
[64] Presidents New Freedom Commission, 2003.

undiagnosed or untreated[65]. Suicide was also the fourth leading 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 in 1999. The rate of teen suicide (for those from ages 15 to 19) has tripled since the 1950s[66]. According to the Indiana State Department of Health, suicide is the third leading cause of death for young people in **Indiana** ages 12 to 22, third only after accidents and homicide. 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)[67].

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., guns), media education on proper reporting of suicides, postvention (helping survivors after a loss due to suicide) and crisis intervention[68]. 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[69].

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[70].

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[71] 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[72]. Screening instruments for teen suicide prevention should be evaluated to assess the advantages and risks of broader use in Indiana.

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[65] President's New Freedom Commission on Mental Health, 2003.
[66] President's New Freedom Commission on Mental Health, 2003.
[67] Indiana State Department of Health Youth Risk Behavior Survey, 2005.
[68] Silverman, no date.
[69] American Association of Suicidology, 1999.
[70] Carpenter, 2006.
[71] Shaffer, D. and Craft, L., 1999.
[72] Shaffer, D., Gould, M., et. al., 1996.

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.

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[73].

The National Center for Mental Health and Juvenile Justice (http://www.ncmhjj.com/faqs/default.asp) identifies six key issues.

1. There is a growing awareness of mental health disorders among youth in the general population. About 20% of the children and adolescents are experiencing a mental disorder; about 10% experience mental illness severe enough to cause impairment at home, in school, and in the community; but less than half receive the treatment they need.
2. The prevalence of mental disorder among youth in the juvenile justice system is two to three times higher than in the general population. Developing research indicates that anywhere from 70% to 100% of youth in the juvenile justice system are believed to have a diagnosable mental health disorder (Teplin et al, 2002; Otto et al., 1992; Virginia Policy Design Team, 1994; Wierson, Forehand and Frame, 1992). About 20 percent of youth in the juvenile justice system have a serious mental disorder. More than half of youth in the juvenile justice systems have co-occurring substance abuse needs[74].
3. There is an increasing awareness and crisis surrounding the care and treatment of youth with mental disorders in the juvenile justice system nationally and in Indiana (Bar Association, 2006). Over the last ten years, attention is being given to the behavioral health needs of this population have been neglected for a long time. Both the juvenile justice and mental health systems are concerned about the criminalization of mental illness. Investigations into the conditions of confinement of youth in juvenile detention and correctional facilities across the county consistently highlight the lack of appropriate screening, assessment and treatment for youth, the sometimes inappropriate use of medication and inappropriate responses to suicide threats (DOJ, 2003).
4. A number of factors contribute to the sense of crisis regarding unmet behavioral health needs of youth in juvenile justice. There appears to be increasing number of youth with mental health disorders entering the criminal justice system. Many are incarcerated for minor, non-violent offenses. Some wonder if the system is becoming a last resort for many youth.
5. In spite of these challenges, there are signs of improvement: the availability of new and effective tools and services. Screening and assessment tools, specifically designed for youth in juvenile justice identify needs. Such screening tools are being used in 45 states and across the juvenile justice system in 28 states. Structured assessments are used in 15 states. Experts in both the mental health and correction systems believe many children with mental disorders would be better served in the community with a range of therapies and family supports[75]. Promising and evidence based practices offer hope and have documented effective positive outcomes for youth and their families.

[73] Koppelman, 2005.
[74] National Mental Health Association, 2001.
[75] Koppelman, 2005.

6. Although much is happening, more needs to happen. Policy makers need to understand the importance of this issue. Diversion programs are needed for youth who commit minor offenses. We need to push for effective community-based treatment options. Behavioral health screening is recommended for youth entering the juvenile justice system, and further evaluation, when needed. Treatment services need to be improved for youth in secure facilities. Re-entry programs for youth transitioning out of residential care need to be strengthened.

Suspension and Expulsion

Indiana ranks first in the nation in its rate of school expulsions[76] and ninth in out-of-school suspensions[77] according to the latest available statistics from the U.S. Department of Education.[78] According to the Indianapolis Star, 28% of Indiana's students dropout of high school[79]. While schools must ensure safe school climates and strive towards this goal, Indiana's Child Left Behind project has found that expulsion and out-of-school suspensions do not contribute to this goal[80] nor change student behavior.[81]

The Center for Evaluation and Education Policy (CEEP) at Indiana University Bloomington and the Indiana Youth Services Association formed the Children Left Behind (CLB) project in 2004 to document the use and effects of school exclusion on students in Indiana's schools, and to create a meaningful dialogue between educators, juvenile justice professionals, policymakers and community members on the most effective methods of school discipline. Key findings of the CLB project include the following[82]:

- Nationally, higher rates of out-of-school suspensions are associated with lower achievement, higher dropout rates, and poorer school climate. The impact of serious emotional disturbances (SEDs) on learning is well documented. Children with SEDs have the highest rate of school failure; only about 42 percent of these students graduate from high school, compared with 57 percent of all students with disabilities[83]. Indiana's dropout rate for high school is 28%, 48% for African American students and 47% for Hispanic students[84]. Nationally, 80% of prisoners are dropouts, 45% of homeless young adults are dropouts, 50% of heads of households on welfare are dropouts, and 40% of dropouts are not accounted for in US wage labor survey[85].
- Indiana schools that have higher rates of out-of-school suspensions have lower passing scores on ISTEP, the state's standardized test of achievement.
- There is evidence of minority overrepresentation in both expulsion and suspension.
- Alternatives to out-of-school suspensions and expulsions are available. Principals of Indiana are using various innovative disciplinary strategies to maintain school discipline and maximize educational opportunities.

It is also important to note that in recent years there has been an increase in the number of expelled students in pre-kindergarten. In a national pre-kindergarten study, pre-kindergarten students were expelled at a rate more than three times that of their older peers in the K-12

[76] IC 20-33-8-3 defines expulsion as a disciplinary or other action whereby a student is separated from school attendance for a period exceeding ten days.
[77] IC 20-33-8-7 defines suspensions as any disciplinary action that does not constitute an expulsion, where a student is separated from school for a period not more than ten school days.
[78] James, T. 2006.
[79] Indianapolis Star, May 14, 2006.
[80] James, T. 2006.
[81] Skiba, R., Rausch, M.K., & Ritter. S., Education Policy Brief 2(3) Summer 2004, p. 6.
[82] James, T. 2006.
[83] US Department of Education, 2001.
[84] Toppo, et al, 2006.
[85] Indianapolis Star, May 14, 2006.

grades. Rates of expulsion varied widely among the 40 states funding pre-kindergarten (Indiana does not fund pre-kindergarten programs). In addition, pre-kindergarten expulsion rates vary by classroom setting. In spite of these statistics, studies have shown that the likelihood of expulsion decreases significantly with access to classroom-based behavioral consultation[86].

An examination of Indiana's data on suspension and expulsion revealed that the majority of student suspensions are in categories which do not represent the most serious infractions; over 90% of out-of-school suspensions were accounted for by infractions in the categories of "Disruptive Behavior" and "Other." A very small percentage of suspensions and even expulsions in Indiana occur because of the most serious infractions—e.g., weapons and drugs.[87] The increasing tendency to criminalize school behavior is associated with increased school dropout, higher levels of incarceration, and minority overrepresentation in juvenile detention.[88] Many communities are coming to the realization that suspension and expulsion simply shift the location of the problem—from disruptions in the school to crime in the streets.[89]

The CLB project data indicates substantial racial disparities in the use of out-of-school suspensions and expulsions in the state, particularly among African American students. African American students are four times as likely to receive out-of-school suspension and about two and a half times as likely to be expelled as white students. Previous studies have found no evidence that such disproportionality is due to higher rates of misbehavior by minority students—if anything, African American students appear more likely to be suspended and expelled for more subjective and minor infractions. The data also revealed evidence of disproportionate suspensions and expulsions for Hispanic students. This finding is especially noteworthy, since this population is the fastest growing subgroup nationally and in Indiana. Together these data yield the disturbing conclusion that some racial/ethnic groups in Indiana are being subjected at a higher rate to school consequences that remove them from the opportunity to learn.[90]

In this age of accountability in our nation and state, it has become an accepted fact of school life to evaluate school practices in terms of their impact on student achievement. Thus it is noteworthy that statewide data shows that those schools with the highest rates of out-of-school suspension have lower passing rates on ISTEP than those with the lowest rates of suspension. The data cannot be explained as a function of high or low poverty—the negative relationship between a school's use of suspension and its average ISTEP scores continues to hold when poverty, race, and a number of other demographic variables are controlled. Regardless of school demographics, schools with higher ratios of out-of-school suspension have lower average passing scores on ISTEP.[91]

The Children Left Behind series made the following recommendations for effective approaches to maintaining safety and discipline, and especially for increasing available options that address issues of student behavior:

1. Reserve zero tolerance disciplinary removals for only the most serious and severe of disruptive behaviors, and explicitly define those behaviors.
2. Replace one-size-fits-all disciplinary strategies with graduated systems of discipline; scale consequences to the seriousness of the infraction.
3. Improve data collection strategies on school discipline at the state level; assist local educators in using disciplinary data to address their school's safety and disciplinary needs.

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[86] Gilliam, W. S. 2005.
[87] Wald, J. & Losen, D. 2003 & Rausch, M.K., Skiba, R. 2004, page. 6.
[88] Skiba, R., Rausch, M.K., Ritter, S. Education Policy Briefs, 2(4), Summer 2004, p. 3.
[89] Skiba, R., Rausch, M.K., Ritter, S. Education Policy Briefs, 2(4), Summer 2004, p. 3.
[90] Rausch, M.K. & Skiba, R., 2004.
[91] Rausch, M.K. & Skiba, R., 2004.

4. Improve collaboration and communication among schools, parents, juvenile justice, and mental health to develop an array of alternatives for challenging youth.
5. Implement preventive measures that can improve school climate and reconnect alienated students.
6. Expand the array of options available to schools for dealing with disruptive or violent behavior. In particular, ensure that teachers receive training in classroom management strategies that provide them with the tools they need for handling misbehavior at the classroom level.
7. Evaluate all school discipline or school violence prevention strategies to ensure that all disciplinary interventions, programs, or strategies are truly effective.
8. Provide teacher training programs to provide pre-service teachers the tools they need to address student misbehavior at the classroom level.

Sections of this plan list recommendations that are related to the reduction of suspensions and expulsions such as a tiered plan to address general and individualized behavioral management issues and an assessment to inform individualized plans. Please refer to the sections on assessment and school learning standards for more information.

Appendix E: 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 that protect 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 F: 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.

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[92] and American Psychological Association[93]. Additionally, states, such as Hawaii[94], 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[96] [97]
- Applying implementation research[98]
- Measuring fidelity
- Tracking outcomes
- Using data for quality improvement

FAPE (Free Appropriate Public Education) – Special education and related services that must meet state standards provided to student with disabilities without charge.

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.

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 and other contracted providers, as well as 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

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[92] Institute of Medicine, 2001.
[93] Chambless, D L., et al. 1998.
[94] Evidence Based Services Committee, 2004.
[95] Godbole, A., et al, 2005.
[96] Prochaska, J. O., et al, 1994.
[97] Rogers, E. M., 2003.
[98] Fixsen, D. L., et al, 2005.

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 – This comprehensive spectrum of services 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 programs with new counties being added yearly.

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[99]." 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.

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

Appendix G: Task Force Members

FIRST NAME	LAST NAME	ORGANIZATION
Ann	Alley	Medicaid
Cathy	Boggs	FSSA/Division of Mental Health and Addiction
Jennifer	Campbell	Dept. of Education/Division of Exceptional Learners
Sheron	Cochran	Dept. of Education/Division of Exceptional Learners
Judith	Ganser	Indiana State Department of Health
Dee	Kempson	Dept. of Education/Student Services
Mary Beth	Lippold	Dept. of Child Services
Bob	Marra	Dept. of Education/Division of Exceptional Learners
Kevin	Moore	Department of Corrections
Jim	Payne	Dept. of Child Services
Bob	Postlethwait	Family Representative
Kristen	Schunk	Dept. of Education/Division of Exceptional Learners
Cheryl	Shearer	FSSA/Division of Mental Health and Addiction
Scott	Tittle	Governor's Office
David	Uberto	Department of Corrections
Jerry	Vance	Department of Corrections
Andrea	Wilkes	Indiana State Department of Health
Gina	Woodward	Dept. of Education/Student Services

Appendix H: 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.

Appendix I: Schedule of Public Forums

DATE	LOCATION
Wednesday, November 16, 2006	Indiana Government Center South Auditorium 402 W. Washington Street Indianapolis, IN 46204 Phone (317) 233-3117
Saturday, March 25, 2006	Lake County Public Library 1919 W. 81st Avenue Merrillville, IN 46410 (Rooms A&C) Phone 219.769.3541 Hosted by the Family Action Network of Lake County, IN, Inc.
Tuesday, April 25, 2006	Columbus City Hall, Meeting Hall, 1st floor 123 Washington St. Columbus, IN 47201 Phone: 812.376.2500 Hosted by the Bartholomew System of Care Family Support Group

Plan Endnotes

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End of Report.