

Child Protection Accountability Commission

MENTAL AND BEHAVIORAL HEALTH SERVICES TO CHILDREN IN AND ADOPTED OUT OF FOSTER CARE¹ SUBCOMMITTEE

FINAL REPORT

November 21, 2008

¹ Throughout this report, the term “foster care” refers to the legal custody of the Department of Services for Children, Youth, and Their Families over any child who has been found to be abused, dependent, or neglected.

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Preface

On behalf of the Mental and Behavioral Health Services to Children In and Adopted out of Foster Care Subcommittee, we respectfully submit our report to the Child Protection Accountability Commission (CPAC or the Commission). We believe with the submission of this report our sub-committee has fulfilled the charge given us by CPAC to:

1. Examine how mental health and behavioral health services are delivered to children in foster care and those adopted out of foster care and make recommendations as necessary for change; and
2. Examine the continuum of providers, services and resources for same and make recommendations as necessary for change.

Children enter foster care through dependency, abuse, or neglect. When a child is placed in the care and custody of the State, the State becomes the legal custodian and the child becomes “our” child. Therefore it is our moral obligation to ensure that the quality of mental and behavioral health services available to children placed in foster care is equal to the quality which we as parents would demand for our own children. Our work was conducted based on this premise and the belief that appropriate mental health interventions are critical in helping children and their families heal. It is our sincere hope that this report will serve as a catalyst and a blue print for improving the availability and delivery of mental and behavioral health services for children in and adopted out of foster care.

We wish to thank the many individuals who served as Subcommittee Members as well as those who appeared before the Subcommittee to provide testimony and to share their experiences with us. The important, complex and sometimes difficult information revealed and keen insight provided by both Subcommittee members and those offering testimony have proven invaluable in increasing the Subcommittee’s understanding of how the current system works, its strengths and its challenges, and in developing the recommendations contained in this report. We did not limit ourselves to recommendations based on financial implications or the challenges involved in changing the way systems have always worked. Rather we based our recommendations on what we believe will work best for children in and adopted out for foster care and their families.

From our very first meeting on May 21, 2007 through our last on October 27, 2008, the meetings have been well attended, and Subcommittee meeting discussions have been candid and always respectful. Varying and sometimes directly opposing points of view were presented fairly and discussed always in the spirit of providing a better understanding of how our current mental and behavioral health care system works and what we can do to improve the system.

Lastly, we wish to extend our sincere gratitude to Molly Dunson, Office Manager with the Office of The Child Advocate, for her many hours of copious note taking at our Subcommittee meetings, for her invaluable contributions to the report drafting process, and for keeping us organized, focused and always moving forward toward our goal.

Respectfully submitted,
Janice Mink
Randall Williams

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Executive Summary

Most children in or adopted out of foster care have experienced complex trauma as a result of child abuse or neglect rendering them unique from other children with similar mental health diagnoses. This complex trauma makes mental health supports, treatment, and expertise in some form necessary for their long-term success and the stabilization of placements and families. The 2001 Governor's Task Force report on Foster Care identified supports that were critical to supporting and retaining foster families and were related to mental and behavioral health services, prompting CPAC to form a subcommittee to examine the way these services are delivered to children in and adopted out of foster care and make recommendations for improvement. To that end, the Mental and Behavioral Health Services to Children in and Adopted out of Foster Care Subcommittee (the Subcommittee) spent a year listening to testimony about the successes and challenges of the current mental health system for children in Delaware.

The Subcommittee, through the testimony presented, identified 10 areas within the system that impact or present challenges to the delivery of mental and behavioral health services to children in and adopted out of foster care, and proposed recommendations for change within each area. The areas identified were access to the Division of Child Mental Health Services (DCMHS), crisis services, insurance, coordination and communication, training/education and information dissemination, providers, prevention and early intervention, family involvement and support, resources, and current environment.

DCMHS is the agency through which every child in foster care, and many who are adopted out of foster care, must access more intensive mental health services. Testimony revealed several challenges to accessing services through DCMHS. Intake and eligibility were noted as challenges, due to such factors as people referring children to DCMHS not having sufficient information about the child and his or her family; the requiring of consents; time limitations being placed on the process; and similar referral packages needing to be submitted for the different agencies contracted by DCMHS to provide treatment. Furthermore, DCMHS indicated difficulty in serving the population of children who are mentally challenged to such a degree that they are unable to benefit from cognitive therapy, as its treatment modalities are unsuccessful on this population. Decisions about the appropriate level of care and the factors considered when making level of care determinations were other challenges identified in testimony. It was also felt that DCMHS often closes cases too quickly after a step-down to outpatient services, and that it is even more difficult to get DCMHS to accept a referral after a child's case has been closed. Finally, it is difficult for children who require ongoing treatment beyond the outpatient level after turning 18 to be referred to Delaware's adult mental health system without an interruption of care.

Another way children may become involved with DCMHS is through child priority response services, or what are commonly known as crisis services. However, there is limited staff for these services and they cover broad geographical areas, and sometimes families may have to wait before they can be assisted, if they are assisted at all. Overall, there are not adequate resources allocated to meet the needs of children and families in crisis in the state. In an attempt to provide

appropriate crisis services, DCMHS has sought to reevaluate the current resources and enhance these services, but has been unsuccessful in its attempts to do so.

Issues surrounding Medicaid eligibility for children in and adopted out of foster care, as well as issues with private insurance, were a significant concern of the Subcommittee. Children in paid foster care placements are eligible for Medicaid if they meet specific income criteria, but for children placed with relatives, non-relative caregivers, or in other non-paid placements, eligibility is determined based on the income of the home in which they live, potentially interrupting the stability of their mental health treatment. As children are adopted out of foster care, typically they are placed on the family's private insurance and Medicaid is elected as secondary coverage, but families may subsequently discover that their private insurance will not cover all of the services a child may need, or that their insurance company will authorize services by providers who do not have the clinical expertise to treat complex trauma associated with child abuse and neglect instead of denying services so families can access Medicaid. These issues may result in some children ending up in (or back in) foster care, sometimes due to disrupted adoptions.

One of the most common challenges brought before the Subcommittee was the lack of communication and coordination in all aspects of the system. There was a feeling that, in general, stakeholders were not getting enough information about the children and families they serve to sufficiently meet their needs. Best practices indicate that consistency and continuity of service are vital, and that there must be a focus on how children and families move through the system and how to make those moves successful. Lack of coordination and communication among system partners and those who are part of children's lives often results in such things as missed appointments, inappropriate services and/or placements, poor planning and difficult transitions, and, ultimately, the failure of children to thrive and succeed.

Testimony was presented to the Subcommittee which indicated that Division of Family Services (DFS) workers, foster and adoptive families, and other partners in the mental health system for children do not always have the understanding and knowledge of the system to ensure that children are getting the services they need, and that there is not currently an easy, user-friendly way to find services and providers. Furthermore, foster and adoptive families are not always fully apprised of and prepared for the complex trauma issues surrounding child abuse and neglect, and the resulting behaviors that manifest upon placement into a family. Therefore, the Subcommittee believed that training and other resources should be developed to educate all child welfare system employees and partners on available resources and how to access them, and what behaviors to expect from children who have suffered complex trauma due to child abuse and neglect.

One of the primary concerns of the Subcommittee was the dearth of available and appropriate providers in the state, and the subsequent waiting lists for services or lack of adequate specialized services that result. There is a documented lack of mental health professionals in the state, especially in psychiatry, and a lack of available services to address children with substance abuse issues, children with inappropriate or problematic sexual behaviors, young children, and children with developmental disabilities. Some felt that there is a general lack of providers who are comfortable and competent to work with children in and adopted out of foster care, who suffer from complex trauma associated with child abuse or neglect. Moreover, Delaware faces

several challenges to recruiting and maintaining professionals to work with these populations, including its lack of a research-based medical university, lower Medicaid reimbursements than neighboring states, little to no incentives for professionals to get dual licenses from the state or to provide more specialized treatment, and a credentialing process that lacks uniformity, is lengthy, and lacks flexibility.

Another recurring theme throughout the Subcommittee's work was the need for more prevention services, and the need to intervene earlier in the lives of at-risk children and families. Testimony indicated that emphasis on high quality child care and early childhood programs for at-risk families and/or abused or neglected children are two ways to intervene early and support children and families. Delaware also has had a need for more mental health interventions for young children. Prevention, however, would require a shift not only in focus, but also in resources. Delaware currently has very little state dollars allocated for targeted prevention programs, and while DCMHS has embarked on several secondary and tertiary prevention efforts targeted at children in foster care, there is no committed plan for prevention for the families that the Department of Services for Children, Youth, and their Families (DSCYF) serves.

The Subcommittee was unanimous in its agreement that family involvement is vital to the success of children. Family involvement can address several issues that inhibit the mental and behavioral health supports of children in and adopted out of foster care, such as "no shows" or missed appointments, families' lack of understanding of and preparation for children's behaviors that may lead to placement disruptions, and the treating of children's mental health diagnoses only, rather than treating their relationships issues as well. Unfortunately, it can be difficult to get families involved in children's treatment, especially when they are not mandated to do so.

Mental health resources, both financial and provider, for children and adolescents, particularly those in and adopted out of foster care, are quite limited in Delaware. Funding sources, payment streams, insurance requirements, expertise, and training all complicate the ability to deliver mental health treatment to children in and adopted out of foster care. Unlike Delaware's educational and correctional systems, a per child allocation of money is not provided for every child who enters the DSCYF system. The number of children being served by the Children's Department continues to grow, while the resources available to serve them do not. When there are insufficient services to meet the needs of children in and adopted out of foster care, DCMHS must constantly perform risk assessments to determine which child needs which service or intervention most, and some children may be placed in settings that do not meet their mental and behavioral health needs when other, more appropriate placements are unavailable. As budgets are stretched thin, the mental health system will need to leverage its resources to continue serving children in meaningful ways.

Mental and behavioral health issues and approaches to ameliorate same are not well understood across our society. The philosophical approach and resultant treatment for mental health and substance abuse, while not well understood, is based in research, federal guidelines, and evidence-based practice. Nonetheless, the child mental health system has developed an environment that often presents challenges to serving children and families. This environment can make it difficult for those inside the system to understand the issues that those outside the system face, and is a result of such things as internal policies and procedures, traditional practices, treatment agendas and biases, a limited view of the system, and scarce resources.

In response to the myriad of challenges noted here, the Subcommittee makes the following recommendations:

Access to DCMHS

1. DSCYF should create an environment of mental health care by requiring DCMHS to ensure the availability of mental health services and case management to every child in foster care from their entry into DSCYF custody until their exit from same.
2. In DSCYF so creating an environment of mental health care, DFS and DCMHS should develop and update where appropriate written policies and protocols to ensure the mental health needs of every child in foster care are being met.
3. DCMHS should be required, as may be amenable to the adoptive family, to provide case management services for every child adopted out of foster care until age 18, regardless of whether the child has a current need for mental or behavioral health services. Notwithstanding this recommendation, should a child adopted out of foster care be placed or relocate out of state, DCMHS may terminate case management services after transition to the receiving state's mental health service system.
4. DSCYF should undertake an evaluation of its organizational structure; inter-divisional communications, policies, procedures and processes; and staffing patterns as they relate independently and collectively to the delivery of mental and behavioral health services to children in and adopted out of foster care. Opportunities should be explored to:
 - Streamline policies and procedures for access to and delivery of mental health services in order to maximize efficiency and effectiveness;
 - Eliminate inter-divisional barriers/impediments in order to provide a seamless mental and behavioral health services delivery system from the time the child enters the foster care system until the child exits same;
 - Align staffing patterns (classification, allocation, and deployment) to support and complement the mental and behavioral health delivery system;
 - Maximize the utilization of all financial resources through effective case management practices.
5. Where there is disagreement about level of care for a child in foster care, the DCMHS clinical staff should meet the child prior to making his or her decision about the appropriate level of care.
6. DCMHS should ensure its level of mental health treatment takes into account the environment of care as DCMHS does in substance abuse treatment. The primary focus should be what is most appropriate for the child, while factoring in the least restrictive environment where the child can succeed and be safe.
7. DCMHS, DFS and the Division of Developmental Disabilities (DDDS) should work together to craft Memoranda of Understanding (MOU), protocols, and/or legislation to assure that the mental and behavioral health needs of the cognitively disabled population of DSCYF children are appropriately met, and that the responsibilities of each agency are clearly delineated and met with the concomitant resources to serve this challenging population.
8. DSCYF, in conjunction with DCMHS and the Division of Medicaid and Medical Assistance (DMMA), should continue to work together to extend DCMHS case management services for children who age out of foster care until age 21, and work toward a seamless transition to the adult mental health system.

Crisis Services

1. DSCYF should develop a crisis response service that adequately meets the needs of children and families in crisis, looking at the outcomes of the SOS program for guidance.

Insurance

1. CPAC, together with leaders of the new administration, shall work together to create a task force or subcommittee to include private insurance companies, adoptive families and representatives of DMMA to:
 - Develop recommendations for improving the depth and breadth of skilled clinicians approved by private insurance companies and third-party administrators who are competent to treat complex trauma as a result of child abuse and neglect;
 - Develop a pilot project to be led by a private insurance company or third-party administrator to test the recommendations; and
 - Explore the feasibility of allowing families who have adopted children out of foster care to continue using Medicaid for mental health benefits while utilizing private health insurance for physical health benefits.
2. CPAC should introduce legislation to require continuity of necessary and appropriate mental health care after adoption finalization, which would enable a child to remain with their mental health provider regardless of a change in insurance after adoption.
3. DFS, DCMHS, and the Interagency Committee on Adoption (ICOA) should work together to develop written documentation and training on how to guide adoptive families in their personal choice regarding medical coverage for their adopted child. This documentation and training would then be used to train new adoption and permanency workers from the State and contracted agencies, as well as raise awareness in the child welfare legal community as to the need to make well-informed choices on medical care benefits prior to finalization.
4. CPAC, together with DMMA and DSCYF, should explore the state and federal requirements and limitations on Medicaid eligibility for children in DSCYF custody who are not in paid foster care placements, and propose statutory and policy changes to ensure that all children in DSCYF custody remain Medicaid eligible throughout the duration of that custody.
5. DMMA and DSCYF should explore opportunities to streamline the Medicaid application process for children in foster care.

Coordination and Communication

1. DCMHS, DFS, and OCA should share databases and information systems related to all children in and adopted out of foster care so as to ensure they receive appropriate mental and behavioral health services, including but not limited to Trauma Focused Cognitive Behavioral Therapy through the Child Well Being Initiative.
2. DCMHS and DFS should partner to ensure the Family and Child Tracking System (FACTS) event summarizing DSCYF history on a family is implemented and accessible to all necessary parties. To the extent that mental health treatment history can be referenced or included in the summary, it should be. Currently DSCYF is able to generate a report of all “placements,” regardless of the division. This information should be incorporated or referenced in the history as well.
3. Should FACTS II come to fruition, consideration should be given to eliminating the requirement of separate case files for DCMHS, DFS and the Division of Youth Rehabilitative Services (DYRS) in DSCYF custody cases.

4. DCMHS, in conjunction with a representative group of providers, should develop a standardized summary form to be used by all mental health professionals in the treatment of children in or adopted out of foster care which shall be completed prior to the transfer and/or at the conclusion of treatment. DCMHS will ensure that all of its approved therapists complete this form, and provide it to DCMHS, DFS, and the new mental health provider, if applicable. This form shall become part of the permanent DSCYF record on the child in or adopted out of foster care.
5. DCMHS progress reviews and case management of every child in foster care should be proactive and monitor the child's progress in mental health treatment regardless of the level of care being provided.
6. DCMHS and DFS should implement a structured communication policy, protocol, or Memorandum of Agreement (MOA) and/or give consideration to the co-location of DCMHS staff serving this population directly within the DFS units. The goal of this recommendation is to foster a team concept in serving children in DFS custody which must necessarily start within DSCYF. At a minimum, specialized units within DCMHS should be considered to focus on children in and adopted out of foster care.
7. Via protocols or MOA between DCMHS and DFS, transition plans should be completed prior to the movement of a child for placement or mental health treatment.
8. DSCYF should implement a policy, protocol, or MOA between DCMHS, DFS and DYRS to ensure that children in or adopted out of foster care who become detained have no interruption in mental health treatment while in secure care.
9. DSCYF should provide training to its employees in accordance with recommendation #1 in the Training, Education, and Dissemination of Information section of this report.
10. DSCYF and the Department of Education (DOE) should promptly complete the execution of the MOU between them.
11. Using the executed MOU, DSCYF (DFS, DCMHS and DYRS if applicable) and DOE shall conduct TIMELY and mandatory transition meetings for children that are in DSCYF custody prior to the child re-entering school from alternative schools, detention, or treatment facilities. These transition meetings shall ensure that the child's educational and mental health needs will be appropriately met in home, school, and community. Delays in this meeting should not result in retaining a child in an inappropriate setting.
12. DSCYF (DFS, DCMHS and DYRS if applicable) should proactively create a communication system for letting schools know who is responsible for a child in DSCYF custody and to encourage open and frequent communication through that system.
13. DSCYF (including DFS and DCMHS) should create and/or improve the Level of Care forms and/or Child Profiles provided to foster and adoptive families to fully include a child's DSCYF and trauma background, behaviors, mental health needs, and other important factors so that families are prepared for the children entering their home. This should result in increased stability of placement due to a thorough knowledge base, the availability of appropriate supports, and the preparation of the family for acting-out behaviors that often result in disruptions.
14. DFS and DCMHS should jointly increase the resources and supports to prepare and train families to work with children with behavioral difficulties in order to minimize disruptions which impact not only the child and family, but also DCMHS and DFS.

Training, Education, and Dissemination of Information

1. CPAC's Training Subcommittee should create a subgroup with appropriate members to develop a core and advanced curriculum training, similar to CAN 101, to educate all child welfare system employees, including schools, judges, lawyers, medical providers, mental health providers, contract agencies and families on, but not limited to, the following issues:
 - How to access mental and behavioral health services for children in Delaware;

- The levels of care available;
 - Resources;
 - Behaviors of complex trauma due to child abuse and neglect, and family management and support of children who suffer from complex trauma, acknowledging an expectation that children who enter foster care have experienced trauma from the removal itself.
2. DCMHS, DMMA, the Office of Prevention and Early Intervention (OPEI), DFS, and the CPAC Training Subcommittee (or a component thereof), should develop a user-friendly website that lists all available mental and behavioral health services and providers in Delaware, together with credentials, areas of specialty, and clinical requirements for service access. The group should investigate potential linkage with similar work being undertaken by the Division of Substance Abuse and Mental Health (DSAMH) and by DOE. Adequate resources, including the use of grants, should be explored to assure the information is current and accurate. The website <http://www.networkofcare.org> should be explored thoroughly.
 3. DSCYF, and in particular DFS with the guidance of experts in this area, should require in future foster home contracts that families and contract agency workers be trained and supported on complex trauma associated with child abuse and neglect, and the behaviors that stem therefrom.
 4. DSCYF, and in particular DFS with the guidance of experts in this area, should require in future adoptive placements that agencies identify appropriate mental health therapists in the community to support adoptive families with regard to the behaviors that stem from placement of children with complex trauma associated with child abuse and neglect, to minimize disruptions.

Providers

1. DCMHS, DMMA, and provider agencies should create a plan to provide incentives for mental health professionals to develop skills and provide treatment to children in and adopted out of foster care.
2. DCMHS, DMMA, and provider agencies should explore options to reimburse mental health professionals for attending trainings on providing treatment to children in and adopted out of foster care.
3. DCMHS, DMMA, and provider agencies should partner with the local colleges and universities to regularly utilize student interns in all of their mental health programs for children, with clear cut internship guidelines and supervision that will cultivate an interest by students in providing mental health services to children in and adopted out of foster care following graduation.
4. DCMHS, DMMA, and provider agencies should partner with the local colleges and universities to build an incentive package for attracting and retaining mental health professionals in Delaware. In so doing, they should review the strategies employed by the State of Maryland, and consider modification to licensing and supervision requirements, loan forgiveness opportunities, career ladders and resources through Delaware Institute for Medical Education and Research (DIMER), Delaware's process for loan repayments for medical professionals.
5. DCMHS, DMMA, and provider agencies should partner with the local colleges and universities to explore creative ways to count clinical hours required for a degree that meets the purpose of clinical hours while maximizing the ability to provide services to children receiving mental health treatment.
6. DCMHS, DMMA, and the Office of Professional Regulation (OPR) should conduct a market analysis of Medicaid reimbursement rates for children's mental health services in the surrounding state area (NJ, PA, MD, VA, WV).
7. DCMHS, DMMA, and the Managed Care Organizations (MCO) should work together to streamline the credentialing process for professionals and develop a policy to allow provisional paneling so professionals can treat and bill for services.

8. DCMHS should pursue with OPR the granting of provisional licenses for already-licensed professionals in good standing from other states while they go through the process of licensure in Delaware, enabling them to treat and bill for services.
9. DSCYF should increase resources to enable its employees to acquire the education needed for licensure.

Prevention and Early Intervention

1. DSCYF should evaluate OPEI to ensure concrete and direct goals are in place to support its Divisions – DCMHS, DFS and DYRS – and how they interact to serve families. DSCYF should pursue and maintain grants that support these goals.
2. CPAC should partner with DOE and the Governor’s Council on Early Childhood to ensure that children in and adopted out of foster care are benefiting from quality child care, thereby helping to reduce the needs for deep-end mental health services in the future.
3. DSCYF, and specifically the employees of DFS and DCMHS, should be trained on the entitlements of children in foster care to Title IV-E – Part C – Birth to 3 screenings and services and early Head Start to maximize opportunities for positive brain development in our young children in foster care.
4. OPEI, together with DCMHS and DFS, should examine the continuum of community based services and explore opportunities to develop prevention programs with agencies such as Big Brothers, Big Sisters, YMCAs, and Boys and Girls Clubs, so as to connect children in DSCYF custody and families with informal supports to build resiliency.
5. DCMHS, together with its community partners, should examine its continuum of care for services available to children with substance abuse issues, and how those services can be provided concurrently with mental health services to avoid the need for more deep-end mental health or substance abuse treatment in the future.

Family Involvement and Support

1. DFS and all of its contracted foster care providers should require foster parents to be actively involved with children’s therapy.
2. DCMHS and DFS should work together to ensure that services are flexible and provided in a location appropriate to facilitate family involvement in treatment.
3. DSCYF should provide regular respite care for foster and adoptive families, as part of a support system that works to preserve placements.
4. When necessary, DFS should transport children in foster care to treatment.

Resources

1. DSCYF should review its instilled System of Care principles and partner with CPAC to determine the feasibility of implementing a system where monies are allocated for each child entering DSCYF custody and the money then follows the child.
2. OPEI, in coordination with DSCYF, should aggressively pursue grants and funding opportunities to increase community based mental health services for children in and adopted out of foster care.
3. DSCYF, in conjunction with the state Office of Management and Budget (OMB), should reevaluate the Cost Allocation Plan relative to Appropriated Special Funds (ASF) allocated to the provision of mental and behavioral health services to children so as to maximize funding available for this purpose.
4. The Governor should appoint a Task Force or charge CPAC with:
 - Conducting an analysis similar to the Governor’s Task Force on Foster Care to structure the levels of mental health services, conducting an analysis of what resources are

available at each level, and developing a plan for the increasing of resources to meet the mental and behavioral health needs of children in and adopted out of foster care;

- Considering whether the current management and financial structure of DSCYF meets the needs of the children and families it serves as it relates to the delivery of mental health services, and how to improve the delivery of services by DSCYF in the most appropriate, cost efficient, child-driven manner that eliminates disagreements over responsibilities and finances between divisions; and
 - Exploring with DMMA the requirements and flexibilities in the current Medicaid 1115 Waiver.
5. DCMHS should continue funding for an Institute to support evidence-based practices such as the Child Well Being Initiative.
 6. DCMHS should obtain additional resources to increase availability of wraparound services.

Current Environment

1. DCMHS and DFS should coordinate levels of care to decrease placement disruptions and ensure appropriate treatment.
2. DSCYF should explore financial restructuring of placements and opportunities for reimbursement outside of Medicaid.
3. DCMHS should restructure its assessment for mental health treatment to take into consideration a child's environment, recognizing that children in foster care have experienced trauma and their behaviors are often a result thereof.
4. DSCYF should utilize OPEI to connect parents with community resources in accordance with the recommendations made in the Prevention section of this report.

Background

The protection of our children is a basic and compelling obligation that no agency should be expected to handle alone. The 1997 death of a four year old boy named Bryan Martin demonstrated the need for multidisciplinary collaboration and accountability in Delaware's child protection system. Following Bryan's death, Delaware enacted the Child Abuse Prevention Act of 1997 (16 Del. C., Ch. 9), which made significant changes in the way Delaware investigates child abuse and neglect. The Child Abuse Prevention Act also made changes requiring Delaware to foster a child protection community of cooperation, accountability, and multidisciplinary collaboration. Part of the strategy in that regard was the establishment of a forum for interdisciplinary dialogue and reform. That forum is the Child Protection Accountability Commission.

In Delaware a number of different entities, working together, are charged with establishing, maintaining and monitoring the health, safety and well-being of the state's abused, neglected and dependent children. The Department of Services for Children, Youth, and Their Families, the Department of Justice (DOJ), Family Court, the Office of the Child Advocate (OCA), law enforcement, the medical community, educators, child care providers and others work together to shoulder the responsibility of ensuring child safety and well-being.

CPAC's overall statutory mission is to monitor Delaware's child protection system to ensure the health, safety, and well-being of Delaware's abused, neglected, and dependent children. 16 Del. C. § 912(b).

The statutory duties of the Commission are as follows (16 Del. C. § 912(b)):

1. Examine and evaluate the policies, procedures, and effectiveness of the child protective system and make recommendations for changes therein, focusing specifically on the respective roles in the child protective system of the Division of Family Services, the Division of Child Mental Health Services, the Department of Justice, the Family Court, the medical community, and law enforcement agencies;
2. Recommend changes in the policies and procedures for investigating and overseeing the welfare of abused, neglected, and dependent children;
3. Advocate for legislation and make legislative recommendations to the Governor and General Assembly;
4. Access, develop, and provide quality training to staff of the Division of Family Services, Deputy Attorneys General, Family Court, law enforcement officers, the medical community, educators, day care providers, and others on child protection issues; and
5. Review and make recommendations concerning the well-being of Delaware's abused, neglected, and dependent children including, but not limited to, issues relating to foster care, adoption, mental health services, victim services, education, rehabilitation, substance abuse, and independent living.

Additionally, CPAC has been designated by DSCYF, in its state plan under the federal Child Abuse Prevention and Treatment Act (CAPTA), to serve as Delaware's Citizen Review Panel. Amended in 1996, CAPTA requires that CPAC, in its role as citizen review panel, examine the

policies, procedures and practices of state and local agencies and, where appropriate, specific cases to evaluate the extent to which state and local child protection system agencies are effectively discharging their child protection responsibilities.

CPAC fulfills its duties by holding quarterly meetings to facilitate multidisciplinary dialogue among the various state agencies and other system stakeholders. In these meetings policy review, problem-identification and decision-making occur. Numerous subcommittees have been formed to manage and address the emerging issues, trends and problems identified at CPAC meetings. CPAC's subcommittees meet between Commission meetings and throughout the year, as may be required. The Commission and its subcommittees then work together with their system partners to bring about the necessary reforms.

Subcommittee Purpose

In Fiscal Year 2007, the Foster Care Subcommittee of CPAC focused on the need for additional foster care resources – particularly for populations that are difficult to place – understanding caseload issues, and exploring resource needs as they relate to the 2001 Governor’s Task Force recommendations.

The Foster Care Subcommittee reviewed the 2001 Governor’s Task Force report on Foster Care and determined that resources to support foster parents remained an issue.² Supporting foster parents is critical to retaining them, and the supports identified in the Governor’s Task Force Report that were viewed as most important in this regard were behavioral specialists and after hours crisis support. The Foster Care Subcommittee explored the cost and learned that DCMHS was unsuccessful in its Fiscal Year 2007 request for funds for these services, notwithstanding support for the request from DFS. Since the additional supports deemed necessary for successful foster parenting were mental health related, CPAC determined that the best path forward would be to re-focus the mission of the Foster Care Subcommittee. The Foster Care Subcommittee was restructured and combined with the Mental Health Assessments Subcommittee, and focused on mental health and behavioral issues that arise for children in foster care and those adopted out of foster care. The new subcommittee was called the Mental and Behavioral Health Services to Children in and Adopted out of Foster Care Subcommittee (the Subcommittee). The charge of the Subcommittee was twofold:

3. To examine how mental health and behavioral health services are delivered to children in foster care and those adopted out of foster care and make recommendations as necessary for change; and
4. To examine the continuum of providers, services and resources for same and make recommendations as necessary for change.

In order to fulfill its charge, the Subcommittee felt that it would be beneficial to hear from organizations and/or individuals involved in securing or providing mental and behavioral health services for children in or adopted out of foster care. The Subcommittee invited partners from all aspects of the child protection system to report on their experiences with Delaware’s mental health system for children, including DCMHS, DFS, Family Court, the DOJ, OCA, the Court Appointed Special Advocate program, DOE, the Child Placement Review Board, service providers, and foster/adoptive parents. Presenters were asked to address their role in obtaining or providing mental and behavioral health services to children in or adopted out of foster care; their experiences in obtaining those services, including any challenges encountered in obtaining or providing services; and what recommendations they had for improving the system of delivering mental and behavioral health services to children in or adopted out of foster care.

² The Governor’s Foster Care Task Force report can be found at:
http://governor.delaware.gov/publications/0601foster_care.shtml

Overview of Delaware’s Mental Health System for Children

Delaware’s child mental and behavioral health services delivery system encompasses several entities. One of the goals of the Subcommittee was to develop an understanding of how these entities work together to ensure that children in and adopted out of foster care receive the mental health services they need. To that end, the Subcommittee began its work with an overview of Delaware’s mental and behavioral health system for children.

HOW DELAWARE’S CHILDREN RECEIVE MENTAL HEALTH SERVICES

In Delaware, child mental and behavioral health services are provided and/or funded by private health insurance, public health insurance, or a mixture of private and public. With private health insurance, services are authorized and paid for by the insurance companies, and Managed Care Organizations (MCO) manage the provision of benefits. While most private insurance plans include some number of outpatient therapy sessions and some more restrictive care, such as hospitalization, in general they do not provide a wide range of mental and behavioral health treatment options. However, Delaware has Serious Mental Illness (SMI) parity, meaning that for individuals with serious mental illness as defined by 18 Del. C. § 3343, mental health benefits must equate with other medical health benefits. Very few children are diagnosed with disorders considered to be SMI; the most common of these diagnoses among children is bipolar disorder.

For those children and families who are eligible, Medicaid is another option for the authorization and funding of mental health services. All children in paid foster care placements are eligible for Medicaid if they meet specific income criteria. Eligibility of children in DSCYF custody³ who are not in paid foster care placements is determined by the eligibility of the placement in which they live. Medicaid defines a paid foster care placement as a home or institution where a public agency assumes full or partial financial responsibility.

In Delaware, every child receiving Medicaid is entitled to 30 units of outpatient therapy per year, which is higher than most other states. There are three MCOs that manage Medicaid benefits in the state: Delaware Physicians Care Inc. (DPCI), Diamond State Partners, and Unison Health Plan (Unison). Physicians, psychologists, social workers and other treatment providers contract with the MCOs to provide services to Medicaid subscribers. The MCOs have lists of their credentialed providers available to children in the State of Delaware. For children in state operated foster care homes, a referral is made by DFS, in conjunction with the child’s legal guardian, to get services in place. Other children are in contracted foster care homes, and these contracted foster care agencies coordinate mental and behavioral health services on behalf of the children in their care, and bill Medicaid directly for services.

For the large majority of children in foster care and their families⁴, mental and behavioral health issues are most appropriately addressed in outpatient counseling, working with a therapist. However, for children who need more intensive services or more than 30 outpatient sessions per year, DCMHS may manage and coordinate additional mental and behavioral health care.

³ Throughout this report, “DSCYF custody” refers only to children in DSCYF custody who have been found to be abused, dependent, or neglected, and not to delinquent children in DSCYF custody.

⁴ Throughout this report, the word “families” will be used to include biological, foster, and adoptive families.

PARTNERS IN DELAWARE'S MENTAL HEALTH SYSTEM FOR CHILDREN

The Division of Medicaid and Medical Assistance and Managed Care Organizations

Diamond State Health Plan is Delaware's Medicaid managed care program, and is managed by the state's Division of Medicaid and Medical Assistance (DMMA). Delaware's three MCOs – DPCI, Unison, and Diamond State Partners – all fall under the Diamond State Health Plan. These MCOs are responsible for coordinating the medical and mental and behavioral health benefits for their subscribers. Physicians, psychologists, and other therapists contract with and/or are paneled by the MCOs to provide the services.

Delaware uses Federal matching funds through the use of the Diamond State Health Plan section 1115(a) Demonstration Waiver (1115 Waiver) to deliver services to eligible children using the care assurance model. The 1115 Waiver is designed to use a managed care delivery system to create efficiencies in the Medicaid program and enable the extension of coverage to certain individuals who would otherwise be without health insurance. The State's goal in implementing the waiver is to improve the health status of low-income Delawareans by improving access to health care for the Medicaid population; improving the quality of health services delivered; and expanding coverage to additional low-income Delawareans with resources generated through managed care efficiencies. The 1115 Waiver covers all Medicaid recipients who qualify for medical, mental health, and/or substance abuse services under Managed Care, including children in paid foster care placements.

To determine Medicaid eligibility, an application must be made on behalf of a child, and then Delaware's Division of Social Services (DSS), housed in the Department of Health and Social Services (DHSS), processes the case. All children in paid foster care placements in the State of Delaware meet the criteria for managed care. Children who are newly enrolled in Medicaid will be issued a Medicaid card. Children who enter foster care and are already enrolled in Medicaid will continue using their current Medicaid number. The next step is selecting an MCO. For children in foster care, either a foster parent or a caseworker can choose the MCO. If a choice is not made, a default program will be chosen. The individual choosing the program may use any criteria they wish in making a selection, including such things as previous experience, special needs, or physician involvement with the program. Services from an MCO are triggered when a child presents with a request through their physician or another source. When children need deep-end mental health or substance abuse services or have exhausted their Medicaid allowance, the MCO will then coordinate with DCMHS.

The basic Medicaid benefits package is 30 outpatient units of mental health care, and coordination of services should the person exhaust their 30 units or require more intensive services, such as hospitalization. The MCO's responsibility under this basic package is any combination of counseling, substance abuse treatment, or other appropriate outpatient services. While some private insurance companies will not authorize two providers at once for the same level of care (i.e. counseling and substance abuse treatment), this is not the case with Medicaid. Outside of these 30 outpatient units, the MCO is responsible for management of medication, emergency room visits, and coordination of care. The MCO makes sure that routine medically necessary care, evaluations as appropriate, and emergency services are available to children.

Each of the MCOs has a website, wherein users can find lists of all the providers affiliated with their MCO. These websites will have the most updated lists as providers change. Furthermore, each MCO has care coordinators who can help fit clients with the right therapists, although detailed information on expertise regarding children in and adopted out of foster care is not documented. The more information that is given about what type of help a child needs, the better the match that can be made. This level of information and assistance is more than what is currently available on the websites. The MCOs document every call, so service gaps can be identified and documented.

The MCOs do internal reviews to make sure they are serving the right populations. In Fiscal Year 2008, the MCOs were required to begin tracking specific issues related to children in foster care, such as how many individuals received physical/mental health exams within a given timeframe.

The Division of Child Mental Health Services

DCMHS serves children under the age of 18 who are in need of mental health or substance abuse treatment services and are Medicaid eligible or without insurance. Its mandate is to serve children with moderate to severe mental illness. DCMHS serves nearly 2,900 clients annually⁵, with a budget of \$39 million and about 225 staff throughout the state. Overall, children involved with DFS make up about 25% or more of the children served by DCMHS. Of the 767 children discharged from mental health intensive outpatient services over the last 6 years, 55% had a history of DFS involvement only, and 30.5% had a history with both DFS and the Division of Youth Rehabilitative Services (YRS).

DCMHS does not operate or provide outpatient counseling. For children who need services in excess of the 30 outpatient units provided by Medicaid, DCMHS is able to manage and coordinate additional care through the use of the Medicaid 1115 Waiver. This waiver allows DCMHS to provide a care assurance model of service provision. The child may continue seeing the same therapist and DCMHS will be billed for the sessions. For children with no insurance, DCMHS has contracts with large provider agencies across the state where children and families can go for outpatient treatment, and the agencies bill DCMHS for the sessions.

DCMHS has no special unit for children in foster care or for post-adoption services. However, DCMHS has implemented some efforts on behalf of children in foster care. These efforts include mental and behavioral health screening for all children who enter foster care, assessments and consultation services, mental health and developmental disabilities intensive outpatient services (IOP) and day treatment, and crisis services. In addition, DCMHS runs the Trauma Focused Cognitive Behavioral Therapy Project, which is a pilot project focused on treating Post Traumatic Stress Disorder in children who have experienced trauma, and the Child Development Community Policing Project, through which children from the city of Wilmington who are exposed to violence and in need of mental health treatment are referred to DCMHS. DCMHS will soon offer training to DFS on creating trauma-informed child welfare practice. Finally, they purchased “Maybe Days” books for foster families, which help foster parents talk through issues that concern the children in their care and help relieve children’s stress. DCMHS

⁵ During Fiscal Year 2008, DCMHS served 2,876 children.

also publishes an annual newsletter for foster families. In its proposed Fiscal Year 2009 budget, DCMHS requested Behavioral Health Consultants, who would be located in DFS offices. This initiative was identified as a critical need for children in the 2001 Governor's Task Force Report on Foster Care, and was DSCYF's primary new funding priority in FY09. This initiative was not approved for funding in FY09 due to the tight fiscal climate.

The Division of Family Services

For children in DSCYF custody, DFS workers have the primary responsibility to secure mental and behavioral health services. Their role in the delivery of these services includes completing referrals for services, finding agencies close to where the child is living, and making sure the child gets to the intake evaluation and subsequent appointments, which may include providing transportation if the foster family cannot get the child there. Foster Home Coordinators and treatment workers from DFS work with foster parents and help them access services for the children in their care. The role of the Foster Home Coordinator is to get information from the foster family and share it with the DFS worker, to help them determine what avenue to take. Treatment workers may also help foster parents obtain services through the DCMHS early screening process and by making referrals to provider agencies. For workers with caseloads consisting of youth with the goal of Another Planned Permanent Living Arrangement (APPLA), the focus is on intensifying and continuing help for youth so that they may have a successful transition to adulthood.

The Division of Youth Rehabilitative Services

The Division of Youth Rehabilitative Services strives to support public safety and positive change of children, families and communities through guidance, education and empowerment. DYRS operates five secure care facilities for detained and committed youth. The secure care facilities provide education, treatment, counseling, recreation, vocational training, medical care, and family focused case management. Youth on probation or aftercare are supervised by the Community Services unit. Probation officers are responsible for ensuring youth comply with all court ordered conditions which includes connecting youth and families with mental and behavioral health services and monitoring attendance and participation in school or an alternative educational program. Youth who become involved with the juvenile justice system are often receiving or have received services from DFS or DCHMS, including youth in or adopted out of foster care. Court ordered referrals to these agencies sometimes result when youth enter the juvenile justice system.

Child Placement Review Board

The Child Placement Review Board (CPRB) conducts independent reviews of children in foster care and specified adjudicated youth. Delaware citizens, appointed by the Governor, evaluate and assess the appropriateness of the child's permanency goal and whether the provided services fully address the child's needs. The Board advocates for mental and behavioral health services on behalf of individual children and works with system partners to improve services state-wide.

Community Service Providers

DCMHS contracts with many community service agencies to provide mental and behavioral health services to children and families. The providers below were represented on the Subcommittee and/or presented to the Subcommittee; this is not an exhaustive list of the providers contracted with DCMHS.

People's Place

People's Place is a non-profit social service agency that provides outpatient mental health services, among its many other services. Other services provided to children and families include domestic violence services, family visitation centers, long-term foster care group homes, short-term non-secure detention homes, independent living programs for youth in foster care, and in-school prevention and assistance programming in the Milford School District. People's Place has five sites, in Kent and Sussex Counties, where seven full time therapists, three part time therapists, a psychiatrist and a psychologist serve children and families. While mental health services are not really built into the foster care group homes, most of the children in the homes are seen in People's Place's outpatient facility or already have a therapist elsewhere. People's Place's psychiatrist will also serve those children if they do not already have a psychiatrist. The group home staff will participate in counseling if necessary, and each group home has case managers to coordinate with schools, DCMHS, and other people in the children's lives.

Delaware Guidance Services

Delaware Guidance Services (DGS) is a statewide agency whose primary service is providing outpatient mental health services to children and families. DGS provides family focused and community based treatment. One third of the children served by DGS in New Castle County receive psychiatry services through DGS, and 1/2 of the children served by DGS in Kent and Sussex Counties receive psychiatry services, in addition to psychotherapy, through the agency. DGS staff visit schools to treat children, and will go into the community and to the homes for intensive outpatient treatment. In New Castle County, mental health aides work with children in the community to apply what they are learning in therapy in their home, school, and community. From southern New Castle County to Sussex County, DGS also provides priority response services to children and families. DGS has about 50 licensed clinicians and 6 psychiatrists statewide, who serve about 8,000 children each year.

Children and Families First

Children and Families First (CFF) strengthens families through adoption, foster care, counseling, teen services, parenting education and support programs, welfare to work services, and programs that support older adults, reduce infant mortality, and increase child care quality and availability. Mental health services are a relatively small part of the social services CFF provides to children and families, with one or two counselors doing outpatient therapy in each county. CFF also provides the Treatment Foster Care Program, which is designed to provide stability for adolescents who have mental and/or behavioral health issues. The program also provides intensive therapeutic treatment to meet the child's specific needs.

Aquila

Aquila provides comprehensive outpatient substance abuse treatment for adolescents and their families. In the 1990s, approximately 10% of Aquila's clients were in foster care. Today, approximately 35% of its clients are in foster care. Children in foster care are referred to Aquila from DFS, DCMHS, Family Court, probation officers, and occasionally from walk-ins. All of the agency's clients have both mental health and substance abuse issues, and two-thirds have known trauma histories. Aquila provides services to treat all of these issues. Aquila hires professionals who are skilled at understanding all of these issues; therefore, all of their therapists have Master's degrees. They also have psychiatrists in New Castle County one day a week, and in Georgetown they are contracted through Delaware Guidance. Aquila sometimes has waiting lists for its IOP program, which can be up to 4 weeks at most, but they will keep children in outpatient treatment while they are waiting.

Court Appointed Special Advocate Program

The mission of the Court Appointed Special Advocate (CASA) program is to provide independent and quality representation and advocacy for all abused and neglected children who are the subject of court proceedings. The CASA program is managed by the Family Court and is comprised of citizen volunteers who have agreed to represent the best interests of abused, neglected, and dependent children, including advocating for mental and behavioral health services when necessary.

Department of Justice

The Delaware Department of Justice (DOJ) has both criminal and civil divisions. The Deputy Attorneys General (DAG) in the civil division provide legal representation to most state agencies. The Department of Justice has recently created a Family Services Division which houses both civil and criminal matters that affect families. This includes the Deputies who represent DCMHS and DFS. DAGs are also involved in the prosecution and sentencing of juvenile offenders, many of whom have mental and behavioral health issues and are in the legal custody of DSCYF.

Educational System

Children arrive at school with a variety of societal issues, and educators must also be part social workers to deal with their students' issues and to provide stability for at-risk students, as school may be the only stable place in their lives. Schools provide stability through the use of the McKinney Vento Homeless Assistance Act, which affords children designated as homeless the right to stay in their current school and to have transportation provided to that school when feasible. School districts have liaisons who assist homeless students and students in foster care with enrollment and other school-related issues. DOE and DCMHS are also piloting a grant to address the mental health needs of children in school by helping school personnel identify and understand mental health issues, developing language and protocols to help school personnel make referrals to access services for children, and training school personnel on these protocols. Furthermore, in select schools, children may receive therapy in the school via in-school programs or community therapists.

DOE also has an Office of Early Care and Education, which helps to staff the Governor's Council on Early Childhood, whose mission is to improve early childhood services in Delaware. It is important that children in foster care receive the highest quality daycare and early childhood services possible, in order to support their early brain development. Last year, however, DFS referred 1,026 children to DHSS for subsidized childcare through purchase of care (POC), and programs accepting child care subsidy have been shown to provide statistically significant poorer quality care than programs that do not accept child care subsidy⁶. Thus, the initiatives of the Early Childhood Council are vital in ensuring that children in foster care are benefiting from high quality care that meets their mental and behavioral health needs early on and reduces the need for deep-end services in the future.

Two other educational initiatives that benefit children in foster care and address their mental and behavioral health needs include the Positive Behavior Support (PBS) program, and the Interagency Collaborative Team (ICT). The goal of the PBS program is to teach and support appropriate behaviors, and it has been found to be very successful with children in foster care. However, at this time, the PBS program is not in every school in Delaware. The ICT is a funding body, which consists of people from all agencies that serve children and reviews cases of children with severe disabilities and special education needs that cannot be met by a local school district. The ICT is currently funding 12 children in foster care, through private day schools and residential programs.

Family Court

The Family Court has jurisdiction over all domestic matters, including dependency/neglect proceedings involving children in foster care. Family Court provides oversight to ensure that children and families are getting the services they need to remain safe and to achieve permanency. This may include ordering mental health interventions when the evidence demonstrates such interventions are medically necessary.

Office of the Child Advocate

The mission of the Office of the Child Advocate (OCA) is to safeguard the welfare of Delaware's children through educational advocacy, system reform, public awareness, training, and legal representation of children. Through these avenues, OCA oversees the child protection system to ensure children are being served and their needs are being met, including their mental and behavioral health needs. Through its legal representation component, OCA and its volunteers advocate for mental health treatment for children in foster care. OCA also staffs CPAC, which is another entity that monitors the delivery of services to children in the child protection system, and makes recommendations for change in policy and procedure as necessary.

⁶ See the Delaware Early Care and Education Baseline Quality Study, Child Care Subsidy section, pages 347 – 423 - <http://www.udel.edu/cds/downloads/BaselineQualityStudy2005.pdf>

Methodology

The Subcommittee met 12 times from May of 2007 to May of 2008. While the first few meetings were spent planning the Subcommittee's course and gaining a better understanding of Delaware's mental health system for children, the remaining 9 meetings were used for the Subcommittee to hear testimony from 38 individuals who have had experience delivering or attempting to secure mental and behavioral health services for children in foster care and those adopted out of foster care, for the purpose of identifying specific issues with the current system, as well as recommendations for improvement. The testimony and ensuing discussions of the individual cases and the mental health system for children in general were frank and informative, and were the springboard for the final recommendations of the Subcommittee.

The following sections of the report include testimony regarding the challenges to various components of the public mental health system for children, DCMHS, and DSCYF, as well as reports from individuals regarding specific cases and services. In the spirit of cooperation and valuing partner input, DSCYF and DCMHS listened carefully to the testimony of participants and users of the system, and chose not to refute or debate the facts or testimony presented, nor offer additional information. Instead, DCMHS chose to use the testimony as information to help make improvements to the mental health system for children.

Successes of Delaware's System

Many positive aspects of Delaware's mental health system for children were recognized during the testimony presented to the Subcommittee. Delaware's Medicaid 1115 Waiver, for example, was touted as one of the most flexible in the country, along with the fact that the 30 outpatient units guaranteed to all Medicaid-eligible children is higher than in most other states. Some felt that DCMHS workers have been helpful as members of treatment teams, and have been a critical part of getting needed services for children. The staff at many of DCMHS' operated or contracted treatment facilities, such as Terry Children's Psychiatric Center and Delaware Guidance Services, were also commended for their involvement and commitment to children and families. The leadership at DCMHS was also recognized for their dedication to moving the system forward.

Another positive report was that many providers are working to be more flexible about how and where they provide treatment to children and families. They are willing to meet clients in school, in the home, and in the community, as well as having flexible hours. DCMHS pays providers higher rates when they go out of the office to meet with children and families. The MCO DPCI has implemented an initiative where psychologists and social workers may treat children in their school. So far this has been implemented in select schools in the Woodbridge School District, but DPCI hopes to offer this opportunity to all school districts in Delaware that are interested. They are beginning with identifying children in foster care, but plan to extend these services to all children receiving Medicaid. While this approach is not a panacea, it has provided another tool for the delivery of mental health services to children in and adopted out of foster care.

Delaware's school system also helps children in foster care with mental and behavioral health issues in other ways. The McKinney Vento Homeless Assistance Act affords children designated as homeless the right to stay in their current school and to have transportation provided to that school when feasible, in an effort to support stability in these children's lives. Delaware is currently the only state in the nation that considers children in foster care to be homeless. Another way Delaware's educational system is attempting to provide stability to children in foster care is through an 18-month grant between DOE and DSCYF. The purpose of the grant is to address the mental health needs of children in school by helping school personnel identify and understand mental health issues, developing language and protocols to help school personnel make referrals to access services for children, and training school personnel on these protocols. Over 50 schools were assessed in order to design the appropriate referral protocol and to better link children to mental health treatment. A Memorandum of Understanding (MOU) is also being developed between DOE, DCMHS, and DFS to address transitions between mental health services, placements, and school.

Several presenters praised DCMHS' Families and Communities Together (FACT) grant project, which piloted a wraparound service delivery model for children with special educational needs. The FACT grant concluded in 2006, but DCMHS was able to sustain wraparound services and eligibility was opened to all children. That program is going well and as of October of 2008 is serving about 86 children, although many more could benefit from these services if more resources were available.

DCMHS is implementing a new program, the Child Well Being Initiative. DCMHS received the 4-year \$1.6 million grant for this program in October of 2005, in order to develop evidence based practice for the treatment of child Post Traumatic Stress Disorder (PTSD), and to disseminate that practice to outpatient child mental and behavioral health service providers. DCMHS pursued this grant, in part, to increase service delivery to children in foster care. The intervention used in DCMHS' program is Trauma-Focused Cognitive Behavioral Therapy, and was originally developed for use with children who were sexually abused. The reason DCMHS chose this intervention was because it was developed based on children who were sexually abused and thus had exposure to the child welfare system. The objectives of the grant are to take the intervention beyond sexual abuse and use it to treat children who have been exposed to other types of trauma, and to develop a curriculum and training center for therapists who want to use the intervention on a long-term basis. Ideally, this intervention will become a fixture in the child mental and behavioral health system. DCMHS plans to use the results of the pilot to create a workbook for providers.

In order to ensure mental and behavioral health support for youth in state-operated juvenile justice secure care facilities, DCMHS has a team of psychologists and substance use specialists located within the facilities. Services provided include screening and assessment, consultation, out-patient equivalent treatment (counseling and psychiatry services) and referral and linkage to continued mental health and substance use services for youth at the time of release from secure care. These services benefit all youth, including youth in and adopted out of foster care, who are in DYRS secure care settings.

DCMHS has also recognized the importance of early detection and connection to services, and has recently implemented a screening process, whereby all children entering foster care between the ages of 4 and 17 are screened to assess their mental and behavioral health needs. DCMHS reported that the average number of outpatient therapy sessions Delaware children in foster care are getting is 8, compared to the national average of 3. DCMHS has also recently been awarded a federal grant to generate resources to better serve young children.

Delaware's child mental health system is often looked to as a model for the nation. System partners have strived to close service gaps, leverage resources, and work collaboratively to meet the mental and behavioral health needs of children and families. However, there are still challenges to the system and the way services are delivered to children in and those adopted out of foster care.

Challenges to Delaware's Mental Health System for Children

ACCESS TO DCMHS

Structure of DCMHS

DCMHS is the agency through which every child in foster care, and many who are adopted out of foster care, must access more intensive mental health services. While few services are provided directly by DCMHS, DCMHS serves as the gatekeeper for those services. In order to discharge its function of determining that a particular mental health service is medically necessary, it has employed a staff of case managers, clinicians and psychologists who work together as part of clinical services management (CSM) teams. CSM teams plan, authorize, monitor, and coordinate mental health and substance abuse services that are more intensive and restrictive than community-based, unmanaged, outpatient services. These services include inpatient hospitalization, group and individualized residential treatment, day hospital and day treatment, intensive outpatient, therapeutic respite, and therapeutic mentors. They provide professional direction, planning, oversight, and case management services for the clients and families on their team.

Each CSM team is headed by a licensed mental health professional responsible for the overall functioning of the team and the clinical/treatment approach for the child. The CSM team leader provides continuous planning and review for individualized mental health and substance abuse treatment plans, as well as supportive services, for the team's clients and families. They work within the professional standards set by their respective disciplines as well as the framework of Delaware statute and DSCYF policy. They consult with families, service providers, schools, sister agencies, and other professionals to ensure that DCMHS services are as effective and collaborative as possible. Their ongoing review of clinical materials, plans, and treatment progress ensures that the well-being of the client and community is continuously safeguarded, and that treatment services are both the most effective and least restrictive. Team leaders manage crises and emergencies that occur in their team's caseloads, and work with a variety of agencies and service providers to ensure client safety. They take a leadership role in local multi-agency groups, advise and consult with service providers to enhance their effectiveness, and provide clinical expertise in monitoring contracted service providers. The CSM Team leaders also participate on many committees and workgroups at the state level (e.g., Sexual Offender Management Board, Governor's Advisory Council on Mental Health, Court Improvement Project, Developmental Disabilities Council), the department level (e.g., Monthly Permanency Planning Meeting, Service Integration Fund, ISP development), and the division level (e.g., leadership).

CSM teams provide case management services supervised by a psychiatric social worker (PSW). The PSW supervisor is responsible for the effectiveness of DCMHS case management working with the families, services providers, the courts, schools, and sister agencies. They identify barriers to effective collaboration with families and promote best practices in social service provision and case management to overcome them. They provide expertise in accessing formal and informal supports to augment the functioning of families and enhance the effectiveness of the mental health and substance abuse services DCMHS provides. They assist case managers in

developing an effective multi-agency team approach with families and with resolving disagreements that may arise in the course of planning and service delivery. In addition, they carry a reduced case load for which they provide direct case management services, and these cases are frequently the most challenging assigned to the team. They also serve on multi-agency groups and committees and consult with sister agencies as requested.

The majority of case management is provided by several clinical service coordinators (CSC) assigned to the team. As case managers, CSCs are the initial and primary point of contact for families. They meet with newly referred families, explain the DCMHS service system, and develop an understanding of the family's culture, strengths, challenges, and preferences in services. CSCs function as part of a local service team comprised of the child and his or her family, service providers, schools, and sister agencies. They take the lead in conducting planning and review meetings as service approaches are developed and revised. They work with the courts to inform them of DCMHS services and future plans. They work to solve problems in service provision, develop formal and informal supports for the household, and address any concerns encountered in a multi-agency context. They provide their team leader with timely clinical information and work with the team leader to revise service approaches for the future. CSCs are the initial point of contact for emergencies and crises, and work closely with involved parties to implement crisis management plans developed by the team leader and providers.

Functioning of the CSM team is augmented by a family services assistant (FSA), who provides paraprofessional services including transportation, administrative assistance, and family support as necessary. The FSA's performance of routine and logistical tasks enables the other team members to focus on effective service provision to their families.

Intake/Eligibility

Most children in or adopted out of foster care have experienced complex trauma as a result of child abuse or neglect rendering them unique from other children with similar mental health diagnoses. This complex trauma makes mental health supports, treatment, and expertise in some form necessary for their long-term success.

Currently, in order for a child in or adopted out of foster care to receive services through DCMHS, the child must be referred to DCMHS' intake unit. Intakes require the completion of a 3 page form, typically completed by a mental health professional or a DFS worker. CMH staff are also available to assist with completion of the paperwork. The form also requires consent to treatment from the parent/custodian. The information provided on the intake form is used to determine whether the child has a moderate to severe mental illness which cannot be managed through the 30 units of outpatient counseling provided by Medicaid. Children may also be eligible for DCMHS assistance when the 30 units of outpatient counseling have been exhausted. Once the intake is sufficiently completed, DCMHS licensed staff determines if the child is eligible for services.

Despite these seemingly clear-cut guidelines, issues with DCMHS' intake process arose throughout the testimony given by various people involved with securing and providing mental health services to children in and those adopted out of foster care. Testimony indicated that the

amount of paperwork involved with the intake process is burdensome, and that even when properly filled out, it is perceived that it can be very difficult to get DCMHS to open cases.

One of the challenges noted in the testimony was that people referring children to DCMHS, often DFS workers, may not have sufficient information about the child and his or her family, making it difficult to determine the appropriate services and get them in place. Another challenge was that the intake package may still be difficult to read and understand. The process may be complex, requiring consents and placing time limitations on the process. Furthermore, similar referral packages may need to be submitted for the different agencies contracted by DCMHS to provide treatment, even though DCMHS already has the information available. Each of these hurdles to the intake process increases the amount of time that children are going without necessary treatment.

Another briefly mentioned, but critically important challenge, is with children who are mentally challenged to such a degree that they are unable to benefit from cognitive therapy. The testimony revealed that DCMHS has repeatedly indicated difficulty in serving this population as its treatment modalities are unsuccessful on this population. Moreover, the Division of Developmental Disability Services (DDDS), housed within DHSS, has provided Court testimony that they have no services, other than occasional respite, to provide to the disabled population in the custody of DSCYF. Due to a lack of appropriate services and a clear statutory mandate of responsibility, the testimony revealed that the mental health and foster care systems are ill-equipped to meet the needs of these children.

Level of Care

If children are deemed eligible to receive services through DCMHS, the treatment team leader then makes a determination about the level of care that is clinically warranted and needed. In the case of the most restrictive services, such as residential care, the Director of Clinical Services and/or the consulting psychiatrist will review the case to assure the availability of services, and the level of care that is the least restrictive, clinically indicated, and appropriate. If the determined level of care is not available for a particular child, other services are looked at to meet the child's needs.

Delaware's Medicaid Waiver, as well as agreement with federal and state authorities, requires that licensed staff make the clinical decisions about levels of care. Best practices and federal guidelines require children to be treated in the least restrictive environment; if a child is in a more intensive/restrictive setting, there must be a plan in place to return the child back to the community when clinically indicated. Children are closely monitored while in treatment services. Clinical services staff are to be in constant contact with foster care workers, treatment staff, families, and other involved parties, and licensed staff and providers will make changes to the treatment plan as clinical conditions dictate. Risk assessment is a constant process of assessing safety and clinical risk factors and determining the most clinically appropriate treatment setting.

Appeals

DCMHS has an appeal process through which service providers, parents and/or legal guardians may request an appeal of decisions on such matters as eligibility, levels of care, and continued stay. DCMHS' appeal policies are in concert with Federal Medicaid regulations and DSCYF policy. DCMHS stated that it takes approximately 30 days to work through the 3-step appeal process, during which time information is usually discovered that was not originally known. Appeals are usually about a child being stepped down from a more intense level of service, and once the appeal process starts the child is supposed to remain in his or her current level of service until the matter is resolved, unless the placement becomes unsafe for any reason. If there is disagreement, it can be taken directly to the Medicaid office rather than going through the DCMHS appeal process, but that happens infrequently. About 28% of appeals last year were granted.

Case Closure

A related issue that came up several times during the testimony was closure of DCMHS cases. It was felt that DCMHS often closes cases too quickly after a step-down to outpatient services, with little to no transition planning, and that children who were making progress then begin to deteriorate. In order to get their case re-opened, a whole new referral process and intake package must be completed. Compounding the problem was the sense that it is even more difficult to get DCMHS to accept a referral after a child's case has been closed. Finally, it is difficult for children who reach their eighteenth birthday and require ongoing treatment beyond the outpatient level to be referred to Delaware's Division of Substance Abuse and Mental Health (DSAMH), the adult mental health system's counterpart to DCMHS, without an interruption of care.

The following recommendations for change are made:

1. DSCYF should create an environment of mental health care by requiring DCMHS to ensure the availability of mental health services and case management to every child in foster care from their entry into DSCYF custody until their exit from same.
2. In DSCYF so creating an environment of mental health care, DFS and DCMHS should develop and update where appropriate written policies and protocols to ensure the mental health needs of every child in foster care are being met.
3. DCMHS should be required, as may be amenable to the adoptive family, to provide case management services for every child adopted out of foster care until age 18, regardless of whether the child has a current need for mental or behavioral health services. Notwithstanding this recommendation, should a child adopted out of foster care be placed or relocate out of state, DCMHS may terminate case management services after transition to the receiving state's mental health service system.
4. DSCYF should undertake an evaluation of its organizational structure; inter-divisional communications, policies, procedures and processes; and staffing patterns as they relate independently and collectively to the delivery of mental and behavioral health services to children in and adopted out of foster care. Opportunities should be explored to:
 - Streamline policies and procedures for access to and delivery of mental health services in order to maximize efficiency and effectiveness;

- Eliminate inter-divisional barriers/impediments in order to provide a seamless mental and behavioral health services delivery system from the time the child enters the foster care system until the child exits same;
 - Align staffing patterns (classification, allocation, and deployment) to support and complement the mental and behavioral health delivery system;
 - Maximize the utilization of all financial resources through effective case management practices.
5. Where there is disagreement about level of care for a child in foster care, the DCMHS clinical staff should meet the child prior to making his or her decision about the appropriate level of care.
 6. DCMHS should ensure its level of mental health treatment takes into account the environment of care as DCMHS does in substance abuse treatment. The primary focus of DSCYF and its divisions should be what is most appropriate for the child, while factoring in the least restrictive environment where the child can succeed and be safe.
 7. DCMHS, DFS and DDDS should work together to craft MOUs, protocols, and/or legislation to assure that the mental and behavioral health needs of the cognitively disabled population of DSCYF children are appropriately met, and that the responsibilities of each agency are clearly delineated and met with the concomitant resources to serve this challenging population.
 8. DSCYF, in conjunction with DCMHS and DMMA, should continue to work together to extend DCMHS case management services for children who age out of foster care until age 21, and work toward a seamless transition to the adult mental health system.

CRISIS SERVICES

Another way children may become involved with DCMHS is through child priority response services, or what are commonly known as crisis services. However, there is limited staff for these services and they cover broad geographical areas, and while they will try to handle all calls that come in, sometimes families may have to wait before they can be assisted, if they are assisted at all. Testimony highlighted the frustrations of those who attempted to access crisis services and were not served. One report indicated that the caller was told she could not take the child directly to a treatment center but would have to get a referral from the DFS worker first, while another was told that crisis would not respond at all because the child had made similar threats before.

A new intervention DCMHS is piloting is the SOS program, in which contracted clinicians provide consultation and direct intervention to challenging foster children and foster families where placement disruption may likely occur. The intervention is designed to be short term with the goal of stabilizing the behavior of the child and preserving the placement. While DCMHS is pleased with the initial response and potential of this program, the program's capacity is currently very limited, and cannot fully respond to the extent of the community need.

Overall, there are not adequate resources allocated to meet the needs of children and families in crisis in the state. Testimony indicated that in an attempt to provide appropriate crisis services, DCMHS has repeatedly sought to reevaluate the current resources and enhance these services; however, the Division has been unsuccessful in its attempts to do so.

The following recommendation for change is made:

1. DSCYF should develop a crisis response service that adequately meets the needs of children and families in crisis, looking at the outcomes of the SOS program for guidance.

INSURANCE

Although all children in paid foster care placements are eligible for Medicaid, if they meet the income criteria, and the mental and behavioral health benefits that come with it, private insurance still plays a role in the larger process, and can create challenges and barriers to treatment upon entry into and exit from the foster care system.

When children first enter DSCYF custody, DFS must apply for Medicaid for those children. If the children are in paid foster care placements, they are eligible. However, if the children are placed with relatives, non-relative caregivers, or in other non-paid placements, eligibility is determined based on the income of the home in which they live. Even if the child is Medicaid eligible, once no longer placed in paid foster care, the child is no longer eligible, potentially interrupting the stability of the mental health treatment that is necessary to keep the family stable. Should this occur, DFS is required to pay for the medical costs out of pocket.

Even for those children who are eligible for Medicaid, the testimony revealed that the application process can be cumbersome and lengthy. Experiences elicited through testimony indicated that delays in receiving Medicaid approval and a Medicaid card can oftentimes inhibit the ability to obtain immediate mental health intervention, causing disruptions in placement, behavioral issues in school, and the need for crisis responses.

As children are adopted out of foster care, insurance becomes a further barrier to prompt and appropriate mental health interventions. Both DFS and licensed adoption agencies counsel their families on choosing primary health insurance coverage for their soon-to-be adopted child. Families may choose to place the child on their private health insurance or to continue the adopted child on Medicaid. The testimony revealed that typically this counsel encourages the family to place the adopted child on the private insurance of the adoptive family, and to elect Medicaid instead as secondary coverage. The logic behind this advice was unknown to the Subcommittee. What families subsequently discover is that private insurance benefits often cannot meet their family's mental and behavioral health needs.

Navigating private insurance benefits can be difficult and confusing, as well as time consuming. Families are sometimes unaware of the mental and behavioral health benefits they are entitled to as part of their insurance package, and were not counseled to consider the available mental health benefits prior to adoption finalization. The most obvious and immediate issue is that oftentimes a child will have to change mental health providers to comply with the new private insurance provider list. This breaks the continuity of care at a fragile time for a child who has just become legally part of a new family. Then, when families try to access mental and behavioral health services under their private insurance plan, they sometimes run into barriers when their insurance will not cover all of the services a child may need, or when their insurance company's authorized providers do not have the necessary skills or offer the necessary treatment to meet the needs of their child. By way of example, substance abuse is a very common co-occurrence with mental health issues, but many therapists are not equipped to address substance abuse issues, so children may need to see two separate therapists. However, private insurance providers often prohibit children from being treated in two disciplines at the same time.

Moreover, insurance companies may not have therapists with the appropriate clinical expertise, but instead of denying services so families can access Medicaid, the private insurance company will authorize services that do not meet the child's needs, or require treatment by therapists who admittedly do not have the clinical expertise to treat complex trauma associated with child abuse and neglect. Testimony speculated that insurance companies are likely unwilling to deny services because there could be adverse consequences from accrediting agencies, and companies may be less likely to purchase insurance from a company that regularly issues denials. It was noted that there is a level of frustration from parents because their primary insurance will not issue a denial if they have authorized service from a therapist, even though the clinician does not have the clinical expertise to treat the issues presented by these children – specifically complex trauma stemming from child abuse or neglect. As the secondary payer, Medicaid cannot authorize services without a denial from the primary insurance carrier. Another challenge to private insurance is that many companies consider children's issues to be behavioral rather than mental health related, and therefore deny treatment.

Families are often without knowledge as to how to challenge these denials. Even when families have the knowledge, they are often without the time or the resources to pursue appeals or referrals to the Insurance Commissioner's Office. When their children are in crisis, and they are attempting to hold down a job, take care of their home and family, and meet other everyday responsibilities, it can be very difficult to take the necessary steps to obtain coverage.

The Subcommittee learned from Delaware's Insurance Commissioner that this testimony is accurate, and there has been much friction around claims for mental health service availability, especially as it pertains to children and young adults. There is an estimated 4-5 times the amount of appeals and other grievances around mental health benefits than other kinds of insurance benefits, likely due to the fact that insurance companies do not really understand mental health claims because they are not cut and dry, or else they just do not want to pay such claims. Nonetheless, insurance companies are mandated to provide "reasonable and accessible" health care, including mental health services. In fact, just in recent weeks a federal law passed requiring mental health services to be covered in a health insurance policy at the same level as physical health.⁷ This means that if there are not adequate providers (both in number and in specialty) in a certain area, the company is required to obtain an adequately skilled provider within a reasonable distance. The Insurance Commissioner's Office has challenged private insurance companies on both a systemic and an individual level in order to improve mental health services, but problems still persist. In addition, Delaware has many large employers that are self-insured. These employers hire insurance companies as third-party administrators to manage the benefits, but because the company is self-insured, the Insurance Commissioners Office has little power to ensure compliance.

As a result of these insurance disputes and the minimal mental health services purchased and provided under private insurance plans, which result in a lack of prompt and appropriate mental health treatment, testimony indicated that some children end up in (or back in) foster care. Sadly, some of this population of children entering foster care are from disrupted adoptions – adoptive families who have struggled to meet the child's mental health needs but for a variety of reasons cannot obtain the necessary mental health services to keep this child and the rest of their family safe. Oftentimes, these children become the costliest clients of DSCYF.

⁷ The mental health parity law, Public Law 110-343, was signed by President Bush on October, 3, 2008.

Given this complicated set of difficulties, especially for children adopted out of foster care who continue to struggle with mental and behavioral health issues, the logical conclusion is for every child to remain on Medicaid. However, this solution was equally troubling to members of the Subcommittee. On one hand, Medicaid has more resources to meet the mental and behavioral health needs of children with complex trauma due to abuse or neglect. On the other hand, the question was raised as to whether the private insurance companies insuring the families of this State should be encouraged to provide appropriate coverage to meet these needs. Especially with the recently passed federal law on mental health parity, and the special “non profit” status many private insurance companies receive in this state, private insurers should not be allowed to avoid their responsibilities to these children and their adoptive families. These are dilemmas without easy resolutions.

The following recommendations for change are made:

1. CPAC, together with leaders of the new administration, shall work together to create a task force or subcommittee to include private insurance companies, adoptive families and representatives of DMMA to:
 - Develop recommendations for improving the depth and breadth of skilled clinicians approved by private insurance companies and third-party administrators who are competent to treat complex trauma as a result of child abuse and neglect;
 - Develop a pilot project to be led by a private insurance company or third-party administrator to test the recommendations; and
 - Explore the feasibility of allowing families who have adopted children out of foster care to continue using Medicaid for mental health benefits while utilizing private health insurance for physical health benefits.
2. CPAC should introduce legislation to require continuity of necessary and appropriate mental health care after adoption finalization, which would enable a child to remain with their mental health provider regardless of a change in insurance after adoption.
3. DFS, DCMHS, and the Interagency Committee on Adoption (ICOA) should work together to develop written documentation and training on how to guide adoptive families in their personal choice regarding medical coverage for their adopted child. This documentation and training would then be used to train new adoption and permanency workers from the State and contracted agencies, as well as raise awareness in the child welfare legal community as to the need to make well-informed choices on medical care benefits prior to finalization.
4. CPAC, together with DMMA and DSCYF, should explore the state and federal requirements and limitations on Medicaid eligibility for children in DSCYF custody who are not in paid foster care placements, and propose statutory and policy changes to ensure that all children in DSCYF custody remain Medicaid eligible throughout the duration of that custody.
5. DMMA and DSCYF should explore opportunities to streamline the Medicaid application process for children in foster care.

COORDINATION AND COMMUNICATION

One of the most common challenges brought before the Subcommittee was the lack of communication and coordination in all aspects of the system. There was a feeling that, in general, stakeholders were not getting enough information about the children and families they serve to sufficiently meet their needs. Best practices indicate that consistency and continuity of service are vital, and that there must be a focus on how children and families move through the system and how to make those moves successful. Lack of coordination and communication among system partners and those who are part of children's lives often results in such things as missed appointments, inappropriate services and/or placements, poor planning and difficult transitions, and, ultimately, the failure of children to thrive and succeed.

Lack of Information/Failure to Share – DSCYF History/Family History

Lack of information and/or not sharing information about a child's or family's background can lead to inappropriate placements or treatment. Currently, no mechanism exists within the DSCYF Family and Child Tracking System (FACTS) information system which synthesizes and summarizes a family's history with DSCYF. In addition, each Division within the Department opens its own "case" within FACTS, and often information held by one Division is not readily accessible by another Division. Several death and near death reviews indicate that the lack of use of history on a family was a contributing factor. As a result, a joint subcommittee between CPAC and the Child Death, Near Death and Stillbirth Commission addressed the issue of information sharing and use of history. The report is available at:

http://courts.delaware.gov/childadvocate/pdf/Information_Sharing_FinalReport.pdf.

One recommendation from that report was the addition of an "event" in FACTS to summarize history. This "event," once implemented, would also be critically important to DCMHS in assessing the trauma history of a child to ensure the most appropriate mental health treatment is provided. This may also help ensure appropriate referrals to DCMHS' Child Well Being Initiative.

The following recommendations for change are made:

1. DCMHS, DFS, and OCA should share databases and information systems related to all children in and adopted out of foster care so as to ensure they receive appropriate mental and behavioral health services, including but not limited to Trauma Focused Cognitive Behavioral Therapy through the Child Well Being Initiative.
2. DCMHS and DFS should partner to ensure the FACTS event summarizing DSCYF history on a family is implemented and accessible to all necessary parties. To the extent that mental health treatment history can be referenced or included in the summary, it should be. Currently DSCYF is able to generate a report of all "placements," regardless of the Division. This information should be incorporated or referenced in the history as well.
3. Should FACTS II come to fruition, consideration should be given to eliminating the requirement of separate case files for DCMHS, DFS and DYRS in DSCYF custody cases.

Transitions Between Therapists/Mental Health Services

Many speakers commented on the difficulty of getting records from therapists, or having records transferred from one therapist to another when a child changes services. This causes several issues. First, it can be detrimental to a child's progress to have to start all over again at the beginning so that a new therapist can get caught up. It can also place a burden on the families or caseworkers who have to fill out more paperwork or go through the same information again and again. Furthermore, it is a risky professional decision to treat a child without having all of the necessary information. Without the pertinent background information, it can be difficult to properly evaluate a child's needs, develop an appropriate treatment plan, or ensure that children are not being placed in settings in which they are destined to fail.

The following recommendations for change are made:

1. DCMHS, in conjunction with a representative group of providers, should develop a standardized summary form to be used by all mental health professionals in the treatment of children in or adopted out of foster care which shall be completed prior to the transfer and/or at the conclusion of treatment. DCMHS will ensure that all of its approved therapists complete this form, and provide it to DCMHS, DFS, and the new mental health provider, if applicable. This form shall become part of the permanent DSCYF record on the child in or adopted out of foster care.
2. DCMHS progress reviews and case management of every child in foster care should be proactive and monitor the child's progress in mental health treatment regardless of the level of care being provided.

Communication Among Sister Agencies

Another issue that became apparent throughout the testimony was the lack of communication and coordination among the different divisions of DSCYF and the agencies they contract with. A fact highlighting this lack of coordination is that DCMHS feels it is not reaching all of the children it should be serving, including children in foster care. DCMHS reported that 35% of referrals to DCMHS come from providers, while only about 7% come from DFS caseworkers. Greater communication between these divisions would result in more children in foster care getting needed mental health treatment. Should the overall recommendation that DCMHS provide services to every child in DFS custody be implemented, this situation would be partially addressed.

When children in foster care are referred to and accepted by DCMHS, there are often still issues with communication. In several cases, the failure of the divisions' caseworkers to meet and plan for transitions resulted in children being placed in detention facilities, rather than other appropriate treatment settings. Moreover, according to testimony, the perception was that once the children were in these detention facilities they were not receiving intensive mental health treatment. Other individuals discussed examples when the division workers could not provide recommendations for treatment, or simply could not come up with a plan to get the services in place, so necessary services were simply not delivered.

Testimony presented to the Subcommittee also highlighted the discord between the divisions and their contracted providers. There were several examples in which the service providers recommended specific interventions, but DCMHS either denied those services or made different recommendations. There were also examples of when line level DCMHS workers made agreements for services with other partners, only to have those agreements disapproved by DCMHS administration. Individuals also testified that their experiences showed when the divisions and/or providers involved could not agree on or come together to provide a plan for transition and treatment, the result for those children was going without mental health treatment and, often, regression or failure in home, school, or community.

The following recommendations for change are made:

1. DCMHS and DFS should implement a structured communication policy, protocol, or memorandum of agreement (MOA) and/or give consideration to the co-location of DCMHS staff serving this population directly within the DFS units. The goal of this recommendation is to foster a team concept in serving children in DFS custody which must necessarily start within DSCYF. At a minimum, specialized units within DCMHS should be considered to focus on children in and adopted out of foster care.
2. Via protocols or MOA between DCMHS and DFS, transition plans should be completed prior to the movement of a child for placement or mental health treatment.
3. DSCYF should implement a policy, protocol, or MOA between DCMHS, DFS and DYRS to ensure that children in or adopted out of foster care who become detained have no interruption in mental health treatment while in secure care.
4. DSCYF should provide training to its employees in accordance with recommendation #1 in the Training, Education, and Dissemination of Information section of this report.

Educational Transitions

Testimony from DOE indicated that the number one issue that schools have identified is the need for better communication and coordination among schools, foster parents, and caseworkers. This lack of communication often makes it hard to identify children in foster care, which in turn makes it hard to address their mental and behavioral health needs in meaningful ways. School personnel need to know who they can contact when issues arise with students in foster care, particularly when the need for behavioral health services is apparent.

When children are returning to the community from alternative settings, re-enrollment can be an issue when workers attempt to enroll children without the school having all of the necessary information. Schools need information before they can enroll a student, and must take steps to ensure the safety of all the students in the school. When communication breaks down during these transitions, it can result in delays and children being retained in inappropriate educational settings. While DFS reports that there is a protocol for enrolling children in school and that they have identified key points of contact throughout the state for workers, this protocol may not always be followed. Each school district has a liaison that workers should communicate with when a child is going to be discharged from services to ensure that a smooth transition back into the school takes place and that their mental and behavioral health needs are identified.

The following recommendations for change are made:

1. DSCYF and DOE should promptly complete the execution of the Memorandum of Understanding between them.
2. Using the executed Memorandum of Understanding, DSCYF (DFS, DCMHS and DYRS if applicable) and DOE shall conduct TIMELY and mandatory transition meetings for children that are in DSCYF custody prior to the child re-entering school from alternative schools, detention, or treatment facilities. These transition meetings shall ensure that the child's educational and mental health needs will be appropriately met in home, school, and community. Delays in this meeting should not result in retaining a child in an inappropriate setting.
3. DSCYF (DFS, DCMHS and DYRS if applicable) should proactively create a communication system for letting schools know who is responsible for a child in DSCYF custody and to encourage open and frequent communication through that system.

Informing Families

The importance of foster families knowing what to expect was also emphasized. It is often easier for them to deal with difficult behaviors if they are prepared for them and understand the reasons behind the behaviors. This was referred to as "trauma-informed care." DFS has limited resources to provide this type of support to foster families. Testimony indicated that children can achieve success when foster families are provided with resources ahead of time and told what to expect from the children placed with them.

The following recommendations for change are made:

1. DSCYF (including DFS and DCMHS) should create and/or improve the Level of Care forms and/or Child Profiles provided to foster and adoptive families to fully include a child's DSCYF and trauma background, behaviors, mental health needs, and other important factors so that families are prepared for the children entering their home. This should result in increased stability of placement due to a thorough knowledge base, the availability of appropriate supports, and the preparation of the family for acting-out behaviors that often result in disruptions.
2. DFS and DCMHS should jointly increase the resources and supports to prepare and train families to work with children with behavioral difficulties in order to minimize disruptions which impact not only the child and family, but also DCMHS and DFS.

TRAINING, EDUCATION, AND DISSEMINATION OF INFORMATION

Testimony was presented to the Subcommittee which indicated a lack of knowledge and understanding of available mental health services, and how to access them. By way of example, DFS workers, who are responsible to coordinate the securing of mental and behavioral health services for children on their caseloads, indicated that they are not always aware of available resources, especially in counties other than the ones in which they work. They are also not aware of how to locate that information and/or how to get recommendations for a particular clinician who can meet the child's therapeutic needs. The Subcommittee heard concerns that DFS workers do not always have the understanding and knowledge of the child mental and behavioral health system to be able to ensure that children are getting the services they need and that gaps do not occur unnecessarily.

Some of the Subcommittee members concluded that if DFS workers, who are "inside" the system, are unsure as to what services are available and how to access them, then certainly those people who are "outside" the mental health system, such as judges, lawyers, school personnel, medical providers, and foster and adoptive families are at a distinct disadvantage. Many of the system partners who presented to the group and who were consumers of the system felt that it was imperative for all stakeholders to have an easy, user-friendly way to find services and providers, and to understand what options are available to children who need mental and behavioral health interventions. In contrast, some members of the Subcommittee who were providers of the system were dismayed with the lack of knowledge, and perplexed by the need to improve access to information.

Foster and adoptive families, who accept these children in their home, and the contract agencies or DFS foster home coordinators who support them, are at a particular disadvantage. Oftentimes, they must be the first line of advocacy for a child in order to stabilize their household in a timely manner. In addition to not always being fully apprised of a child's behaviors prior to placement, foster and adoptive families are not fully educated on what mental and behavioral health services are available to help their family, and even more critical, are sometimes not prepared and supported by their agencies and coordinators for the behaviors occurring in the home. While some agencies provide a high level of support and preparation for the complex trauma issues surrounding child abuse and neglect, and the behaviors that manifest upon placement into a family, many do not. Children and families struggle as a result.

The following recommendations for change are made:

1. CPAC's Training Subcommittee should create a subgroup with appropriate members to develop a core and advanced curriculum training, similar to CAN 101, to educate all child welfare system employees and partners, including schools, judges, lawyers, medical providers, mental health providers, contract agencies and families on, but not limited to, the following issues:
 - How to access mental and behavioral health services for children in Delaware;
 - The levels of care available;
 - Resources;
 - Behaviors of complex trauma due to child abuse and neglect, and family management and support of children who suffer from complex trauma,

acknowledging an expectation that children who enter foster care have experienced trauma from the removal itself.

2. DCMHS, DMMA, OPEI, DFS and the CPAC Training Subcommittee (or a component thereof), should develop a user-friendly website that lists all available mental and behavioral health services and providers in Delaware, together with credentials, areas of specialty, and clinical requirements for service access. The group should investigate potential linkage with similar work being undertaken by DSAMH and by DOE. Adequate resources, including the use of grants, should be explored to assure the information is current and accurate. The website <http://www.networkofcare.org> should be explored thoroughly.
3. DSCYF, and in particular DFS with the guidance of experts in this area, should require in future foster home contracts that families and contract agency workers be trained and supported on complex trauma associated with child abuse and neglect, and the behaviors that stem therefrom.
4. DSCYF, and in particular DFS with the guidance of experts in this area, should require in future adoptive placements that agencies identify appropriate mental health therapists in the community to support adoptive families with regard to the behaviors that stem from placement of children with complex trauma associated with child abuse and neglect, to minimize disruptions.

PROVIDERS

One of the primary concerns of the Subcommittee and those who provided testimony was the dearth of available and appropriate providers in the state, and the subsequent waiting lists for services or lack of adequate specialized services that result. While the MCOs reported that they believed there were an adequate number of providers to meet the overall needs of Delaware's children, while acknowledging challenges in specific areas, DCMHS repeatedly told the group that there is a documented lack of mental health professionals in the state, especially in psychiatry.⁸ Some of the specific areas in which DCMHS acknowledged a lack of services and/or providers were substance abuse, children with inappropriate or problematic sexual behaviors, young children, and children with developmental disabilities. Some members of the group felt that there is a general lack of providers who are comfortable and competent to work with children, especially children in and those adopted out of foster care, who suffer from complex trauma associated with child abuse or neglect.

Delaware faces several challenges to recruiting and maintaining high quality, trained professionals to work with these populations. Extensive education is required for many mental health professions, and most school programs do not offer specialized training on how to work with children in foster care or with traumatic histories. Moreover, Delaware is at somewhat more of a disadvantage, due to its lack of a research-based medical university, although DCMHS does have a good partnership with the University of Delaware, as well as schools in other states such as Children's Hospital of Philadelphia and Jefferson University. The University of Delaware has recently embarked on a partnership with Jefferson University, which may begin to address this area. Professionals who testified suggested that Delaware may have trouble finding mental health clinicians who work with children and who are willing to work within Delaware's Medicaid system, because the payments are often lower and reimbursements are slower than in neighboring states. They also opined that there are little to no incentives for professionals to get dual licenses from the state or to provide more specialized treatment. Finally, they commented that the credentialing process required by Medicaid and private insurance companies lacks uniformity, is lengthy, and lacks flexibility.

Due to the lack of providers, those trying to get children into mental health treatment often experience waiting lists and lengths of time before children can be evaluated or treated. Numerous speakers noted this issue as one of the most troubling facing Delaware's mental health system for children. While children wait for mental health services, their school performance may suffer, their behavior may deteriorate, their placements may be jeopardized, and they may end up needing more intense interventions than they otherwise would have. Some speakers mentioned that sometimes services that were recommended as part of a treatment plan were never implemented. When a necessary mental health service is not available for a child due to waiting lists or budget cuts, the child is often given a different service that may be less than optimal to meet their mental health needs. One extremely successful mental health service, Intensive Outpatient (IOP), has historically had waiting lists, especially in Kent and Sussex

⁸ There is a shortage of mental health practitioners in Southern New Castle County, Northern and Western Kent County and Western and Southern Sussex County according to the findings of the Mental Health Data Gathering Project of the Delaware Health Care Commission., June 30, 2006 – <http://dhcc.delaware.gov/pdfs/MentalHealthReportVolumeI.doc>

Counties. With the latest round of potential budget cuts in the Fall of 2008, this service may become significantly limited, particularly in Kent and Sussex Counties.⁹

The following recommendations for change are made:

1. DCMHS, DMMA, and provider agencies should create a plan to provide incentives for mental health professionals to develop skills and provide treatment to children in and adopted out of foster care.
2. DCMHS, DMMA, and provider agencies should explore options to reimburse mental health professionals for attending trainings on providing treatment to children in and adopted out of foster care.
3. DCMHS, DMMA, and provider agencies should partner with the local colleges and universities to regularly utilize student interns in all of their mental health programs for children, with clear cut internship guidelines and supervision that will cultivate an interest by students in providing mental health services to children in and adopted out of foster care following graduation.
4. DCMHS, DMMA, and provider agencies should partner with the local colleges and universities to build an incentive package for attracting and retaining mental health professionals in Delaware. In so doing, they should review the strategies employed by the State of Maryland, and consider modification to licensing and supervision requirements, loan forgiveness opportunities¹⁰, career ladders and resources through Delaware Institute for Medical Education and Research (DIMER), Delaware's process for loan repayments for medical professionals.
5. DCMHS, DMMA, and provider agencies should partner with the local colleges and universities to explore creative ways to count clinical hours required for a degree that meets the purpose of clinical hours while maximizing the ability to provide services to children receiving mental health treatment.
6. DCMHS, DMMA, and the Office of Professional Regulation (OPR) should conduct a market analysis of Medicaid reimbursement rates for children's mental health services in the surrounding state area (NJ, PA, MD, VA, WV).
7. DCMHS, DMMA, and the MCOs should work together to streamline the credentialing process for professionals and develop a policy to allow provisional paneling so professionals can treat and bill for services.
8. DCMHS should pursue with OPR the granting of provisional licenses for already-licensed professionals in good standing from other states while they go through the process of licensure in Delaware, enabling them to treat and bill for services.
9. DSCYF should increase resources to enable its employees to acquire the education needed for licensure.

⁹ A DSCYF report at the CPAC Quarterly Meeting on October 8, 2008, revealed a potential \$6.4 million budget cut being required by the Office of Management and Budget. This, coupled with the hiring freeze, has significantly hindered DCMHS' ability to operate IOP services, particularly in Kent and Sussex Counties.

¹⁰ Provisions for public service student loan forgiveness were recently passed in federal Public Law 110-315. The law includes mental health professionals who work full-time to provide services to children or adolescents.

PREVENTION AND EARLY INTERVENTION

Another recurring theme throughout the Subcommittee's work was the need for more prevention services, and the need to intervene earlier in the lives of at-risk children and families. A child welfare expert from the Child Welfare League of America (CWLA) advised that the system should think holistically; rather than just looking at meeting deep-end needs, child protection communities should think about prevention and early-intervention, as well as community-based services for children who return home. This was referred to as a continuum of prevention. The continuum includes programs, such as mentoring, that build the resiliency of children and families, so that they do not end up in foster care. The CWLA expert indicated that while the children in foster care are a small population of those who use the mental health systems for children nationally, they are the population which consumes the greatest number of mental health resources and has the most complex needs due to their complex trauma and family dysfunction.

DCMHS reaffirmed its emphasis on early detection and connection to services, and noted that the early screening process of children entering foster care is working toward this goal. This is a tertiary prevention effort aimed at reducing the incidents of further child abuse or neglect against these children. DCMHS has also been providing Trauma-Focused Cognitive Behavioral Therapy through a federal grant for the last three years, and has also just obtained a grant to help the child mental health treatment system train all outpatient providers in Parent-Child Interaction Therapy to provide better treatment for young children.¹¹ These are also tertiary prevention efforts which directly benefit children in and adopted out of foster care.

Delaware also has an Office of Prevention and Early Intervention (OPEI) which is currently housed in the management and budget division of DSCYF. OPEI presented to the Subcommittee and reported that it has been evolving over the last few years by making more data-informed decisions, doing more to leverage its resources, and thinking about prevention across the lifespan. It views prevention as increasing the protective factors in families such as resilience, social competence, and available assets, as well as decreasing the risk factors of families. In addition, OPEI looks at cultural competence and sustainability of programs. OPEI indicated that nationwide prevention efforts also focus on collaboration, coalition building, community capacity building, and community readiness, especially with faith-based organizations. OPEI opined that prevention has always been primarily in the community, and the state is not necessarily the best provider of prevention and early intervention services.

OPEI represented there are several trends in the field of prevention. First, there is more of a focus on universal approaches, in which everyone participates and there is no target population. This is referred to as primary prevention. This involves general education and outreach – the federal government is pushing for more of this kind of prevention. Another trend in the field of prevention is to use more empirically sound and heavily researched strategies, and to utilize multiple strategies together in multiple domains. It was unclear if this approach targeted at-risk populations or was again universal. Another new focus of prevention efforts is environmental

¹¹ See Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) provided by DCMHS through the Child Well-Being Initiative –

http://www.nctsnet.org/nctsn_assets/pdfs/promising_practices/TF-CBT_fact_sheet_2-11-05.pdf.

See also Parent-Child Interaction Therapy (PCIT) to be provided by DCMHS –

http://www.nctsnet.org/nctsn_assets/pdfs/promising_practices/PCIT_fact_sheet_2-11-05.pdf.

strategies, which target population-level change and policy change, rather than individual change. These efforts help to create a culture of stability and safety; prevention efforts also work to create a culture of academic success and to instill those values early on – again appearing to be a primary prevention effort. One such population that prevention is focusing on more is the growing teenage population. Again, it was unclear if there were at-risk teenagers identified or the prevention efforts were focused on the entire teenage population. Finally, those in the field of prevention are looking to focus more on the front end of the service spectrum, wherever that may be, and to intervene earlier and more often.

The Subcommittee and its guests found its focus and struggle to be specifically with a target population – older youth in foster care. These older youth generally do not have as much success in foster care as younger children because their challenges make placement difficult, they are often difficult to engage in mental health treatment, and can be difficult to find appropriate treatment for at all. Sometimes these youth are just getting mental and behavioral health services for the first time in their lives. It was felt that if the system could reach these neglected and abused children and their support systems earlier in their lives, perhaps it would be possible to meet their needs and prevent more significant problems later.

Along those lines, emphasis on high quality child care and early childhood programs for at-risk families and/or abused or neglected children are two ways to intervene early and support children and families. It is important that children in foster care receive the highest quality daycare and early childhood services possible, in order to support their early brain development. Last year, however, DFS referred 1,026 children to DHSS for subsidized childcare through POC, and programs accepting child care subsidy have been shown to provide statistically significant poorer quality care than programs that do not accept child care subsidy. Delaware also has had a need for more mental health interventions for young children, such as Parent-Child Interaction Therapy, and DCMHS is hopeful that the recent grant award will help to build a skilled cadre of mental health experts to work with infants and toddlers and their foster families and child care providers.

Two additional target populations identified through testimony were children in DFS custody whose parents had also been raised in foster care and/or whose parents had substance abuse problems. While no local intervention was identified, the Subcommittee acknowledged that secondary prevention efforts aimed at these families before significant problems arise may help keep them intact and keep their children out of foster care.

Prevention, however, would require a shift not only in focus, but also in resources. Delaware currently has very little state dollars allocated for targeted prevention programs; moreover, members of the group felt there was not enough political will to spend more of Delaware's limited resources on prevention. While DCMHS has embarked on several secondary and tertiary prevention efforts targeted at children in foster care, there is no committed DSCYF plan for prevention for the families that DSCYF serves.

The following recommendations for change are made:

1. DSCYF should evaluate OPEI to ensure concrete and direct goals are in place to support its Divisions – DCMHS, DFS and DYRS – and how they interact to serve families. DSCYF should pursue and maintain grants that support these goals.
2. CPAC should partner with DOE and the Governor’s Council on Early Childhood to ensure that children in and adopted out of foster care are benefiting from quality child care, thereby helping to reduce the needs for deep-end mental health services in the future.
3. DSCYF, and specifically the employees of DFS and DCMHS, should be trained on the entitlements of children in foster care to Title IV-E – Part C – Birth to 3 screenings and services and early Head Start to maximize opportunities for positive brain development in our young children in foster care.
4. OPEI, together with DCMHS and DFS, should examine the continuum of community based services and explore opportunities to develop prevention programs with agencies such as Big Brothers, Big Sisters, YMCAs, and Boys and Girls Clubs, so as to connect children in DSCYF custody and families with informal supports to build resiliency.
5. DCMHS, together with its community partners, should examine its continuum of care for services available to children with substance abuse issues, and how those services can be provided concurrently with mental health services to avoid the need for more deep-end mental health or substance abuse treatment in the future.

FAMILY INVOLVEMENT AND SUPPORT

The Subcommittee was unanimous in its agreement that family involvement is vital to the success of children. A member of DCMHS staff observed that children in foster care whose foster parents are actively involved in their treatment have made more progress than children whose foster parents were not involved. While some of the contracted foster care providers do require their foster parents to participate in treatment, DFS expects but does not mandate participation in its foster parent contracts. Family involvement can address several issues that inhibit the mental and behavioral health supports of children in and adopted out of foster care.

A significant issue presented to the Subcommittee by many professionals was the issue of “no shows,” or children not making it to their scheduled therapy appointments. “No shows” affect the system in several different ways. The most obvious and important consequence of “no shows” is that children are not receiving necessary mental health interventions. Compounding this problem is the fact that many agencies will discontinue a child’s service altogether after a certain number of sessions have been missed, or will at least delay further sessions until the problem has been satisfactorily addressed. From the providers’ perspective, “no shows” are also detrimental because they result in lost appointments and, ultimately, lost payments. Some providers will try to accommodate families caring for more than one child by scheduling successive appointments for all of the children in the home; however, agencies stand to lose a significant amount of time and resources if an entire family fails to keep their appointments, and so they are becoming reluctant to schedule sessions this way. One provider who presented to the Subcommittee noted that it is expensive to provide services for this population, and while agencies want to be flexible, they must also be mindful of financial issues. Requiring and supporting family involvement in therapy, however, can make significant progress in reducing the number of missed appointments children incur.

Another issue that can be addressed through greater family involvement in treatment is problems that arise when families do not have a thorough understanding of the behaviors they should expect when caring for a child who has experienced trauma due to abuse and/or neglect. Testimony indicated that when families know what behaviors to expect, understand the reasons behind the behaviors, and are prepared to handle them, placements are more likely to be stabilized. When families participate in therapy, this understanding can be strengthened, and children and families can work through issues as they arise. They can also learn how to sustain positive progress and newly learned behaviors.

Finally, testimony indicated that family participation in therapy is vital for therapists to gain an accurate and complete understanding of what is happening in the child’s life. Furthermore, the array of issues facing children in foster care such as trauma due to abuse and/or neglect, the effects of exposure to drugs and/or alcohol, and the impacts of multiple placements and the severing of multiple caregiver relationships, may result in the escalation of mental health problems, pushing away of subsequent caregivers, and a severely wounded capacity to trust adults. The implication of these issues, according to testimony, is that children in foster care need to be treated in the context of relationships, at home or in the community with the family, and that simply treating their mental health diagnosis is insufficient.

Unfortunately, it can be difficult to get families involved in children's treatment, especially when they are not mandated to do so. Practical barriers such as transportation issues and inflexible time schedules can be a hindrance, as can "cultural" barriers such as a lack of understanding of the importance of therapy or a perception that the family's input is neither solicited nor valued.

When the system asks that families be active participants in interventions designed to keep children safe and to address their mental and behavioral health needs, it must also be prepared to support families to do so. The Subcommittee struggled to come up with ideas for improving the participation of families, but agreed that greater flexibility in the times and locations at which services are provided were essential to increased participation and decreased "no show" rates. Other supports identified for families included regularly scheduled respite care with qualified providers, training on what to expect from children who have experienced trauma due to abuse and/or neglect, and more easily-accessible information on how to find and access resources in the community.

The following recommendations for change are made:

1. DFS and all of its contracted foster care providers should require foster parents to be actively involved with children's therapy.
2. DCMHS and DFS should work together to ensure that services are flexible and provided in a location appropriate to facilitate family involvement in treatment.
3. DSCYF should provide regular respite care for foster and adoptive families, as part of a support system that works to preserve placements.
4. When necessary, DFS should transport children in foster care to treatment.

RESOURCES

Mental health resources, both financial and provider, for children and adolescents, particularly those in and adopted out of foster care, are quite limited in Delaware. Funding sources, payment streams, insurance requirements, expertise, and training all complicate the ability to deliver mental health treatment to children in and adopted out of foster care. Unlike Delaware's educational and correctional systems, a per child allocation of money is not provided for every child who enters the DSCYF system. Instead the Department must advocate for increased funding each year to meet the needs of its growing population.

When created, Delaware's integrated Children's Department was an innovative and effective way to manage the provision of services to children and families. However, the funding for such services is still categorized within the three primary divisions. This categorized funding often leads to disputes over payment and/or placement when more than one division is treating a child. DCMHS asserted that treatment decisions should be made based on the needs of children, not based on funding streams, but several presenters felt that treatment decisions had been made based on which division was paying for services, or which division had available placements in particular settings. The testimony further revealed Division disagreements on whether a particular service a child needs is a "placement" or a "treatment." If the service is deemed a "treatment," the disagreement then turns to whether a mental health treatment is needed or if this is simply a "behavioral" issue. There is simply too much work to do and too few financial resources to continue to operate in this fashion.

Currently, in looking at DCMHS and its management of mental health services for children, there are several levels of service. The most restrictive level is inpatient psychiatric facility placement. Delaware has two such facilities, Rockford Center and Dover Behavioral Health. The next level of service is residential treatment centers (RTC). There are 6 RTCs in Delaware, 3 of which are operated directly by DCMHS and 3 that are contracted with local providers. The least restrictive level of service is community-based services.

Resources are stretched thin at the community level – the place where most children are and should be served. The highest-level community-based service is Individual Residential Treatment homes (IRT). Then are a number of community-based services that can be mixed and matched to provide for a child. Those include an aide, IOP, outpatient, school-based therapy, and other similar services. At each community level, and intermittently at the RTC level, there are insufficient services to meet the needs of children in and adopted out of foster care. Further complicating the issue is the fact that while services may be available within the state, they may not be available in the community where a child lives. As such, DCMHS must constantly perform risk assessments to determine which child needs which service or intervention most.

Another possible result of the lack of resources in the child protection system is children being placed in settings that do not meet their mental and behavioral health needs when other, more appropriate placements are unavailable. Such placements often disrupt when foster families or facility staff are unable to effectively handle the issues and behaviors these children display, resulting in multiple moves and transitions in placement for children. One of the most common concerns the Subcommittee heard was the detrimental effect on children of multiple placements.

The number of children being served by the Children's Department continues to grow, while the resources available to serve them do not. The MCO DPCI reported that it saw a 35% increase in the utilization of outpatient services over three months. DCMHS has increased the number of children it serves by 30% over the last six years. As budgets are stretched thin, the mental health system will need to leverage its resources to continue serving children in meaningful ways. As discussed in the prevention section of this report, one such way to do this is through building community capacity to serve and support children and families so they do not end up in the child protection system. Another is through the creative use of the Medicaid 1115 Waiver. Finally, grants and federal funds must continue to be explored by the leadership of DSCYF.

The following recommendations for change are made:

1. DSCYF should review its instilled System of Care principles and partner with CPAC to determine the feasibility of implementing a system where monies are allocated for each child entering DSCYF custody and the money then follows the child.
2. OPEI, in coordination with DSCYF, should aggressively pursue grants and funding opportunities to increase community based mental health services for children in and adopted out of foster care.
3. DSCYF, in conjunction with the state Office of Management and Budget (OMB), should reevaluate the Cost Allocation Plan relative to Appropriated Special Funds (ASF) allocated to the provision of mental and behavioral health services to children so as to maximize funding available for this purpose.
4. The Governor should appoint a Task Force or charge CPAC with:
 - Conducting an analysis similar to the Governor's Task Force on Foster Care to structure the levels of mental health services, conducting an analysis of what resources are available at each level, and developing a plan for the increasing of resources to meet the mental and behavioral health needs of children in and adopted out of foster care;
 - Considering whether the current management and financial structure of DSCYF meets the needs of the children and families it serves as it relates to the delivery of mental health services, and how to improve the delivery of services by DSCYF in the most appropriate, cost efficient, child-driven manner that eliminates disagreements over responsibilities and finances between divisions; and
 - Exploring with DMMA the requirements and flexibilities in the current Medicaid 1115 Waiver.
5. DCMHS should continue funding for an Institute to support evidence-based practices such as the Child Well Being Initiative.
6. DCMHS should obtain additional resources to increase availability of wraparound services.

CURRENT ENVIRONMENT

Mental and behavioral health issues and approaches to ameliorate same are not well understood across our society. The philosophical approach and resultant treatment for mental health and substance abuse, while not well understood, is based in research, federal guidelines, and evidence-based practice. Nonetheless, the child mental health system has developed an environment that often presents challenges to serving children and families. This environment can make it difficult for those inside the system to understand the issues that those outside the system face. This environment is a result of such things as internal policies and procedures, traditional practices, treatment agendas and biases, a limited view of the system, and scarce resources.

One of the cultural aspects of the system that many presenters identified as an area of struggle is levels of service, and the notion that children must fail at lower levels, such as incurring new criminal charges, going into crisis, hurting or threatening to hurt themselves or others, or not complying with current services, before they can obtain additional or higher levels of service. It was felt that the system focuses more on placing children in the least restrictive setting, rather than the most appropriate service. If children deteriorate in the least restrictive setting, they are then moved to a more intense service. However, when they fail, it disrupts their school placements, their foster homes, and other aspects of their lives. Testimony indicated that there is a perception that some DCMHS clinical staff making the decisions about levels of service have little to no real knowledge of the children for whom they are making decisions, generally having never even met them. Moreover, several speakers felt that the criteria for services often exclude children who genuinely need them, and that more flexibility in the system and more responsiveness to the individual needs of children are necessary. Finally, DCMHS residential care options are not always in alignment with DFS residential care options, so changes in levels of care can result in disruption of relationships and services.

Another cultural phenomenon of the child mental health system is that often the trauma these children have experienced causes behavioral issues that keep them from getting the mental health services they need, because certain problems are labeled “behavior issues” as opposed to mental health issues. Being labeled a behavior issue may prevent Medicaid or insurance coverage for treatment, or may prevent anyone from recommending treatment at all. Behaviors that, for example, cause disruption in agency waiting rooms, are not always recognized as stemming from the traumatic experiences a child has had, but are dismissed as merely troublesome behavior.

Community mental health providers, who often provide an array of services to a number of children, may not always be aware of the issues facing others in the larger child serving system. They generally have a thorough understanding of the system and how it works, and may not realize the difficulty others have in finding services and navigating the system. They also may be unaware of the shortcomings in areas of service other than their own.

The following recommendations for change are made:

1. DCMHS and DFS should coordinate levels of care to decrease placement disruptions and ensure appropriate treatment.

2. DSCYF should explore financial restructuring of placements and opportunities for reimbursement outside of Medicaid.
3. DCMHS should restructure its assessment for mental health treatment to take into consideration a child's environment, recognizing that children in foster care have experienced trauma and their behaviors are often a result thereof.
4. DSCYF should utilize OPEI to connect parents with community resources in accordance with the recommendations made in the Prevention section of this report.

Conclusion

While Delaware's mental and behavioral health system for children in and adopted out of foster care can celebrate many successes, it still has many challenges to overcome. The hope of the Subcommittee is for this report to be used as a blueprint for the state to begin addressing some of these challenges through innovative, child-focused solutions. While the recommendations from this report are numerous, with the partnerships of the child protection community, they are not insurmountable.

It is the hope that this report sheds light on the challenges to obtaining mental and behavioral health services for Delaware's children in and adopted out of foster care, and on what can be done to strengthen the mental health system for children to better serve the children and families of Delaware.